Queen Victoria Hospital NHS
NHS Foundation Trust

ANNUAL REPORT QUALITY ACCOUNTS AND FINANCIAL ACCOUNTS

2009/10

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

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PRESENTED TO PARLIAMENT
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1.0 INTRODUCTIONS

1.1 CHAIRMAN'S INTRODUCTION

WE ARE PLEASED TO PRESENT THE ANNUAL REPORT FOR QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST.

This year, our expert and committed staff have continued to deliver care of the highest quality, achieving excellent clinical standards and patient safety.

In a challenging financial climate, we have undertaken a number of key service reviews, and have introduced a programme of cost control measures. These have successfully controlled the annual increase in our costs and enabled us to continue to invest in our aged estate. We completed the plans for the development of our buildings and the first phase of a long term strategic plan for the site. Unfortunately the changing national financial position has meant that we are unable to progress these developments as quickly as we would like but we continue to drive forward improvements wherever possible.

This year has also seen some changes in the membership of the Board. I would like to thank those colleagues who have moved on for their invaluable contribution to our success this year. I look forward to working with my excellent team of executive and non-executive colleagues as we continue to build upon this year's strong performance.

Peter Griffiths
Chairman

1.2 CHIEF EXECUTIVE'S INTRODUCTION

THROUGHOUT THE YEAR, WE HAVE MAINTAINED OUR FOCUS ON PROVIDING A HIGH QUALITY BURNS CARE AND RECONSTRUCTIVE SURGERY SERVICE TO THE POPULATION OF SURREY, SUSSEX, AND KENT, AND COMMUNITY HOSPITAL CARE TO THE PEOPLE OF EAST GRINSTEAD.

We are proud that QVH continues to be one of the leading hospitals in the country in terms of quality of care, staff satisfaction and financial performance.

We have continued to perform well in patient surveys for both outpatient and inpatient care, achieving scores that put us in the top 20% of hospitals in the country. We have undertaken a comprehensive review of patients' and visitors' opinions of our services, and instigated a number of changes to ensure that we continuously improve our standards.

We have maintained our strong record for patient safety and infection control, with only one case of hospital acquired MRSA and one case of Clostridium Difficile during the year. We received a clean bill of health following an inspection by the Care Quality Commission and are leading the way with innovative approaches to infection control at the cutting edge of reconstructive surgery.

This year we have identified that, despite high patient satisfaction and excellent performance against national targets, there are a number of ways in which we can improve the efficiency of our processes and make our services even more convenient for patients, minimising cancellations, late bookings, or requirements for several visits to the hospital for tests and scans. We have initiated a programme of streamlining to address these areas and will be realising the benefits over the coming year. The first phase of our restructuring programme is now being consulted upon and will enable us to reduce our overhead costs. This reflects the challenges we face in the coming year but I remain confident the Trust can take the required actions to maintain the quality of our services to patients whilst ensuring a sound financial position.

Dr Adrian Bull
Chief Executive

1.3 BOARD OF GOVERNORS' INTRODUCTION

THE GOVERNORS OF QVH ARE IN A UNIQUE POSITION. WE ARE ABLE TO BRING AN ALL-ROUND PERSPECTIVE TO THE TRUST.

Many of us have direct experience of QVH because we or one of our family members received care as a QVH patient. We also have a detailed knowledge of the strategic direction and challenges through our work as a Board of Governors, our individual roles on other boards and committees and the open access we have to the Trust's executive and non executive directors. We have a thorough understanding of how things work on the ground in the hospital through our Governor tours which cover all aspects of the hospital's work from inpatients to outpatients, cleaning and infection control to estates and facilities, where we hear the views of both patients and staff.

From this position of understanding and experience, the Governors of QVH fully endorse the remarks made by the Chairman and Chief Executive. Together they have accurately described both the strong performance of QVH and its staff over the last year, and the challenges we face at this difficult time for the NHS. They have underlined the commitment of all at QVH to remain focused on quality, safety and clinical excellence.

The Governors of QVH oversee the activities of the hospital on behalf of the members and we do this against six themes;

- the experiences of patients as they follow their individual pathway
- the quality of the clinical service provided and its outcomes
- the levels of organisational performance achieved in relation to national standards and local plans
- the financial background
- the development plans both long and short term
- the maintenance of the ethos and reputation that underpins everything.

The Governors of QVH recognise that to continue achieving the highest levels of quality we must maintain a secure financial position and continue to innovate, making the most of opportunities to embrace new clinical practice and organisational procedures as medical science evolves.

Bernard Atkinson
Vice-Chairman of the Board of Govenors

2.0 DIRECTOR'S REPORT

2.0 DIRECTOR'S REPORT

WHO WE ARE AND WHAT WE DO

QVH became a foundation trust (FT) in July 2004 under the Health and Social Care (Community Health and Standards) Act 2003. As an FT we now have almost 11,000 public members across the South East of England.

The hospital is at the forefront of specialist care in reconstructive surgery. It is a regional and national centre for maxillofacial, reconstructive plastic and corneo plastic surgery, as well as for the treatment of burns. 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.

PRINCIPAL ACTIVITIES OF THE TRUST

In 2009/10, the principal activities of the trust were the provision of;

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

The reconstructive surgery services are also provided 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.

BUSINESS REVIEW, MANAGEMENT COMMENTARY, OPERATING AND FINANCIAL REVIEW

QVH met its activity targets for the 2009/10. Changes to tariff, variation in case mix, reduction in one-off earnings (such as for out-of-network burns cases), and in-year cost pressures, have meant that QVH has not met all its financial targets, but has nevertheless maintained its Financial Risk Rating with Monitor at level 4. This is the second highest rating (out of five), which will be graded as 'excellent' by the CQC for management of resources, and means that there are no regulatory concerns. For the purposes of calculating the Trust's Financial Risk Rating, Monitor has excluded from the surplus calculation £2m of asset impairments relating to revaluation of the site at the year-end and investment in development, design, and planning for the strategic redevelopment of the site carried out over the past two years.

As the tertiary centre of expertise of reconstructive surgery for the South East region, QVH has continued to extend its contact and working relations with hospitals across the region, and its membership of and contribution to cancer networks in Sussex, Kent and Medway, and Surrey.

The principal risks and uncertainties facing the organisation arise from the national financial position, and are shared with the NHS in general. Specifically these are the freezing of the Payment by Results tariff for hospital services in 2010/11, and the continued increase in pay and non-pay costs through the implementation of national pay deals and general inflation. Current negotiations with NHS West Sussex are in hand to finalise contracts for 2010/11. Particular issues of concern relate to the need for continued financial support for the additional costs of providing reconstructive surgery for children, and microvascular surgical reconstruction of breasts at the same time as or following mastectomy, the costs of which are not adequately covered in national tariffs. Negotiations with the Burns Consortium have been completed satisfactorily. Increased controls on activity by PCTs (e.g. diversion of patients requiring hand surgery to the independent sector Sussex Orthopaedic Treatment Centre, reductions in tariff for urgent cases in excess of the 08/09 baseline levels, and other revenue pressures) require careful management and reduction of structural costs in the organisation.

In recent years considerable analysis of our estate has shown key vulnerabilities and inefficiencies arising from the current state and arrangement of our buildings. Significant investment has been made to stabilise the infrastructure (water, power, medical gases, etc.) Alternative plans have been drawn up to address the key requirement, which is the refurbishment or replacement of our theatres. These plans will be pursued in due course subject to affordability.

The further development of service line management and accounting at the start of the year highlighted the individual performance of our clinical areas. As a result detailed reviews have been conducted of Jubilee Centre (community) and of orthodontics, with plans now in train to improve the financial position of these services.

ENVIRONMENT MATTERS

QVH is committed to minimising its impact on the environment.

A major part of our 2009/10 capital programme focussed on replacing heating systems within theatres and associated departments. The original system was over 40 years old and highly inefficient in its consumption of energy. Work on this was completed at the end of Q3 and early indications show that the new system has reduced gas consumption by 20%-25%.

We have seen a reduction in our water consumption of 10% during the last financial year due to a greater vigilance in responding to leaks across the ageing estate.

QVH is committed to developing its recycling programme. During 2009/10 we recycled 60% of all cardboard and 100% of waste electrical and electronic equipment (WEEE), together with 100% of confidential paper. We only managed to recycle 25% of aluminium and non-confidential paper, however plans are now in place to ensure this will be increased significantly in 2010/11.

We continue to support the prepayment of public transport costs such as rail season tickets. In addition, we have reviewed our staff travel programme and a revised car parking policy has placed a greater emphasis on discouraging staff from travelling to work by car. This policy will be implemented during the summer of 2010/11 and should result in a further 10% of staff seeking alternative ways in which to get to and from work.

QVH continues to support staff working from home as part of their normal working week and this financial year has seen the Remote Access System extended to cover 100 staff.

