Queen Victoria Hospital
NHS Foundation Trust

# Annual Report, Quality Accounts and Financial Accounts

2011/12

# Queen Victoria Hospital NHS Foundation Trust

## Annual Report, Quality Accounts and Financial Accounts 2011/12

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

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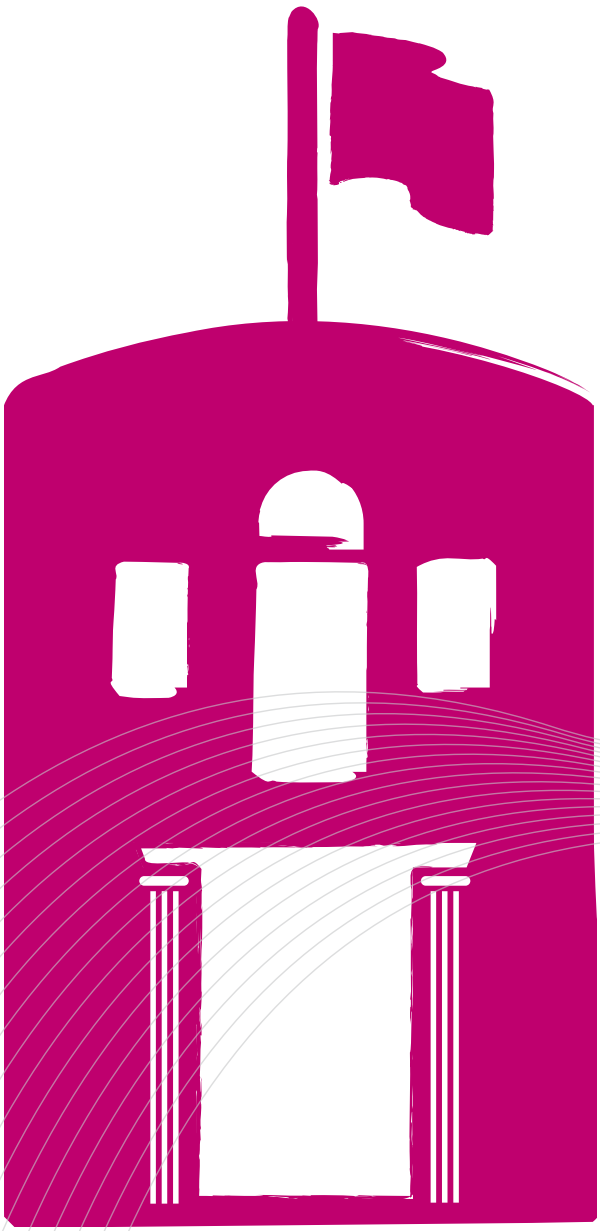
# 1.0 Introductions



# 1.1 Chairman's introduction

## I am pleased to present the 2011/12 annual report for Queen Victoria Hospital NHS Foundation Trust.

Over the past year, QVH has continued to provide its patients with services of the highest standard and has also achieved a number of significant developments that will help secure the hospital's position as the region's specialist centre for reconstructive surgery and care. Many of these developments are the culmination of several years of planning and preparation.

I am delighted that the hospital has this year been able to commence work on the building of six new operating theatres and supporting infrastructure. These new facilities will replace six of our existing theatres which are housed in buildings that are over 50 years old. They will enable us to provide a better experience for our patients, to improve our efficiency, and to reduce the expensive maintenance costs of our old theatres.

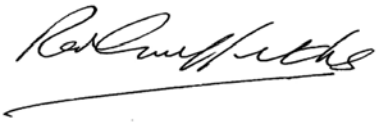
This new building work would not have been possible without the improved financial position the trust has achieved to generate a surplus that fulfils the requirements of our authorisation as a foundation trust. Our strong financial position is the result of the hard work of staff across the hospital to maximise the use of our resources and our programme of systematic improvements to our patient pathways. This streamlining work, which began in 2009, ensures our processes are both as efficient and convenient for patients as possible.

This year has also seen significant change in the personnel governing the trust. Deputy Chairman Hugh Ure retired from the trust board after 11 years and Lester Porter was appointed as a new non-executive director. In addition, 11 new members joined our board of governors following elections in May. In June, a number of governors reached the end of their maximum term, including Bernard Atkinson who served as Vice-Chairman of the Board of Governors. He is succeeded by Ian Stewart who was re-elected this year for a second, three year term as a public governor. Both Hugh and Bernard played important roles in the achievements of the trust and, on behalf of the board, I would like to thank them, and the other public governors who stepped down this year, for their significant contributions to the hospital's on-going success.

Their successors join us at an exciting time. While the hospital ends the year in a strong position, we face a challenging environment. The NHS faces the twin pressures of adapting to new commissioning arrangements and the need to achieve continuous efficiency improvements, all in the context of the most challenging economic circumstances since the inception of the NHS.

We continue to develop our strategy and business plan to adapt to the changing landscape. We are working to develop strong relationships with local commissioners to understand their needs and are promoting our reputation as the provider of choice for both patients and commissioners. With a clear focus on our core specialities and the continued delivery of the highest quality care, we believe that we are well placed to face the future with confidence.

On behalf of the board, I extend my thanks to my director and governor colleagues and to all of the trust's staff for their tremendous efforts and achievements.



**Peter Griffiths**
Chairman
28 May 2012

# 1.2 Chief Executive's introduction

## 2011/12 has been a year of good progress at QVH.

Anyone who has visited the hospital will know that we have an ageing and challenging estate. Our staff have been providing exceptional care in unexceptional buildings for a long time. In the last three years we have steadily improved the site's mechanical and electrical infrastructure. This year construction has commenced on our new operating theatres, due to be ready for use in 2013. Our refurbished paediatric inpatient unit (Peanut Ward), new burns rehabilitation rooms and new outpatients department have all been completed.

We have also made progress in strengthening our focus on our core specialties as the region's centre for reconstructive surgery and expert therapy and rehabilitation.

This year, working with local NHS partners, we ceased providing inpatient medical care from our Jubilee Wards following the development of alternative community healthcare services for local residents. Using the space that has been vacated, we have returned our sleep studies centre to the main hospital site, which will enable it to develop further as befits the most comprehensive service of its kind in the south of England.

We continue to the lead the way in the development and introduction of new techniques and treatments. This year, QVH became the first NHS hospital in the country to offer an innovative new non-invasive procedure for treating Dupuytren's contracture, a common but debilitating hand condition. And we received a major research award from the children's charity Sparks, in conjunction with the Blond McIndoe Research Foundation, to assess new techniques for treating children who have suffered scalds.

Throughout the year, we have maintained the excellent standards of clinical quality, safety and patient experience for which the hospital is renowned. At QVH we combine clinical excellence with a strong culture of personal care for everyone we treat. All the staff at QVH can be proud of the fact that patients continue to tell us that we're getting it right. Results from the 2011 national NHS inpatient survey found that QVH is one of the best hospitals in the country in the eyes of patients, achieving the highest scores of any hospital trust in 27 of the 61 questions asked. We were proud to be identified as the most recommended NHS hospital in the country in the 2011 Dr Foster Hospital Guide. We were equally proud to find that the majority of QVH staff surveyed for the national NHS staff survey would recommend the trust as a place to work or receive treatment.

The high performance of the hospital over the past year is due to the hard work and compassionate approach of our staff, with the help and encouragement of our board, governors, volunteers and our other supporters. It is through their dedication that we have continued to prosper in the face of financial constraints, are delivering on our plans for the future, and are continuing to achieve the highest levels of clinical care and patient satisfaction.

**Dr Adrian Bull**
Chief Executive
28 May 2012

# 2.0 Overview of 2011/12

# 2.1 Our proud achievements

**High quality patient care**

- Our specialist services continue to record excellent clinical outcomes for patients, compared with national and international benchmarks and averages.
- Results from the 2011 national NHS inpatient survey showed that QVH is one of the best hospitals in the country in the eyes of patients. We achieved the highest scores of any hospital trust in 27 of the 61 questions asked.
- In November we were found to be the most recommended NHS hospital in the country according to the independent Dr Foster Hospital Guide. Only two private hospitals received a higher level of recommendation.
- Following the 2011 national staff survey, we were highlighted by the Department of Health, along with three other trusts, as scoring most highly on standards of care, staff motivation and for staff feeling valued by colleagues.
- Our own regular surveys of inpatients show that 99% would be happy to recommend the hospital to their family or friends.
- We received glowing praise from patients following an unannounced inspection of care for older people by the Care Quality Commission (CQC) in April.
- We have achieved 100% of our Commissioning for Quality and Innovation (CQUIN) targets which included:
  - improving responsiveness to the individual needs of patients
  - going further in tackling venous-thromboembolism (VTE)
  - implementing the sit and see project to improve care for our elderly patients
  - improving waiting times in ophthalmology.
- We continue to have a zero tolerance approach to hospital acquired infection and had no cases of Clostridium difficile this year.

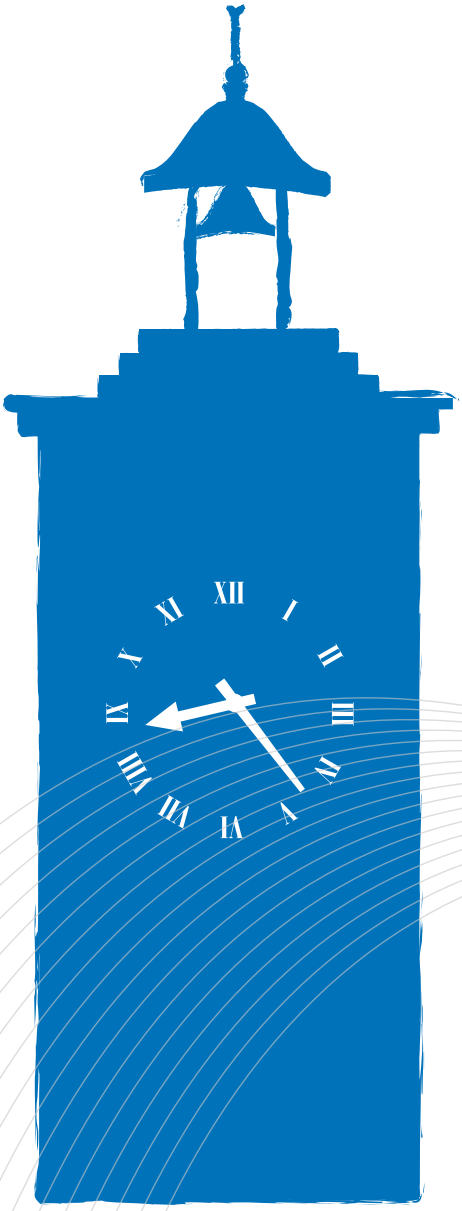
**More patients receiving essential care**

- We provided life-saving and life-changing treatment and care to tens of thousands of people during the last year, including:
  - 18,000 inpatients
  - 166,000 outpatients seen (compared to 148,000 in 2010/11)
  - 2,000 attendances at our minor injuries unit.
- We are also treating patients sooner as we continue to improve the way we run our services:
  - we have halved the average time trauma patients wait before surgery from 18 hours in 2009/10 to 8 hours in 2011/12
  - 89% of trauma patients had their surgery within 24 hours, compared to less than 80% the previous year.

**Financial stability and investment**

- As a result of our continued good work to control costs and be as efficient as possible, we have been able to invest £7m in new equipment and facilities, including:
  - building a brand new outpatients department
  - refurbishing our children's and burns wards
  - significant improvement on our power plant and distribution services
  - preparatory work ahead of building six new operating theatres next year.

# 3.0 Directors report



# 3.1 Directors overview

**Who we are and what we do**

Queen Victoria Hospital (QVH) became an NHS foundation trust in July 2004 under the Health and Social Care (Community Health and Standards) Act 2003. As a foundation trust, we have around 10,000 public members in Kent, Surrey and Sussex.

At QVH we provide specialist reconstructive surgery and expert therapy and rehabilitation services for people across the south of England who have experienced damage or disfigurement as a result of disease (including cancer), trauma, burns, major surgery or a congenital condition. Our leading consultant teams hold clinics at our hospital site in East Grinstead, West Sussex, and at a wide network of other sites across the south east region. In addition, we also provide a minor injuries unit and other services for people living in and around East Grinstead.

The hospital is at the forefront of specialist care in reconstructive surgery and rehabilitation. It is a regional and national centre for maxillofacial, reconstructive plastic and corneoplastic surgery, as well as for the treatment of burns. QVH is a surgical centre for skin cancer and for head and neck cancer; it provides microvascular reconstruction services for breast cancer patients following, or in association with, mastectomy. It belongs to relevant cancer networks and multi-disciplinary teams in Kent, Surrey, and Sussex. As a regional centre, we serve a population of over four million people in the south east as well as those from further afield. We also provide community, medical and rehabilitation services to the local population.

In 2011/12, the principal activities of the trust were the provision of:

- reconstructive surgery (head and neck, maxillofacial, corneoplastic, oculoplastic, general plastic, oncoplastic and trauma)
- rehabilitation therapy
- burns care
- community medical services (outreach therapy services and minor injuries unit).

Reconstructive surgery services are also provided by QVH in facilities at other hospital sites across Kent, Surrey and Sussex – in particular at Surrey and Sussex Hospital, Brighton and Sussex University Hospitals, Medway Hospitals, Darent Valley Hospitals, Maidstone, and East Sussex Hospitals.

In 2011/12, the following individuals served as directors of the trust.

| Name | Position |
|---|---|
| Jeremy Beech | Non-Executive Director |
| Dr Adrian Bull | Chief Executive |
| Peter Griffiths | Chairman |
| Richard Hathaway | Executive Director of Finance and Commerce |
| Dr Renny Leach | Non-Executive Director |
| Mr Ken Lavery | Medical Director |
| Amanda Parker | Executive Director of Nursing and Quality |
| Lester Porter | Non-Executive Director |
| Shena Winning | Non-Executive Director |
| Hugh Ure | Non-Executive Director |

A register of terms of office and meeting attendance of the board of directors is provided in annex E. The biographies of the members of the board of directors are provided in annex F.

**Operational performance**

In 2011/12, QVH has delivered a strong performance in both quality and finance. Building on the improvements in 2010/11, we have continued to improve the efficiency and effectiveness of our services whilst achieving our financial plan.

The hospital has achieved the national and local performance targets it has been set. There were two cases of MRSA infection during the year, against a target limit of one. This, however, is below the de minimis number of six cases set by Monitor.

A detailed analysis of the trust's performance against national targets is provided at annex B on page 87.

We have continued to achieve high levels of satisfaction among patients. In both our own patient surveys and in the national surveys, we score highly on all measures. In particular, over 90% of patients continue to say that they would recommend the hospital as a place of treatment for family and friends. Complaints remain at a low level and letters of compliment on the care experienced by patients are regularly received. In addition, QVH was assessed by Dr Foster as the most highly recommended NHS hospital in England, and the mid-year detailed inspection on compassion and nutrition by the Care Quality Commission resulted in a number of commendations on the exemplary quality of care provided at the hospital.

In September last year, after a long period of declining demand for the wards' services, the second Jubilee Ward for medical patients was closed with the agreement of the relevant commissioners. Alternative arrangements for patients in need of such care have been made locally. The hospital

continues to provide medical outpatients services for elderly patients, along with physiotherapy, speech therapy, and rehabilitation services for the local community. Following the closure of the medical ward, the Sleep Studies Centre, which for some years has been provided off site, was relocated to the Jubilee Centre. This has allowed further development of that centre, as befits the most comprehensive sleep studies service in the South of England.

Referrals to QVH remained relatively static in 2011/12, after a decline in 2010/11. However, there has been a decline in referrals into services at Dartford and Medway, predominantly into the maxillofacial services where NHS Kent have set up an intermediate and minor oral surgery pathway that triages referrals from dental practitioners and offers more minor oral surgery within the community.

Despite the decline in referrals, additions to waiting lists have remained static over the year suggesting that the referrals no longer received were not patients requiring surgery.

Significant steps have been taken during the year towards addressing the key issue of the hospital's infrastructure and estates. A major electrical upgrade of main distribution circuits was completed early in the financial year. Work has commenced to relocate a number of departments, including outpatients 2 and corneoplastics, into new premises in preparation for the new theatre block, which will replace six of the hospital's existing theatres. This programme of work is well under way, with an expectation that the new theatres will be open in the summer of 2013. The hospital's children's ward (Peanut Ward) has been refurbished, and two new rehabilitation rooms for burns patients have also been opened.

### Financial performance

QVH delivered a strong financial performance in 2011/12, achieving a surplus of £2.9m before impairments and transformation costs.

QVH incurred a further £0.5m costs in 2011/12 relating to the second phase of its staff restructuring and other change costs. The trust also reduced the carrying asset value of certain developments completed in year following the Valuation Office assessment at year end. The asset values were reduced by £1.765m which in turn reduces the reported surplus for the year. In accordance with the agreed treatment with Monitor, these costs are also excluded from the financial risk rating calculation. QVH achieved an overall financial risk rating of 5 (5 being the lowest level of financial risk attainable under Monitor's compliance framework).

The business plan again identified a savings requirement of £2.1m, in line with national efficiency requirements, as well as improved operational efficiency in order to deliver its targets. These targets were achieved in the year.

| All figures in £m | Actual 2011/12* | Restated actual 2010/11 (see note) |
|---|---|---|
| Operating income | 55.9 | 56.6 |
| Pay | (35.8) | (36.2) |
| Non-pay costs excluding impairments | (16.3) | (17.1) |
| Interest and dividend | (0.9) | (0.8) |
| Surplus before impairments and transformation costs | 2.9 | 2.5 |
| Impairments | (1.7) | (3.5) |
| Transformation costs | (0.5) | (0.7) |
| Surplus / (deficit) | 0.7 | (1.7) |
| Cash balance | 6.0 | 7.0 |
| Financial risk rating at Q4 | 5 | 5 |

*Figures subject to rounding
Note: During 2011/12 a national exercise to reflect the impact of accounting changes to the treatment of donated assets and deferred income has been undertaken. This has resulted in the comparative figures for 2010/11 in the accounts being restated. The above table reflects the restated 2010/11 position.

### Income

Overall income has fallen as expected in 2011/12. This follows the reduction in the national tariff, which means trusts generally receive less income for each patient treated than in 2010/11, coupled with the NHS strategy of treating fewer patients in hospital and more in community settings.

The change in accounting for donated assets means that these are now treated as income in the year of receipt, which has the appearance of increasing operating income.

QVH continued to treat a relatively small number of private patients and remained within its private patient income cap for the year.

Despite the healthy cash balances held, interest income remained low at just £16,000 given the low national interest rate levels.

### Expenditure

The trust achieved savings in both pay and non-pay expenditure in year. Further streamlining of management functions was carried out in May 2011 which reduced posts. The loss making Jubilee service also closed during the year and contributed to the savings from November 2011.

Non-pay costs also fell, partly reflecting reduced activity levels but also further procurement savings from the renegotiation of contracts for the supply of goods and services. However, continuing high levels of inflation offset some of the savings achieved. Further reductions in depreciation charges also contributed to the overall reduction.

**Cash**

The cash position remains reasonably strong with £6m at year end. The trust has significantly improved in creditor payment performance in year and has improved its overall debtor position. A significant investment in fixed assets has begun with several projects (such as the rebuilding of the paediatric ward) being completed and the approval of the business case to construct six new operating theatres (which has now commenced). The trust is borrowing £10.1m from the Foundation Trust Financing Facility to fund the theatre construction and has drawn down the first £1m of the loan in March 2012.

## 3.2 Regulatory ratings

The trust reports to Monitor on a quarterly basis and its 2011/12 ratings are summarised below.

| | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Finance | 4 | 5 | 5 | 5 |
| Governance | Green | Green | Green | Amber-Green |

QVH has met the key performance measures for waiting times for 2011/12 as required by national standards and the Monitor compliance framework, except for achieving the 18 week waiting time target in March 2012.

QVH also remained within its limit for cases of Clostridium difficile for the year. The trust exceeded the maximum allowable cases of MRSA, having two cases against a target of one, but these are below the de minimis threshold applied by Monitor and therefore did not count against the governance rating.

QVH is registered with the Care Quality Commission (CQC) and is licensed to deliver specified services at one location; the QVH site. During 2012, the Sleep Studies location was removed as the service was relocated to the main hospital site.

CQC provide us with a quality and risk profile to inform our quality and safety activity and help ensure compliance with essential standards. The most recent profile shows 'green' for six outcomes and 'low neutral' for five, with no outcomes rated 'amber' or 'red'. For five outcomes, there was insufficient data to calculate a risk estimate.

## 3.3 Patient care

Our staff focus on delivering safe and effective care, coupled with an excellent patient experience.

During the year, we have strengthened our core specialist services. In 2010/11, we reported that the model of care and the number of beds within the Jubilee Centre, which delivers medical rehabilitation and care for local people, had been reduced due to a lack of patient demand. This reduced demand continued during 2011/12 and, following joint working with the primary care trust and local partners, a new model of community based care was developed. This enables patients to either remain at home or have their care delivered within a nursing home and, as a result, the Jubilee Centre beds were closed in September 2011.

Additional services invested in during 2011/12 include the development of the new Xiapex treatment for patients suffering with Dupytren's contracture, preventing the need for surgery, additional consultant posts to support the development of the major trauma unit at Brighton and major head and neck cancer services. We are also increasingly offering more immediate breast reconstructions for women with cancer across the south.

In addition to services, we have also invested in a number of technologies to improve the administration of patient pathways, including electronic discharge notifications, self check in kiosks in outpatients and automated letter printing. 2011/12 also saw the opening of the Macmillan Information Centre which provides support to QVH patients affected by cancer and the local community around East Grinstead.

We constantly review the quality of care that we deliver through national and local surveys, reviewing comments on care on the NHS Choices website and reviewing complaints and Patient Advice and Liaison Service (PALS) activity.

This year we have also begun proactively evaluating how caring and compassionate our staff are when delivering care to patients through the Care and Compassion (Sit and See) project. This takes key indicators of good fundamental practice and uses them as vital signs to measure care, kindness and compassion for elderly and vulnerable patients. The tool was developed to support a more person-centred (rather than institutionalised) approach to patient care and as a result of national concern at the recurring theme of neglect in investigations of care for elderly patients in the NHS as a whole. For QVH this project has been one of our Contracting for Quality and Innovation (CQUIN) measures for 2011/12 and senior nurses have supported the project with enthusiasm.

The audit department supports the monitoring of care quality and many of the audit outcomes are expanded on within our quality accounts. In addition, they support the trust in ensuring that National Institute for Health and Clinical Excellence (NICE) guidance is reviewed. Where guidance is found to be relevant to the organisation, they ensure audit work is in place to demonstrate compliance.

We maintain a zero tolerance approach to hospital acquired infections. Adherence to good infection prevention and control practice has remained high on our agenda during 2011/12. All departments have reported monthly on compliance with hand hygiene, staff being bare below the elbows when in clinical areas and MRSA screening. In addition, routine audit has taken place to monitor compliance with the Health & Social Care Act 2008.

During the year we have had no cases of Clostridium difficile. The trust experienced two unconnected cases of MRSA bacteraemia in 2011/12. Both cases occurred in patients with extensive skin loss following burns. Infections such as MRSA bacteraemia are not an uncommon occurrence in patients with such injuries. The infection did not cause significant clinical problems for the treatment of either patient.

All other national targets were achieved during 2011/12 (see annex B).

Targets agreed with local commissioners were all linked to our CQUIN programme. These were to:

- **Improve responsiveness to the personal needs of patients.** This measure is a composite score of five patient experience questions in the national NHS inpatient survey. In 2010, we achieved a score of 82.6% and in 2011 we achieved 85%, compared the 2011 national average of 67%. This work was supplemented with surveys carried out by governors in our outpatient departments which confirmed that we are providing outpatients with a good experience. This is a national CQUIN.
- **Reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE).** During 2010/11, in excess of 90% of QVH inpatients were risk assessed for VTE. All patients identified as being at risk are given appropriate preventative treatment to avoid this complication during surgery. In 2011/12, we aimed to risk assess more than 90% of inpatients and to have recorded completion of each assessment electronically by Q4. At the end of March 2012, we had achieved 90.8%. This is a national CQUIN.
- **Implement the Sit and See project.** This takes key indicators of good fundamental practice and uses them as vital signs to measure care, kindness and compassion. We were targeted to introduce the Sit and See tool and to then evaluate five areas per quarter, looking into the care patients receive. This has been completed as required.
- **Improve the patient experience in ophthalmology.** This was linked to three measures looking at waiting times for tests and for new and follow-up patients. For all of these, 100% of patients were seen within the target times by the end of 2011/12.

For all these measures, we have regularly audited care and introduced actions to ensure that the services and experience of patients is improved.