EMPLOYEES

At any one time during 2009/10 the Trust employed approximately 900 individuals in approximately 800 'whole time equivalent' posts and had a low staff turn-over rate. The Trust is committed to providing a good working environment for its staff and has always enjoyed good results in the annual NHS staff surveys, achieving high scores for the last four years. For 2009/10 we have, again, achieved above average scores, including a high number which place us in the top 20% of Trusts. From last year's results we identified four issues that we wanted to improve upon in 2009/10 and our results show significant progress against three of these issues (reduction in staff working extra hours, improvements in staff receiving appraisals and having personal development plans). It is especially important to recognise that 2009/10 has been a challenging year for QVH. To achieve good staff survey results this year demonstrates the commitment and resilience of our staff.

SOCIAL AND COMMUNITY MATTERS

The Trust has an established Public Engagement Committee which met six times during the financial year. Members of the committee include representatives of the West Sussex Local Involvement Network (LINks), Health Overview and Scrutiny Committee (HOSC), the Council for Voluntary Services and local government as well as lay representatives and public governors. During the course of the year the Committee has discussed a range of important issues and received a series of important presentation on topics including patient experience, quality and diversity, standards for better health and the 2009 national outpatient survey.

Despite its role as a regional centre of tertiary surgery, QVH has always had a close relationship with the local community in East Grinstead. Approximately 50% of the foundation trust's 10,650 public members live in East Grinstead and the surrounding villages so our programme of member communications and events reaches many people in our community. In 2009/10 approximately 450 local people attended a range of events including public meetings of the Board of Governors, the Annual General Meeting, an information evening on skin cancer and a departmental open evening in maxillofacial surgery.

During the course of the year, senior representatives of the Trust have attended local residents meetings to continue to discuss the plans for our site and estate, and we have continued to host regular meetings of the local NHS retirement fellowship. The Trust is a corporate member of the East Grinstead Business Association, and local businesses kindly support various initiatives and events, including the 2009 QVH staff awards. The Trust's charitable fund received generous donations and legacies throughout the year which have been used to support a wide variety of initiatives to improve patient experience, benefit staff facilities and improve the hospital site. The Trust also benefitted from the strong and generous support of its League of Friends.

Finally, the Trust enjoys a good working relationship with local media who are very supportive of the hospital. The Trust has been able to collaborate on the most effective methods and timings to employ to release important messages or respond to emerging news.

ANALYSIS USING FINANCIAL KEY PERFORMANCE INDICATORS

A summary of the Trust's financial performance for the year ended 31 March 2010 is set out in the table below.

	Plan YTD	Actual YTD
Turnover	£54.6m	£54.5m
EBITDA (earnings before interest, taxes, depreciation, and amoritization)	£4.3m	£3.7m
Surplus / (deficit) before impairments	£1.1m	£1.0m
Site redevelopment impairment	-	£(1.1m)
Asset value impairments	-	£(0.9m)
Surplus / (deficit)	£1.1m	£(1.0m)
Cash balance	£1.0m	£4.8m
Financial risk rating	4	4
Private patient Income (%)	0.20%	0.18%

The year-end financial position of the Trust shows a £1.0m surplus before accounting for asset value impairments of £0.9m and impairment of capitalised development costs of £1.1m. Monitor's rating of our financial risk (the FRR) does not include the one off impairments, which means that their rating of the Trust is an FRR of 4 – which is classed as excellent by the Care Quality Commission.

This performance has been achieved through a focus on cost management measures through the year, improved efficiency and productivity across the hospital, and a tight focus on cash particularly in the second half.

Short term cost and cash management must be translated into sustainable cost and productivity improvements to maintain the Trust's performance in future years. The Trust has undertaken a strategic review of its operations and identified potential opportunities for reducing its cost base. Actions taken in 2009/10 successfully delivered a £700,000 improvement to the year end result compared to the mid year forecast. The Trust has begun implementation of the next phase in a number of areas such as reducing corporate and support costs, where a consultation on restructuring is now underway.

PATIENT CARE

QVH continues to work to improve access to its specialist services for the population of the region. This includes the provision of clinics and day surgery at Medway, Dartford, Maidstone, Redhill, Brighton, and East Sussex Hospitals among others. The hospital is a centre of excellence and expertise in its core areas of burns and reconstructive surgery.

We continue to deliver against the Department of Health's national targets for waiting times. This year, we failed to achieve the threshold for one target – access within 31 days for patients referred with suspected cancer. However, this was due to over-stringent interpretation of rules on the implementation of this target on the part of the QVH which was subsequently recognised by the Department. Correct classification of all cases would have achieved the target and we are confident that all our patients benefitted from appropriate and timely treatment.

The hospital has an active and dynamic programme of clinical audit. We are now developing a standard approach to assessing the success rates of our 'free flap' transplant surgery – the fundamental and most complex element of our reconstructive surgery.

QVH also has a comprehensive and diligent approach to the identification and management of quality and risk through the Quality and Risk Committee. This key sub committee of the Board ensures that there is robust governance of all risk and quality issues through regular examination and review of the risk register, reported incidents, standardised quality metrics, and review of quality management programmes.

The results of the 2009 national NHS outpatients survey shows that QVH has maintained high levels of patient satisfaction. QVH ranks significantly better than most other Trusts surveyed across the country. Areas in which the hospital has improved since the last survey include staff knowing more about a patient's medical history, patients reporting greater privacy when being examined or treated, and shorter waiting times for appointments.

In 2009/10 we initiated a programme of streamlining to improve the efficiency of our processes and to make our services even more convenient for patients by minimising cancellations, eliminating late bookings, and reducing the need for several visits to the hospital for tests and scans. While many of the benefits of this work are expected to be realised in 2010/11, there have already been some significant improvements. For instance, we have reduced the average time from referral for plastic surgery outpatients appointments to booking an appointment from 40 days to just 5; there have also been significant improvements in our trauma pathways, and in the flexibility of our admissions procedures for patients undergoing elective surgery.

The Trust received 92 formal complaints during 2009/10 (5.2 complaints per 1,000 spells), an increase of 25 compared with 2008/09 (3.6 complaints per 1,000 spells). 85% of complaints received in 2009/10 were responded to within 25 working days in accordance with the NHS Complaints Procedure (April 2009). The remaining 15% of complaints took longer to investigate due to the complexity of the concerns raised or because the complaint related to care provided by QVH and other NHS organisations and, therefore, required a joint response. In all of these cases the patients were fully informed of any delays that were incurred. During the course of the financial year the Trust received 259 letters and cards of thanks and compliments to staff and departments.

STAKEHOLDER RELATIONS

As a tertiary centre, QVH has key relationships with partner hospitals across the region, sharing facilities and offering its expertise to local populations. The provision of medical care in the community wards at East Grinstead is important for the local community, and much work has been done to ensure that this facility supports the local acute hospitals by providing step down and rehabilitation care for local patients.

NHS West Sussex is our lead PCT, and we continue to work closely together on the development and extension of our services, while also working constructively on issues such as procedures and treatments which are designated as not usually funded.

DIRECTORS' DISCLOSURES

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 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 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 8 to the accounts and details of senior employees' remuneration can be found on page 29 of the report.

3.0 PERFORMANCE

3.1 OPERATIONAL PERFORMANCE

OPERATIONAL PERFORMANCE AT QVH DURING 2009/10 WAS VERY GOOD. WE MET ALL OF OUR EXISTING COMMITMENT INDICATORS AND ALL BUT ONE OF THE NATIONAL PRIORITY INDICATORS.

This meets the criteria for a rating of 'excellent' by the Care Quality Commission in respect of quality of service, to match the 'excellent' for management of resources according to Monitor's assessment of our financial risk rating.

The national priority indicator that we did not meet was the target for 31 days from diagnosis to treatment for cancer. However, as explained in the director's report on page 15 this was due to our over-stringent interpretation of the implementation rules on the part of the QVH which was subsequently recognised by the Department of Health. Correct classification of these cases would have achieved the target.

While QVH met the 18 week referral to treatment target at Trust level, there were difficulties to achieve this in some specialties and work is in progress to ensure that all of our patients are treated within 18 weeks of being referred.

Infection rates were maintained at very low levels with only one case of Clostridium Difficile and one case of MRSA. Although we would like to see no cases of infection at all, this represents a very strong performance and reflects our excellent screening processes.

The table below shows the levels of activity across QVH in 2009/10 compared with those anticipated in the business plan.

In most areas of QVH's business we have had a very successful year, carrying out more activity than planned. The 9% difference between the planned and actual number of procedures carried out in outpatients is good news for patients who can receive their treatment sooner and more conveniently in an outpatient setting. For the NHS this is good news too as it means that, by avoiding the need to admit patients, we can carry out this type of treatment more cost effectively.

Activity levels across QVH

	Plan	Actual	% difference
In-patient	4,155	4,297	3%
Day cases	8,504	8,095	-5%
Emergencies	4,012	3,955	-1%
Outpatients new	25,796	27,047	5%
Outpatients follow ups	65,435	66,972	2%
Outpatient procedures	10,090	10,956	9%
Attendances	38,160	39,463	3%
Bed days	19,808	20,031	1%

3.2 SERVICE TRANSFORMATION

During 2009 QVH has been working on a 'streamlining' project to see how we can change the way we work to improve the care and service we provide to patients while using our own resources more efficiently.