QVH is required to register with the Care Quality Commission (CQC) and is currently registered to provide the following services: blood and transplant, hospital, and rehabilitation (illness or injury). QVH has no conditions on registration and CQC has not taken any enforcement action against QVH during 2011/12. QVH is subject to periodic reviews by CQC and the last review was on 29 July 2011. The CQC's assessment of QVH following that review was that on inspection all standards are being met in respect of:

- treating people with respect and involving them in their care
- providing care, treatment and support which meets people's needs
- caring for people safely and protecting them from harm
- staffing
- management.

Results from the 2011 national NHS inpatient survey show that QVH achieved the highest scores out of all 161 hospital trusts in England for 27 of the 61 questions patients were asked. QVH scored better than average on 47 of the questions and about the same as average on the remaining 14. The annual survey of patients at all hospital trusts in England covers all aspects of patients' care and treatment, including the way they were treated by doctors and nurses, the information they were given and their views on cleanliness, comfort and quality of food. The findings help the NHS to improve the way it cares for and treats patients, enabling hospital trusts to see how they are doing year-on-year and how they compare with others. QVH scored particularly well on questions about the hospital's doctors and nurses and the quality of care and treatment.

Results from the 2011 national outpatient survey shows that, of the 39 questions asked of our patients, we were in the top 20% of trusts for 29 and scored about the same as average for the remaining 10 questions. As with the inpatient survey, we scored particularly highly on the quality of care received from doctors and other professionals, with one of the highest scores of any trust for 'Did you have confidence in the doctor examining and treating you?'

However, these achievements do not make us complacent and our quality account priorities for 2012/13 include actions to further improve the experience of patients when they are waiting and our communications with them.

### Research and development

Research is a vital part of life at QVH. We carry out research into all the specialties provided at QVH. We consider all aspects of the journey back to health to be essential for our research portfolio and our projects extend from the laboratory to the psychology of recovery.

We are fortunate to have the world renowned Blond McIndoe Research Foundation (BMRF) within the grounds of the hospital whose scientists collaborate closely with QVH staff. We have close ties with other leaders in associated fields of research including Brighton and Sussex Medical School, the University of Brighton and Imperial College. We also work closely with other academic institutions and industrial partners both nationally and internationally.

Our aim is to not only improve outcomes for our own patients but also to benefit patients throughout the world. Our staff have the skills, knowledge and determination to achieve this aim.

In 2011/12 our busy research programme included the following significant developments:

- We devoted considerable effort to attracting external funding to the research programme. The Anaesthetics Department, with a team led by Dr Julian Giles, submitted and won a prestigious National Institute for Health Research (NIHR) award for £79,688, for a study of non site-specific pain. The same team has also prepared to bid for support to investigate remote ischemic preconditioning.
- In collaboration with the BMRF, the trust was awarded a grant by the charity Sparks for £211,402 to carry out a study of the use of sprayed cells on paediatric burns. The grant will support the full-time salary of a PhD researcher.
- The trust's clinical lead for burns, Mr Baljit Dheansa, secured a grant award from the Burns Network of £51,489 to run a project looking at returns to work following burn injury. This will be carried out in collaboration with the University of Sussex.

**Complaints handling**

Complaints are an important source of information about how patients view the services and care we provide. Information from complaints is used to inform training programmes and this can provide a powerful learning experience for all grades of staff. Following complex complaints, formal action plans are used, where required, with responsibility for monitoring progress held within the corporate affairs and quality and risk departments. Monthly reports are provided to the clinical cabinet and the board of directors and quarterly reports are provided to the quality and risk committee and board of governors.

The board of directors has corporate responsibility for quality and care and the management and monitoring of complaints. The chief executive, as the accountable officer, delegates responsibility for the day-to-day management of complaints to the PALS and complaints manager, who ensures that:

- Formal complaints are fully investigated with comprehensive written responses provided from the chief executive or his deputy
- Conciliation meetings with the complainant are arranged where appropriate
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible
- We are open and cooperative when complainants request a review at a higher level (i.e. Parliamentary and Health Service Ombudsman).

The director of nursing and quality has responsibility at board level for all complaints and holds monthly complaint review meetings with the chief executive, head of corporate affairs and the PALS and complaints manager. The group review the management of complaints received, emerging trends and the actions arising.

QVH will always attempt to resolve complaints locally wherever possible, using written responses, informal meetings and more formal conciliation meetings as appropriate. All complainants are offered the opportunity of a conciliation meeting. If a complainant remains unhappy with the outcome of the trust's investigation, they can ask the Parliamentary and Health Service Ombudsman to investigate.

A full patient experience annual report for 2011/12, which incorporates data and information about complaints, patient advice and liaison contacts, compliments and other patient experience feedback and activities, is available on our website.

## 3.4 Staff engagement

QVH works in partnership with local trade union representatives to consult with staff and communicate changes, service developments, events, news and achievements.

There are two official consultation forums:

- the Joint Consultative and Negotiating Committee which is made up of trade union and management representatives; and
- the Local Negotiating Committee which is made up of management and medical staff representatives and a British Medical Association representative.

There are a number of communication forums within the trust, including monthly team briefings, briefings and 'walk-arounds' by the chief executive, the internal staff newsletter and an intranet site.

Following each annual staff survey, action plans are produced to address any areas of concern highlighted by the responses. In 2011, we also identified issues that were raised both in the survey and through a series of 'culture and values' focus groups. A response was developed and implemented for each issue and publicised on the intranet and through the internal staff newsletter.

During 2011/12, we developed the second phase of our project on organisational culture and values. This involved unveiling the values chosen by staff (they are 'continuous improvement of care', 'humanity' and 'pride', in addition to the previously agreed 'quality') and was followed by staff working in their teams and departments to explore the behaviours they felt would demonstrate the values being met.

**2011 staff survey**

QVH scored very well in the national survey of NHS staff, comparing favourably with other acute specialist trusts and making some improvements on our very high scores from the 2010 survey.

One of the most important measures is the overall indicator of staff engagement. This is calculated by combining several key findings around ability to contribute to improvements, motivation, and how highly staff would recommend the trust.

QVH scored 3.88 out of 5, an increase on last year's 3.84 and above the 3.77 average for acute specialist trusts.

QVH compared favourably with other acute specialist trusts. To help us make sense of our results, our scores are compared with those of other specialist trusts rather than general acute trusts because specialist trusts tend to score more highly on many of the survey questions.

There are 38 'key findings' in the survey. On half of them we scored better than the specialist trust average this year and improved significantly on our comparison with these trusts last year.

| | 2010 survey | 2011 survey |
|---|---|---|
| QVH better than specialist trust average | 12 | 19 |
| QVH about the same as specialist trust average | 16 | 17 |
| QVH worse than specialist trust average | 10 | 2 |

Some of the areas where we scored better than average include:

- staff feeling satisfied with the quality of work and patient care they are able to deliver (84%)
- staff motivation (3.88/5)
- recommendation of the trust as a place to work or receive treatment (4.01/5)
- good communication between senior management and staff (38%)
- effective team working (3.79/5)
- perceived fairness and effectiveness of incident reporting procedures (3.61/5)

Our four highest scores were:

- trust commitment to work life balance (3.56/5)
- percentage of staff experiencing physical violence from patients, relatives or the public (1%)
- percentage of staff experiencing discrimination (7%)
- perceptions of effective action from trust towards violence and harassment (3.81/5 which was the top score of all specialist trusts).

The two areas where we scored worse than average were:

- percentage of staff suffering work-related injury (15% - although a slight improvement on 17% in 2010)
- percentage feeling pressure to attend work when unwell (26%).

Our four lowest scores included the two worse than average scores above along with:

- percentage of staff reporting errors, near misses or incidents (96% - the same as the national average)
- percentage of staff working extra hours (67% - the same as the national average).

Measures to address these areas will be part of an action plan to improve performance across the trust. In addition, although 38% of staff reporting good communication between senior management and staff is a significantly better score than average, we would like it to be higher and will work further on this.

On three of the 38 key findings we improved significantly on last year's scores; for the remaining 35 we remained about the same. The three areas where we improved significantly were:

- work pressure felt by staff (2.9/5)
- percentage of staff receiving health and safety training (85%)
- percentage of staff having equality and diversity training (59%).

The percentage of staff receiving health and safety training was a weak score in the previous year's survey and action to address this was part of the resulting action plan. It is pleasing to note that these action plans are effective in improving performance.

## 3.5 Stakeholder relations

Because QVH provides burns and reconstructive surgery for a population of some 4 million people across Kent, Surrey and Sussex, many individuals, communities and organisations have an interest in the organisation.

With the implementation of the Health and Social Care Act 2012, the structure of stakeholder organisations in both local government and the health service is changing. Health oversight and scrutiny committees will develop into the new health and wellbeing boards, which will include local government and health service representation. Primary care trusts, now clustered, are sponsoring the development of clinical commissioning groups, which will take over their commissioning function. Clinical networks, in addition to the cancer networks which are already formally established, are being developed. Specialist commissioning (which covers the burns services at QVH) is being re-designed as it is incorporated into the new national NHS Commissioning Board.

The biggest test for QVH is that its services are spread thinly across these organisations in the three counties. As a result, the impact of QVH services is less material in each case than that of other general and local hospitals, which can mean that attention to QVH issues is less than it might be; at the same time, the ability of QVH to contribute to the debates and service reviews in each area is constrained by time and

geography. QVH, for example, must contribute to the three cancer networks that cover the three counties - at board level, at multidisciplinary teams, and at diagnosis orientated groups. This places significant demands on both executive and clinical staff. This spread carries a significant risk for the organisation of unintended consequences from decisions made about health care services when those decisions do not take QVH into account.

In order to continue to provide the hospital's tertiary specialist services that are unique in the south east, the hospital must also be able to continue providing the more common and routine procedures in each of its speciality disciplines. It is these which provide the clinical and financial sustainability that allows the complex treatment of rare and occasional problems. In this, the continued support of commissioners, GPs in the surrounding area and patients who choose to come to QVH, or to its services at other hospitals, are essential.

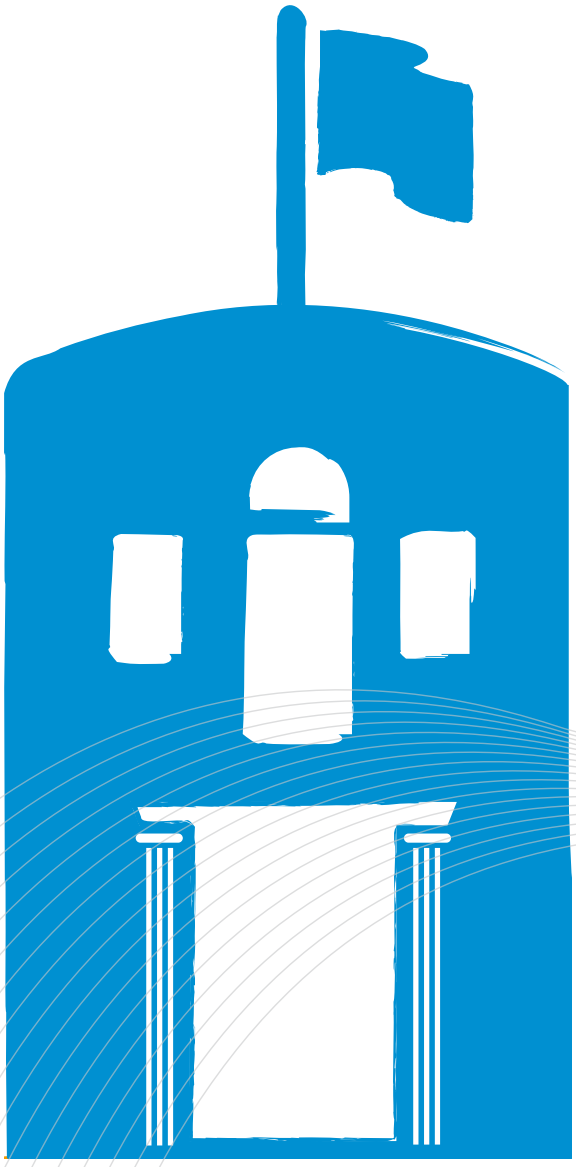
QVH works closely with district general and teaching hospitals across the three counties, providing tertiary support in the management of patients with complex soft tissue damage, corneal, or maxillofacial surgical needs. To ensure access to its specialist services, these relationships at both clinical and corporate levels are crucial. QVH works to ensure that it provides services which are complementary to and supportive of the services provided locally by these partner hospitals, while seeking to ensure development of these services in similarly complementary fashion.

The hospital continues to value highly the support and encouragement of its local population and East Grinstead Town Council. The hospital is fortunate to have a strong body of members and governors, a willing body of volunteers, and a supportive league of friends.

## 3.6 Directors' disclosures and other disclosures in the public interest

The remaining directors' disclosures and a range of other disclosures in the public interest are provided in full in annex G on page 94.

# 4.0 Governance report



The following sections set out the trust's governance arrangements, giving details of the ways in which the boards work separately and together to provide cohesive and robust governance arrangements. Directors are responsible for setting the trust's strategic direction, providing effective leadership within the external regulatory and internal control frameworks, and exercising the powers and performance of the trust. Functions and duties are delegated to management in line with the trust's scheme of delegation. Directors have a responsibility to take account of governors' views in terms of the trust's forward planning. The board of governors has clear statutory duties and also actively contributes to the trust's strategic planning and in holding the board of directors to account.

## 4.1 Board of governors

The board of governors comprises 20 public governors, three staff governors and four stakeholder governors who represent key organisations that the trust works closely with: the QVH League of Friends, East Grinstead Town Council, NHS commissioners and the local authority. Due to staff reconfiguration in the latter two organisations, we have been carrying vacancies to these posts since October 2011.

The board of governors usually holds four meetings in public each year, which trust members are encouraged to attend. Where possible, these meetings are also attended by all members of the board of directors. This allows further interaction between the non-executive directors and governors and enables the board of directors to brief governors on matters they should be aware of. This is delivered through a regular report from the board of directors, presented by the chief executive, and additional reports including infection control, patient experience and staff issues and development. This year, the board of governors received presentations from lead clinicians on breast surgery, skin cancer, burns and clinical outcomes.

**Membership**

2011 was the seventh anniversary of trust's authorisation as a foundation trust and the constitution stipulates a maximum seven year term of office for governors. Six public governors reached the end of their maximum term in June 2011. In addition, seven others were eligible for re-election. Following a review of the constitution, in consultation with the board of directors and board of governors, the number of public governor places was reduced from 24 to 20 in anticipation of this and other constitutional amendments being approved by the foundation trust regulator Monitor. Subsequently, submission of the revised constitution was deferred to allow time to incorporate changes brought about by the health service reforms.

The election for 14 public governor and two staff governor positions was undertaken on our behalf by Electoral Reform Services during April and May 2011, in readiness for new governors to commence their duties from 1 July 2011. In preparation for recruiting such a large number of new governors, the trust held three open events where members were encouraged to come and meet current governors, along with members of the executive team, in order to fully understand the role. As a result, 22 candidates stood for public election. An 18.6% turnout for the public election resulted in three re-elections and 11 new members joining the six continuing governors.

Three staff members stood for election and two staff governors were re-elected for a further term.

Norman Webster, Leader of the Council, replaced Chris Rolley as the appointed governor for East Grinstead Town Council and joined the board in July 2011.

A full list of governors who were in post during 2011/12 can be found in annex D on page 90, along with their terms of office and attendance at formal meetings.

**Roles and responsibilities**

In order for the board of governors to conduct its business efficiently, there are two sub-committees. These allow smaller groups of governors to discuss matters in more detail and make recommendations to the full board at their formal meetings which are held in public.

The governor steering group, chaired by public governor John Bowers, met monthly to review the regular finance and performance reports of the board of directors and to discuss governor business. These meetings were attended regularly by the chief executive, chairman and a non-executive director in order for governors to be briefed about trust activities and to discuss any concerns they may have. The minutes from these meetings are shared with the full board of governors.

The appointments committee, chaired by public governor Valerie King, makes recommendations to the full board of governors regarding the remuneration and appointment of the chairman and non-executive directors, in addition to reviewing protocols, role descriptions and appraisal processes. In 2011/12, the committee focused its attention on detailed succession planning for the future replacement of the chairman and non-executive directors to ensure a smooth transition for the trust and maintain a strong and balanced board of directors.

The individual positions of vice-chairman (of the board of governors) and governor representative were combined this year and Ian Stewart, supported by the board of governors, took on the role in July 2011. He represented the board of governors at the full board of director meetings (in a non-voting capacity) and reported back to the governor steering group at their monthly meetings and to the wider board of governors via the 'governors' monthly update' and through his report at formal meetings.

In addition to the sub-committees of the board of governors, governors are invited to join various committees and groups across the organisation. This enables governors to see the work of the management teams and non-executive directors and also ensures the 'lay' view is considered and incorporated in management decisions where appropriate. These committees include: quality and risk; audit; patient experience; theatre project steering group; and equality, diversity and human rights.

Members may contact governors and request to view the register of governors' interests by contacting the company secretary.

## 4.2 Board of directors

### Membership and compliance

At 31 March 2012, the QVH board of directors comprises a chairman, four non-executive directors and four executive directors. There are no vacancies and the board has not carried vacancies during the course of the year. The trust believes the board of directors to be complete, appropriate and compliant with the provisions of the *NHS Foundation Trust Code of Governance* and its own terms of authorisation.

### Non-executive directors

Paragraph 9.4 of the trust's constitution sets out the process for selection and appointment of non-executive directors (NEDs). All NED appointments are subject to the approval of the board of governors and are for an initial term of three years, which can be renewed for a further term subject to satisfactory performance appraisal. Paragraph 9.10 of the constitution sets out the circumstances that disqualify a person from becoming or continuing as a NED. In addition, should a NED not receive a satisfactory performance appraisal and prove unwilling or unable to address the issues raised, their appointment can be terminated with the approval of the board of governors.

In September 2011, independent director Hugh Ure came to the end of his term as a non-executive director after six years (11 years in total including service prior to the trust being authorised as a foundation trust). Lester Porter was appointed to the position in the same month, following a recruitment process that took place in 2010/11. The vacancy to which Mr Porter had applied, and had been the preferred candidate for, had become obsolete with the removal of an executive post from the board. Mr Porter's appointment to the vacancy left by Mr Ure was recommended by the appointments committee to the full board of governors at a meeting, held in private on 12 April 2011, and was approved.

During 2011, the appointments committee of the board of governors, which has responsibility for the appointment, remuneration and terms of non-executive directors, reviewed the terms of office of the chairman and non-executive directors as part of a succession planning process. After due consideration, the appointments committee recommended to the board of governors that the terms of office of Peter Griffiths, Jeremy Beech, and Shena Winning be extended by one year and that of Renny Leach be extended by two years. At the conclusion of these extended terms, each non-executive would have completed eight years' service in the role. The appointments committee and board of governors' considerations included the independence of each non-executive director having served on the board for more than six years from the date of their first appointment. On balance, the board of governors considered the plan appropriate and approved it. Each of the relevant non-executive directors accepted an extension to the terms of their contract. Information about terms of office and full details of the membership of the board throughout the year is set out in annex E on page 91.

### Relationship with governors and members

The board of directors maintains close links with the board of governors through various mechanisms, including a governor representative's attendance at every board of directors meeting, directors' attendance at each board of governors meeting, and directors' attendance on a regular basis at governor steering group meetings and governor forum meetings. This allows directors and governors to freely and regularly exchange views and information on matters of importance and topical interest. Governors represent members' views to directors, to ensure these are taken into account in terms of forward planning.

### Interests

A register of directors' interests is kept by the trust and is available on request to the company secretary.

### Meetings

All meetings of the board of directors in 2011/12 were held in private and attended by the governor representative, programme director, head of HR and company secretary.

### Evaluation

The board reviews its own performance and that of its sub-committees on an annual self-assessment basis. A review, lead by the chairman, was in progress as at 31 March 2011. In addition, both executive and non-executive directors are subject to annual performance appraisal.

### Sub-committees

There are four formal sub-committees of the board:

- Audit committee
- Charitable funds advisory committee
- Nomination and remuneration committee
- Quality and risk committee.

The audit committee and nomination and remuneration committee membership comprises solely non-executive directors. The quality and risk committee membership comprises both executive and non-executive directors.

A table setting out the members of the board throughout 2011/12 and their membership of, role in and attendance of each of the three sub-committees is provided in annex E on page 91.

## 4.3 Audit committee

The audit committee meets quarterly to maintain an effective system of governance, risk management and internal control (including financial, clinical, operational and compliance controls and risk management systems). The committee is also responsible for maintaining an appropriate relationship with the trust's auditors.

### Membership and attendance

Provision F3.1 of the *NHS Foundation Trust Code of Conduct* recommends that the audit committee comprises three non-executive directors. However, given the size of the trust, the QVH audit committee comprises two independent non-executive directors.

The audit committee is chaired by non-executive director Shena Winning who is a chartered accountant with over 20 years' experience within the retail sector.

In September 2011, Hugh Ure retired as a non-executive director. His place on the audit committee was taken by Renny Leach. Full details of the membership and attendance of the audit committee meetings held during 2011/12 is provided in annex E on page 91.

In 2011 the trust undertook a full market review of external audit provision. Following a competitive procurement process, KPMG replaced PWC as the trust's external auditors from 2011/12. The trust would like to thank PWC for their services during their time as the trust's auditors.

### How the committee discharges its responsibilities

The prime purpose of the audit committee is the scrutiny of the establishment and maintenance of an effective system of governance, risk management and internal control. This should include financial, clinical, operational and compliance controls and risk management systems. The committee is also responsible for maintaining an appropriate relationship with the trust's auditors.

During the year, the committee received reports from the trusts internal and external auditors that provided the committee with a review of the trust's internal controls and risk management systems. The internal auditors were able to report full or significant assurance for 84% of the areas reviewed, resulting in a head of internal audit opinion of 'significant' assurance.

The audit committee meets four times a year and its meetings are attended by the trust's director of finance and commerce and has representation from the trust in respect of risk management, the external and internal auditors and local counter fraud service. At the beginning of every audit committee meeting, there is a closed session between the chair of the audit committee and committee members with the internal and external auditors.

In performing any work outside their statutory role, the external auditors took all necessary steps to ensure they maintained their independence from the trust. In 2011/12, PWC completed a limited review of contractual arrangements in regard to private patient activity. The contract sum was not material and the work was undertaken by a separately managed team within PWC.

### Counter fraud

In 2011/12, QVH appointed Chantrey Vellacott as providers of the trust's local counter fraud specialist (LCFS) service. An annual work plan was agreed with the LCFS and delivery was overseen by the audit committee. Our counter fraud policies and procedures are widely publicised and covered at induction for new staff.

## 4.4 Charitable funds advisory committee

The charitable funds advisory committee (CFAC) meets quarterly to oversee the management, investment and disbursement of the Queen Victoria Hospital (QVH) NHS Foundation Trust Charitable Fund within the regulations provided by the Charities Commission and to ensure statutory compliance. It manages the income and expenditure of a suite of general funds and supervises the expenditure and income of a suite of directorate funds. It makes recommendations to and acts on behalf of the board of directors as corporate trustee of the charitable funds.

### Membership

The CFAC is chaired by Renny Leach, non-executive director and senior independent director. Other members include non-executive director Shena Winning and the director of finance and commerce. Two representatives of the board of governors also attend meetings of the CFAC.

Full details of the membership and attendance of the CFAC meetings held during 2011/12 is provided in annex E on page 91.

## 4.5 Nomination and remuneration committee

The nomination and remuneration committee meets at least three times a year to review and make recommendations to the board of directors on the composition, balance, skill mix and succession planning of the board and recommendations on the appointment of executive directors. It is also responsible for setting the overall policy for the remuneration of all trust staff and it specifically authorises the remuneration packages and contractual terms for the chief executive, the executive directors and other senior managers who report directly to the chief executive.

**Membership**

Hugh Ure, deputy chairman of the trust and senior independent director, was chairman of the nomination and remuneration committee until he left the trust on 30 September 2011. He was replaced as chairman of the committee by the trust board chairman, Peter Griffiths.

The chief executive and all non-executive directors are members of the committee. The head of human resources is secretary and adviser to the committee and the head of corporate affairs attends meetings as adviser to the committee.

Full details of the membership and attendance of the nomination and remuneration committee meetings held during 2011/12 is provided in annex E on page 91.

**Activities**

During 2011/12 the committee pursued its agreed rolling work programme. The committee made decisions or recommendations on the following issues:

- review of its terms of reference
- national pay award
- leadership programme
- W Hutton report on pay
- J Hutton report on pension reforms
- performance of the direct reports of the chief executive
- performance of the chief executive
- aligned appointments process
- culture and values project
- equal pay
- salary benchmarking
- succession planning for executive and non executive directors
- work plan for 2011/12.

The broad aim of the trust's remuneration policy is to set remuneration levels in order to attract and retain skilled and talented staff throughout the trust. In doing this, the committee takes account of current NHS practice, as well as considering wider commercial practice. The majority of staff in the trust are covered by the national Agenda for Change terms and conditions. The chief executive, executive directors and other very senior managers are covered by local senior manager terms and conditions. Doctors in the trust are covered by the national medical and dental terms and conditions.

Pay and terms for executive directors was not altered during 2011/12.

In line with the requirements of the NHS Foundation Trust Code of Governance, the executive directors' performance was monitored and reviewed against trust and individual objectives through the appraisal process, both informally and formally.

The contracts are permanent and substantive and all have a three month notice period with the exception of the chief executive, who has a six month notice period. There are no specific clauses regarding compensation and early termination.

The board of governors, on the recommendation of the appointments committee, determines the remuneration and appointment of the trust's chairman and the non-executive directors. Valerie King, a publicly elected governor, is chairman of the appointments committee. Other members are drawn from public governors, stakeholder and staff governors.

The salary details of the trust's chairman, executive and non-executive directors are set out in annex C on page 88. There have been no compensatory agreements during 2011/12.

**Executive directors who served in 2011/12**

The following executive directors served in 2011/12:

- Adrian Bull, Chief Executive
- Ken Lavery, Medical Director
- Richard Hathaway, Director of Finance and Commerce
- Amanda Parker, Director of Nursing and Quality.

## 4.6 Quality and risk committee

The quality and risk committee meets quarterly to assure the board that all reasonable steps are being taken to manage risk and drive continuous improvement in quality and patient safety. On behalf of the board of directors, the committee ensures there is a sound system of risk management in place, with appropriate delegation of the operational management of risk to key committees and directorates. The committee uses an assurance framework to provide the board with assurance that the trust has arrangements in place that are linked to the delivery of the key strategic objectives. It monitors compliance with relevant regulatory standards, in particular those of the Care Quality Commission and those associated with hygiene and infection control.

The committee also reviews and monitors progress against the QVH quality accounts.

### Membership

Jeremy Beech, non-executive director, is chair of the quality and risk committee. Non-executive director Renny Leach was replaced by Lester Porter as committee member during the year. Membership also includes all executive directors and appropriate members of the senior management team and staff from across the organisation. A representative of the board of governors also attends meetings of the committee.

Full details of the membership and attendance of the quality and risk committee meetings held during 2011/12 is provided in annex E on page 91.

## 4.7 Foundation trust membership

The trust has two constituencies of foundation trust members: public and staff.

Full public membership is open to anyone over 18 years of age who lives within the counties of Kent, Surrey and Sussex. Affiliate membership is available for those aged between 16 and 18 years of age or who live outside of the counties served by the trust. Full members are eligible to vote in annual elections for public governor positions. On 31 March 2012, there were 9,508 full public members and 387 affiliate members.

All staff with a permanent contract of employment are given automatic staff membership but may choose to opt out. Staff members are encouraged to vote for our three staff governor positions as and when elections occur. On 31 March 2012, there were 756 staff members.

### Strategy

The trust aims to maintain approximately 10,000 public members. Since 31 March 2011, public membership has fallen by 837 or 8%. However, affiliate members were erroneously counted as full public members in the annual report for 2010/11. We believe, therefore, that public membership has remained broadly stable. Nonetheless, the board of governors has re-formed its membership taskforce, comprising a majority of newly elected governors, to work with the trust's corporate affairs team to maintain membership and improve opportunities for members to engage with the board of governors and trust management.

### Disclosures and contact details

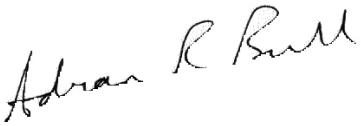
A public register of members is available for viewing by contacting the company secretary. Members should also contact the company secretary to communicate with governors and directors.

# 5.0 Quality accounts

# 5.1 Statement on quality

At Queen Victoria Hospital NHS Foundation Trust (QVH) we continue to focus on the quality of care that we provide to our patients. During the year a number of assessments showed that the hospital continues to achieve among the highest levels of patient satisfaction in the country. We received commendations from the Care Quality Commission following an unannounced inspection of our attention to the dignity and privacy of our patients and were ranked the most recommended NHS hospital by Dr Foster. These quality accounts describe the performance of the hospital across a range of issues in 2011/12 and demonstrate how we continue to deliver safe and effective care for patients. The accounts identify our key priorities for 2012/13 which we believe will further improve our patients' care and hospital experience.

I certify that to the best of my knowledge the information in this document is accurate.



**Dr Adrian Bull**
Chief Executive
28 May 2012

# 5.2 Priorities for improvement and statements of assurance from the board

**Performance against 2011/12 priorities**

In our 2010/11 quality accounts we set out four priorities for quality improvement. We have made good progress in three of the four areas and will continue to make improvements, measure and report progress. In the fourth priority (taking of consent prior to day of admission for surgery) we recognised that we would need more than one year to achieve our objective. We have made good initial progress, and this issue will be maintained as a key priority for the coming year.

> **Priority 1**
>
> We aim to guarantee that once an outpatient appointment is made to attend QVH it will not be changed, except at the patient's request.

Our goal was to achieve in excess of 90% of outpatient appointments unchanged by QVH and during 2011/12 we have achieved an average over the year of 91%.

This priority had been identified in 2010/11 and was refined during 2011/12 because of limited progress in the previous year. For 2011/12 we focused on outpatient appointments at QVH and excluded those at other hospitals where we provide consultant clinics. We felt this would better reflect improvements to processes under our control rather than those out of our control at other trusts which our consultants visit.

During 2011/12 we have:

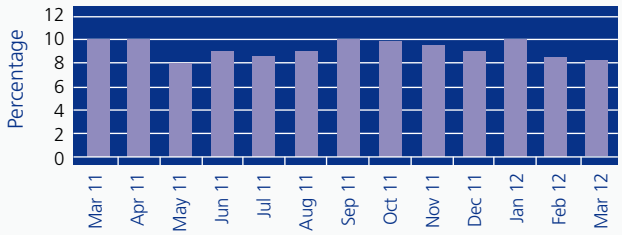
- Ensured all areas adopt the same process in offering a date and time for appointments and amended our 18 week policy to reflect this.
- Reinforced the process to reduce the number of clinics that are cancelled at short notice, thus reducing errors in clinic cancellations, and requested that this is monitored by each department.
- When clinics are proposed to be cancelled, QVH aims to either arrange cover or provide alternative arrangements including bringing patients forward to an earlier date thus minimising disruption to patients.
- Introduced nurse-led clinics in corneoplastics and appointed an orthoptist as planned to increase outpatient capacity in these specialties, this then allowed more clinic slots to be made available within consultant clinics.

Additionally, although it was not the focus for this year, we have been working with partner trusts to ensure that cancellations at clinics with our visiting consultants are also minimised.

Progress reports have been made monthly to our management team and quarterly to our quality and risk committee.

Overall, we have ensured that fewer than 10% of outpatient appointments have been cancelled by QVH (except in September) which is a slight improvement on the year before, with more noticeable changes in the last two months of the year as improvements in processes become more established.

**Hospital cancelled outpatient appointments 2011/12**




Closer examination of the performance of individual departments during the year showed that those outliers not achieving 10% were concentrated in a small number of departments. These included corneoplastics, sleep studies, facial palsy, psychology, gynaecology and care of the elderly. In each of these areas specific causes have been identified, including staff shortages or where a service relies on a single clinician.

It is acknowledged that cancellation of appointments is still a concern with one patient complaining during 2011/12 of a repeated cancellation. The effect of action taken this year is not yet reflected within our Picker national survey results within which the score remains at 14% of patients having their appointments cancelled.

## Priority 2

We aim to provide all patients with written communication about their surgery and discharge management.

Results from our inpatient and outpatient surveys show us that we are improving in how we communicate with patients in respect of their surgery and discharge.

This measure was identified from the 2010 cancer survey and national inpatient survey. Both indicated that patients were not receiving sufficient written information to support them in their decision making and on discharge. Lack of information can mean that patients are unclear of what actions to take if their condition worsens; they may be unclear about any follow up arrangements and potentially may return to hospital.

To address this, over the past year we have audited patient consent forms to assess whether leaflets on surgical procedures were provided in advance. We have also audited the percentage of patients whose GP was sent an electronic discharge notification detailing the care and treatment the patient received and the provision of follow up care. In addition, we have reminded staff to ensure that letters are copied to patients.

We have used the following inpatient survey questions to measure progress:

- **"Were you given written information about what you should do after leaving hospital?"**
  In 2010, QVH scored 7.9/10 against a highest national score of 8.8. The 2011 survey shows that we have improved with a score of 8.5 against a highest national score of 9.
- **"Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?"**
  In 2010, QVH scored 5/10 against a highest national score of 9.1. The 2011 survey shows a significant improvement to 8.7 against a highest national score of 9.3.

We also used the national outpatient survey score for:

- **"Did not receive copies of all letters sent between hospital doctors and family doctor (GP)?"**
  For this group of patients, our score has significantly improved. In 2011 it was 21% (low is good) against a national average of 41%. In 2009 it was 45% and 56% in 2004, so a steady improvement has been achieved.

The audit of patient consent forms has shown a slow but steady increase in the number of patients reporting that they received leaflets.

## Priority 3

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

The taking of patient consent was identified as a stretch target to be achieved over a number years. During our first year we have improved from a baseline of 15% to 30%.

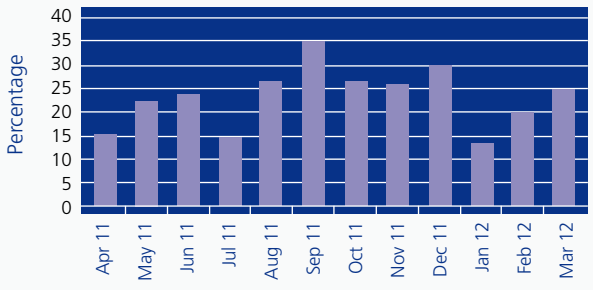
Before patients can come to a decision about treatment, they need comprehensible information about their condition and possible treatments and investigations, including the associated risks, benefits (including the risks and benefits of doing nothing) and alternatives.

Patients should be able to consent to surgery in advance and then confirm that consent on the day. We recognised that we could improve our processes by providing patients with earlier information.

We set aspirational aims and recognised that we would need to maintain this priority for more than one year in order to achieve the necessary culture change and to embed new ways of working.

Over the year, we have continued to increase the number of patients who are given all the information that they need to give fully informed consent prior to the day of surgery. We had set our goal of 75% of patients consenting prior to the day of surgery. We have audited our progress through our elective surgery cases admitted through the admissions lounge and the day surgery unit and by sampling our current audit of consent, looking at ten case notes each fortnight. We found that we had doubled the rate of prior consent from around 15% to around 30% between April and December. More focused activity will be undertaken in 2012/13 and is detailed in our priorities for the year.

**Patient consent prior to day of surgery**



**Priority 4**

We aim to roll out electronic discharge notification for all patients by March 2012.

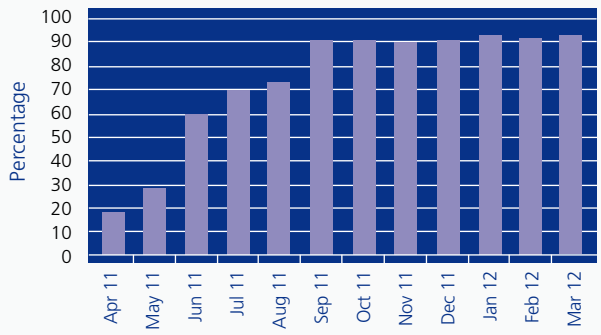
Electronic discharge notification (EDN) ensures that a patient's GP is aware of their hospital treatment, discharge arrangements and discharge medication within 24 hours. Our aim was to have discharge notification sent to GPs for 100% of QVH patients by March 2012. We have achieved 94% consistently during the last quarter of 2011/12.

During 2011/12, QVH commenced electronic notification to GPs. The system was rolled out steadily across all wards and departments during the year as each specialty was rolled out in turn and staff were trained. By October we achieved 90% and this was sustained for the rest of the year.

During the last part of the year, the project group has focused on targeting the final few individuals to use the system and refining the layout of the EDN to suit staff and GP needs as well as reduce our administrative processes.

Progress reports have been made monthly to the project group and the management team and quarterly to the quality and risk committee. Because of the significant and sustained improvement in the number of patients leaving hospital with an EDN, this will be removed from the quality account priorities for 2012/13 and will instead be subject to standard internal reporting.

**Percentage of discharged patients with an electronic discharge notification**




# Statements of assurance from the trust board

**Review of services**

During 2011/12, QVH provided burns care, general plastic surgery, head and neck surgery, orthodontic and corneoplastic surgery and community and rehabilitation services. QVH has reviewed all the data available to it on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by QVH.

**Review of quality of care**

QVH has systems and processes in place, through quarterly directorate reviews conducted by the chief executive, to assure itself regularly on the quality of service provided to patients. At these meetings, the safety of care is monitored through governance reports on incidents, infection control and identified risks. Where there are concerns, action plans are put in place and reviewed at the monthly operational meetings of the directorates. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints and ward and outpatient feedback questionnaires. In addition, a summary quality dashboard is presented monthly to the clinical cabinet and board of directors of the organisation.

Where the executive team or a directorate identify a significant concern they will instigate actions that are documented and regularly reviewed. Significant incidents are reported through to the trust board and followed up through the quality and risk committee.

# Priorities for 2012/13

In developing priorities for 2012/13 the following were approached: the trust's governors; the programme board which includes representation from NHS West Sussex; a local GP representative; representatives from commissioners in Kent and Surrey; and staff from across the organisation. All were asked to identify areas that would support the trust in improving patients' safety, experience or outcomes and which they thought should be included as a priority for 2012/13.

Information from national reports, QVH results from national inpatient and outpatient surveys, in-house patient experience reviews, clinical incident reporting, complaints, patient safety reviews and clinical audit were considered alongside the proposals received. In addition, progress against previously identified priorities was reviewed to assess whether they should be retained as a priority to ensure continued progress and improvement. All information was considered together by the trust management team in order to prioritise and then identify objectives for 2012/13.

This process resulted in four priorities covering patient experience, effectiveness and safety for 2012/13 which were presented to the quality and risk committee for approval and then agreed by the trust's board of directors. These are:

## Priority 1

We aim to reduce the preoperative length of stay for elective patients.

With advances in day surgery, the types of anaesthetics available and pre-assessment, it is increasingly possible to reduce preoperative lengths of stay to minimal levels unless there is a justified clinical reason for a longer stay. Coming into hospital for longer than necessary can cause stress and frustration for patients who would prefer to be at home rather than in hospital. A reduction in lengths of stay would also free up capacity to reduce bed pressures that are experienced during the day. Our goal is to reduce our preoperative length of stay from 10% to 5% during 2012/13.

We aim to reduce our overall preoperative length of stay by 5% ensuring that elective patients are only admitted early for clinical reasons. This will require a combined approach between nursing and medical staff to ensure it is achieved.

Activities to support achievement include reviewing the preadmission pathway to ensure that that patients receive clear written details of their pending admission after their outpatient or pre-assessment appointment.

We will audit our progress monthly by:

- analysing the number of patients admitted more than a day before surgery
- auditing the reasons why a patient has been admitted one day or more before surgery
- assuring ourselves through discharge questionnaires that shorter admission times are not having a negative effect on patient experience.

Baseline audit for December 2011 showed that:

- 10% of elective patients are admitted one day or more before surgery across all specialties
- this equated to 88 bed days in one month
- extrapolated over the year, this equates to four beds which are occupied solely by preoperative patients.

Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee

## Priority 2

We aim to improve the outpatient experience of all patients.

QVH prides itself on providing a good patient experience. While this is generally true, patient experience can still be variable at times with a number of areas in which further progress can be made. The national outpatient surveys provide key information, supplementing the hospital's own patient surveys, and these have highlighted that improving problem scores in a number of areas could significantly improve our patients' experience, therefore our goal is to reduce our national survey problem scores by 10%.

We aim to improve our outpatient problem scores by a minimum of 10% for:

- Other patients could overhear discussions with receptionists
- Patient not told why they had to wait
- Patient waited for longer than they were told, or were not told how long the wait would be
- Nobody apologised for the delay when waiting to be seen.

We will do this by ensuring courtesy, communication and explanation for all patients attending the hospital as outpatients or for minor procedures. This will be achieved by realigning reception roles, introducing automated information and self check-in kiosks in outpatient departments and promoting awareness and competence among all staff.

Baseline audit shows our current problem scores to be:

- **Other patients could overhear discussions with receptionists** - 76% in 2009 and 75% in 2011 with a national average of 72%
- **Patient not told why they had to wait** - 62% in 2009 and 64% in 2011 with a national average of 67%
- **Patient waited for longer than they were told, or were not told how long the wait would be** - 56% in 2009 and 61% in 2011 with a national average of 69%.
- **Nobody apologised for the delay when waiting to be seen** - not included in 2009 and 40% in 2011 with a national average of 47%.

Progress will be evaluated through monthly questionnaires using the Picker Institute questions to allow for consistent benchmarking as there is no national outpatient survey planned for 2012. Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee.

## Priority 3

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments and investigations including the associated risks, benefits (including the risks/benefits of doing nothing) and alternatives.

They should be able to consent to surgery before the day of their surgery, and then be able to confirm that consent on the day.

This priority was included in the priorities for 2011/12 for which we set ourselves a challenging target knowing that some progress would be made in-year but would need to be maintained for a period of time until practice was changed and embedded within the medical staff way of working. This will remain a priority for 2012/13 with the same target to achieve.

We recognise we could improve our current processes to benefit patients by providing them with earlier information.

We aim for 75% of elective surgery patients at QVH to have their consent completed prior to the day of surgery and our goal for 2012/13 is to achieve 50%.

Activities to support improving our current performance include:

- ensuring consent forms are available at all outpatient appointments
- educating medical staff
- revising our current consent form design.

We will continue to audit our progress for patients being admitted through our elective surgery admissions lounge and day surgery unit, assessing a sample of patients in these areas one week of every month. We will also extend our audit of consent by looking at ten case notes per fortnight of patients admitted directly to inpatient wards.

Baseline audit from 2011 show that we made steady progress through the year, with a maximum monthly achievement of 39%.

Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee.

## Priority 4

We aim to provide health care professionals with dementia awareness training in order to complete dementia screening and dementia risk assessment of patients.

The Department of Health is committed to improving care for dementia and ensuring early diagnosis. The report of the National Audit of Dementia Care in General Hospitals 2011 provided clear recommendations to chief executives, directors of nursing and medical directors. These included the provision of awareness training for all staff and more in depth training for core staff.

Our goal is to deliver dementia awareness training to more than 75% of our qualified nursing staff, allied health care professionals and medical staff to support the roll out of dementia screening and risk assessment as required by the national commissioning for quality initiative for 2012/13.

Progress reports will be made monthly to our management team and quarterly to our quality and risk committee.

# Participation in clinical audits

During 2011/12, six national clinical audits and four national confidential enquiries covered NHS services that QVH provides.

During 2011/12 QVH participated in 66% of the specified national clinical audits (QVH were not eligible for two due to low patient numbers) and 100% of the national confidential enquiries which we were eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2011/12 are as follows:

| National clinical audits | Participation |
|---|---|
| Head and neck cancer (DAHNO) | ✓ |
| Heavy menstrual bleeding (RCOG National Audit of HMB) | ✓ |
| Cardiac arrest (National Cardiac Arrest Audit) | ✗ |
| Adult critical care (ICNARC CMPD) | ✗ |
| Bedside blood transfusion (National Comparative Audit of Blood Transfusion) | ✗ |
| Care of dying in hospital (NCDAH) | ✗ |

| National confidential enquiries | Participation |
|---|---|
| Bariatric surgery (NCEPOD) | ✓ |
| Cardiac arrest procedures (NCEPOD) | ✓ |
| Peri-operative care (NCEPOD) | ✓ |
| Surgery in children (NCEPOD) | ✓ |

We do not participate in the National Cardiac Arrest Audit as our number of cardiac arrests that are treated with cardiopulmonary resuscitation is so low (less than five per year). All cardiac arrests are audited locally, and we took part in the NCEPOD cardiac arrest procedures study during 2011.

We do not participate in the Adult Critical Care Case Mix Programme because our intensive care unit serves a very select case mix, predominately burns patients and post-surgical head and neck cancer patients. This presents difficulties with comparison as the national audit is primarily focused on adult general critical care units.

We did not participate in the National Care of the Dying Audit – Hospitals because the number of deaths at QVH was far below the minimum number of cases required to take part in this audit. We have, however, carried out trust-based reviews of the use of the Liverpool Care Pathway (LCP) and of the withdrawal/withholding of life support on our burns unit. Ongoing spot-check audits of the use of the LCP are also carried out in the burns unit.

We did not participate in the bedside blood transfusion audit as the number of patients who underwent transfusion in the three months over which the study took place was below the minimum number of cases required by NHS Blood and Transplant. Nameband audits (a key element of the bedside blood transfusion audit) are undertaken regularly at QVH.

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

| National audits/ confidential enquiries | % cases submitted |
|---|---|
| Head and neck cancer (DAHNO) | 100% coded cases |
| Heavy menstrual bleeding (RCOG National Audit of HMB) | 75% cases (estimated) |
| Bariatric surgery (NCEPOD) | Bariatric surgery is not carried out at QVH, but organisational data were submitted |
| Cardiac arrest procedures (NCEPOD) | 100% |
| Peri-operative care (NCEPOD) | 100% |
| Surgery in children (NCEPOD) | 100% |

Other national audits we have participated in during 2011/12 include:

- National NHS adult inpatient survey 2011
- National NHS outpatient department survey 2011
- International burn injury database (IBID), incorporating the national burn injury database (NBID)
- National audit of back pain management by NHS occupational health services in England: round 2
- Bisphosphonate-related osteonecrosis (BRONJ) national audit.

The reports of 13 national clinical audits were reviewed by QVH in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided:

- Continue progress towards implementation of single database for collection of DAHNO data to ensure data completeness
- Continue collaboration with NHS Innovations to develop QVH-designed database to monitor breast 'free flap' outcomes
- Consider adoption of e-learning training course for intravenous insulin infusions following collaboration between pharmacy and anaesthetics departments
- Seek closer collaboration between QVH 'Bone and Balance' group and bone services in East Sussex
- Incorporate relevant recommendations from NHSBT comparative audit of blood transfusion within QVH blood transfusion policy
- Ensure continuing audit of end of life care
- Adopt dementia assessment as a CQUIN for next year
- Carry out additional prospective data collection for QVH clinical indicators programme mortality reviews.

The reports of 116 local clinical audits were reviewed by QVH in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided:

- Improve compliance with pre-incision antibiotic administration via team safety briefings
- Develop a new module of the anaesthetic electronic record to document recovery data
- Carry out review and audit of NICE hypothermia guidelines
- Develop toxic shock syndrome recognition and management guidelines
- Encourage monthly attendance of visiting intensivists at extended ward rounds
- Support ongoing joint working and training with surrounding units providing mastectomy/breast reconstruction services
- Improve risk assessment and documentation of pressure ulcer management in perioperative care
- Develop and implement a head and neck cancer-specific consent form

- Roll out a new telemedicine website across Southeast England and East Anglia
- Carry out ongoing audit in the use of mandibular advancement splints for sleep apnoea
- Develop enhanced recovery pathways for breast cancer patients
- Continue monitoring compliance with early warning scoring documentation to ensure appropriate response to patient deterioration
- Develop a research protocol regarding the sectioning of melanoma specimens
- Monitor the quality and accuracy of clinical record keeping via the health records committee.

## Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by QVH in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 352.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting 24 clinical research studies in 2011/12, involving 28 clinical staff covering three medical specialties (plastics, anaesthetics and corneoplastics) as well as professions allied to medicine.

## Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2011/12 and for the following 12 month period are available online at www.qvh.nhs.uk.

The monetary value attached to achieving CQUINs for 2011/12 was £864,192. Activity to achieve CQUINs was undertaken and payment is agreed.

## Statements from the Care Quality Commission

QVH is required to register with the Care Quality Commission (CQC) and its current status is 'registered without compliance conditions'.

CQC has not taken any enforcement action against QVH during 2011/12.

During the year we have participated in the CQC special review of dignity and nutrition for older people and QVH was found to meet both of the essential standards of quality and safety reviewed.

**Data quality**

We strive to achieve high quality information that is accurate, up-to-date, free from duplication and free from confusion.

The data quality indicators reported below via the Secondary Uses Service (SUS) show that we achieve higher than the national average for inclusion of valid NHS numbers and General Medical Practice Codes for admitted patient care, outpatient care and accident and emergency care. This is an improvement on the previous year where we were slightly under the national average for NHS numbers for outpatient care.

The data quality group, set up in August 2010, continues to monitor data quality in the organisation via monthly meetings with dashboards in the following areas:

- internal metrics on data quality completeness and validity
- SUS data quality dashboards
- PCT data challenge dashboards
- other areas by exception.