A number of pilots have been carried out in different parts of the organisation (see case study below) which have shown that this approach has the potential to make significant improvements to the way we work and the service we offer patients.

We will now adopt this approach to improving our services across the hospital.

CASE STUDY

NEW APPROACH SAVES TIME AND MONEY

By taking a fresh look at how it is working, QVH has managed to dramatically reduce the average time from referral to booking for plastic surgery outpatient appointments from 40 days to just five.

By reviewing data about how the hospital is performing, managers saw that this was an area where things could be better. The people who best know how to make improvement are usually the people doing the job on the front line. So everyone involved in plastic surgery outpatient appointments, from admissions officers to consultants, worked together to devise a new system.

They identified and introduced various changes. For example, bookings managers began proactively calling patients to make appointments, rather than waiting for patients to contact them, and introduced new working patterns so their office was open longer, making it easier for patients to get in touch.

By streamlining the process, they have improved the quality of service for patients and cut costs at the same time. Staff in other clinics and specialties will be using the same approach to take a fresh look at what improvements they could make over the coming months.

3.3 FINANCIAL PERFORMANCE

Following a challenging year, the financial position as at the end of March 2010 shows a surplus of £1m prior to a £2m expense for impairment of asset values. The plan for 2009/10 was a surplus of £1.1m.

In agreement with Monitor the Trust excluded the impairments for the purposes of calculating the Trust's Financial Risk Rating (FRR), and hence for the FRR the Trust shows a surplus for 2009/10 of £1m. The Trust's year end position maintains its FRR of 4.

PERFORMANCE SUMMARY

The table below summarises the overall financial position for the Trust compared to 2008/09.

	2009/10	2008/09
Turnover	£54.5m	£52.4m
Pay costs	£36.2m	£34.6m
Non pay costs excluding impairments	£16.4m	£16.0m
Interest and dividends	£0.9m	£0.6m
Surplus before impairments	£1.0m	£1.2m
Surplus / (deficit)	(£1.0m)	£0.8m

Income increased by 3.7% overall last year which reflected both additional activity undertaken and changes to the national tariff. The Trust remained within its private patient income cap for the year with income of £95,000.

Pay costs increased by 4.6% over the year reflecting the national pay awards and a small increase in staff numbers employed. The Trust also incurred greater expenditure on interim and agency staff than in the previous year to support the increased activity levels.

The historically low level of interest rates nationally led to reduced income from interest received which generated only £14,000 in 2009/10 against £194,000 in 2008/09.

Measures were adopted throughout the year to control costs and drive through efficiencies focussing on headcount, non-pay expenditure, theatre productivity, off-site activity and Jubilee Ward. The measures undertaken have succeeded in taking the Trust's underlying position (excluding non recurrent items) from a monthly loss to a small surplus of £50-100K per month.

The cash position for the Trust at year end is £4.8m. It must be noted that £1.9m of this is a capital receipt received in this year for spend that is to be incurred in 2010/11, so the underlying position is actually £2.9m which is in line with previous years. This position has been recovered from a low point during the year of £1.8m by cost control and effective cash management.

It must be emphasised that, whilst some significant progress in strengthening the Trust's financial position has been made, there are significant challenges ahead with the economic pressures leading to less funding available in the future combined with higher demand and an estate that requires significant investment. The Trust has undertaken a strategic review of its operations which has been shared with Monitor and a plan for further improvement to the underlying financial position has been agreed. This will focus on reducing the cost base through streamlining service delivery and improved focus on the performance of individual specialties through service line reporting.

3.4 REGULATORY RATINGS

For both annual risk assessment and in-year monitoring, Monitor assigns a risk rating in three areas – finance, governance and mandatory services. Monitor uses these risk ratings to guide the intensity of its monitoring and signal to the Trust its degree of concern with any issues identified and evaluated.

Monitor uses four criteria to assess the Trust's financial risk rating: underlying financial performance; achievement of financial plan; financial efficiency; and liquidity. At the end of the financial year the Trust achieved a risk rating of four, in a range of one to five where five is best.

Monitor uses a traffic lights indicator for governance and mandatory services risk rating to indicate compliance with its terms of authorisation. An amber risk rating reflects that concerns exist about one or more aspects; a red risk rating indicates there are concerns that the Trust is in significant breach of its terms of authorisation.

At the end of the financial year QVH continued its excellent record from previous years by achieving green in all quarters (see tables below).

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial risk rating	5	5	5	5	4
Governance risk rating	●	●	●	●	●
Mandatory services	●	●	●	●	●

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	4	4	3	4
Governance risk rating	●	●	●	●	●
Mandatory services	●	●	●	●	●

● **Red**
Rating indicates concerns that the trust is in significant breach of its terms of authorisation.

● **Amber**
Reflects that concerns exist about one or more aspects.

● **Green**
Excellent record.

3.5 STAFF ENGAGEMENT

STAFF SURVEY

The 2009 staff survey was once again very positive for QVH with the Trust's scores for 18 of the 40 key indicators in the top 20% of results and a further 13 above average. There was a good response rate of 57% which was 5% higher than the previous year.

The table below sets out the following, comparing the Trusts scores with the national average:

- Four best scores
- Four worst scores
- Four areas of greatest improvement since 2008/09
- Four areas of greatest decline since 2008/09.

One key message from the 2009 survey is that, although we continue to perform better than the rest of the NHS in most areas, this year we have slipped in some scores against the QVH standard in 2008.

	Best / worst scores	Change since 2008	QVH score	National average
Best scores				
Good communication between senior management and staff	✓	2% worse	48%	32%
Perception of effective action from employer towards violence and harassment	✓	0.02 worse	3.82	3.62
Staff intention to leave jobs*	✓	0.13 worse	2.30	2.51
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwell	✓	New for 2009	15%	23%
Worst scores				
Percentage of staff suffering work-related injury in the last 12 months	X	6% worse	20%	13%
Percentage of staff experiencing physical violence from patients/relatives in the last 12 months	X	2% better	4%	4%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	X	3% worse	34%	34%
Percentage of staff appraised with staff development plans in the last 12 months*	X	10% better	64%	65%
Other significant changes since 2008/09				
Percentage of staff working extra hours	n/a	7% better	65%	66%
Percentage of staff appraised in the last 12 months	n/a	13% better	75%	75%
Percentage of staff suffering a work related injury in the last 12 months	n/a	6% worse	20%	14%
Trust commitment to work/life balance (however this is still a best 20% score)	n/a	0.11 worse	3.66	3.51
Quality of job design	n/a	0.07 worse	3.50	3.45

**This score is now only 1% below the NHS average and is a score that has significantly improved since the 2008 survey.*

ONGOING ENGAGEMENT

As in previous years, we will use an action plan to address areas of weaknesses – three out of the four worst scores from last year's survey had significantly improved in the 2009 survey following the implementation of an action plan. For example, because appraisal completion scores in the 2008 staff survey were below average, we have worked on awareness raising of the requirement for appraisal, developed a monitoring system for recording completed appraisals and overhauled the appraisal documentation to make it more streamlined and user friendly.

In 2010/11 the Risk Team will be focussing on the work related injuries, physical violence and errors and near misses indicators, whilst the Head of HR will continue to lead the work to improve further on appraisal and personal development plans.

We will also be looking at other ways to measure staff satisfaction and engagement, including investigating the staff experience element of the toolkit that is being developed as part of the 'Energising Excellence' work led by the NHS South East Coast strategic health authority.

There are a number of communication forums within the Trust, including monthly team briefings, briefings and 'walkrounds' by the Chief Executive, the weekly 'Connect' newsletter and an intranet site.

The sixth annual QVH staff awards were held in November 2009. The awards, funded by the charitable fund and donations, honoured many staff for their achievements in services to patients, education, performance or loyalty to the organisation.

The Trust 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 (JCNC) 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.

Achievements this year include:

- During 2009/10, the Trust's Head of HR and Chair of the JCNC secured funding for a partnership working initiative. A 'partnership day' was held in February 2010 which included presentations and visits to wards and other departments within the Trust to raise awareness of partnership working and to encourage staff to get involved in trade union activities
- The Trust continues to run regular job evaluation panels to evaluate new and re-designed roles. This could not be managed without the dedicated support of the union representatives
- The Occupational Health Service that began in August 2008 is now well embedded in the Trust and is proving to be very successful. The Occupational Health Nurse runs health promotion events and awareness raising events throughout the year. The staff survey results continue to show that QVH has one of the lowest levels of stress across the acute specialist sector.

3.6 EQUALITY AND DIVERSITY

QVH is committed to ensuring that its services and employment practices are fair, accessible and appropriate for the diverse patient community we serve and the workforce we employ. Our patients, their carers and visitors and our staff deserve the very best we can give them in an environment in which all feel respected, valued and empowered.