The group has also introduced a 'pre-validation' routine for data quality where external data requests are replicated internally first so departments have the opportunity to investigate any errors and take corrective action before final submission.

In the coming year, the group will continue to refine the pre-validation routine and focus on an action plan which includes standardising departmental procedures and training. The group will also be focusing on ethnicity data collection and standardising procedures for establishing the responsible commissioner.

QVH submitted records during April 2011 to February 2012 to SUS for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99.2% for admitted patient care
- 99.5% for outpatient care
- 97.7% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

**Clinical coding error rate**

QVH was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- primary diagnoses incorrect (plastics) 3.0%
- primary diagnoses incorrect (other) 3.0%
- secondary diagnoses incorrect (plastics) 6.5%
- secondary diagnoses incorrect (other) 8.1%
- primary procedures incorrect (plastics) 5.1%
- primary procedures incorrect (other) 7.2%
- secondary procedures incorrect (plastics) 1.2%
- secondary procedures incorrect (other) 1.6%.

Clinical coding results should not be extrapolated further than the sample audited.

**Information governance toolkit attainment levels**

QVH's overall information governance assessment report score for 2011/12 was 77% and was graded 'satisfactory'.

# 5.3 Review of quality performance 2011/12

QVH has established processes for reporting on patient safety, clinical effectiveness and patient experience across its acute and community services. Progress against key quality indicators is shown below. Feedback from our ability to deliver operational performance targets, feedback from patients, patient complaints and national surveys have all contributed to the identification of our additional priorities for 2012/13.

**Patient safety**

We are committed to preventing harm to patients by continuing to develop and improve clinical leadership, communication and learning to create an environment of trust between patients and staff that ensures safe, high quality, effective care is delivered to all our patients.

Clinical incidents, including all deaths and complications, continue to be discussed at regular clinical directorate meetings and, where appropriate, at bimonthly joint hospital clinical audit meetings. Learning points and actions from these meetings are disseminated through the directorates, clinical policy and quality and risk committees, clinical cabinet and the board of directors.

This year's data shows that QVH continues to improve in key areas of patient safety. There has been a reduction in the number of incidents that have caused harm to patients and there have been no incidents resulting in death or severe harm to patients. Staff commitment to safe care is evident in improved hand washing and in the completion of safer surgery checklists and surgical team safety briefings.

The score for assessment of patients' risk of venous-thromboembolism (VTE) has gone down in 2011/12. However, it should be noted that for 2010/11 this score was evaluated on a small data set of patients each month. During 2011/12 we have taken our score from all admitted patients. We are satisfied that achieving in excess of the national 90% benchmark for VTE assessment of all patients, and maintaining 100% of patients having a nutritional risk assessment, demonstrates continued staff commitment to ensuring safe care for patients. This is also recognised by staff themselves as the national NHS staff survey showed that the great majority of QVH staff would recommend this hospital as a place for family to be treated. Indeed, QVH achieved one of the three highest scores in the country on this measure.

We can continue to improve in consultant review of patients admitted as an emergency. NCEPOD recommends that all emergency admissions are reviewed by a consultant within 24 hours of admission, and that this is documented clearly. Our audit this year showed an overall reduction on this measure. However, our maxillofacial consultants improved significantly with their documented review percentage increasing during the year from 69% to 85%. Within plastic surgery, the percentage has decreased and this has been discussed at our joint hospital clinical audit meeting with suggestions made for improvement.

During the year, we breached our target maximum number of patients with MRSA bacteraemia, with two cases against our maximum of one. However, these patients both had large surface area burns to their body. These patients are known to be at a much higher risk of hospital acquired infection as skin provides a protective barrier and their burn results in immunosuppression, making them more susceptible. Both instances were immediately reviewed by the trust infection prevention and control team and findings from their investigations were presented to a strategic health authority review panel to identify any other actions that could have been taken. In both instances the outcomes for the patients were good and they recovered and returned home.

The ability of QVH to continue to deliver patient care under most circumstances is supported by its emergency and business continuity plans. These are exercised throughout the year as required by the Civil Contingencies Act. We take the protection of our workforce seriously and during 2010/11 we achieved 49.7% in flu vaccination uptake for frontline staff. For 2011/12 we set ourselves an aspiration target of 60% uptake of flu vaccinations to frontline staff and are proud to have achieved 59%.

Within our 2010/11 quality accounts we reported on patients receiving all correct physiological monitoring during admission and the percentage receiving correct action when measures fell outside normal limits. The methodology for our first score will be reviewed during 2012/13 as our current audit method results in failed scores due to the inclusion of low complexity surgical cases in which some measures may not be recorded as they are not required. The second score has been removed from the 2011/12 quality account as the methodology used was not robust. QVH will review this audit to ensure that notes of patients where intervention was required are reviewed at the earliest opportunity, allowing much earlier feedback to staff and allow more timely preventive action to be taken. To support early recognition of a change in patients' monitored parameters, QVH is looking into the use of information technology to alert staff.

| Patient safety indicator and why we measure it | How the data is collected | Our target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Clinical incidents reported per 1000 patient spells**<br>We absolutely encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. Of these incidents, 67% caused no harm or were near miss incidents, compared with 70% causing no harm in similar trusts. We aim for an open reporting system to aid learning from incidents. | Monthly analysis of Datix clinical incident reporting system | N/A | 62 per 1000 SEC NRLS benchmark (April to Sept 2011) | 50 per 1000 patient spells | 51 per 1000 patient spells | 44 per 1000 patient spells |
| **Number of clinical incidents reported that have caused patient harm (actual number)**<br>Although we would like to see a large number of clinical incidents reported to aid governance, we would like a low number of incidents that have caused patient harm. | Monthly analysis of Datix clinical incident reporting system | 0 | 24.3% of all incidents reported (NRLS of specialist trusts April to Sept 2011) | 217 incidents causing harm<br>25% of all reported incidents | 187 incidents causing harm<br>22% of all reported incidents | 124 incidents causing harm<br>17% of all reported incidents<br>0 causing severe harm or death |
| **Documented consultant review of emergency admissions within 24 hours**<br>NCEPOD recommends that all emergency admissions are reviewed by a consultant within 24 hours of admission, and that this is documented clearly. | Internal six monthly retrospective audit of 50 trauma patients | 100% | 92% (NCEPOD) | 66% | 82% | 72% |
| **Hand hygiene (washing or alcohol gel use)**<br>Good hand hygiene is linked with a reduction in hospital acquired infections. | Internal monthly audit of the five moments of hand hygiene | 100% | N/A | 87% | 93% | 97% |
| **VTE risk assessment (percent of admissions)**<br>Patients assessed for the risk of venous-thromboembolism can have the correct precautions, including compression stockings and low molecular weight heparin. (This metric for 2011/12 has been measured against where patient data has been loaded electronically). | Monthly internal audit | 100% (90% national target | 26 – 70% average rate in SEC SHA 2010 | 92% | 97% | 90% |
| **Nutritional assessment within 24 hours of admission**<br>Maintenance of nutrition is important for physical and psychological well-being. When illness or injury occur, nutrition is an essential factor in promoting healing and reinforcing resistance to infection. | Monthly internal audit | 100% | N/A | 84% | 99% | 100% |
| **Theatre lists starting with a surgical team safety briefing**<br>A whole team safety briefing with surgical, anaesthetic and nursing staff before theatre lists begin improves communication, team work and patient safety in the operating theatre. | Three monthly internal audit | 100% | N/A | 91% | 83% | 86% |

| Patient safety indicator and why we measure it | How the data is collected | Our target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Use of the WHO Safer Surgery checklist**<br>The correct use of a checklist prior to anaesthesia and surgical incision reduces "never events" such as wrong site surgery. | Monthly internal audit | 100% | Sign in | 81% | 83% | 96% |
| | | | Time out | 62% | 66% | 84.8% |
| | | | Sign out | 50% | 55% | 62.9% |
| **Development of pressure ulcer grade 2 or over (per 1000 spells)**<br>Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat. In the majority of cases they can be prevented if simple measures are followed. | Internal audit | 0 | 6.0 / 1000 spells (SEC SHA average Mar 10-Feb 11) | 0.5 / 1000 spells (total number = 10 cases) | 0.5 / 1000 spells (total number = 9 cases) | 0.5 / 1000 spells (total number = 8 cases) |
| **Patient falls, including falls associated with harm (actual number)**<br>New falls assessment procedures have been introduced, including alerting all staff to patients at risk. Actions of ward staff are reviewed following a fall. Rates of patient falls tend to be higher in elderly patients who are being rehabilitated. | Internal audit | 0 | 7.4 / 1000 spells (SEC SHA average Mar 10-Mar 11) | 121 falls<br>7.3 / 1000 spells<br>30 causing harm<br>1.7 / 1000 spells | 82 falls<br>4.8 / 1000 spells<br>31 causing harm<br>1.8 / 1000 spells | 56 falls<br>3.4 / 1000 spells<br>20 causing harm<br>1.2 / 1000 spells |
| **Number of reportable MRSA bacteraemia cases**<br>MRSA in the blood may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis. | Internal audit | 1 | N/A | 1 | 2 | 2 |
| **Number of reportable Clostridium difficile cases**<br>Clostridium difficile may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis. | Health Protection Agency | 5 | National average 2010 28.9 / 100,000 bed days | Total = 1<br>4.2 / 100,000 bed days | Total = 6<br>25.2 / 100,000 bed days | Total = 0<br>0 / 100,000 bed days |
| **Patients receiving all correct physiological monitoring during admission**<br>Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to prevent physiological deterioration of patients. | Internal fortnightly audit of 10 patient records | 100% | N/A | 72% | 80% (2010) | 80% (2011) |
| **Staff recommendation of the trust as a place to work or receive treatment**<br>Data is taken from respondents to the NHS staff survey. This indicates an employee's view of the quality of care delivered by their organisation. (Scale 1-5) | National staff survey | | 3.90 national average acute specialist trusts 2011 | | 3.94 | 4.01 |

| Patient safety indicator and why we measure it | How the data is collected | Our target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Percentage of staff witnessing harmful errors, incidents or near misses in the last month**<br>Ideally no errors, incidents or near misses should occur. Where these are known about staff will report them for investigation. | National staff survey | NA | 31% national average acute specialist trusts 2011 | 34% | 36% | 31% |
| **Percentage staff uptake of seasonal influenza vaccine**<br>Frontline staff uptake of influenza vaccine is crucial in ensuring the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans. | Internal audit | >60% | National rate 34.2% 2010 | 24.9% | 49.7% | 59% |

# Clinical effectiveness

QVH provides very specialist surgical services to a distinct group of patients. Because of this, our services are often not included in national measures and audits of clinical effectiveness, which rightly tend to focus on outcome measures for common diseases such as heart or lung disease, common cancers and common procedures such as orthopaedics and colorectal surgery.

Therefore, we are continuously developing our own measures of clinical effectiveness, using internationally accepted markers, where possible. Much of this work remains in development, but below are examples of how we can quality assure the work which we undertake.

Guidance produced by the National Institute for Health and Clinical Excellence (NICE) supports clinicians in their decisions and provides a benchmark for audit. At QVH we have a robust process led by our medical director that ensures that all guidance relevant to QVH is reviewed by an expert. Our audit team work with our specialty teams to ensure that relevant audit is undertaken and results provided back to teams within the organisation.

| All specialties | | | | | | |
|---|---|---|---|---|---|---|
| **Clinical effectiveness indicator and why we measure it** | **How we measure it** | **Target** | **Benchmark** | **2009** | **2010** | **2011** |
| **In-hospital surgical mortality**<br>Because of our specialist work it is not comparable to present a hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rates presented here represent only two deaths, so one death can make a large difference to the rate. All deaths at QVH are reviewed within specialties and a multidisciplinary forum. | Continuous monitoring of PAS data | N/A | N/A | 0.013% | 0.021% | 0.015% |
| **Unexpected return to theatre within 7 days**<br>A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. We monitor rates in individual surgical specialties and overall to monitor quality of service. | Continuous monitoring of PAS data (change of methodology April 2010) | <1% | N/A | 0.97% | 0.83% | 0.84% |

## All specialties (continued)

| Clinical effectiveness indicator and why we measure it | How we measure it | Target | Benchmark | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| **Unexpected readmission to QVH within 28 days following discharge**<br>This may be due to a complication such as wound infection, dehiscence, or other complication from surgery. | Continuous monitoring of PAS data (change of methodology September 2010) | <1.5% | N/A | 1.08% | 1.04% | 1.08% |
| **Unplanned transfer out of QVH for additional care**<br>We are supported by surrounding trusts in the provision of specialist services such as respiratory medicine and cardiology, which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services. | Continuous audit by ITU outreach nursing staff (change of methodology June 2010) | <0.5% | N/A | 0.46% | 0.35% | 0.28% |

## Burns care

In 2011 the burns centre accepted 905 adult burns referrals, an increase from 870 in 2010. Of these, 203 patients required inpatient care of which 33 required intensive care treatment (ICU). We were unable to accept one ward patient and one ICU patient during April 2011 due to refurbishment of the burns centre operating theatre. A further two ward patients and one ICU patient could not be admitted during 2011 due to a lack of beds appropriate for the level of care they required. These five patients were treated in alternative burns centres in the Southeast.

The mortality rate for adult burns inpatients in 2011 was 0.9% which equated to two patients. All patients who die have their case discussed at burns multidisciplinary governance meetings so that any learning points can be built upon. If it is thought, either by the team or by the clinical audit lead, that further review and discussion is required then the patient's case is subsequently presented at a joint hospital clinical audit meeting.

We accepted 650 paediatric burns referrals during 2011, 91 of whom required inpatient care on our paediatric ward. QVH aims to enable all burn injuries to heal within 21 days and for 2011 the average healing time for paediatric burns was 13 days. Eighty-three percent of paediatric burns were healed within 21 days.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Burn wounds healing within 21 days** | Prospective database of all adult burns | 100% | N/A | N/A | 77% | 72% |
| **Average time for burn wound healing**<br>Burns healing in less than 21 days are less likely to be associated with poor long term scars. A shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. The burns service has a 26% 'did not attend' rate for follow up, so the percentage healing within 21 days is likely to be higher. | | < 21 days | N/A | N/A | 16.8 days | 16 days |
| **Average length of inpatient stay per percentage burn**<br>Length of inpatient stay of burns patients is related to the size of their burn, measured as a percentage of their body surface area. We aim that, on average, adult patients under the age of 75 should require 1 day inpatient stay / 1% burn. Over 75 the length of stay is often complicated by the requirement of complex social care packages which take time to arrange. | Prospective database of all adult burns | <75 years old 1 day | N/A | N/A | 1 day | <1 day |
| | | >75 years old 2 days | | | 2 days | 2 days |

## Plastic surgery – breast surgery, hand surgery, skin cancer care and trauma

Our plastic surgery clinical directorate is one of the largest in the country and generates a significant part of the surgical activity within the trust. Our team of 17 specialist consultants are supported by a wider network of junior surgeons, specialist nurses, occupational therapists, physiotherapists and speech and language therapists.

### Breast surgery

QVH is the major regional centre for complex, microvascular breast reconstruction following, or simultaneously with, resection for cancer. Our integrated team of consultants and specialist breast care nurses provide a wide range of reconstructive options and flexibility and also undertake surgery to correct breast asymmetry and breast shape deformity.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| **Breast reconstruction after mastectomy using free tissue transfer – flap survival**<br>The gold standard for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but carries greater risks of failure than an implant or pedicled flap reconstruction, so it is important we monitor our success. In 2011, we performed 121 free flap breast reconstructions on 113 patients. | Continuous prospective electronic database | 100% | 95-98% (published literature)<br>98% BAPRAS 2009 | 98.7% | 98.4% | 99.2% |

### Hand surgery

Our hand surgery team covers a range of elective conditions as well as trauma. It includes consultants with specific interests in congenital hand anomalies; rheumatoid and osteoarthritis; wrist surgery for arthritis and instability; compression neuropathies; and post-trauma reconstruction. We offer, where appropriate, non-operative and minimally invasive treatment alternatives such as wrist arthroscopy, needle aponeurotomy (fasciotomy) and endoscopic carpal tunnel release. We manage soft tissue and bony trauma and provide advice on other urgent problems including tendon ruptures, infections, extravasation injuries and pain syndromes.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| **Rupture rate following repair of flexor tendon injuries**<br>Hand surgery accounts for 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and post-operative therapy. | Ongoing monthly audit between hand surgeons and therapists, with complications collected via a trauma database | 0% | 9-13% (published literature) | 6-7% | 4% | 3.5% |

**Skin cancer care and surgery**

Our Melanoma and Skin Cancer Unit (MASCU) is the tertiary referral centre for all skin cancers across the South East Coast catchment area and is recognised by the Kent and Sussex cancer networks. The team mainly consists of consultant plastic surgeons but also includes a maxillofacial surgeon, an ophthalmic surgeon and dermatology for multidisciplinary working.

QVH also provides specialist dermato-histopathology services for skin cancer.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Complete excision rates in basal cell carcinoma**<br>BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage or immuno-modulators or a combination. Surgical excision is highly effective with a recurrence rate at 2%. Complete surgical excision is important to reduce recurrence rates. Sometimes this is not possible because of the size or position of the tumour. Sometimes the incomplete excision will only become evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases. | Audit of two months activity (286 BCC cases) | 100% | 88.9-95.3% (published literature) | 92.9% | 92.0% | 90.7% |
| **Complete excision rates in malignant melanoma**<br>Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Sometimes total excision is not possible because of the health of the patient or the size, position or spread of the tumour, and the MDT may recommend incomplete excision. | Audit of two months activity (42 melanoma cases) | 100% | 75%<br>NICE guidance | 83% | 100% | 90% |

## Head and neck, including head and neck oncology, orthognathic and orthodontic surgery

Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body. In particular, QVH is the Kent and Sussex surgical centre for head and neck cancer and is recognised by the Royal College of Surgeons as a training centre for head and neck surgical fellows.

We also have the largest maxillofacial and general prosthetics laboratory in the country which provides a wide range of support to orthodontists and to maxillofacial and plastic surgeons. Our specialist orthodontic team advises and treats children and adults with complex orthodontic problems such as facial deformity and anomoly, hypodontia, malalignment of the jaws and positional problems of the teeth.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Nerve injury rates in third molar (wisdom tooth) extraction and mandibular (jaw) fracture surgery**<br>Wisdom tooth extraction is a commonly performed procedure. A recognised complication is inferior dental or lingual nerve injury which may be temporary or permanent. We treat approximately 1,000 patients for wisdom teeth extraction each year. This year we had no cases of permanent nerve injury.<br>(The rates for 2011/12 have been collected initially by telephone interview, rather than direct examination as in previous years, which may explain the slight change in rates for temporary numbness) | Prospective audit of 93 patients | 0%<br>0% | Temporary numb lip 5-10%<br>Temporary numb tongue 2-8% | 2%<br>4% | 4.4%<br>4.4% | 5%<br>9% |
| **Facial nerve injury rates in condylar fracture (jaw fracture) repair**<br>We monitor damage to the facial nerve during open fixation of mandibular fractures. We continue to have a zero permanent nerve injury rate. | Trauma Card (continuous trauma and complications database) | 0% | 17% | 12.5% | 9% | 0% |
| **Peer Assessment Rating (PAR) index for orthodontic treatment**<br>The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The index is designed to look at a large group of patients rather than an individual patient's outcome. | Continuous prospective data collection of all orthodontic patients | > 70% very high standard<br>< 50% poor standard | | 95% | 95% | 95% |

| | | | |
|---|---|---|---|
| **Patient reported outcome measures in orthognathic surgery (correction of bony jaw abnormalities)**<br>This PROM has been developed to look at patient satisfaction with the orthodontic and orthognathic surgery service and satisfaction with the appearance, dentition and face following treatment. | Prospective database of all orthognathic surgery patients | | |
| | How do you rate the orthodontic service and care? | **2010**<br>88% excellent<br>12% good | **2011**<br>80% excellent<br>10% good<br>10% average |
| | How do you rate the surgical service and care? | 82% excellent<br>18% good | 90% excellent<br>10% good |
| | How satisfied are you with facial appearance? | 75% very satisfied<br>25% satisfied | 70% very satisfied<br>10% satisfied<br>20% neither satisfied or dissatisfied |
| | How satisfied are you with dental appearance? | 91% very satisfied or satisfied | 80% very satisfied<br>10% neither satisfied or dissatisfied<br>10% dissatisfied |

## Corneoplastic and oculoplastic surgery

Our corneoplastic unit and eye bank is a high-profile and technologically advanced specialist and tertiary referral centre for complex corneal problems and oculoplastics. Our specialist cornea services include high risk corneal transplantation; stem cell transplantation for ocular surface rehabilitation; innovative partial thickness transplants (lamellar grafts); and vision correction surgery.

The team also offer specialist techniques in oculoplastic surgery including Mohs micrographic excision for eyelid tumour management; facial palsy rehabilitation; endoscopic DCR; and modern orbital decompression techniques for thyroid eye disease.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease**<br>We performed 1,210 phacoemulsification procedures for cataracts in 2011/12, 99% of these as day cases. We monitor the number of these patients who achieve significant improvement to the vision in that eye. | Annual audit of 100 patients | 100% | 96% (UK EPR) | 96% | 96% | 96% |

## Anaesthetics

We have 19 consultant anaesthetists at QVH with supporting staff in the operating theatres, high dependency unit and in the burns centre. The department has pioneered and developed special expertise in dealing with patients with abnormal airways due to facial deformity, techniques to lower blood pressure and reduce bleeding during delicate surgery, and the use of ultrasound for the placement of regional local anaesthetic for the upper limb.

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Percentage of patients requiring no recovery room intervention following anaesthesia**<br>The anaesthetic recovery room exists to ensure patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties. In 2011 this figure no longer includes paediatric patients. | Continuous prospective audit of all inpatient recovery room procedures | 100% | | N/A | 83% | 79% |

# Patient experience

We are rightly proud of the quality of experience that patients tell us they receive at QVH. During 2011/12 the number of complaints we received was lower than for the previous year and we continue to receive a high number of compliments from our patients. We have achieved delivery of care in single sex accommodation for all patients. Over 90% of patients were satisfied with their privacy when discussing care, and over 95% of patients would recommend QVH to others. We also saw a continued improvement in the assessment that patients gave of our responsiveness to their personal needs.

Patient comments on their care during 2011/12 include:

> "The staff were amazingly good at caring for me and keeping me up to date with my treatment."

> "I was very happy with everyone connected with this hospital. The best treatment I have ever received in a hospital – from the person on the enquiry desk to the doctors."

> "Excellent nursing care, cleanliness of all areas, friendliness of all grades of staff, and kindness and understanding when I felt very low."

> "A very high standard of care, cleanliness and catering all round."

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009/10 | 2010/11 | 2011/12 |
|---|---|---|---|---|---|---|
| **Failure to deliver single sex accommodation (occasions)** In all wards outside of theatre recovery areas and critical care we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting. | Internal continuous audit | 0 | N/A | 144 | 1 | 0 |
| **Complaints per 1000 spells** It is important to monitor complaints about the quality of service we provide, in order to facilitate continuous improvement. | Internal continuous audit | 0 | N/A | 5 | 4.8 | 4.4 |
| **Claims per 1000 spells** This reflects legal action against the trust by patients/carers and includes all cases whether founded or unfounded. | Internal continuous audit | 0 | N/A | 0.7 | 0.8 | 0.8 |
| **Percentage of patients who would recommend QVH to a friend or relative** | National inpatient survey | 100% | 91.2% Picker average 2011 | 99% | 98% | 96.1% |
| **Percentage of patients who felt they were always treated with respect and dignity** How patients feel their dignity was respected is important in being able to measure the quality of service they are provided. Scoring has been altered from % to a scale of 1-10. | National inpatient survey | 10 | 9.7 highest national score 2011 | 92% | 9.5 | 9.7 |

| Clinical effectiveness indicator and why we measure it | How the data is collected | Target | Benchmark | 2009 | 2010 | 2011 |
|---|---|---|---|---|---|---|
| **PEAT scores**<br>PEAT is an annual assessment of inpatient healthcare sites in England with more than 10 beds.<br>PEAT is self assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). The benchmark is the % achieving excellent. | National Reporting Learning Service | Excellent | All trusts 2010/11 | | | |
| | Environment | | 25% | Excellent | Good | Good |
| | Food | | 57% | Good | Excellent | Excellent |
| | Privacy | | 48% | Good | Good | Excellent |
| **Percentage of patients who rated their quality of care as good or excellent**<br>We invite all patients to complete a questionnaire about their quality of care on discharge. | In-house discharge questionnaire | 100% | | New measure | 98% | 99% |
| **Responsiveness to inpatients' personal needs**<br>This is an amalgamated score from five questions within the national inpatient survey and is used as a CQUIN measure. | CQUIN score 2011 | | 67.39 national average 2011 | 81.3 | 82.6 | 85 |
| **Percentage of patients who reported sufficient privacy when discussing their condition or treatment**<br>That patients felt their privacy was respected when discussing their condition is a key measure of the quality of care delivered. | In-house discharge questionnaire | 100% | 93% highest score achieved in national inpatient survey | New measure | 94% | 97% |
| **Satisfaction with anaesthetic service**<br>Those who rated their anaesthetic service as good or excellent. | Survey of all patients during one week who had general or regional anaesthesia | 100% | N/A | New measure | 98% | 98% |

## Performance against key national targets for 2011/12

Performance against national targets is set out in annex B on page 87.

# 5.4 Statements from third parties

During April 2012, third parties were asked to comment on the accuracy of the quality accounts and were sent a draft of the document. Amendments from the draft include updating final figures to ensure that full year data is captured where possible.

## Statement from West Sussex Local Involvement Network (LINk)

The West Sussex LINk confirms that to the best of its knowledge Queen Victoria Hospital NHS Foundation Trust's quality accounts contain accurate information. The trust should be congratulated for the extensive work carried out to improve services during the current and continuing financial climate.

**2011/12 priorities**

The LINk agrees that three of the 2011/12 priorities were achieved and welcomes that the trust will continue to look at the remaining one in 2012/13. This was a remarkable achievement considering that the following activities took place over the last year - the sleep clinic was transferred on to the site, a new children's ward was opened after a new builder replaced the previous one, and a new outpatients department was opened.

The LINk is pleased that the trust, along with other providers of acute services throughout Sussex, cooperated in the formation of a consortium to commission a non-urgent patient transport service, and the award of a new contract. It also participated in the Sussex Together initiative and contributed to the Sussex trauma network.

**Priorities for 2012/13**

Priority 1: We aim to reduce the preoperative length of stay for elective patients.

The LINk agrees this would help to reduce stress on the patient and also reduce the pressure on beds.

Priority 2: We aim to improve the outpatient experience of all patients.

The new outpatient accommodation will assist greatly in achieving this priority. This change has been welcomed by patients.

Priority 3: We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

This priority has been carried forward from 2011/12. It was anticipated, last year, that it may take some time to achieve.

Priority 4: We aim to provide health care professionals with dementia awareness training in order to complete dementia screening and risk assessment of patients.

This is a practice the LINk hopes will be adopted throughout the NHS.

**Performance against key national targets for 2011/12**

The LINk is pleased to see all but one of these targets were met. The LINk understands that patients with large surface burns have a much higher risk of hospital acquired infection. It is pleasing that this was contained and did not pass to other patients.

## Statement from Health and Adult Social Care Select Committee

Thank you for offering the Health and Adult Social Care Select Committee (HASC) the opportunity to comment on the 2011/12 quality account for Queen Victoria Hospital NHS Foundation Trust.

Unfortunately, it is difficult for the HASC to comment on quality accounts this year. As you may be aware, this is a new committee, formed by the merger of the former Adults' Services Select Committee and Health Overview and Scrutiny Committee (HOSC). HASC has a new membership, and until last Friday (when it was appointed) did not have a chairman for the past month. In addition, the former HOSC's liaison arrangements with NHS trusts will need to be reviewed, given changes to the new committee's membership, and its wider remit covering both health and adult social care. We will therefore not be providing a comment on your quality account this year.

However, this is in no way a reflection of the importance of the work of QVH, and I would like to reassure you that the committee will maintain a strong interest in the trust, and will aim to build on the positive relationships established with you by the HOSC.

## Statement from NHS Sussex and clinical commissioning groups

Thank you for sending NHS Sussex a draft copy of your quality account for 2012. We have reviewed the content against the national criteria and specifically against the organisation's performance and ambitions.

NHS Sussex finds that the account meets the national guidance and framework issued by the Department of Health in December 2010.

NHS Sussex considered that there were areas of significant strength within the 2012 accounts. The accounts have a very clear link with the 2011 accounts and give a robust and clear indication of performance against the organisation's 2011/12 objectives, including clear descriptions of how these objectives were achieved. The accounts highlight that the objective of taking consent prior to the day of surgery will need to be taken forward into the 2012/13 accounts.

QVH should also be commended on the breadth and balance of data presented in regard to the published quality indicators.

NHS Sussex and QVH have worked collaboratively to move quality improvement forward. These improvements have been evidenced by the organisation's success in achieving 100% of its quality improvement and innovation goals agreed in its 2011/12 CQUINs targets. These included the following quality improvement goals:

- To improve responsiveness to personal needs of patients
- Reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE)
- The 'Sit and See' project has been designed to take key indicators of good fundamental practice, and use them as vital signs to demonstrate care, kindness and compassion
- Patient experience ophthalmology.

NHS Sussex regularly monitors the performance and quality of services through both quality and contractual meetings with the trust and also through receipt of the trust's quality and risk committee papers and minutes.

In relation to the priorities for 2012/13, NHS Sussex feels that there is a clear explanation of how and why the organisation has set the priorities with a clear plan of how the organisation will achieve its priorities.

NHS Sussex considers the four published priorities are appropriate for this organisation. These strengthen and support the quality improvement and innovation goals agreed in its 2012/13 CQUINs targets.

This document highlights the progress the trust has made in moving forward its quality agenda and has identified how it will continue to monitor its progress in these areas. It has also set out its plans for further improvement during 2012/13.

A continued focus on patient experience and on improving outcomes during 2012/13 will work to the benefit of patients and improve the quality of services provided by QVH.

## Statement from West Sussex Local Safeguarding Children Board

You have invited me to review the accuracy of the information and to offer any other relevant information or comment. As the relatively newly appointed independent chair for West Sussex Local Safeguarding Children Board (LSCB), I do not feel that I can comment on the accuracy of the information contained in the report. I am of course particularly interested in any reports that relate to the services provided to children in West Sussex.

The report does appear to reflect broadly positive progress in relation to the 2011/12 priorities. I have noted however that the report does not specifically highlight services offered to or received by children and young people in the catchment.

From this perspective I have to express some disappointment that there is no specific mention of the hospital's approach to dealing with the needs of children and young people. Additionally, from a safeguarding perspective, I could find no reference to safeguarding processes, training, communication sharing or joint working. As an example, it might have been possible to link some of these messages with discharge notifications to GPs.

I would like to suggest that these are issues that you might consider for the future versions of this annual report.

The LSCB and I value the provision of a representative from the hospital as a member of the LSCB. We also value the contributions of all health trusts to the important work of safeguarding in West Sussex. As such, I welcome this opportunity to provide this feedback on behalf of the LSCB, which I hope is of assistance to you.

## Statement from the board of governors

The board of governors takes a close interest in all forms of the patient experience within QVH. This covers the general experience of attending and being treated at the hospital to the specific issues of patient safety and clinical outcomes. The governors have multiple areas of interaction with the management and activities of the hospital and with the patients.

A governor representative attends the meetings of the board of directors, reporting back to the governors. Similarly a governor attends the meetings of the quality and risk committee which reviews all quality and risk activities within the trust on behalf of the board. The governors' steering group meets monthly with the executive reviewing operational reports and discussing any issues arising. Every month governors undertake patient surveys in the hospital's outpatient clinics. The results from these surveys are included in the regular patient experience reports which cover all aspects of the patient experience and are presented to the board of directors and the board of governors. Governors attend meetings of the patient experience taskforce which monitors patient experience and maintains an action plan for improvements. There are other areas of involvement including individual governor tours of specific areas of the hospital and governor attendance on some of the regular management inspections which cover cleanliness and safety issues within all departments of the hospital. In addition, the governors have been very pleased to note the results of the national inpatient and outpatient surveys undertaken throughout the NHS. QVH has maintained consistently high scores on these surveys. In the Dr Foster Hospital Guide for 2011, QVH was the top NHS hospital in terms of patients recommending the hospital.

The work the governors undertake gives us a clear and comprehensive view of the activities within QVH and of the quality of the patient experience. We have reviewed the quality accounts produced for 2011/12 and are satisfied that they give an accurate and reliable picture of the quality of QVH's activities. We also agree with the priorities for improvement. The management, staff and governors of QVH take pride in the high standard of care being achieved within the hospital. However, we are pleased to note that QVH is constantly striving to improve. The many operational reports produced are aimed at recording the positives but also at learning from the negatives. We are confident that QVH has high quality of care as a key priority and that it will continue to maintain and improve upon the current excellent standard.

## Independent auditor's report to the Council of Governors of Queen Victoria Hospital NHS Foundation Trust on the annual quality report

We have been engaged by the Council of Governors of Queen Victoria Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Victoria Hospital NHS Foundation Trust's quality report for the year ended 31 March 2012 (the "quality report") and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA – incidents of MRSA bacteraemia; and
- 62 day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

### Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the independent regulator of NHS foundation trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified below; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the quality report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with the sources specified below.

The sources with which we shall be required to form a conclusion as to the consistency of the quality report are limited to:

- board minutes for the period April 2011 to May 2012;
- papers relating to quality reported to the board over the period April 2011 to May 2012;
- feedback from the commissioners dated 16 May 2012;
- feedback from LINks dated 16 May 2012;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2010/11;
- the national outpatient survey 2011 and national inpatient survey 2011;
- the national staff survey dated 2011;
- Care Quality Commission quality and risk profiles dated February 2012;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 11 May 2012; and
- feedback from other named stakeholders involved in the sign off of the quality report:
  - West Sussex Local Safeguarding Children Board dated 24 May 2012
  - Health and Adult Social Care Select Committee dated 16 May 2012
  - Board of Governors dated 16 May 2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those sources, (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Queen Victoria Hospital NHS Foundation Trust as a body, to assist the council of governors in reporting Queen Victoria Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the annual report for the year ended 31 March 2012, to enable the council of governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Queen Victoria Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board ("ISAE 3000"). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of quality reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS foundation trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Queen Victoria Hospital NHS Foundation Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the quality report is not consistent in all material respects with the sources specified above; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

**KPMG LLP**
Statutory Auditor
London, May 2012

## Statement of director responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

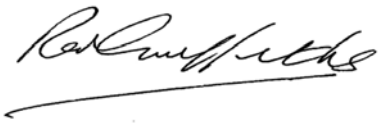
In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting manual 2011/12;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2011 to June 2012
  - papers relating to quality reported to the board over the period April 2011 to June 2012
  - feedback from commissioners dated 22/05/2012
  - feedback form governors dated 16/05/2012
  - feedback from LINks dated 16/05/2012
  - feedback from Health & Adult Social Care Select Committee dated 22/5/2012
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012
  - the national patient survey, April 2012
  - the national staff survey, February 2012
  - the Head of Internal's Audit's annual opinion over the trust's control environment dated 11/05/2012
  - CQC quality and risk profiles dated 29/02/2012.

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report (both available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

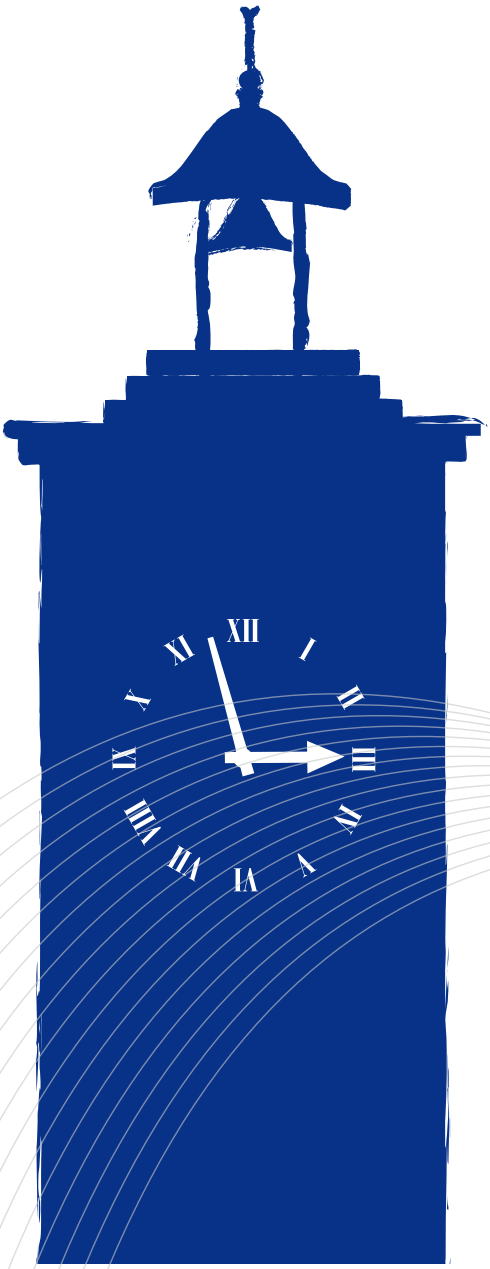
By order of the Board



**Peter Griffiths**
Chairman
28 May 2012

**Dr Adrian Bull**
Chief Executive
28 May 2012

# 6.0 Financial accounts



# 6.1 Statement of accounting officer's responsibilities

**Statement of the chief executive's responsibilities as the accounting officer of Queen Victoria Hospital NHS Foundation Trust**

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by the independent regulator of NHS foundation trusts ("Monitor").

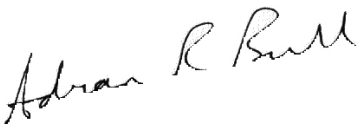
Under the NHS Act 2006, Monitor has directed Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the accounts direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Queen Victoria 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 Annual 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 Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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



**Dr Adrian Bull**
Chief Executive
28 May 2012

# 6.2 Independent auditors' report to the board of governors

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2012 on pages 56 to 59. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the board of governors of Queen Victoria Hospital NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the board of governors of the trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the board of governors of the trust, as a body, for our audit work, for this report or for the opinions we have formed.

**Respective responsibilities of directors and auditors**

As described more fully in the statement of accounting officer's responsibilities on page 54, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

**Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements. In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the state of Queen Victoria Hospital NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2011/12*.

**Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

In our opinion the information given in the directors' report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the annual governance statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the annual governance statement or that risks are satisfactorily addressed by internal controls.

**Certificate**

We certify that we have completed the audit of the accounts of Queen Victoria Hospital NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

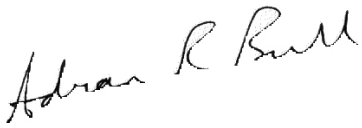
**Neil Thomas**
For and on behalf of KPMG LLP
Statutory Auditor
Chartered Accountants
15 Canada Square
London E14 5GL

29 May 2012

# 6.3 Statements and notes

## Foreword to the accounts

These accounts for the year ended 31 March 2012 have been prepared by Queen Victoria Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.



**Dr Adrian Bull**
Chief Executive
28 May 2012

| STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2012 | | | | |
|---|---|---|---|---|
| | **Notes** | | **2011/12 £000** | 2010/11 (restated) £000 |
| **Operating income** | 2, 3, 4 | | **55,887** | 56,593 |
| **Operating expenses excluding impairments** | 5 | | **(52,579)** | (54,019) |
| **Impairments of property, plant and equipment** | | | **(1,765)** | (3,454) |
| **Operating surplus/(deficit) including impairments** | | | **1,543** | (880) |
| **Finance costs** | | | | |
| Finance income | 9 | 16 | | 71 |
| Finance expense – unwinding of discount on provisions | 18 | (16) | | (16) |
| Finance expense – other | 19 | (8) | | (2) |
| PDC dividends payable | | (861) | | (828) |
| **Net finance costs** | | | **(869)** | (775) |
| **SURPLUS/(DEFICIT) FOR THE YEAR** | 25 | | **674** | (1,655) |
| **Other comprehensive income:** (See statement of changes in taxpayers' equity on page 58) | | | | |
| Revaluation gains/(losses) on property, plant and equipment | | | **741** | 11 |
| Impairment through revaluation reserve | | | **(708)** | – |
| **TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE PERIOD** | | | **707** | (1,644) |

| STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012 | | | | |
|---|---|---|---|---|
| | Notes | **31 March 2012 £000** | 31 March 2011 (restated) £000 | 31 March 2010 (restated) £000 |
| **NON-CURRENT ASSETS:** | | | | |
| Intangible assets | 10 | **93** | 65 | 87 |
| Property, plant and equipment | 11 | **30,706** | 28,025 | 32,128 |
| Trade and other receivables | 14 | **–** | 15 | 48 |
| **Total non-current assets** | | **30,799** | 28,105 | 32,263 |
| **CURRENT ASSETS:** | | | | |
| Inventories | 13 | **304** | 225 | 319 |
| Trade and other receivables | 14 | **2,223** | 2,452 | 3,339 |
| Cash and cash equivalents | 15 | **5,979** | 6,967 | 4,801 |
| **Total current assets** | | **8,506** | 9,644 | 8,459 |
| **CURRENT LIABILITIES:** | | | | |
| Trade and other payables | 16 | **(3,476)** | (3,434) | (5,393) |
| Other liabilities | 17 | **(495)** | (254) | – |
| Provisions | 18 | **(29)** | (433) | (38) |
| **Total current liabilities** | | **(4,000)** | (4,121) | (5,431) |
| **NON-CURRENT LIABILITIES:** | | | | |
| Provisions | 18 | **(465)** | (460) | (522) |
| Long term borrowings | 20.1 | **(1,000)** | (43) | – |
| **Total non-current liabilities** | | **(1,465)** | (503) | (522) |
| **TOTAL ASSETS EMPLOYED** | | **33,840** | 33,125 | 34,769 |
| **TAXPAYERS' EQUITY:** (See statement of changes in taxpayers' equity on page 58) | | | | |
| Public dividend capital | | **12,212** | **12,212** | **12,212** |
| Revaluation reserve | | **12,808** | **14,014** | **15,964** |
| Income and expenditure reserve | | **8,820** | **6,899** | **6,593** |
| **TOTAL TAXPAYERS' EQUITY** | | **33,840** | **33,125** | **34,769** |

The accounts on pages 56 to 59 were approved by the board on 24 May 2012 and are signed on the board's behalf by:

**Dr Adrian Bull**
Chief Executive
28 May 2012

The notes on pages 60 to 81 form part of these accounts.

| STATEMENT OF CHANGES IN TAXPAYERS' EQUITY | | | | | |
|---|---|---|---|---|---|
| | Public dividend capital £000 | Revaluation reserve £000 | Donated assets reserve £000 | Income and expenditure reserve £000 | **Total £000** |
| **2011/12** | | | | | |
| Taxpayers' equity at 1 April 2011 – as previously stated | 12,212 | 12,125 | 1,883 | 4,505 | **30,725** |
| Prior period adjustment | - | 1,889 | (1,883) | 2,394 | **2,400** |
| Taxpayers' equity at 1 April 2011 – restated | 12,212 | 14,014 | – | 6,899 | **33,125** |
| Surplus/(deficit) for the year | – | – | – | 674 | **674** |
| Transfers between reserves | – | (1,247) | – | 1,247 | **–** |
| Revaluation of property, plant and equipment | – | 741 | – | – | **741** |
| Impairments | – | (708) | – | – | **(708)** |
| Other reserves movements | – | 8 | – | – | **8** |
| **Taxpayers' equity at 31 March 2012** | 12,212 | 12,808 | – | 8,820 | **33,840** |
| | | | | | |
| **2010/11** | | | | | |
| Taxpayers' equity at 1 April 2010 – as previously stated | 12,212 | 14,075 | 2,326 | 3,971 | **32,584** |
| Prior period adjustment | – | 1,889 | (2,326) | 2,622 | **2,185** |
| Taxpayers' equity at 1 April 2010 – restated | 12,212 | 15,964 | – | 6,593 | **34,769** |
| Surplus/(deficit) for the year | – | – | – | (1,655) | **(1,655)** |
| Transfers between reserves | – | – | – | – | – |
| Revaluation of property, plant and equipment | – | 11 | – | – | **11** |
| Other reserve movements | – | (1,961) | – | 1,961 | **–** |
| Taxpayers' equity at 31 March 2011 | 12,212 | 14,014 | – | 6,899 | **33,125** |

**Prior period adjustments**

1 As noted in note 1.4, IAS 20 has been adopted from 1 April 2011, resulting in the elimination of the donated asset reserve and the transfer of the balance to the revaluation reserve (£1,889,000) and income and expenditure reserve (£437,000) as a prior period adjustment in 2010/11.

2 In accordance with the guidance on the treatment of government granted assets set out in the Treasury's 2011/12 FReM, income received in previous years and deferred pending completion of capital projects has now been accounted for as income in the years of receipt.

| STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012 | | | | |
|---|---|---|---|---|
| | Notes | | **2011/12 £000** | 2010/11 (restated) £000 |
| **Operating surplus/(deficit)** | | | **1,543** | (880) |
| **Non-cash income and expense** | | | | |
| Depreciation and amortisation | 5 | | **1,820** | 2,233 |
| Impairments | 5 | | **1,765** | 3,454 |
| Transfer from the donated asset reserve | 4 | | **–** | – |
| (Increase)/decrease in inventories | 13 | | **(79)** | 94 |
| Decrease in trade receivables | 14 | | **229** | 887 |
| Increase/(decrease) in trade and other payables | 16 | | **42** | (1,959) |
| Increase/(decrease) in provisions | 18 | | **(399)** | 333 |
| Increase/(decrease) in other liabilities | 17 | | **241** | 254 |
| Net cash inflow from operations | | | **5,162** | 4,416 |
| **Cash flows from investing activities** | | | | |
| Interest received | 9 | **16** | | 9 |
| Payments to acquire intangible assets | 10 | **(52)** | | (15) |
| Payments to acquire property, plant and equipment | 11 | **(6,434)** | | (1,305) |
| **Net cash used in investing activities** | | | **(6,470)** | (1,311) |
| **Cash flows from financing activities** | | | | |
| Loans from Foundation Trust Financing Facility | 20.1 | | **1,000** | – |
| Capital element of finance lease rental payments | 19 | | **–** | (4) |
| Interest paid | 19 | | **–** | (2) |
| PDC dividends paid | | | **(680)** | (933) |
| **Increase in cash** | | | **(988)** | 2,166 |
| **Cash and cash equivalents at 1 April 2011 – as previously stated** | 15 | | **6,967** | 4,801 |
| **Cash and cash equivalents at 31 March 2012** | 15 | | **5,979** | 6,967 |

# Notes to the financial statements

## 1. Accounting policies

These financial statements have been prepared in accordance with International Financial Reporting Standards as adopted by the European Union (IFRSs as adopted by the EU), IFRIC Interpretations and the Companies Act 2006 applicable to companies reporting under IFRS. They have been prepared under the historical cost convention as modified by the revaluation of land and buildings.

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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.

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

### 1.1 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

### 1.2 Expenditure on employee benefits

***Short-term employee benefits***

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

***Pension costs***

*NHS pension scheme*

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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

*Additional pension liabilities arising from early retirements*

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

### 1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### 1.4 Property, plant and equipment

***Recognition***

Property, plant and equipment are capitalised where:

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

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

***Measurement***

*Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest valuations were undertaken in 2012 as at the prospective valuation date of 31 March 2012 and were accounted for in the 2011/12 accounts.

Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost.

The depreciated replacement cost of specialised buildings is based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

For non-operational properties including surplus land, the valuations are carried out at open market value.

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

Land, buildings and fixtures are stated in the balance sheet at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Equipment is stated in the statement of financial position at its revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. In the intervening periods the trust considers depreciated historic cost to be a suitable estimate of fair value. In the absence of regular markets from which market values can be assessed, revaluations are based on suitable indices such as the Hospital Service Cost Index published by the Department of Health.

*Subsequent expenditure*

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

*Depreciation*

Items of property, plant and equipment are depreciated on a straight line basis over their remaining useful economic lives. This is considered to be consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The remaining economic lives of each element of each building are determined by an independent valuer and each element is depreciated individually.

Plant, machinery and transport equipment are generally given lives of five, ten or fifteen years, depending on their nature and the likelihood of technological obsolescence.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the trust, respectively.

*Revaluation and impairment*

In accordance with the NHS Foundation Trust Annual Reporting Manual, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments resulting from loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:

(i) the impairment charged to operating expenses; and

(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Gains and losses recognised in the revaluation reserve are reported in the statement of comprehensive income as an item of 'other comprehensive income'.

Land and buildings (including furniture and fittings) were revalued as at 31 March 2012 and the effect of that revaluation has been included in these accounts.

The revaluation was carried out by an independent, qualified valuer on the modern equivalent asset basis and the assumption that the property is sold as part of the continuing enterprise in occupation. The valuation was based on the existing site rather than an alternative.

The valuations were carried out on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property.

For specialised buildings where there is no market-based evidence of fair value, the latter is estimated using a depreciated replacement cost approach based on the assumption of the asset's replacement by a modern equivalent asset, in accordance with RICS and International Valuation Standards.

For non-operational properties including surplus land, the valuations were carried out at open market value.