Our approach to promoting equality and diversity (E&D) includes:

- The development and publication of an Equality Scheme 2010/13 and action plan to promote equality and diversity, to meet our legal duties, and to provide a framework for a co-ordinated approach on age, religion belief and sexual orientation
- Quarterly Equality, Diversity and Human Rights Steering Group
- An executive lead in E&D – the Director of Nursing and Quality
- Conducting and publishing the equality impact assessment of our services, functions and policies to ensure that equality and fairness are embedded into service delivery, planning, procurement and employment
- Providing equality, diversity and human rights training to all staff
- Annual workforce statistics are prepared for the board and published on the internet which include analysis of statutory E&D monitoring metrics
- Liaison with internal and external stakeholders in the development, implementation and review of equality action plans to continually improve our healthcare services. Stakeholders include PALS, patient information group, public engagement group and the patient experience taskforce
- Evaluation of employment and recruitment policies and practices is regularly conducted to ensure they are legally compliant and do not directly, indirectly, intentionally or unintentionally discriminate against applicants or employees
- Appraisal and personal development processes are in place to ensure consistent development opportunities for all staff.

SUMMARY OF PERFORMANCE – WORKFORCE STATISTICS

The staff headcount has reduced from 962 in 2008/09 to 948 in March 2010.

The ethnicity of the South East Coast region, based upon census 2005 mid-year estimates is 91% White British. The ethnicity of staff at QVH is 82% White British and 15% Black and Minority Ethnic (BME). This indicates that QVH has an ethnically diverse workforce in comparison with the locality. Three percent of the workforce chose not to declare their ethnicity but 87% of the QVH foundation trust members chose not to declare.

One percent of staff have self declared that they have a disability, compared with 18% of the general population (2001 census). Eighty-one percent of staff chose not to formally declare their disability status however members have not, to date, been asked to declare their disability status.

The table below sets out the demographics of our staff and members

	Staff 2008/09	%	Staff 2009/10	%	Membership 2008/09	%	Membership 2009/10	%
Total	962		948		10,558		10,649	
Age								
0-16	0	-	0	-	0	-	0	-
17-21	16	2	12	2	40	<1	35	<1
22+	946	98	936	98	3,252	31	3,413	32
Not stated	0	-	0	-	7,266	69	7,201	68
Ethnicity								
White British	807	84	767	82	1,179	11	1,270	12
White Other	9	<1	30	3	6	<1	8	<1
Asian or Asian British	58	6	57	6	14	<1	15	<1
Black or Black British	13	1	19	2	10	<1	11	<1
Other	42	4	42	4	5	<1	7	<1
Not stated	33	3	33	3	9,344	89	9,251	87
Gender								
Male	230	24	226	23	4,421	42	4,441	42
Female	732	76	722	77	5,192	49	5,212	49
Trans-gender	0	-	0	-	0	-	0	-
Not stated	0	-	0	-	945	9	996	9
Recorded disability								
No	177	18	177	18	0	-	0	-
Yes	10	1	19	1	0	-	0	-
Not stated	775	81	761	81	10,558	100	10,649	100

4.0 RESOURCES

4.1 ESTATE AND CAPITAL

DURING 2009/10 QVH COMPLETED A CAPITAL PROGRAMME ACROSS THE ESTATE. THIS PROGRAMME COMPRISED BOTH BACKLOG MAINTENANCE AND DEVELOPMENT PROJECTS AND ALL WERE COMPLETED WITHIN BUDGET.

We have carried out six maintenance projects this year with a total budget of nearly £1million. These have included replacement calorifiers (water heaters) and heating in the Staff Development Centre building. We have also upgraded our emergency lighting systems, improved critical ventilation systems and replaced a number of generators.

We have invested nearly £1.5million in development works, including developing a new paediatric assessment unit, works to improve privacy and dignity for patients on Burns and Canadian wings, and to improve the use of space across the site.

Over £1million is planned for continued investment in the coming year, including the refurbishment of Peanut Ward for children and improvements to electrical systems across the site.

4.2 SUSTAINABILITY

COMMENTARY

In response to the carbon reduction strategy for the NHS, QVH is developing its own strategy to reduce its carbon footprint and is taking responsibility for its carbon emissions. This strategy will comprise four key actions:

- Establish Sustainable Development Management Plan for approval by the Board of Directors
- Sign up to the Good Corporate Citizenship Assessment Model
- Monitor, review and report on carbon
- Actively raise carbon awareness at every level of the organisation.

SUMMARY OF PERFORMANCE – NON FINANCIAL AND FINANCIAL

The table below shows the improvements we are making in reducing waste, greater recycling and cutting our use of finite resources.

Area		Non financial data (applicable metric) 2008/09	Non financial data (applicable metric) 2009/10	Financial data (£k) 2008/09	Financial data (£k) 2008/10
		Tonnes	Tonnes		
Waste minimisation and management	Domestic	59	60	10.5	12
	Clinical	109	120	52	59
	Waste electrical equipement (WEE)	1	1	1	1
	Recycled	10	12	2.5	3
Finite resources	Water	341,147m^3	299,920m^3	27	24
	Electricity	6,874 GJ	9,926 GJ	304	244
	Gas	21080 GJ	21,500 GJ	268	210
	Gross internal area (GIA)m^2	19,290	20,290		

FUTURE PRIORITIES AND TARGETS

- Implementation of a carbon management strategy, approved by the Board of Directors
- Assurance that all new buildings will be low carbon by 2015
- Implementation of a sustainable travel plan for all NHS bodies, approved by the Board of Directors
- Creation and achievement of a target for better waste management
- Reduction in sources of carbon emissions by improvement of goods, services and equipment procurement
- Annual reporting on sustainability targets and performance results.

4.3 REMUNERATION REPORT

Salary entitlements of senior managers

	1 April 2009 to 31 March 2010			1 April 2008 to 31 March 2009		
	Salary	Other remuneration	Benefits in kind	Salary	Other remuneration	Benefits in kind
Name and title	(Bands of £5,000) £000	(Bands of £5,000) £000	Rounded to nearest £100	(Bands of £5,000) £000	(Bands of £5,000) £000	Rounded to nearest £100
P. Griffiths (Chairman)	40-45	0	0	40-45	0	0
J. Beech (Non Executive Director)	10-15	0	0	10-15	0	0
R. Hoey (Non Executive Director)	0	0	0	5-10	0	0
R. Leech (Non Executive Director)	10-15	0	0	10-15	0	0
H. Ure (Senior Independent Director and Non Executive Director)	15-20	0	0	15-20	0	0
S. Winning (Non Executive Director)	10-15	0	0	10-15	0	0
A. Bull (Chief Executive)	140-145	0	0	35-40	0	0
C. Becher (Director of Nursing & Quality)	15-20	0	0	90-95	0	0
T. Bolot (Interim Director of Finance)	115-120	0	0	0	0	0
S. Colclough (Chief Executive)	0	0	0	95-100	0	0
S. Flint (Director of Finance)	55-60	0	0	100-105	0	0
K. Lavery (Medical Director)	10-15	185-190	0	10-15	165-170	0
A. Parker (Director of Nursing & Quality)	60-65	20-25	0	0	0	0
M. Sherry (Director of Performance, Technology & Innovation)	65-70	0	0	0	0	0

Pension entitlements of senior managers

		Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real increase in Cash Equivalent Transfer Value
			(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)		
	£000	£000	£000	£000	£000	£000	£000
A. Bull (Chief Executive)	7.5-10	22.5-25	20-25	60-65	424	238	174
C. Becher (Director of Nursing & Quality)	0-2.5	0-2.5	45-50	135-140	1,006	801	14
S. Flint (Director of Finance)	0-2.5	0-2.5	25-30	75-80	456	418	9
K. Lavery (Medical Director)	0-2.5	2.5-5	70-75	210-215	1,805	1,505	45
A. Parker (Director of Nursing & Quality)	5-7.5	15-17.5	20-25	65-70	407	239	104
M. Sherry (Director of Performance, Technology & Innovation)	0.2.5	2.5-5	20-25	70-75	523	442	39

NOTES

1. As non executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non executive directors. This applies also to T. Bolot.

2. 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.

3. 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.

4. 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.

5. The following directors joined the board during the year: A. Parker (August 2009), M. Sherry (August 2009).

C.Becher left the board in May 2009.
S. Flint left the board on 16 October 2009.

The following directors left the board during 2008/09: S.Colclough (January 2009), R.Hoey (September 2008).

Adrian R Bull

Dr Adrian Bull
Chief Executive

8 June 2010

5.0 GOVERNANCE

5.1 BOARD OF DIRECTORS

MEMBERSHIP

At 31 March 2010, the QVH Board of Directors consists of the Chairman, five non executive directors (of which one post is vacant) and four executive directors (of which one post was vacant but was filled on 1 April 2010 with the appointment of Richard Hathaway as the Director of Finance and Commerce).

The biographies and core skills of the current membership of the Board are as follows:

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 Guys & 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 Chairman of Queen Victoria Hospital NHS Foundation Trust at East Grinstead.

Peter is a member and the Deputy Chairman of the Foundation Trust Network Board.

Dr Adrian Bull
Chief Executive

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.

Tim Bolot
Interim Director of Finance

Tim joined the Trust for an interim period until a permanent replacement for the post was recruited to take up the post on 1 April 2010.

An experienced and well respected finance director, Tim is an expert in short term and interim engagements.

He is a trained barrister and solicitor as well as an accountant and has worked extensively within the NHS and also in the commercial sector.