Plant and machinery, transport equipment and information technology equipment were last revalued as at 31 March 2008 using suitable indices supplied by the Department of Health. The movement in indices since that time has not been sufficient to affect values materially.

***Donated assets***

From 1 April 2011 foundation trusts have adopted IAS 20 in accordance with the Treasury FReM. Donations are therefore recognised in income and a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010/11 results have been restated.

**1.5 Intangible assets**

***Recognition***

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

***Internally generated intangible assets***

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the trust intends to complete the asset and sell or use it;
- the trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

***Software***

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

***Measurement***

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the statement of comprehensive income as an item of 'other comprehensive income'.

In the case of software, amortised historic cost is considered to be the fair value.

***Amortisation***

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. In the case of software licenses useful economic life is assumed to be five years.

**1.6 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is determined by reference to current prices, using the first in, first out (FIFO) method.

### 1.7 Cash and cash equivalents

Cash and cash equivalents include cash in hand, deposits held at call with banks and bank overdrafts. Bank overdrafts are shown within current borrowings in current liabilities on the statement of financial position..

### 1.8 Trade receivables

Trade receivables are recognised at fair value less provision for impairment. A provision for impairment of trade receivables is established when there is objective evidence that the trust will not be able to collect all amounts due according to the original terms of the receivables. Significant financial difficulties of the debtor, probability that the debtor will enter bankruptcy or financial reorganisation, and default or delinquency in payments (more than 60 days overdue) are considered indicators that the trade receivable is impaired. The amount of the provision is the difference between the asset's carrying amount and the estimated future cash flows. The carrying amount of the asset is reduced through the use of a provision for doubtful debts account, and the amount of the loss is recognised in the income statement within 'operating expenses'. When a trade receivable is uncollectible, it is written off against the provision account. Subsequent recoveries of amounts previously written off are credited against 'operating expenses' in the income statement.

### 1.9 Trade payables

Trade payables are recognised at fair value. Fair value is deemed to be invoice value less any amounts that the trust does not believe to be due.

### 1.10 Financial assets 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.

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

***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 'financial liabilities'.

***Loans and receivables***

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets at the prices current when the goods or services were delivered.

The trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Interest on loans and receivables is calculated using the effective interest method and credited to the statement of comprehensive income.

***Financial liabilities***

All financial liabilities are recognised initially at cost, which the trust deems to be 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 statement of financial position date, which are classified as non-current liabilities.

***Impairment of financial assets***

At the statement of financial position date, the trust assesses whether any financial assets are 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 statement of comprehensive income and the carrying amount of the asset is reduced through the use of a bad debt provision.

### 1.11 Leases

***Finance leases***

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual

finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the statement of comprehensive income.

***Operating leases***

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

***Leases of land and buildings***

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Where land is leased for a short term (e.g. ten years) and there is no provision for the transfer of title, the lease is considered to be an operating lease.

***The trust as lessor***

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

**1.12 Provisions**

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.9% in real terms.

***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 trust is disclosed at note 18. The trust does not carry any amounts relating to these cases in its own accounts.

***Other NHSLA schemes***

The 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.

**1.13 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 where an inflow of economic benefits is probable.

*Contingent liabilities* are not recognised, but are disclosed unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

**1.14 Public dividend capital**

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 predecessor NHS trust. HM Treasury has determined that, as PDC is issued under legislation rather than contract, it is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

(i) donated assets;
(ii) net cash balances held with the Government Banking Service; and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

**1.15 Value added tax**

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

**1.16 Corporation tax**

Section 148 of the Finance Act 2004 amended S519A of the Income and Corporation Taxes Act 1988 to provide power to the Treasury to make certain non-core activities of foundation

trusts potentially subject to corporation tax. This legislation became effective in the 2005/06 financial year.

In determining whether or not an activity is likely to be taxable, a three-stage test may be employed:

- *Is the activity an authorised activity related to the provision of core healthcare?* The provision of goods and services for purposes related to the provision of healthcare authorised under Section 14(1) of the Health and Social Care Act 2003 (HSCA) is not treated as a commercial activity and is therefore tax exempt.
- *Is the activity actually or potentially in competition with the private sector?* Trading activities undertaken in house which are ancillary to core healthcare activities are not entrepreneurial in nature and not subject to tax. A trading activity that is capable of being in competition with the wider private sector will be subject to tax.
- *Are the annual profits significant?* Only significant trading activity is subject to tax. Significant is defined as annual taxable profits of £50,000 per trading activity.

The majority of the trust's activities are related to core healthcare and are not subject to tax. Where trading activities are undertaken that are commercial in nature they are considered insignificant with profits per activity below the £50,000 tax threshold.

No corporation tax was charged to the trust for the financial year ending 31 March 2012.

**1.17 Foreign exchange**

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

**1.18 Third party assets**

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

**1.19 Accounting standards issued but not yet applied**

*IASB standard and IFRIC interpretations*

The following accounting standards have been issued but have not yet been adopted. NHS bodies cannot adopt new standards unless they have been adopted in the HM Treasury FReM. The HM Treasury FReM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

In some cases, the standards may be interpreted in the HM Treasury FReM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation and the likely impact on the assumption that no interpretations are applied by the HM Treasury FReM.

*i) IFRS 7 – Financial instruments: disclosures*
This is an amendment to the standard to require additional disclosures where financial assets are transferred between categories (e.g. 'fair value through profit and loss', loans and receivable, etc). It is applicable from 2012/13. It is unlikely to affect NHS bodies as they rarely transfer financial instruments.

*ii) IFRS 9 – Financial instruments*
This is a new standard to replace - IAS 39 Financial instruments: recognition and measurement. Two elements of the standard have been issued so far: financial assets and financial liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: amortised cost and 'fair value through profit and loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

*iii) IFRS 10 – Consolidated financial statements*
This builds on existing principles by identifying the concept of control as the determining factor in whether an entity should be included within the consolidated financial statements of the parent company and provides quidance to assist in the determination of control. It is yet to be adopted by the EU and the effective date is 2013/14.

*iv) IFRS 11 – Joint arrangements*
This provides for a more realistic relfection of joint arrangements by focussing on the rights and obligations of the arrangements, rather than its legal form. It also requires a single method of accounting for interests in jointly controlled entities as such ensures consistency of reporting of joint arrangements. It is yet to be adopted by the EU and has an effective date of 2013/14.

*v) IFRS 12 – Disclosure of interests in other entities*
This is a new and comprehensive standard on disclosure requirements for all forms of interests in other entities, including joint arrangements, associates, special purpose vehicles and other off balance sheet vehicles. This is yet to adopted by the EU and has an effective date of 2013/14.

*vi) IFRS 13 – Fair value measurement*
This provides a single source of guidance for all fair value measurements, clarifying the definition of fair value and enhancing disclosures about reported fair value estimates. This is yet to be adopted by the EU and has an effective date of 2013/14.

*vii) IAS 1 – Presentation of financial statements on other comprehensive income (OCI)*
This provides amendments that will improve and align the presentation of items of other comprehensive income (OCI) in financial statements prepared in accordance with IFRS and those prepared in accordance with US GAAP. This

amendment requires some items in OCI in IFRS statements to be reclassified to the profit and loss section of the income statement. This is yet to be adopted by the EU, with an effective date of 2013/14.

*viii) IAS 12 – Income taxes*
The objectives of IAS 12 are to specify the accounting for current and deferred tax. This standard has an effective date of 2012/13 but has not yet been adopted by the EU.

*ix) IAS 27 – Separate financial statements*
This provides the requirement for preparing and presenting consolidated financial statements for a group of entities under the control of a parent and for presenting separate (non-consolidated) financial statments for investments in subsidiaries jointly controlled entities and associates. The effective date is 2013/14 and is yet to be adopted by the EU.

*x) IAS 28 – Associates and joint ventures*
This amended version prescribes the accounting for investments in associates and sets out the requirement provides the requirements for the application of the equity method when accounting for investments in associates and joint ventures. The main change here is that the use of the equity method is now extended to joint arrangements with the proportionate consolidation method eliminated. The effective date is 2013/14 but not yet adopted by the EU.

**1.20 Critical accounting estimates and assumptions**

International accounting standard IAS1 requires estimates, assumptions and judgements to be continually evaluated and to be based on historical experience and other factors including expectation of future events that are believed to be reasonable under the circumstances. Actual results may differ from these estimates. The purpose of the evaluation is to consider whether there may be a significant risk of causing a material adjustment to the carrying value of assets and liabilities within the next financial year, compared to the carrying value in these accounts. The following significant assumptions and areas of estimation and judgement have been considered in preparing these financial statements.

*Value of land, buildings and dwellings £24,975,000 (2010/11 £23,025,000)* – This is the most significant estimate in the accounts and is based on the professional judgement of the trust's independent valuer with extensive knowledge of the physical estate and market factors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

*Accruals of income* – The major income streams derive from the treatment of patients or from funding provided by government bodies and can be predicted with reasonable accuracy. Provisions are made where there is doubt about the likelihood of the trust actually receiving the income due to it. See note 14.1.

Income for an inpatient stay can start to be recognised from the day of admission, but cannot be precisely calculated until after the patient is discharged. For patients occupying a bed at the 2011/12 financial year end, the estimated value of partially completed spells is £36,000 (2010/11 £181,000).

*Accruals of expenditure* – Where goods or services have been received by the trust but have not been invoiced at the end of the financial year estimates are based on the best information available at the time and where possible on known prices and volumes. See note 16.

*Provisions for early retirements* – The trust makes additional pension contributions in respect of a number of staff who have retired early from the service. Provisions have been made for these contributions, based on information from the NHS Pensions Agency. See note 18.

**1.21 Operating segments**

An operating segment is a group of assets and operations engaged in providing products or services that are subject to risks and returns that are different to those of other operating segments. Under IFRS 8 an operation is considered to be a separate operating segment if its revenues exceed 10% of total revenues. Operations that contribute less than 10% of total revenue may be aggregated.

The trust derives its income from the provision of healthcare, chiefly in its capacity as a specialist provider of various forms of reconstructive surgery. Reconstructive surgery includes plastic surgery, burns surgery, maxillofacial surgery and corneoplastic surgery. Its other activities are associated with the provision of community hospital services to its local area.

Reconstructive surgery is the trust's principal activity. Its other activities do not, individually, constitute 10% of revenue and have been agregated. There are therefore two reportable segments.

Total assets are not reported to the board by segment as all costs and activities relating to property, plant and equipment are managed centrally. Other balance sheet items, including current assets and current liabilities are also managed centrally and are therefore not analysed or reported by segment.

**1.22 Pension costs**

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

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

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

## 2. Operating segments

The chief operating decision maker is considered to be the trust board because it is the board that makes all major strategic decisions and oversees the day-to-day running of the trust. At monthly board meetings key operational decisions are reached following scrutiny of performance and resource allocation across the trust's operating segments.

The trust's principal activity is reconstructive surgery. Its other activities do not, individually, constitute 10% of revenue and have been agregated. There are therefore two reportable segments.

All accounting during the year is done on an IFRS basis and financial performance against budget for each segment is presented to senior management on a monthly basis.

The financial results for each segment were as follows:

| | 2011/12 | | 2010/11 (restated) | |
|---|---|---|---|---|
| | **Income £000** | **Expenditure £000** | **Income £000** | **Expenditure £000** |
| Reconstructive surgery | 47,539 | 35,390 | 44,641 | 31,784 |
| All other segments | 8,237 | 4,433 | 11,309 | 4,448 |
| **Total of reportable segments** | **55,776** | **39,823** | **55,950** | **36,232** |
| Corporate services (see note below) | | 10,647 | | 14,215 |
| Depreciation | | 1,796 | | 2,192 |
| Impairment of property, plant and equipment | | 1,765 | | 3,454 |
| Restructuring costs | | 210 | | 739 |
| Finance income | | (16) | | (71) |
| Finance expense – unwinding of discount on provisions | | 16 | | 16 |
| PDC dividends payable | | 861 | | 828 |
| **Surplus/(deficit) for the year** | | **674** | | **(1,655)** |

Corporate services includes all the costs of shared clinical services, the board, finance, IT, human resources, nursing management, estates and facilities.

## 3. Income from patient care activities

| | **2011/12 £000** | 2010/11 (restated) £000 |
|---|---|---|
| NHS foundation trusts | **318** | 280 |
| NHS trusts | **136** | 6 |
| Primary care trusts | **51,623** | 53,160 |
| Department of Health | **–** | 2 |
| NHS other | **–** | 39 |
| Non-NHS: | | |
| Private patients | **102** | 249 |
| Injury costs recovery | **386** | 209 |
| Other | **15** | 115 |
| | **52,580** | 54,060 |

'Injury costs recovery' is income received from insurance companies for the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

***Mandatory and non-mandatory services***

Mandatory services are those which provide for the healthcare of NHS patients. All other services are non-mandatory. Of the total income reported above, £52,478,000, (2010/11 £53,596,000) was derived from the provision of mandatory services.

## 4. Other operating income

| | **2011/12 £000** | 2010/11 (restated) £000 |
|---|---|---|
| Education, training and research | **1,656** | 1,644 |
| Charitable and other contributions to expenditure | **111** | 90 |
| Non-patient care services to other bodies | **–** | 82 |
| Other income | **1,540** | 717 |
| | **3,307** | 2,533 |

## 5. Operating expenses

| | **2011/12 £000** | 2010/11 £000 |
|---|---|---|
| Services from NHS foundation trusts | **1,840** | 678 |
| Services from NHS trusts | **2,571** | 2,399 |
| Services from PCTs | **33** | – |
| Services from other NHS bodies | **180** | 222 |
| Purchase of healthcare from non-NHS bodies | **6** | 230 |
| Executive directors' costs | **436** | 419 |
| Non-executive directors' costs | **117** | 118 |
| Staff costs | **35,202** | 35,658 |
| Consultancy | **–** | 167 |
| Drugs | **1,024** | 958 |
| Supplies and services – clinical (excluding drugs) | **4,586** | 4,686 |
| Supplies and services – general | **13** | 655 |
| Establishment | **1,610** | 1,011 |
| Transport | **173** | 203 |
| Premises | **1,476** | 1,557 |
| Provision for impairment of receivables | **218** | 727 |
| Depreciation | **1,796** | 2,155 |
| Amortisation | **24** | 37 |
| Audit fees – statutory audit | **57** | 149 |
| Other auditor's remuneration – other services | **7** | 33 |
| Clinical negligence | **435** | 363 |
| Restructuring Costs – pay | **345** | 739 |
| Restructuring Costs – non-pay | **143** | – |
| Loss on disposal of buildings | **65** | – |
| Other | **222** | 855 |
| | **52,579** | 54,019 |
| Impairments of property, plant and equipment | **1,765** | 3,454 |
| | **54,344** | **57,473** |

***Notes:***

**External audit** – The contract between the trust and its auditors provides for the latter's liability to be limited to £5,000,000.

## 6. Operating leases

### As lessee

Operating leases relate to buildings, heating systems, medical equipment and vehicles. Buildings are leased for periods of five or ten years. Medical equipment and vehicles are leased for periods of between two and five years.

| Payments recognised as an expense | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Minimum lease payments | **296** | 747 |

| Total future minimum lease payments | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Payable: | | |
| Not later than 1 year | **463** | 464 |
| Between 1 and 5 years | **1,283** | 739 |
| After 5 years | **426** | 30 |
| **Total** | **2,172** | 1,233 |

## 7. Employee benefits and staff numbers

| 7.1 Employee benefits | 2011/12 £000 | 2010/11 £000 |
|---|---|---|
| Salaries and wages | **29,005** | 28,271 |
| Social security costs | **2,522** | 2,510 |
| Employer contributions to NHS pension scheme | **3,367** | 3,423 |
| Agency/contract staff | **1,089** | 1,873 |
| **Employee benefits expense** | **35,983** | 36,077 |
| Non-executive directors benefits not included above | 117 | 118 |
| | 36,100 | 36,195 |

| 7.2 Average number of people employed | 2011/12 Number | 2010/11 Number |
|---|---|---|
| Medical and dental | **124** | 123 |
| Administration and estates | **200** | 187 |
| Healthcare assistants and other support staff | **120** | 130 |
| Nursing, midwifery and health visiting staff | **184** | 191 |
| Scientific, therapeutic and technical staff | **137** | 136 |
| Bank and agency staff | **66** | 55 |
| **Total** | **831** | **822** |

### 7.3 Staff exit packages for staff leaving in 2011/12

Staff exit packages are payable when the trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. During the year there were 11 such cases. The cost of these packages fell within the following bands:

| **Exit package cost band** | **2011/12** | | 2010/11 | |
|---|---|---|---|---|
| **£000** | **Number of compulsory redundancies** | **Total exit packages by cost band** | Number of compulsory redundancies | Total exit packages by cost band |
| 10–25 | **3** | **8** | 1 | 5 |
| 25–50 | **1** | **1** | – | 4 |
| 50–100 | **2** | **2** | 1 | 1 |
| **Total** | **6** | **11** | 2 | 10 |

## 8. Retirements due to ill-health

During the year there were no early retirements due to ill health (2010/11, one).

## 9. Finance revenue

| | **2011/12 £000** | 2010/11 £000 |
|---|---|---|
| Interest revenue from bank accounts | **16** | 9 |
| Increase in discount rate regarding early retirement and injury benefit provision | **–** | 62 |
| | **16** | 71 |

## 10. Intangible assets

| **Software licences** | **2011/12 £000** | 2010/11 £000 |
|---|---|---|
| Gross cost at 1 April 2011 – as previously stated | **229** | 214 |
| Additions | **52** | 15 |
| **Gross cost at 31 March 2012** | **281** | 229 |
| | | |
| Amortisation at 1 April 2011 – as previously stated | **164** | 127 |
| Provided during the year | **24** | 37 |
| **Amortisation at 31 March 2012** | **188** | 164 |
| | | |
| **Net book value** | | |
| Purchased assets at 1 April 2011 – as previously stated | **65** | 87 |
| Purchased assets at 31 March 2012 | **93** | 65 |

## 11. Property, plant and equipment

| 11.1 Property, plant and equipment at 31 March 2012 | Land £000 | Buildings £000 | Assets under construction £000 | Plant and machinery £000 | Information technology £000 | Furniture and fittings £000 | Total £000 |
|---|---|---|---|---|---|---|---|
| **Cost or valuation at 1 April 2011 – restated** | 9,513 | 14,589 | 915 | 10,141 | 2,502 | 601 | **38,261** |
| Additions – purchased | – | 3,822 | 1,608 | 600 | 88 | 10 | **6,128** |
| Additions – donated | – | 94 | – | 52 | – | – | **146** |
| Reclassifications | – | (1,182) | (392) | (855) | (233) | (131) | **(2,793)** |
| Impairments recognised in operating expenses | – | (1,765) | – | – | – | – | **(1,765)** |
| Impairments recognised in revaluation reserve | – | (708) | – | – | – | – | **(708)** |
| Revaluation gain | – | 741 | – | – | – | – | **741** |
| Disposals | – | (129) | – | – | – | – | **(129)** |
| **At 31 March 2012** | **9,513** | **15,462** | **2,131** | **9,938** | **2,357** | **480** | **39,881** |
| Depreciation at 1 April 2011 – as previously stated | – | 1,077 | – | 7,335 | 1,800 | 24 | **10,236** |
| Provided during the year | – | 650 | – | 904 | 216 | 26 | **1,796** |
| Reclassifications | – | (1,633) | – | (847) | (233) | (50) | **(2,793)** |
| Disposals | – | (64) | – | – | – | – | **(64)** |
| **Depreciation at 31 March 2012** | **–** | **–** | **–** | **7,392** | **1,783** | **–** | **9,175** |
| **Net book value** | | | | | | | |
| Purchased assets as at 1 April 2011 – as previously stated | 9,513 | 11,933 | 915 | 2,532 | 700 | 553 | **26,146** |
| Donated assets as at 1 April 2011 – as previously stated | – | 1,579 | – | 274 | 2 | 24 | **1,879** |
| **Total at 1 April 2011 – as previously stated** | **9,513** | **13,512** | **915** | **2,806** | **702** | **577** | **28,025** |
| Purchased assets as at 31 March 2012 | 9,513 | 13,751 | 2,131 | 2,325 | 569 | 462 | **28,751** |
| Donated assets as at 31 March 2012 | – | 1,711 | – | 221 | 5 | 18 | **1,955** |
| **Total at 31 March 2012** | **9,513** | **15,462** | **2,131** | **2,546** | **574** | **480** | **30,706** |

*2010-11 comparators overleaf*

| 11.1 Property, plant and equipment (continued) | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2010-11 comparators** | Land £000 | Buildings excluding dwellings £000 | Assets under construction £000 | Plant and machinery £000 | Information technology £000 | Furniture and fittings £000 | **Total £000** |
| **Cost or valuation at 1 April 2010** | 9,513 | 17,789 | 328 | 9,823 | 2,299 | 587 | **40,339** |
| – restated | – | 26 | 859 | 367 | 203 | 11 | **1,466** |
| Additions – donated | – | – | – | 82 | – | – | **82** |
| Reclassifications | – | 228 | (231) | – | – | 3 | **–** |
| Impairments recognised in operating expenses | – | (3,454) | – | – | – | – | **(3,454)** |
| Revaluation gain/(loss) | – | – | – | – | – | – | **–** |
| Disposals | – | – | (41) | (131) | – | – | **(172)** |
| **At 31 March 2011** | **9,513** | **14,589** | **915** | **10,141** | **2,502** | **601** | **38,261** |
| Depreciation at 1 April 2010 | – | 31 | – | 6,589 | 1,591 | – | **8,211** |
| Provided during the year | – | 1,046 | – | 876 | 209 | 24 | **2,155** |
| Revaluation gain/(loss) | – | – | – | – | – | – | **–** |
| Disposals | – | – | – | (130) | – | – | **(130)** |
| **Depreciation at 31 March 2011** | **–** | **1,077** | **–** | **7,335** | **1,800** | **24** | **10,236** |
| **Net book value** | | | | | | | |
| Purchased assets as at 1 April 2010 | 9,513 | 15,774 | 328 | 2,935 | 699 | 553 | **29,802** |
| Donated assets as at 1 April 2010 | – | 1,984 | – | 299 | 9 | 34 | **2,326** |
| **Total at 1 April 2010** | **9,513** | **17,758** | **328** | **3,234** | **708** | **587** | **32,128** |
| Purchased assets as at 31 March 2011 | 9,513 | 11,933 | 915 | 2,532 | 700 | 553 | **26,146** |
| Donated assets as at 31 March 2011 | – | 1,579 | – | 274 | 2 | 24 | **1,879** |
| **Total at 31 March 2011** | **9,513** | **13,512** | **915** | **2,806** | **702** | **577** | **28,025** |

### 11.2 Protected and non-protected property, plant and equipment

The net book values disclosed above relate entirely to protected assets with the exception of non-protected land valued at £1,807,000 at 31 March 2012 (£1,807,000 at 31 March 2011), which is included within the totals..

### 11.3 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £6,092,000 are still in use.

### 11.4 Property, plant and equipment donated during the year

During the year, medical equipment with a value of £52,000 was donated to the trust by the Queen Victoria Hospital NHS Trust Charitable Fund.

## 12. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

| | **31 March 2012 £000** | 31 March 2011 £000 |
|---|---|---|
| Property, plant and equipment | **8,501** | **602** |

The increase in capital comitments reflects the agreement to proceed with the operating theatres new build under Procure 21+.

## 13. Inventories

| Inventories at 31 March | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Drugs | **90** | 98 |
| Clinical consumables | **206** | 124 |
| Other | **8** | 3 |
| **Total** | **304** | 225 |

## 14. Trade and other receivables

| 14.1 Trade and other receivables comprise: | 31 March 2012 | | 31 March 2011 | |
|---|---|---|---|---|
| | **Current £000** | **Non-current £000** | Current £000 | Non-current £000 |
| NHS and other related party receivables | **1,649** | **–** | 2,516 | 15 |
| Other trade receivables | **1,292** | **–** | 149 | - |
| Accrued income | **36** | **–** | 2 | - |
| Provision for the impairment of receivables | **(1,130)** | **–** | (912) | - |
| Prepayments | **376** | **–** | 697 | - |
| **Total** | **2,223** | **–** | 2,452 | 15 |

The great majority of trade is with primary care trusts, as commissioners for NHS patient care services. As primary care trusts are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

| 14.2 Receivables past their due date but not impaired | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| By up to three months | **23** | 417 |
| By between three and six months | **229** | 10 |
| By more than six months | **639** | 130 |
| **Total** | **891** | 557 |

| 14.3 Provision for impairment of NHS receivables | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Balance at 1 April 2011 | **(861)** | (138) |
| Amount recovered or written off during the year | **–** | 117 |
| Increase in receivables impaired | **(243)** | (840) |
| **Balance at 31 March 2012** | **(1,104)** | (861) |

The provision represents amounts which are either considerably beyond their due date, known to be in dispute or which the trust considers may be disputed by the debtor body.

| 14.4 Provision for impairment of non-NHS receivables | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Balance at 1 April 2011 | **(51)** | (47) |
| Amount recovered or written off during the year | **25** | 47 |
| Increase in receivables impaired | **–** | (51) |
| **Balance at 31 March 2012** | **(26)** | (51) |

## 15. Cash and cash equivalents

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Balance at 1 April 2011 | **6,967** | 4,801 |
| Net change in year | **(988)** | 2,166 |
| **Balance at 31 March 2012** | **5,979** | 6,967 |
| **Comprising:** | | |
| Cash with the Government Banking Service (GBS) | **6,384** | 7,326 |
| Commercial banks and cash in hand | **(405)** | (359) |
| **Cash and cash equivalents as in statement of cash flows** | **5,979** | 6,967 |

The negative balance with commercial banks represents cash in transit. It was covered by a transfer from the GBS account before the cash left the commercial account.

## 16. Trade and other payables

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| NHS payables | **645** | 1,194 |
| Trade payables – capital | **334** | 25 |
| Other payables – revenue | **712** | 290 |
| Accruals | **1,016** | 1,144 |
| | **2,707** | 2,653 |
| Tax and social security costs | **769** | 781 |
| **Total** | **3,476** | 3,434 |

**NHS payables** include £424,000 outstanding pensions contributions at 31 March 2012 (31 March 2011 £442,000).

## 17. Deferred income

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Current | **495** | 254 |

## 18. Provisions

| Current | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Pensions relating to staff | **26** | 26 |
| Legal claims | **3** | 13 |
| Other | **–** | 394 |
| **Total** | **29** | 433 |

| Non-current | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Pensions relating to staff | **465** | 460 |

| Movements in-year | Pensions relating to staff £000 | Legal claims £000 | Other £000 | Total £000 |
|---|---|---|---|---|
| **At 1 April 2011 – as previously stated** | **486** | **13** | **394** | **893** |
| Change in discount rate | **–** | **–** | **–** | **–** |
| Arising during the year | **14** | **–** | **–** | **14** |
| Used during the year | **(25)** | **(10)** | **(394)** | **(429)** |
| Reversed unused | **–** | **–** | **–** | **–** |
| Unwinding of discount | **16** | **–** | **–** | **16** |
| **At 31 March 2012** | **491** | **3** | **–** | **494** |
| **Expected timing of cash flows:** | | | | |
| Within one year | **26** | **3** | **–** | **29** |
| Between one and five years | **97** | **–** | **–** | **97** |
| After five years | **368** | **–** | **–** | **368** |
| | **491** | **3** | **–** | **494** |

The provision for pensions relating to staff comprises £434,000 in respect of injury benefit (31/3/2011 - £419,000) and £57,000 in respect of early retirements (31/3/2011 - £64,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis.

'Legal claims' are claims relating to third party and employer's liabilities. Where the case falls within the remit of the risk pooling schemes run by the NHS Litigation Authority (NHSLA), the trust's liablility is limited to £3,000 or £10,000 depending on the nature of the case. The remainder is borne by the scheme. The provision is shown net of any reimbursement due from the NHSLA.

'Other' provisions in 2010/11 included £394,000 in respect of estimated restructuring costs in 2011/12.

£2,135,000 was included in the provisions of the NHS Litigation Authority at 31/3/2012 in respect of clinical negligence liabilities of the trust.

## 19. Finance lease obligations

| | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Gross liability at commencement | – | 58 |
| Capital repayment during year | – | (4) |
| Finance charges during year | – | (2) |
| | – | 52 |

| Gross lease liabilities at 31 March 2011 | 31 March 2012 £000 | 31 March 2011 £000 |
|---|---|---|
| Due within one year | – | 8 |
| Between 2 and 5 years | – | 42 |
| After 5 years | – | 2 |
| | – | 52 |
| Future finance charges | – | (9) |
| Net lease liabilities | – | 43 |

## 20. Financial instruments

Accounting standards IAS 32, 39 and IFRS 7 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.

Financial instruments are recognised and measured in accordance with the accounting policy described under note 1.10.

### 20.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

| Financial assets | 31 March 2012 Loans and receivables £000 | 31 March 2011 Loans and receivables £000 |
|---|---|---|
| NHS and other related party receivables | **1,022** | 1,860 |
| Accrued income | **36** | 2 |
| Other receivables | **1,292** | 149 |
| Cash at bank and in hand | **5,979** | 6,967 |
| **Total** | **8,329** | 8,978 |

The above balances have been included in the accounts at amortised cost as 'loans and receivables', with no financial assets being classified as 'assets at fair value through the statement of comprehensive income', 'assets held to maturity' nor 'assets held for resale'.

| Financial liabilities | 31 March 2012 Carrying value £000 | 31 March 2011 Carrying value £000 |
|---|---|---|
| Borrowings | **1,000** | – |
| Trade and other payables | **1,607** | 1,501 |
| Accrued expenditure | **1,016** | 1,144 |
| **Total** | **3,623** | 2,645 |

Borrowings represents a loan of £1,000,000 from the Foundation Trust Financing Facility provided by the Department of Health.

All financial liablities are classified as 'other financial liabilities', with no financial liabilities being classified as 'liabilities at fair value through the statement of comprehensive income'.

Other tax and social security cost amounts of £768,000 (2010/11 £781,000) and deferred income of £495,000 (2010/11 £254,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

### 20.2 Maturity of financial assets

All of the trust's financial assets mature within one year.

### 20.3 Maturity of financial liabilities

All of the trust's financial liabilities fall due within one year.

### 20.4 Derivative financial instruments

In accordance with IAS 39, the trust has reviewed its contracts for embedded derivatives that are required to be separately accounted for if they do not meet the requirements set out in the standard. Accordingly the trust has no embedded derivatives that require recognition in the financial statements.

### 20.5 Financial risk management

Because of the continuing service provider relationship that the trust has with primary care trusts and the way those primary care trusts are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

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

*Currency risk*

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

*Credit risk*

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in note 18.

*Liquidity risk*

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

## 21. Prudential borrowing limit

NHS foundation trusts are required to comply and remain within a prudential borrowing limit (PBL). This is made up of two elements:

1 The maximum cumulative amount of long term borrowing. This is set by reference to the four basic ratios set out in Monitor's prudential borrowing code. The financial risk rating set under Monitor's compliance framework determines one of the ratios and therefore can impact on the long term borrrowing limit.

2 The amount of working capital approved by Monitor.

The limits and ratios in respect of QVH are as follows:

| | At 31 March 2012 £000 | At 31 March 2011 £000 |
|---|---|---|
| **The PBL is the sum of:** | | |
| Maximum cumulative long term borrowing limit | **12,000** | 10,100 |
| Approved working capital facility, not exceeding | **4,000** | 4,000 |
| **Total PBL** | **16,000** | 14,100 |

| **Long term borrowing** | At 31 March 2012 £000 | At 31 March 2011 £000 |
|---|---|---|
| Net actual borrowing in year long term | **1,000** | – |
| **Total borrowing against PBL** | **1,000** | – |

Performance of actual against approved PBL ratios are shown below:

| Financial ratio | Approved PBL | | |
|---|---|---|---|
| | **Actual ratios 2011/12** | **Ratios 2011/12** | Actual ratios 2010/11 |
| Minimum dividend cover | **5.9** | >1x | – |
| Minimum interest cover | **126.5** | >3x | – |
| Minimum debt service cover | **126.5** | >2x | – |
| Maximum debt service to revenue | **0.1%** | <2.5% | – |

**Notes**

In 2010/11 there were no loans in existence and the calculation of ratios was therefore not appropriate.

The trust has a maximum long-term borrowing limit of £12,000,000 (2010/11 £10,100,000). During the year the trust made borrowings of £1,000,000 against an agreed Foundation Trust Financing Facility of £10,100,000 (2010/11, none).

The trust has an approved working capital facility of £4,000,000 (2010/11, £4,000,000). During the year the trust drew down none of its working capital facility (2010/11, none).

## 22. Related party transactions

No board members or members of the key management staff or parties related to them undertook any material transactions with Queen Victoria Hospital NHS Foundation Trust during 2011/12 (2010/11, nil).

The trust received donations from the Queen Victoria Hospital NHS Trust Charitable Fund, the trustee of which is Queen Victoria Hospital NHS Foundation Trust.

Goods and services were bought from and sold to McIndoe Surgical Centre Ltd, a private healthcare company many of whose shareholders are consultants employed by the trust and with which the trust has a profit-sharing agreement. A director of Queen Victoria Hospital NHS Foundation Trust is also chair of McIndoe Surgical Centre Ltd.

Other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The trust has financial transactions with many such bodies.

The total income and expenditure transactions with all these organisations and the debtor and creditor balances with them at the year end are shown below.

| | **2011/12** | | 2010/11 | |
|---|---|---|---|---|
| **Private sector and charitable organisations** | **Income £000** | **Expenditure £000** | Income £000 | Expenditure £000 |
| The Queen Victoria Hospital NHS Trust Charitable Fund | 90 | – | 201 | – |
| McIndoe Surgical Centre | 78 | 16 | 142 | 30 |
| | **168** | **16** | 343 | 30 |

| | **31 March 2012** | | 31 March 2011 | |
|---|---|---|---|---|
| | **Receivables £000** | **Payables £000** | Receivables £000 | Payables £000 |
| The Queen Victoria Hospital NHS Trust Charitable Fund | – | – | – | – |
| McIndoe Surgical Centre | 23 | – | 1 | – |
| | **23** | **–** | 1 | – |

| **Whole of Government Accounts bodies** | **2011/12** | | 2010/11 | |
|---|---|---|---|---|
| Bodies with whom either income or expenditure exceeded £150,000 during the year: | **Income £000** | **Expenditure £000** | Income £000 | Expenditure £000 |
| *Income and expenditure* | | | | |
| West Sussex PCT | **20,732** | **36** | 20,856 | – |
| West Kent PCT | **11,509** | **(43)** | 11,565 | 40 |
| Medway PCT | **4,142** | **11** | 4,614 | 53 |
| Surrey PCT | **4,881** | **16** | 4,541 | 21 |
| Eastern and Coastal Kent PCT | **4,245** | **–** | 3,754 | 16 |
| Croydon PCT | **422** | **–** | 1,973 | – |
| London Specialised Commission Group | **2,718** | **–** | 1,858 | – |
| South East Coast Strategic Health Authority | **163** | **2** | 1,530 | 2 |
| Bromley PCT | **818** | **–** | 959 | – |
| Bexley NHS Care Trust | **907** | **–** | 717 | – |
| Isle Of Wight NHS PCT | **23** | **–** | 329 | – |
| Guy's And St. Thomas' NHS Foundation Trust | **306** | **30** | 279 | 7 |
| Hampshire PCT | **194** | **–** | 171 | – |
| Maidstone and Tunbridge Wells NHS Trust | **135** | **534** | 158 | 778 |
| Dartford and Gravesham NHS Trust | **7** | **768** | – | 711 |
| Medway NHS Foundation Trust | **1** | **1,019** | – | 571 |
| East Sussex Hospitals NHS Trust | **145** | **704** | – | 565 |
| NHS Litigation Authority | **–** | **435** | – | 410 |
| South East Coast Ambulance Service NHS Foundation Trust | **2** | **468** | – | 406 |
| Brighton And Sussex University Hospitals NHS Trust | **1,752** | **291** | 48 | 206 |
| Other | **1,620** | **828** | 1,779 | 600 |
| | **54,722** | **5,099** | 55,131 | 4,386 |

| | 31 March 2012 | | 31 March 2011 | |
|---|---|---|---|---|
| *Receivables and payables* | **Receivables £000** | **Payables £000** | Receivables £000 | Payables £000 |
| West Sussex PCT | **24** | **36** | 78 | – |
| West Kent PCT | **125** | **–** | 275 | 50 |
| Medway PCT | **94** | **–** | 166 | 13 |
| Surrey PCT | **41** | **–** | 41 | – |
| Eastern and Coastal Kent PCT | **–** | **–** | – | 142 |
| Croydon PCT | **210** | **–** | 133 | – |
| London Specialised Commission Group | **26** | **–** | 74 | – |
| South East Coast Strategic Health Authority | **–** | **–** | 42 | – |
| Bromley PCT | **12** | **99** | 29 | – |
| Bexley NHS Care Trust | **85** | **–** | – | 35 |
| Isle Of Wight NHS PCT | **10** | **–** | 5 | – |
| Guy's And St. Thomas' NHS Foundation Trust | **293** | **–** | 263 | 15 |
| Hampshire PCT | **(3)** | **–** | 191 | – |
| Maidstone and Tunbridge Wells NHS Trust | **94** | **25** | 78 | 254 |
| Dartford and Gravesham NHS Trust | **1** | **2** | 2 | 62 |
| Medway NHS Foundation Trust | **1** | **17** | – | 25 |
| East Sussex Hospitals NHS Trust | **91** | **67** | 34 | 105 |
| NHS Litigation Authority | **–** | **–** | – | – |
| South East Coast Ambulance Service NHS Foundation Trust | **1** | **36** | 1 | 26 |
| Brighton And Sussex University Hospitals NHS Trust | **271** | **30** | 25 | 22 |
| Other | **740** | **546** | 869 | 419 |
| | **2,116** | **858** | 2,306 | 1,168 |

## 23. Intra-government and other balances

| **At 31 March 2012** | **Receivables: amounts falling due within one year £000** | **Receivables: amounts falling due after more than one year £000** | **Payables: amounts falling due within one year £000** |
|---|---|---|---|
| Balances with NHS bodies | **1,577** | – | 221 |
| Balances with other government bodies | **72** | – | – |
| Balances with bodies external to government | **574** | – | 3,225 |
| | **2,223** | **–** | **3,426** |

| **At 31 March 2011** | **Receivables: amounts falling due within one year £000** | **Receivables: amounts falling due after more than one year £000** | **Payables: amounts falling due within one year £000** |
|---|---|---|---|
| Balances with NHS bodies | 2,287 | 15 | 1,194 |
| Balances with other government bodies | 48 | – | – |
| Balances with bodies external to government | 117 | – | 2,232 |
| | **2,452** | **15** | **3,426** |

## 24. Losses and special payments

Losses and special payments are calculated on an accruals basis.

There were 16 cases of losses and special payments totalling £5,000 approved during 2011/12, (40 cases totalling £134,000 in 2010/11).

There were no fraud cases.

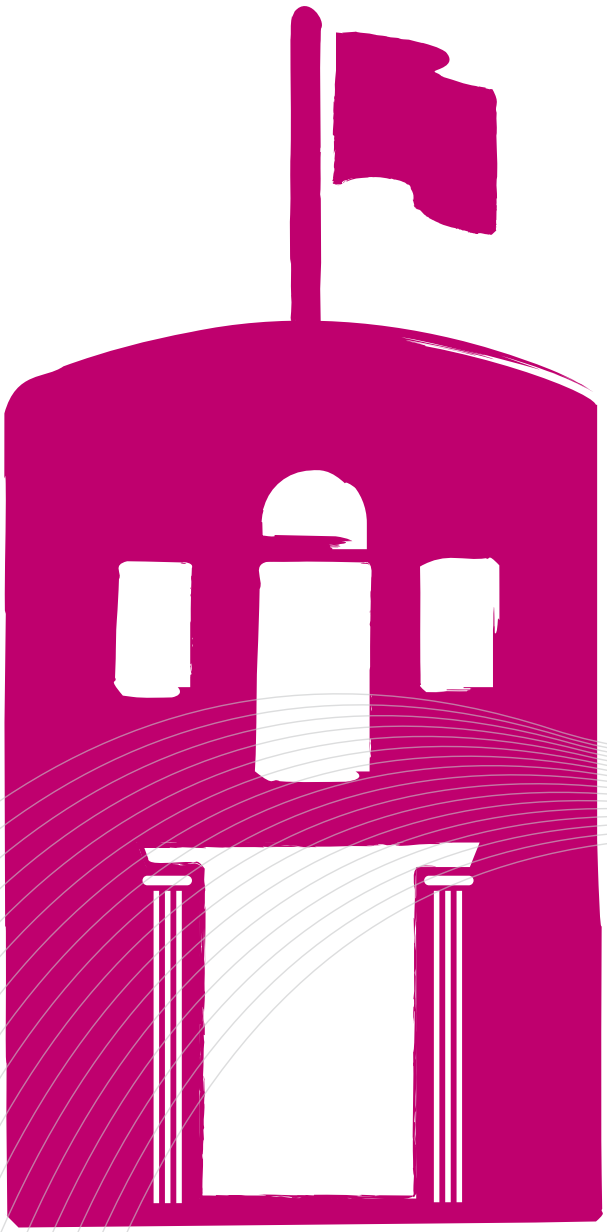
## 25. Financial risk rating

Monitor, the independent regulator of foundation trusts, assigns a risk rating on a scale of 1 to 5 to each foundation trust with 1 reflecting the highest level of risk and 5 the lowest. The rating is based on a basket of financial ratios, each of which has its own weighting. Ratios based on earnings before interest, tax, depreciation and amortisation (EBITDA) are calculated after excluding impairments and restructuring costs. In 2011/12 the trust achieved an overall rating of 5 (subject to confirmation by Monitor), (2010/11, 5).

For the purposes of the risk rating, retained surplus is calculated as follows:

| | **2011/12 £000** | 2010/11 £000 |
|---|---|---|
| Surplus from statement of comprehensive income | **674** | (1,655) |
| Add back: | | |
| Impairments of property, plant and equipment | **1,765** | 3,454 |
| Restructuring costs | **488** | 739 |
| Surplus for risk rating | **2,927** | 2,538 |

# 7.0 Annexes



# Annex A:
# Governance statement

**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 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*.

**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 Queen Victoria Hospital NHS Foundation Trust, to 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 Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

**Capacity to handle risk**

Risk management is a corporate responsibility and, accordingly, the board of directors has ultimate responsibility for ensuring that effective processes are in place. The board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to prevent harm to its patients, staff, public and other stakeholders and to protect the trust from losses or damage to its reputation.

The director of nursing and quality is the trust's lead for risk, supported by the patient safety and governance manager.

The trust's quality and risk committee oversees the management of all areas of risk in the organisation. It is chaired by a non-executive director and is attended regularly by directors and senior managers. Reporting lines to the board for quality and risk are through this committee.

The trust's risk management and incident reporting policy is available for all staff and provides clear procedures for identifying, reporting, investigating, managing and monitoring incidents and risks. Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The trust is committed to supporting its staff in exercising their roles and responsibilities with regard to health and safety and all other forms of risk management. Basic risk training is mandatory for all new staff to the trust and updates are delivered as part of the training programme. Department managers receive more in depth risk training and the trust board members also receive an annual update. The trust has a risk team in place to provide support to staff and ensure effective risk processes are in place.

Systems are in place through effective risk management software, the risk team and organisational structures such as directorates and monitoring committees to manage risks and incidents and to ensure learning as a result of identified issues takes place.

**The risk and control framework**

The trust risk strategy provides an outline of the risk processes such as the source of risks and clear escalation processes. This strategy is supported by the risk management and incident reporting policy. The trust risk assessment tool includes a 5 x 5 matrix to determine the level of risk based on likelihood x consequence and ensures hazards, existing controls and further controls required can be clearly identified and documented. Identification of risk is achieved through the directorates and departments supported by the risk team and can be from a variety of sources such as incidents, audits, external compliance, inspections and service reviews. There is a five step process in place for a risk assessment:

- Look for the hazards
- Decide who / what might be affected and how
- Evaluate the risks and decide whether existing precautions (controls) are adequate or more should be done (actions)
- Record and communicate the findings
- Review.

Risks are recorded onto the central risk register which is a specific risk management software package designed to store information on risks, incidents, complaints, claims, Care Quality Commission standards and freedom of information requests. The software allows risks, incidents complaints and claims to be linked and interpreted to look for trends and areas of concern. This system is managed by the risk team.

Identified risks are classed as departmental or corporate. Departmental risks are low level risks managed within the departments to ensure staff are aware of potential hazards within their working practice. Corporate risks may be from escalated departmental concerns or are risks affecting the whole trust requiring input and monitoring from directorates and senior committees. The trust risk appetite is based on the

level of risk and the authority a manager or committee has in managing it. High level risks (major and catastrophic rated 16-25) will be escalated to directorate level and reviewed by the directorates, quality and risk committee and trust board. If adequate controls cannot be put in place to treat the risk a decision will be made to terminate, transfer or accept the risk.

All risks rated 12 and above are escalated to the trust board and reviewed on a monthly basis. Where applicable actions to reduce each risk are assigned to an individual and monitored for progress by the relevant committee. The quality and risk committee reviews and monitors all corporate risks to ensure reduction of risks is taking place wherever possible. The risk team provides support to all departments and monitors the risks in terms of review dates, determined levels (risk rating) and progress, and highlights concerns to committees and individuals. Each risk is categorised in the system under one of the following headings:

- patient safety
- staff safety
- estates infrastructure and environment
- information governance
- compliance (targets, assessments, standards)
- finance.

Each risk on the register is linked to one of the six key strategic objectives to ensure the organisation can see the risks that could prevent achievement of the objective.

In addition to the risk register the trust has a board assurance framework in place designed to map the key risks and priorities identified in the annual plan that could prevent the organisation meeting its key strategic objectives. The assurance framework comprises the following elements:

- Risk source and description – high rated risks from risk register or priorities within the annual plan with the potential to prevent the trust achieving its six key strategic objectives.
- Key controls – controls currently in place to mitigate against the risks identified. Any gaps in control are identified as actions and listed within the framework for monitoring progress.
- Sources of assurance – these are the sources of assurance currently available for each area of risk. Any gaps in assurance are also identified.
- Current and residual rating – risk rating for each risk source based on assessment of likelihood x consequence taking into account controls in place.

Each risk source is allocated an executive lead to ensure appropriate controls and sources of assurance are in place. Gaps in either of these result in the development of an action plan recorded within the assurance framework. The risk team updates progress with each executive lead and the document is reviewed and monitored by the quality and risk committee, audit committee and trust board.

The trust board also gets its assurances from the internal auditors, external auditors, independent review bodies and audit committee. The audit committee has reviewed the trust's management of risk which is undertaken through the quality and risk committee.

Risk management is included within each directorate meeting agenda and existing risks are discussed along with identification of new risks. Learning from incidents is integral to the risk process therefore the trust has an incident reporting system in place along with a process to investigate, review and learn from events. The clinical policy committee monitors the higher rated incidents to ensure correct action and learning has taken place. The quality and risk committee receives a full report on a quarterly basis covering qualitative and quantitative data on incidents, complaints, claims and patient experience. In addition the trust board receives a monthly quality and risk report providing information on risks, incidents and quality.

Public stakeholders are also involved in managing risks through the risks identified by external assessors, incidents, complaints and other external bodies. Also, a public governor attends the quality and risk committee meetings.

In respect of maintaining registration with the Care Quality Commission (CQC) "Essential Standards of Quality and Safety", a robust assessment of compliance against the 28 outcomes has been undertaken and systems and processes are in place to provide management and board assurance. An executive lead is assigned to each outcome and the risk management software records evidence of compliance. The risk team monitors the process and any potential identified weakness is addressed and assigned to an individual as an action. The quality and risk committee reviews outstanding actions and the CQC quality and risk profile on a quarterly basis to ensure processes are in place to address areas of reduced compliance.

The foundation trust is fully compliant with the registration requirements of the CQC.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

## Review of economy, efficiency and effectiveness of the use of resources

QVH has a strong track record of financial performance with robust processes in place to ensure the economic, efficient and effective use of resources.

We have a robust business planning process that involves comprehensive meetings with the clinical directorates to determine the business plans for the coming year. For 2011/12 the emphasis continued to focus on the planning of clinical activity and the establishment of the activity plans for the next three years and the process developed further the clinical input to planning at service line level.

QVH has strong financial management arrangements in place with a comprehensive finance and performance report presented to the board on a monthly basis which include key performance indicators for productivity and efficiency gains. Detailed activity and performance information is produced monthly for service lines to inform management planning and decision making.

During the year, QVH continued to develop its service line reporting by reviewing the profitability of the sub-specialties within each of the clinical directorates. A number of the key corporate objectives for clinical directorates have been based on the outcome of service line reporting and specific action plans have been introduced where performance was below plan.

QVH continues to undertake value added reviews which are reported to the audit committee.

QVH has reviewed its use of natural resources and has developed a strategy to reduce its carbon footprint. This strategy includes a board approved sustainable development management action plan, a commitment to sign up to best practice models, close monitoring of carbon usage and to promote awareness within the organisation.

## Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare quality accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

QVH has prepared its quality accounts with strong clinical and managerial input including:

- Quarterly updates to the quality and risk committee on progress against priorities identified in the 2010/11 quality accounts
- Monthly updates to clinical cabinet and the board of directors on metrics (including MRSA, cancer 62 days and 18 weeks refer to treatment targets)
- The clinical outcomes group receiving speciality information/ audit and national audit outcome data.