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, prior to commencing his specialist training as an oral and maxillofacial surgeon at Queen Victoria Hospital and Guy's Hospital.

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

Amanda Parker
Director of Nursing & Quality

Amanda 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 Georges, 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 & 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).

Mary Sherry
Director of Performance, Technology & Innovation

Mary joined the Trust from Portsmouth Hospital NHS Trust where she was Associate Director for Patient Pathways.

She has previously worked at Surrey & Sussex Healthcare NHS Trust as Acting Director of Operations and Access and Capacity Manager and managed a range of specialties at St George's and Kingston Hospitals.

Mary has a strong reputation for working very closely with clinicians and staff of all disciplines to achieve improvements in patient services and is well known for her partnership working.

Mary's focus is to formulate the transformation plan based on the systems thinking work that the Trust has been piloting recently. She is also working with the Board and the senior management team, as well as front line staff, to strengthen the Trust's performance and rationalise operating costs, ahead of future financial constraints on the NHS. Key to this is how IT can support both the transformation plan for the Trust and also day to day delivery of services.

Hugh Ure
Senior Independent Director
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.

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.

Jeremy Beech
Non Executive Director

Jeremy, from Frittenden in Kent, is a consulting engineer.

He has spent over 30 years in the fire service occupying positions as Assistant Chief Fire Officer in the London Fire Brigade and then Chief Fire Officer of Kent. He was also one of five UK members of the Channel Tunnel Safety Authority and UK Chairman of the Rescue and Public Safety Working Group.

Jeremy is also a non executive director of the Port of London Authority and a trustee of the Kent Foundation.

Dr Renny Leach
Non Executive Director

Renny lives in Forest Row and has held chief executive, managing director and chairman positions across an extensive range of high profile UK and Scandinavian academic and commercial life science organisations.

Renny's career has focused on the promotion and management of clinical research, particularly in the field of paediatrics and the new born baby. He was previously Director of Clinical Research at the Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust and has worked for the UK Medical Research Council and the Horsham-based charity Action Medical Research.

More recently he has been working with a number of public and venture capital funded companies developing new clinical treatments for common conditions including cancer.

Shena Winning
Non Executive Director

Shena, 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 a Non Executive Chairman of Swallowfield plc and was a Non Executive Director of South East Kent Community Health Trust from July 1996 to January 1998.

During the course of 2009/10 there have been vacancies at both executive and non executive director level; a new post of Executive Director of Performance, Innovation and Quality was created; and, thus, a fifth non executive director post was established to balance the Board.

The post of Executive Director of Finance was vacant on a substantive basis for 6 months but filled on an interim basis for all of that time. A permanent appointment to the post was made from 1 April 2010.

The Trust is working with the Appointments Commission to fill the vacant non executive director position.

Full details of the membership of the Board throughout the year are set out in the table on page 35.

COMPLIANCE

The Trust is confident that the Board of Directors has complied with;

- the framework for the corporate governance of Foundation Trusts as set out in the Monitor Code of Governance (www.monitor-nhsft.gov.uk); and
- the terms of the QVH Constitution, Schedule 1 of the Trust's terms of authorisation as an NHS Foundation Trust (www.monitor-nhsft.gov.uk).

Furthermore, during the 3 and 4 quarters of 2009/10, the Board of Directors;

- undertook an internal review of its effectiveness and has agreed a series of adjustments to its practices to further strengthen its meetings programme; and
- reviewed its practice of holding meetings in private and, in consultation with the Board of Governors, agreed to continue to do so but also to review this decision on an annual basis.

INTERESTS

A register of directors' interests is kept by the Trust and is available on request to the Head of Corporate Affairs (Company Secretary).

MEETINGS

Board of Directors meetings were held in private and attended by the Governor Representative, Programme Director, Deputy Medical Director and Head of Corporate Affairs (Company Secretary).

There are three sub-committees of the Board:

- Audit Committee
- Quality and Risk Committee
- Nomination and Remuneration Committee.

The following table sets out the members of the Board throughout 2009/10 and their membership of, role in, and attendance of, each of the three sub-committees. The Audit Committee and Nomination and Remuneration Committee membership comprises solely of non executive directors. The Quality and Risk Committee contains both executive and non executive directors.

Board of Directors membership and attendance record

Name, title and appointment	Meeting attendance and role 2009/10			
	Board of Directors	Audit Committee	Nomination and Remuneration Committee	Quality and Risk Committee
Peter Griffiths Chairman 1 April 2005 to 31 March 2012	12 of 12 Chairman	-	3 of 3 Member	-
Hugh Ure Senior Independent Director 1 October 2005 to 30 September 2011	10 of 12 Deputy Chairman	6 of 6 Member	3 of 3 Chairman	-
Jeremy Beech Non Executive Director 1 October 2005 to 30 September 2012	12 of 12	-	3 of 3 Member	4 of 4 Chairman
Renny Leach Non Executive Director 1 January 2007 to 31 December 2010	10 of 12	-	2 of 3 Member	3 of 4 Member
Shena Winning Non Executive Director 1 October 2005 to 30 September 2012	12 of 12	6 of 6 Chair	3 of 3 Member	-
Adrian Bull Chief Executive December 2008 to present	12 of 12	2 of 6 In attendance	3 of 3 Member	4 of 4 Member
Ken Lavery Medical Director April 2008 to present	8 of 12	-	-	2 of 4 Member
Sally Flint Director of Finance October 2002 to October 2009	5 of 12	3 of 6 In attendance	-	2 of 4 Member
Ed Rothery Acting Director of Finance September 2009 to October 2009	2 of 12	-	-	-
Tim Bolot Interim Director of Finance October 2009 to March 2010	6 of 12	2 of 6 In attendance	-	-
Caroline Becher Director of Nursing September 2003 to May 2009	1 of 21	-	-	-
Amanda Parker Acting Director of Nursing May to July 2009 Director of Nursing & Quality July 2009 to present	1 of 12 9 of 12	- -	- -	1 of 4 Member 3 of 4 Member
Mary Sherry Director of Performance, Innovation & Technology August 2009 to present	8 of 12	-	-	-

5.2 NOMINATION AND REMUNERATION COMMITTEE

The purpose of the Nomination and Remuneration Committee is to review and make recommendations to the Board of Directors on the composition, balance, skill mix and succession planning of the Board. It recommends the appointment of executive directors. It is responsible for setting the overall policy for the remuneration of all Trust staff, and it specifically authorises the remuneration packages for the Chief Executive, the executive directors and other very senior manager posts.

The Nomination and Remuneration Committee was formed on 1 April 2007, replacing the former Remuneration Committee. This is the third annual report of the committee.

MEMBERSHIP OF THE COMMITTEE

Membership of the committee and their attendance record is set out in the Board of Directors table above.

ACTIVITIES OF THE COMMITTEE

During 2009/10 the Trust continued with an agreed rolling work programme. Three new directors were appointed - Nursing & Quality, Performance, Technology & Innovation and Finance. A new Head of Corporate Affairs was also appointed. The committee made decisions or recommendations on the following issues:

- Standards of business conduct
- The 2009 national pay award
- Recruitment of, job description and salaries for new executive director posts
- Pay for executive directors and other very senior managers
- Revised terms of reference
- Revision to Aligned Appointments Principles
- Review of welfare and reward
- Vacant non executive director post
- Appointment of the Interim Director of Finance
- Review of appraisal and leadership
- Work plan for 2009/10.

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 have been set based on external benchmarking, recommendations by the Head of HR and benchmarking both salary and terms and conditions against other NHS organisations using information networks, the very senior managers pay framework and reports on NHS and foundation trust boardroom pay. The Hay report commissioned in the 2008/09 financial year was used to benchmark salaries, and the Agenda for Change pay rise for 2009/10 was also taken into account.

In line with the requirements of the 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. Ann Horscroft, 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 the financial statements. There have been no compensatory agreements in the 2009/10 financial year.

A list of executive directors who served in the 2009/10 financial year is included in the Board of Directors table above.

5.3 AUDIT COMMITTEE

One of the main principles of the NHS Foundation Trust Code of Governance is that the board should establish formal and transparent arrangements for considering how they should apply the financial reporting and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors. In this respect the code provides that the board must establish an audit committee composed of non-executive directors which should include at least three independent non-executive directors. The board should satisfy itself that at least one member of the audit committee has recent and relevant financial experience.

In line with the code the Trust's Audit Committee is comprised of two non-executive directors. Shena Winning, one of the non-executive directors and chair of the committee is a chartered accountant with over 20 years experience within the retail sector.

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 2009/10 the committee fulfilled its objectives, as set out in its terms of reference, by undertaking the following areas of work;

- monitoring the integrity of the Trust's financial statements
- reviewing the Trust's internal controls and the Trust's risk management systems
- providing the Board with assurance that the Trust has the appropriate risk management and assurance processes in place
- reviewing and monitoring the effectiveness of the Trust's internal audit function
- reviewing and monitoring the external auditors' independence and objectivity
- reviewing the adequacy of management responses to issues identified by audit activity
- receiving regular reports from the Trust's Local Counter Fraud Manager
- undertaking an annual review of the effectiveness of the Audit Committee itself.