## Review of effectiveness

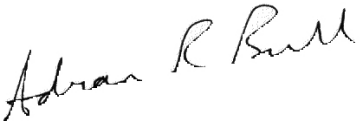
As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal controls includes:

- Regular board review of the assurance framework and risk registers, as well as minutes from audit committee and quality and risk committee meetings. Key risks are fully debated and the board ensures actions are in place where necessary
- The board receives monthly reports on financial and quality performance
- The board receives regular information governance reports
- The audit committee reviews findings from internal and external audit work and ensures links to the risk register and assurance framework are maintained
- The head of internal audit opinion has given a "significant assurance" rating on the effectiveness of the systems of internal control
- The quality and risk committee reviews feedback from external assessments on quality of service, including CQC, NHS Litigation Authority and audit, as well as ensuring internal quality measures are regularly tested and standards are met.

## Conclusion

The trust has faced some significant challenges in 2011/12 and despite continued pressures has continued to achieve excellent operational and financial performance in the year. The review of governance and controls confirms that the trust has managed risks effectively through the year and can provide assurance that effective systems are in place to support the running of the organisation. I am pleased to conclude that at the end of the year there are no significant internal control issues for the trust.



**Dr Adrian Bull**
Chief Executive
28 May 2012

# Annex B:
# Performance against national targets

| National priority indicators | Measure | Target | 2011/12 | |
|---|---|---|---|---|
| Clostridium difficile infections | Count | ≤5 | 0 | Green |
| MRSA bacteraemia | Count | ≤1 | 2 | Red |
| | | | | |
| Cancer: 2 week wait from urgent GP referral to date first seen | % | 93% | 97.49% | Green |
| Cancer: 31 day wait from diagnosis to first treatment | % | 96% | 98.18% | Green |
| Cancer: 31 day wait for second or subsequent treatment - surgery | % | 94% | 98.16% | Green |
| Cancer: 62 day wait from urgent GP referral to treatment | % | 85% | 96.40% | Green |
| | | | | |
| Total time in minor injuries unit | 95th percentile | ≤4 hrs | 3.4 | Green |
| Time to initial assessment for ambulance patients | 95th percentile | ≤15 mins | 0 | Green |
| Time to treatment decision (median) | Median | ≤60 mins | 41.1 | Green |
| Left without being seen | % | ≤5% | 2.33% | Green |
| | | | | |
| 18 week referral to treatment waiting times - admitted | 95th percentile | <23 wks | 20.6 | Green |
| 18 week referral to treatment - admitted | Median | <9.8 wks | 8.3 | Green |
| 18 week referral to treatment - admitted | % treated in 18 weeks | >90% | 91.05% | Green |
| 18 week referral to treatment waiting times - non admitted | 95th percentile | <18.3 wks | 16.4 | Green |
| 18 week referral to treatment - non admitted | Median | <7.6 wks | 6.4 | Green |
| 18 week referral to treatment - non admitted | % treated in 18 weeks | >95% | 96.55% | Green |
| 18 week referral to treatment - incomplete pathways | 95th percentile | <28 wks | 17.1 | Green |
| 18 week referral to treatment - incomplete pathways | Median | <7.1 wks | 6.8 | Green |
| | | | | |
| Cancellation of elective operation for non-clinical reasons | Count | N/A | 132 | |
| Provider cancellations not rebooked within 28 days | Count | 0 | 0 | Green |
| Delayed transfers of care (acute only) | Count | N/A | 14 | |
| | | | | |
| Same-sex accommodation breaches | Count | 0 | 0 | Green |

# Annex C:
# Remuneration report

| Salary and pension entitlements of senior managers | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **A. Remuneration** | **1 April 2011 to 31 March 2012** | | | | **1 April 2010 to 31 March 2011** | | | |
| **Name and title** | **Salary** | **Performance-related bonus** | **Other remuneration** | **Benefits in kind** | **Salary** | **Performance-related bonus** | **Other remuneration** | **Benefits in kind** |
| | (Bands of £5,000) £000 | (Bands of £5,000) £000 | (Bands of £5,000) £000 | Rounded to the nearest £100 | (Bands of £5,000) £000 | (Bands of £5,000) £000 | (Bands of £5,000) £000 | Rounded to the nearest £100 |
| **J Beech** Non-Executive Director | 10-15 | 0 | 0 | 600 | 10-15 | 0 | 0 | 700 |
| **A Bull** Chief Executive | 140-145 | 0 | 0 | 200 | 140-145 | 0 | 0 | 200 |
| **P Griffiths** Chairman | 40-45 | 0 | 0 | 100 | 40-45 | 0 | 0 | 900 |
| **R Hathaway** Director of Finance and Commerce | 100-105 | 0 | 0 | 0 | 100-105 | 0 | 0 | 0 |
| **K Lavery** Medical Director | 10-15 | 45-50 | 135-140 | 0 | 10-15 | 45-50 | 135-140 | 500 |
| **R Leach** Non-Executive Director | 10-15 | 0 | 0 | 0 | 10-15 | 0 | 0 | 0 |
| **A Parker** Director of Nursing and Quality | 90-95 | 0 | 0 | 0 | 90-95 | 0 | 0 | 0 |
| **L Porter** Non-Executive Director | 5-10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **H Ure** Non-Executive Director | 5-10 | 0 | 0 | 700 | 15-20 | 0 | 0 | 1,000 |
| **S Winning** Non-Executive Director | 10-15 | 0 | 0 | 4,500 | 10-15 | 0 | 0 | 0 |

L Porter joined the trust 1 September 2011.

H Ure left the trust 30 September 2011.

All benefits in kind relate to travel expenses.

The median remuneration of all the trust's staff is £26,789.

The ratio of the mid-point of the banded remuneration of the highest paid director to the median is 7.4:1.

| Salary and pension entitlements of senior managers | | | | | | | |
|---|---|---|---|---|---|---|---|
| **B. Pension benefits** | | | | | | | |
| **Name and title** | **Real increase in pension at age 60** | **Lump sum at age 60 related to real increase in pension** | **Total accrued pension at age 60 at 31 March 2012** | **Lump sum at age 60 related to accrued pension at 31 March 2012** | **Cash equivalent transfer value at 31 March 2012** | **Cash equivalent transfer value at 31 March 2011** | **Real increase in cash equivalent transfer value** |
| | (Bands of £2,500) £000 | (Bands of £2,500) £000 | (Bands of £5,000) £000 | (Bands of £5,000) £000 | £000 | £000 | £000 |
| **A Bull** Chief Executive | 0-2.5 | 2.5-5 | 20-25 | 60-65 | 416 | 359 | 44 |
| **R Hathaway** Director of Finance and Commerce | 0-2.5 | 0-2.5 | 25-30 | 80-85 | 438 | 355 | 71 |
| **K Lavery** Medical Director | 0-2.5 | 0-2.5 | 70-75 | 220-225 | See note below | | |
| **A Parker** Director of Nursing and Quality | 0-2.5 | 0-2.5 | 25-30 | 80-85 | 486 | 423 | 48 |

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors.

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 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.

Note: K. Lavery has reached normal retirement age. His pension, therefore, now has no CETV.

# Annex D:
# Board of governors register

| Governor | Constituency | Term | Meeting attendance |
|---|---|---|---|
| Bernard Atkinson | Public | Re-elected 2008 to 2011 | 1 of 1 |
| Len Barlow | Public | Re-elected 2008 to 2011 | 0 of 1 |
| Stuart Barnett | Public | Re-elected 2008 to 2011 | 0 of 1 |
| Brian Beesley | Public | Elected 2011 to 2014 | 3 of 3 |
| Edward Belsey | Public | Elected 2009 to 2012 | 4 of 4 |
| John Bowers | Public | Re-elected 2011 to 2012 | 3 of 4 |
| Patricia Brigden | Public | Elected 2010 to 2013 | 2 of 4 |
| Mabel Cunningham | Staff | Re-elected 2011 to 2014 | 4 of 4 |
| Jenny Cunnington | Public | Elected 2011 to 2014 | 3 of 3 |
| John Dabell | Public | Elected 2011 to 2014 | 3 of 3 |
| Peter Evans | Stakeholder (local authority) | Re-appointed 2009 to 2012 *Resigned Oct 2011* | 0 of 3 |
| Adrian Fuchs | Public | Elected 2008 to 2011 | 1 of 1 |
| Brian Goode | Public | Elected 2010 to 2013 | 3 of 4 |
| Robin Graham | Public | Elected 2011 to 2014 | 3 of 3 |
| Michael Hannah | Public | Elected 2011 to 2014 | 2 of 3 |
| Peter Harper | Public | Elected 2008 to 2011 | 0 of 1 |
| Bill Hatton | Public | Re-elected 2008 to 2011 | 0 of 1 |
| Anne Higgins | Public | Elected 2011 to 2014 | 3 of 3 |
| Caroline Hitchcock | Public | Re-elected 2008 to 2011 | 1 of 1 |
| Sue Hull | Public | Elected 2008 to 2011 | 1 of 1 |
| Valerie King | Public | Re-elected 2011 to 2014 | 4 of 4 |
| Carol Lehan | Staff | Re-elected 2011 to 2014 | 3 of 4 |
| Moira McMillan | Public | Elected 2010 to 2013 | 4 of 4 |
| Shirley Mitchell | Public | Re-elected 2008 to 2011 | 1 of 1 |
| Chris Orman | Public | Elected 2011 to 2014 | 3 of 3 |
| Christian Petersen | Staff | Elected 2010 to 2013 | 4 of 4 |
| Andrew Robertson | Stakeholder (League of Friends) | Appointed 2010 to 2013 | 1 of 4 |
| Chris Rolley | Stakeholder (East Grinstead Town Council) | Re-appointed 2010 to 2013 *Resigned May 2011* | 1 of 1 |
| Gillian Santi | Stakeholder: League of Friends | Elected 2011 to 2014 | 2 of 3 |
| Michael Shaw | Public | Elected 2011 to 2014 | 3 of 3 |
| Manya Sheldon | Public | Elected 2009 to 2012 | 4 of 4 |
| Ian Stewart | Public | Elected 2008 to 2011 | 4 of 4 |
| Jonathan Street | Public | Elected 2011 to 2014 | 3 of 3 |
| Alan Thomas | Public | Elected 2009 to 2012 | 4 of 4 |
| Paul Trevethick | Stakeholder (NHS West Sussex) | Appointed 2010 to 2013 *Resigned Oct 2011* | 0 of 3 |
| Norman Webster | Stakeholder (East Grinstead Town Council) | Appointed 2011 to 2014 | 2 of 3 |
| Peter Wickenden | Public | Elected 2011 to 2014 | 2 of 3 |

**Notes:** Meeting attendance figures are provided for formal meetings of the board of governors held in public, not including the annual general meeting of the trust which was held on 28 July 2011. This column shows attendance compared to the maximum number of meetings each governor was expected to attend within their individual terms of office. • As governor representative to the board of directors, Ian Stewart attended 10 of the 11 board meetings held in 2011/12. • As a governor representative to the quality and risk committee, Moira McMillan attended all four committee meetings held in 2011/12. • As public governor representative to the charitable funds advisory committee, John Bowers attended two of the four committee meetings held in 2011/12. • As staff governor representative to the charitable funds advisory committee, Carol Lehan attended all four committee meetings held in 2011/12.

# Annex E:
# Board of directors register

| Name, title and appointment | Meeting attendance and role 2011/12 | | | | | |
|---|---|---|---|---|---|---|
| | **Board of directors** | **Board of governors** | **Audit committee** | **Charitable funds advisory committee** | **Nomination and remuneration committee** | **Quality and risk committee** |
| **Jeremy Beech**<br>Non-Executive Director<br>1 October 2005 to 30 Sept 2013 | 10 of 11<br>Member | 2 of 4<br>Attendee | –<br>– | –<br>– | 4 of 5<br>Member | 4 of 4<br>Chairman |
| **Adrian Bull**<br>Chief Executive<br>December 2008 to present | 11 of 11<br>Member | 4 of 4<br>Attendee | 2 of 2<br>In attendance as required | –<br>– | 5 of 5<br>Member | 4 of 4<br>Member |
| **Peter Griffiths**<br>Chairman<br>1 April 2005 to 31 March 2013 | 10 of 11<br>Chairman | 4 of 4<br>Chairman | –<br>– | –<br>– | 4 of 5<br>Chairman | –<br>– |
| **Richard Hathaway**<br>Director of Finance and Commerce<br>April 2010 to present | 10 of 11<br>Member | 3 of 4<br>Attendee | 7 of 7<br>In attendance | 3 of 4<br>Member | –<br>– | 3 of 4<br>Member |
| **Ken Lavery**<br>Medical Director<br>November 2007 to present | 6 of 11<br>Member | 2 of 4<br>Attendee | –<br>– | 2 of 4<br>Member | –<br>– | 1 of 4<br>Member |
| **Renny Leach**<br>Non-Executive Director<br>1 January 2007 to 31 December 2014 | 11 of 11<br>Member | 2 of 4<br>Attendee | 2 of 2<br>Member | 4 of 4<br>Chairman | 5 of 5<br>Member | 1 of 2<br>Member |
| **Amanda Parker**<br>Director of Nursing and Quality<br>August 2009 to present | 9 of 11<br>Member | 4 of 4<br>Attendee | 4 of 7<br>In attendance | –<br>– | –<br>– | 4 of 4<br>Member |
| **Lester Porter**<br>Non-Executive Director<br>1 Sept 2011 to 31 August 2014 | 5 of 5<br>Member | 2 of 3<br>Attendee | 3 of 3<br>In attendance | –<br>– | 3 of 3<br>Member | 2 of 2<br>Member |
| **Hugh Ure**<br>Senior Independent Director<br>1 October 2005 to 30 Sept 2011 | 6 of 6<br>Deputy Chairman | 2 of 2<br>Attendee | 5 of 5<br>Member | 2 of 2<br>Member | 3 of 3<br>Chairman | –<br>– |
| **Shena Winning**<br>Non-Executive Director<br>1 October 2005 to 30 Sept 2013 | 11 of 11<br>Member | 1 of 4<br>Attendee | 7 of 7<br>Chairman | 4 of 4<br>Member | 5 of 5<br>Member | –<br>– |

**Notes:**

Lester Porter attended three additional meetings of the board of directors during 2011/12 as non-executive director designate while he prepared to formally join the board. Lester Porter attended meetings of the audit committee as part of his induction process and is not a formal member of the committee.

Hure Ure was chairman of the nomination and remuneration committee from April to September 2011. Peter Griffiths was chairman of the nomination and remuneration committee from October 2011 to March 2012.

# Annex F:
# Board of directors biographies

**Peter Griffiths, Chairman**

Peter Griffiths has spent his entire career in healthcare.

His last executive appointments within the NHS were as Deputy Chief Executive for the Management Executive at the Department of Health and Chief Executive of the Guy's & Lewisham first-wave NHS trust.

In the mid-1990s, Peter moved to the King's Fund as Deputy Chief Executive and Director of their management college and subsequently headed up the Health Quality Service, an independent organisation providing quality development support to health services nationally and internationally. He was also President of the Institute of Health Services Management.

On appointment in 2005, he stepped down as Non-Executive Director of the Sussex Downs and Weald Primary Care Trust to become QVH Chairman.

Peter is also Chairman of the Board of the Foundation Trust Network.

**Dr Adrian Bull, Chief Executive**

Adrian became Chief Executive of QVH on 15 December 2008.

Adrian served for six years as a medical officer in the Royal Navy, completing his training in general practice. On joining the NHS, he gained his MD in epidemiology and became a consultant in public health medicine, holding several senior medical and management positions in health authorities and NHS trusts.

In recent years, Adrian has worked in the private sector as Group Medical Director of PPP Healthcare, Managing Director of Carillion Health, and Commercial and Medical Director for Humana Europe.

**Richard Hathaway, Director of Finance and Commerce**

Richard is a chartered accountant and joined QVH from NHS South East Coast, the region's strategic health authority.

He was Director of Finance at the Royal West Sussex NHS Trust for three years until 2009 and was previously the Director of Finance at Mid Sussex Primary Care Trust. He joined the NHS from an international accountancy practice in 1992.

In addition to financial management, Richard and his team are responsible for QVH's procurement and contracting, performance management, information and IT functions.

**Mr Ken Lavery, Medical Director**

Mr Ken Lavery, consultant in oral and maxillofacial surgery, trained in dentistry and medicine at the University of Dundee. After qualifying he undertook post-graduate training in general surgery, plastic surgery, ENT and neurosurgery, before commencing his specialist training as an oral and maxillofacial surgeon at QVH and Guy's Hospital.

Ken's speciality areas are the surgical aspects of head and neck oncology, reconstruction and salivary gland surgery. He has represented his specialty both regionally and nationally.

Ken was appointed QVH's Medical Director on 1 November 2007.

**Amanda Parker, Director of Nursing and Quality**

Amanda Parker was appointed Director of Nursing and Quality in August 2009, having previously held the post of Deputy Director of Nursing.

She trained at the Middlesex Hospital, going on to specialise in renal medicine before she joined QVH as a theatre nurse in 1992. Here she developed her career in perioperative care which included a joint role with St George's, London as a lecturer practitioner.

Amanda brings strong academic and operational experience to the role. She is a Registered Nurse Teacher with an MA in nursing and education, has an MSc in surgical and perioperative care and served as Chair of the Education Committee on the Board of the Association for Perioperative Practice (AfPP).

**Jeremy Beech CBE, Non-Executive Director**

Jeremy Beech from Frittenden in Kent is a chartered engineer.

He spent over 30 years in the Fire and Rescue Services occupying positions as Assistant Chief Fire Officer of the London Fire Brigade, Chief Fire Officer of Kent, and Chief Executive of the Kent and Medway Fire Authority. He also served for 12 years as one of the five UK members of the Channel Tunnel Safety Authority, and led for the UK on Rescue, Public Safety and Bi-National Planning for emergencies.

Following his fire service career, Jeremy worked for the UK government in maritime counter terrorism, and also as an adviser to government committees and other bodies. He remains a consulting engineer. He served as a Non-Executive Director of the Port of London Authority from 2003 to 2009, and Non-Executive Chairman of MKC Training Services Ltd, from 2008 to 2011. He is Vice Chairman of the Kent Foundation.

At QVH, Jeremy chairs the quality and risk committee.

**Dr Renny Leach, Non-Executive Director and Senior Independent Director**

Renny Leach is currently a board member of two biotechnology companies as well as a contract clinical research company. He is the medical research director for the children's medical research charity Sparks. Renny is a trustee of the Lord Snowdon Award scheme for disabled students and chairs the QVH charitable trust advisory committee. He lives in Forest Row.

Renny was previously Director of Clinical Research at the Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust and has held senior positions within the UK Medical Research Council, the Horsham-based charity Action Medical Research and was CEO of a contract clinical research company.

**Lester Porter, Non-Executive Director**

Lester Porter was appointed a Non-Executive Director of QVH in September 2011.

He has been Chairman of the Thomas Cook Pension Trust since 2005 and has his own executive coaching practice working with individual executives and company boards. He also spent over ten years as an 'angel' investor in start-up businesses based in the south east and holds board positions with several of these companies.

Previously he spent 30 years in a variety of management roles in the healthcare, publishing and financial services sectors, and was latterly with the Thomas Cook Group as Corporate Development Director.

**Hugh Ure, Non-Executive Director**

Hugh is from Haslemere in Surrey. He was appointed to the board in December 2000 and was appointed Deputy Chairman and Senior Independent Director in April 2007. Hugh retired from the board in September 2011.

He is a retired company director who had an extensive international senior management career with Reckitt Benckiser, during which his postings included Australia, Papua New Guinea, South Africa, Sri Lanka, Ireland and the UK.

He also has wide ranging experience as a non executive director, including terms as chairman of the board of a private sector pension fund, a non-executive director on a board in the Ministry of Defence, and is currently a Non-Executive Director of the Benenden Healthcare Society.

**Shena Winning, Non-Executive Director**

Shena Winning from Elham, near Canterbury, is a chartered accountant. Formerly finance director of CarpetRight plc, she has over 20 years experience within the retail sector.

Shena is Non-Executive Director of Nisa-Todays Ltd and Chadwick House Group Ltd and was Non-Executive Chairman of Swallowfield plc from March 2005 to April 2011 and Non-Executive Director of South East Kent Community Health Trust from July 1996 to January 1998.

At QVH, Shena chairs the audit committee.

# Annex G: Disclosures

## Directors' disclosures

### Statement of compliance with the *NHS Foundation Trust Code of Governance*

The board of directors of QVH confirms that the trust complies with the provisions of the *NHS Foundation Trust Code of Governance*.

### Statement of disclosure to auditors

For each individual who is a director at the time the annual report is approved, so far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information. ("Relevant audit information" means information needed by the NHS foundation trust's auditor in connection with preparing their report.)

A director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above if he/she has:

- made such enquiries of his/her fellow directors and of the NHS foundation trust's auditors for that purpose; and
- taken such other steps (if any) for that purpose as are required;
- by his/her duty as a director of the NHS foundation trust to exercise reasonable care, skills and diligence.

### Going concern

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

The accounts have been prepared under a direction from Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 1.2 on page 60 to the accounts and details of senior employees' remuneration can be found in annex C on page 88 of this report.

### Policy and payment of creditors

The trust seeks to comply with the Better Payment Practice Code and pay all suppliers promptly.

### Information governance

The trust recognises its responsibilities as custodian and handler of highly confidential, sensitive information. During 2011/12, a formal information risk reporting structure was firmly established to maintain legal compliance and system security. In addition, QVH continues to focus on improving the integrity and quality of personal data.

All staff are required to undertake information governance training on an annual basis.

The trust had no significant breaches of data security during 2011/12.

The information governance (IG) agenda is supported by the IG Toolkit, a Department of Health initiative to enable NHS organisations to be assessed for IG compliance across management, security, confidentiality, clinical information quality and corporate documentation standards. QVH submitted an overall score of 77% for its 2011/12 assessment, achieving a satisfactory rating across all requirements.

| Information governance incidents 2011/12 | |
|---|---|
| Type | Number |
| Misfiled documentation | 2 |
| Misplaced documentation | 25 |
| Documentation errors/incomplete documentation | 20 |
| Use of unencrypted device | 1 |
| Breach of information security policy | 4 |
| Breach of confidentiality (minor) | 2 |

**Employing disabled persons**

QVH has a robust recruitment and selection policy which was updated in 2011/12 and a full equality and human rights impact analysis which is available from our website. We use the guaranteed interview scheme for recruitment which identifies applicants with a disability using the facilities available on the NHS Jobs recruitment website and we remind managers to interview those applicants providing they meet the essential criteria for the role. Applicants with disabilities who require adjustments are also identified through this process.

Staff who become disabled are supported by their line managers, the occupational health service and, where appropriate, the access to work scheme to enable them to remain in their role. We arrange suitable adjustments where possible and did so for one member of staff during 2011/12. Redeployment to other roles is also considered with advice from our occupational health service and in line with the trust's sickness policy.

Training does not currently target specific groups of staff but formats for delivery of training is under review as part of our equality objective scheme action plan. We work with disabled staff as individuals and discuss their needs with them on a case by case basis.

The trust has been accredited as a 'two ticks' disability employer for many years and is in the process of re-accreditation.

# Other disclosures in the public interest

QVH has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance

Communication and information giving actions are described in section 3.4 on page 18 on staff engagement. In addition, formal consultation is described in the trust's change management policy.

QVH has a whistle blowing policy which explains to staff how they can raise concerns about issues or concerns in the trust. It includes the role of the NHS counter fraud service. This is also covered as part of the trust's induction programme. In addition, we have an incident reporting system which allows staff to raise concerns and record incidents relating to clinical issues.

A redundancy consultation exercise was run between March and July 2011, resulting in seven redundancies.

Following consultation with the local primary care trust, the Jubilee inpatient unit (rehabilitation and elderly care) was closed in September 2011. In August 2011 there were 32 staff assigned to Jubilee. A redundancy consultation was undertaken with these staff. Twenty four were redeployed into vacancies elsewhere in the trust; four staff took voluntary redundancy; two staff resigned; and one staff member retired.

QVH reports sickness absence data quarterly via the health and safety committee and monthly at the people, quality and capital meeting and the board of directors meeting. We had a steady average of 3.5% sickness absence over the previous four years, which reduced to 3% during 2011. This is below the NHS average. Seasonal variations are noted (i.e. higher in winter, lower in summer). A contracted out occupational health service is provided to staff through Team Prevent, with an occupational health nurse on site three days a week and an occupational health physician on site once a month. We also have an employee assistance programme provided by CiC. Both services were subject to appropriate selection processes.

**Queen Victoria Hospital NHS Foundation Trust**

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