In addition to the above, during the year the Audit-Committee commissioned specific pieces of work as set out below.

During the year the Trust evaluated and financially appraised the options for development of its ageing estate. The committee commissioned the Trust's external auditors to undertake a review of the options and their appraisals drawn up by the Trust. The auditor's report provided valuable independent comment that aided the Board in making informed decisions on the future of the Trust.

The committee also engaged the external auditors in preparation for discussions with Monitor in relation to the future of the Trust and consideration of the site development impairment. The auditors provided a letter outlining their opinion on the site development impairment which was provided to Monitor. In carrying out this work the external auditors took all necessary steps to ensure they maintained their independence from the Trust.

During the year the committee has commissioned the internal auditors to undertake specific pieces of targeted analysis to test the strength of controls or procedures. The outcomes from these have been used to review and re-emphasise procedures and controls across the Trust.

During the year the committee was also pleased to receive reports from the Trusts internal and external auditor's 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 85% of the areas reviewed, resulting in a Head of Internal Audit Opinion of significant assurance.

The Audit Committee meets four time's a year and is attended by the Trusts Director of Finance 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.

Attendance of the meetings held during 2009/10 is shown in the table on page 35.

5.4 MEMBERSHIP

SUMMARY

Membership numbers and profiles remained broadly stable compared with those in 2008/09 (and described in the QVH annual plan 2009/10).

Moderate recruitment targets for 2009/10 were set but not achieved: public membership fell by 2% and staff membership rose by 0.2%.

A demographic breakdown of the membership is included in the equality and diversity table on page 25.

Constituency	Eligibility criteria (I)	Eligibility criteria (II)	Membership at 31 March 2010
Public	Over 18 years of age	Resident in Kent, Surrey or Sussex	10,559
Staff		Employed by QVH for over 12 months	844
			11,403

STRATEGY

The membership strategy for the year focused on 'meaningful' membership, which is interested in the future of the hospital and which widely represents the population the hospital serves. In 2009/10 governors were actively encouraged to recruit members by meeting with local interest groups and visiting public libraries, schools career evenings and supermarkets.

DISCLOSURES AND CONTACT DETAILS

A public register of members is available for viewing by contacting the Head of Corporate Affairs. Members should also contact the Head of Corporate Affairs to communicate with governors and / or directors.

5.5 BOARD OF GOVERNORS

THE BOARD OF GOVERNORS REPRESENTS, AND IS ELECTED BY, THE PUBLIC MEMBERS OF THE TRUST.

The Board of Governors has important powers, such as appointing or removing the Chairman of the Trust and other non executive directors. It also decides how much they will be paid and other conditions of service. The Board of Governors also approves the appointment of the Chief Executive and can appoint or remove the Trust's external auditor.

The Board of Governors works through a Governors Steering Group, which supports and facilitates the work of the Board of Governors and actively engages governors in adding value to the Trust. The Governor Steering Group now holds joint meetings with the non executive directors during the year.

Members can contact governors and directors via the Trust or the Trust website and members of the public can view the Register of Governors' interests by contacting the Head of Corporate Affairs.

BOARD OF GOVERNORS PUBLIC MEETINGS

The Board of Governors holds five public meetings a year, including the AGM, in venues in and around East Grinstead. At the public meetings there is a standing item on the agenda regarding the membership, when feedback from the Trust, the governors or members can be discussed freely. At the AGM the Board of Governors is presented with the annual report and the annual accounts, plus the auditor's report.

The Directors, who are accountable to the governors, attend all public Board of Governors meetings and provide the Board of Governors with reports on the management of the Trust, infection control figures and any other matters the governors should be kept aware of. Full and frank discussions take place at public meetings to which the public are encouraged to attend and at which they have the opportunity to ask questions.

GOVERNOR REPRESENTATIVE

The Board of Governors is represented by the Governor Representative, who attends all Board of Directors meetings in full (in a non-voting capacity) and provides a report to governors through formal meetings of the Governors Steering Group and Board of Governors and through the governors monthly 'Update'. The Governor Representative also acts as a link between the Board of Directors and the Board of Governors and actively projects, protects and enhances the Trust`s reputation. In 2009/10 this position was held by Bernard Atkinson.

VICE CHAIRMAN OF THE BOARD OF GOVERNORS

At the beginning of September 2009 the first Vice Chairman of the Board of Governors was appointed - a significant step in the evolution of the Board of Governors. The Vice Chairman provides advice to individual governors as required, supports governors in progressing governor business, represents the governors externally as necessary, works with the Chairman of the Trust on developing Board of Governors' governance arrangements as well as advising him on governor matters. He chairs the Governors Steering Group and when the Chairman cannot attend or, if it is appropriate, he also chairs the Board of Governors.

MEMBERSHIP OF THE BOARD OF GOVERNORS

Public governor elections took place in 2009 with 10,583 election forms being sent out and 2,374 forms being received; a turnout of 22.6%.

Part or full time staff who have a contract with the Trust and who have worked at the Trust for more than 12 months are eligible to be members and stand as staff governor.

Four meetings of the Board of Governors took place between 1 April 2009 and 31 March 2010. As in previous years, apart from sickness, attendance at meetings was good.

The table below lists the members of the Board of Governors, whether they are a public or staff member or representing a stakeholder, and the number of meetings they attended in 2009/10.

Governor	Constituency	Term	Meetings attended (4)
Bernard Atkinson	Public	Re-elected 2008 to 2011	4
Len Barlow	Public	Re-elected 2008 to 2011	4
Stuart Barnett	Public	Re-elected 2008 to 2011	4
Gillian Baxter	Public	Elected 2008 to 2011	4
Edward Belsey	Public	Elected 2009 to 2012	3
John Bowers	Public	Re-elected 2008 to 2011	4
Gillian Brack	Public	Elected 2009 to 2012	3
Tom Cochrane	Stakeholder: Guinea Pigs Club	Reappointed 2007; resigned December 2009*	1
Sarah Creamer	Stakeholder: NHS West Sussex	Appointed 2008 to 2011	0
Mabel Cunningham	Staff	Elected 2008 to 2011	4
Roy Daisley	Stakeholder: University of Brighton	Reappointed 2007 to 2010	3
Peter Dingemans	Public	Re-elected 2008 to 2011	4
Peter Evans	Stakeholder: Local Authority	Reappointed 2009 to 2012	2
Adrian Fuchs	Public	Elected 2008 to 2011	4
Mary Goode	Stakeholder: Brighton & Sussex University Hospitals NHS Trust	Appointed 2009; resigned January 2010**	2
Peter Harper	Public	Elected 2008 to 2011	4
Bill Hatton	Public	Re-elected 2008 to 2011	4
Caroline Hitchcock	Public	Re-elected 2008 to 2011	4
Ann Horscroft	Public	Re-elected 2007 to 2010	2
Sue Hull	Public	Elected 2008 to 2011	3
Valerie King	Public	Re-elected 2008 to 2011	4
Carol Lehan	Staff	Elected 2008 to 2011	3
Shirley Mitchell	Public	Re-elected 2008 to 2011	3
Martin Plimmer	Public	Re-elected 2008 to 2011	4
Derek Pocock	Stakeholder: League of Friends	Reappointed 2006 to 2009	4
Andrew Robertson	Public	Elected 2009 to 2012	4
Chris Rolley	Stakeholder: East Grinstead Town Council	Reappointed 2007 to 2010	2
Manya Sheldon	Public	Elected 2009 to 2012	4
Ian Stewart	Public	Elected 2008 to 2011	4
Alan Thomas	Public	Elected 2009 to 2012	2
Alison Tweddle	Public	Re-elected 2007 to 2010	4
Jill Walker	Public	Elected 2008 to 2011	3
Sharon Watkinson	Public	Re-elected 2007 to 2010	3
Vacant position***	Staff	Vacant	n/a

**Sponsorship withdrawn* ***Awaiting another representative* ****Staff member stood, but ineligible nomination*

5.6 DISCLOSURES

Communication and information giving actions are described in the staff engagement section of this report. In addition, formal consultation is described in the Trusts Change Management Policy which was reviewed in 2009/10.

The Trust has a Whistle Blowing Policy which explains to staff how they can raise concerns about issues 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, the Trust has the Datix incident reporting system which allows staff to raise concerns and record incidents relating to clinical issues.

A formal staff consultation exercise began in March 2010 which relates to a review of the orthodontic service.

The Trust reports sickness absence data quarterly via the Health and Safety Committee and monthly at the People, Quality and Capital meeting. From March 2010 it is also reported on a monthly basis to the Board (prior to this it was bi-annual). The Trust has had a steady average of 3.5% sickness absence over the last four years, which is 1% below the NHS average and 10% below the acute sector average in 2008/09. Seasonal variations are noted (i.e. higher in winter, lower in summer).

6.0 QUALITY ACCOUNTS

6.1 STATEMENT ON QUALITY

QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST (QVH) PRIDES ITSELF ON THE SPECIALIST SERVICES THAT IT PROVIDES.

As one of the largest centres for both reconstructive and head and neck surgery in the country, and as one of the leading centres for corneo and oculoplastic surgery, the large number of complex cases mean that our staff maintain high levels of efficiency and expertise. Because of the close teamwork between our surgeons, anaesthetists, theatre and nursing staff, therapists and psychotherapists, we are able to provide an integrated approach to the complete needs of the patient in both the acute and rehabilitation phases of their condition.

Because of the high-risk and complicated nature of the surgery we carry out, safety is a key issue at all levels of the organisation. We undertake a thorough and comprehensive audit of our observations, response times, preventive precautions, and levels of expertise to ensure the highest standards. We also have a rigorous programme of incident reporting, investigation, and follow up to ensure that lessons are learned and improvements made at every opportunity.

Patient dignity, comfort, and satisfaction are equally important to the hospital which provides local medical services as well as tertiary surgery. In the past year we have carried out a comprehensive analysis of patients' views on the non-technical aspects of their care and have responded to their key concerns. We are proud to have one of the best records in the country from the annual patient survey, and aim to provide personal care at every level.

QVH has consistently met and achieved all government targets for waiting times for cancer, emergency, and planned services. This year we have failed to meet one target (percentage of patients seen within 31 days of referral on a cancer pathway). However, we have achieved this standard in the second half of the year and our results were depressed by the erroneous classification of a number of patients in this category which could not later be revised under the Department of Health's rules.

As part of our focus on the patient experience, we are concerned to ensure that our achievement of national targets is not at the expense of other aspects of patient satisfaction – in particular cancellations of appointments or operations, and late bookings. We have adopted regular measures of these aspects of care and these quality accounts contain a clear commitment to avoid cancellations and late bookings.

We believe it is important that we offer the benefit of our services to the wider population of Kent, Surrey, and Sussex. To achieve this, we continue to establish outreach services, delivered by surgeons, specialist nurses and therapists, to minimise travelling times for patients. For some procedures, such as microvascular reconstruction of breast following (or at the same time as) cancer surgery, we believe that our ability to offer the very best reconstructive techniques enables us to offer care of the highest quality.

We are continuing to develop our objective metrics of quality and safety. Incident reporting has been a standard feature of our board reports for some years and has been continually improved year on year. We are currently focusing on the development of standard metrics for the outcomes of our core surgical competencies in burns treatment and microvascular surgery on free-flaps.

Each clinical directorate is developing its measure of the quality of the care they provide. The information on outcomes published in these accounts demonstrate a performance that is consistently higher (with better outcomes and lower complication rates) than other published rates or national standards. As a leading centre for the services we offer, we will continue to develop and set the standard for outcome measures.

At QVH we believe that, to be of the highest quality, a service must be;

- expert
- holistic
- safe
- comfortable
- reliable
- accessible.

All our staff contribute to the high standards of care that the hospital achieves. The work on these accounts has been led by Amanda Parker, Director of Nursing and Quality, and by Edward Pickles, Consultant Anaesthetist and Director of Audit and Outcomes, supported by Claire Jenkins, Clinical Audit and Outcomes Manager, and Ashley Parrot, Patient Safety Manager.

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

Dr Adrian Bull
Chief Executive

6.2 PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

The table below summarises how we have performed against our priorities for 2009/10 and beyond. The following commentary describes our performance against each outcome in more detail.

Priority	Achieved and will be monitored but not reported again formally	Good progress but will require further work and progress will be reported again	Progress not satisfactory in 2009/10 and will be an ongoing priority
Patient safety			
Culture of patient safety reporting	●		
Physiological monitoring / escalation of care			●
Understand rate of harm / adverse incidents	●		
Implementation of safety briefings and World Health Organisation (WHO)	●		
Consultant review of emergency admissions		●	
Hand decontamination		●	
Clinical quality and effectiveness			
Review of all deaths	●		
Outcome indicators in skin / head and neck cancer		●	
Prospective free flap database		●	
Contribution to national head and neck oncology database			●
Priority to lower limb trauma / outlier patients	●		
Service Level Agreement (SLA) with Brighton for paediatric care	●		
Outcome measures in orthognathic surgery		●	
Development of specialty quality portfolios	●		
Patient experience and access			
National Patient Reported Outcome Measure (PROM) programme	●		
Privacy, dignity, patient information		●	

6.2.1 2009/10 PRIORITIES IN PATIENT SAFETY

Priority 1
Foster an environment in which all staff can legitimately raise concerns about patient safety, and receive feedback on how those concerns have been acted upon.

The primary method of allowing staff to raise concerns about patient safety is through clinical incident reporting. A patient safety incident is any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Organisations that report more incidents usually have a better and more effective safety culture. This is because an organisation cannot learn and improve if it is unaware of any problems.

All QVH staff can report an incident through a computerised system available on any desktop computer. The manager responsible for investigation of the incident is informed automatically and all incidents causing, or having the potential to cause, moderate to severe harm are reported to the clinical cabinet and executive business review.

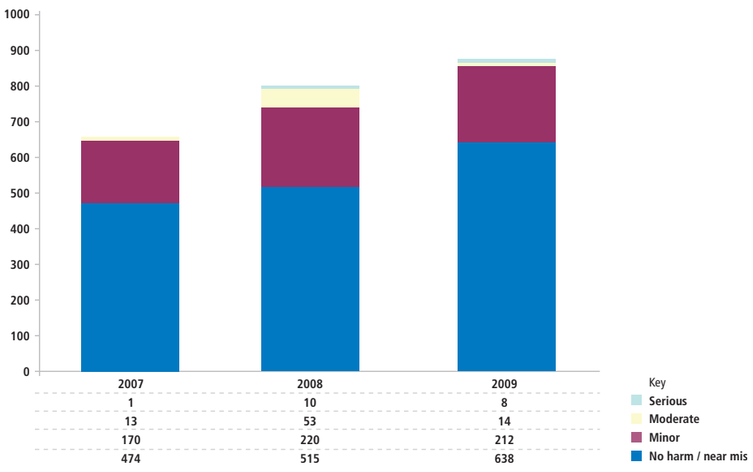
We have continued to encourage clinical incident reporting, in which staff not only report all safety incidents affecting staff and patients, but also all 'near miss' events, where no harm has occurred, but where the potential for harm existed.

As the graph below shows, we have seen an 8% increase in incident reporting, against a 3% increase in activity. This is as an improvement, as the rate of reporting reflects the organisation's openness about patient safety.

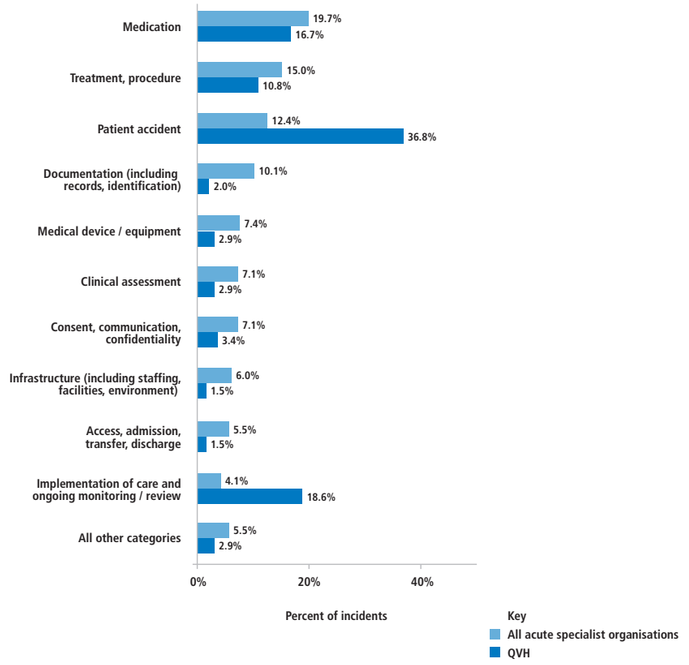
However, we still have the potential for further improvement as we currently report 2.2 incidents per 100 admissions, against a median of 5.5 incidents per 100 admissions to other acute specialist organisations.

The graph opposite shows that we have a different reporting profile to other similar organisations, with a particularly high rate reported for patient accidents. This may reflect our improved reporting culture on the Jubilee rehabilitation unit, where patient falls have been a particular target for improvement in care.

Patient safety incidents by severity



What type of incidents are reported in QVH?
Figure 2: Top 10 incident types



AFTER ACTION REVIEW

In 2009, with assistance from University College Hospital, London, we introduced a new method of learning from clinical incidents called the After Action Review. First used by the US Army, it is a method of formal debriefing, led by a trained facilitator. Staff involved in a clinical incident are brought together in a no-blame environment to discuss what should have happened, what actually happened, why there was a difference, and what can be learnt for next time.

Changes in clinical policy or procedure may be required, although more often the participants just gain understanding of how and why mistakes happen, and how they may be prevented in the future.

PATIENT SAFETY CULTURE AT QVH

In 2009, we carried out a staff survey of the perceptions of the culture of patient safety at QVH, with many encouraging results. A sample of the results is opposite. This survey will allow us to focus on some areas for improvement, particularly with regard to patient safety leadership from medical staff and staff handovers. It will be repeated after one year of safety development, as suggested by the Patient Safety First campaign.

2009 Patient safety staff survey

	Agreed	Disagreed
I would feel safe being treated as a patient at this hospital.	91%	1%
I am encouraged by my colleagues to report any safety concerns I may have.	91%	3%
I know the proper channels to which I should direct questions regarding patient safety.	91%	4%
Safety briefings are common in this area of the organisation.	48%	20%
I am satisfied with the availability of clinical leadership in this area of the organisation from senior doctors.	51%	20%

EXECUTIVE PATIENT SAFETY WALKROUNDS

To further allow staff to communicate their concerns about patient safety, from 'ward to board', we have introduced executive patient safety walk-rounds. Every month, at least two executive directors accompanied by the patient safety and governance manager, and frequently other non-executive and clinical directors, meet with a cross section of staff from one particular area of the hospital, for example theatres or a ward.

An open discussion is held in a no-blame, non-threatening environment, allowing all staff to voice any concerns about patient safety. Some concerns can be dealt with immediately; some require further planning. Staff receive feedback on the actions taken as a result.

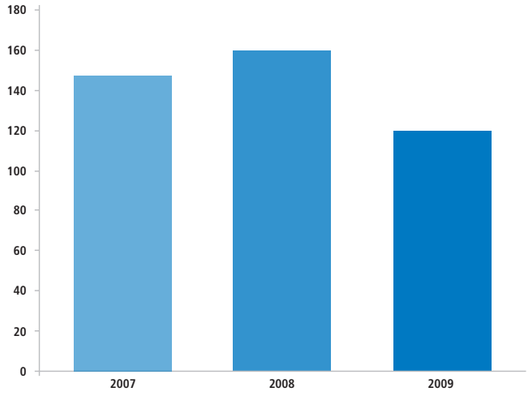
The kinds of concerns raised range from estate issues - such as lighting around outside paths used by patients - or window locks, to medication errors, patient confidentiality and consent, and the availability of medical staff.

PATIENT FALLS

One example of how incident reporting can affect patient care is the trust's efforts to reduce patient falls on the Jubilee rehabilitation unit. The nature of the patients cared for on Jubilee, where mobilisation plays a large part in their rehabilitation, means some patient falls are inevitable.

However, through new methods of risk assessment, with targeted care for at risk patients, we have reduced the number of falls by 25% in 2009 compared with 2008, as shown in the graph below.

Total patient falls



FURTHER IMPROVEMENTS

Our plans to further improve on this priority include:

- Improving feedback to staff following incidents and learning across the organisation
- Continuing to develop the After Action Review programme
- Producing an effective monthly patient safety dashboard visible for all staff to include measures of patient safety
- Completing an independent root cause analysis for all major incidents and any others identified for key learning
- Establishing patient safety champions in clinical areas across the trust
- Continuing to improve reporting culture of incidents, especially from medical staff
- Reviewing and meeting the updated National Patient Safety Agency (NPSA) requirements for 'Being Open'
- Continuing to respond to external recommendations and alerts from governing bodies.

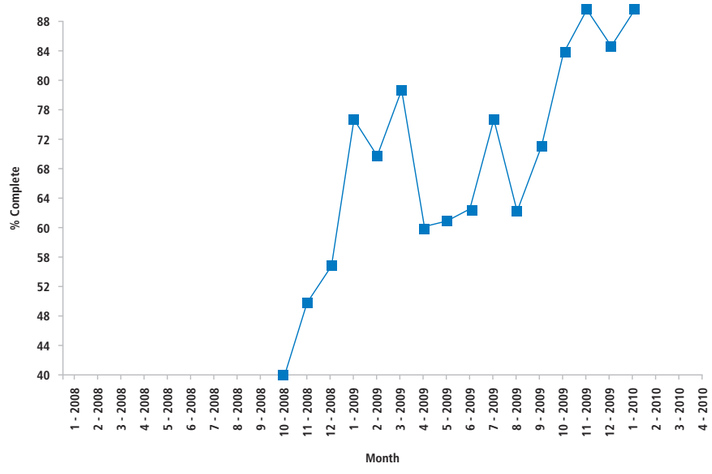
Priority 2

Review the methods, tools and protocols for monitoring patients after surgery and ensure they are fit for purpose, used effectively and prevent patient deterioration.

Nationally, analysis of 576 deaths reported to the NPSA's National Reporting and Learning System over a one year period (2005) identified that 11% were as a result of deterioration of a patient's condition that was not recognised or acted upon. A number of points were identified where the process could fail including not taking observations, not recognising early signs of deterioration, not communicating observations causing concern and not responding to these appropriately.

We have made it a priority to improve the completeness and quality of our physiological observations (pulse, blood pressure, respiratory rate, temperature, pain scores and sedation level) and the chart opposite demonstrates progress with a significant improvement in the number of patients who have all these observations recorded correctly.

Percentage of patients with observations complete



When physiological observations fall outside set limits we use a graded response depending on the severity of the deviation. This may range from a simple increase in the frequency of the observations, to immediate referral to the medical staff or critical care outreach team. Both should be accompanied by documentation in the patient record.

We have a poor record of correctly responding in this way, with only approximately 20% of 'triggers' being acted upon in line with our protocols. This is partly due to the current 'track and trigger' system we have been using, which places very tight limits on physiological variation before demanding escalating care. Nursing staff are tending to ignore breaches as they know the patient is safe.

We are therefore developing a new 'early warning score' physiological observation chart to enable correct identification of patients at risk of deterioration. This is currently being successfully trialled in the burns unit, and will be rolled out to the main hospital in April 2010.

In addition, the chart will utilise the SBAR (situation, background, assessment, recommendation) communication tool to ensure effective, rapid communication between ward staff and medical or critical care teams.

Priority 3

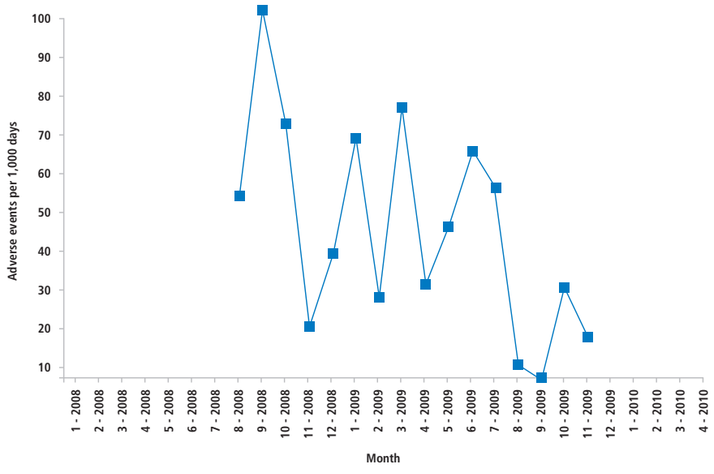
Understand and improve our rate of 'harm events' as defined by the patient safety first campaign.

Traditional efforts to detect harm events or adverse incidents have focused on voluntary reporting (as described above) and tracking of errors. However, it is estimated that approximately one in ten patients suffers an adverse event related to their healthcare and that voluntary reporting may only reveal 10-20% of these events.

The method of 'Global Trigger Tool' monitoring examines 10 random sets of notes every fortnight, looking for examples of where patient care has not followed the correct or expected path. Harm or adverse events include complications of medical treatment, which may occur despite good standards of care. Harm events also include delays in treatment or discharge related to the organisational aspects of care, for example trauma patients waiting for theatre availability.

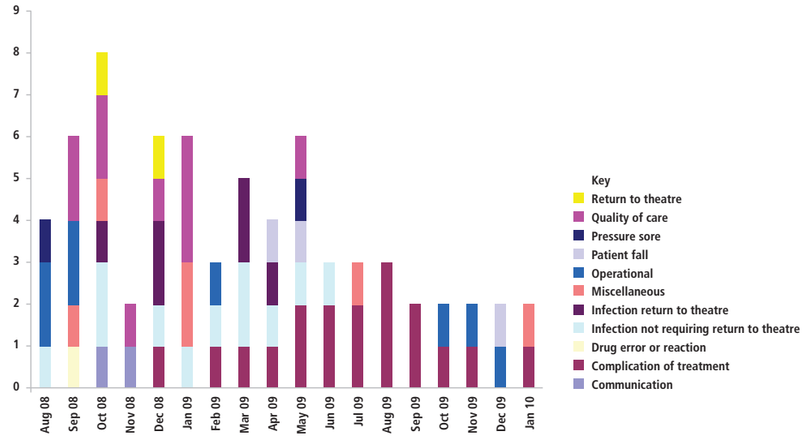
Tracking adverse event rates over time is a useful way to tell if changes being made are improving the safety of the care processes. The improvement in our current adverse event rate, per 1,000 bed days, can be seen below.

Adverse events per 1,000 patient days



Below, the data is presented as number of adverse events found per 10 admissions examined, with a breakdown of the type of harm event.

Adverse events by category



Some of the ongoing work streams to reduce our adverse event rates in some of these areas include:

- **Quality of care** – New 'early warning score' system for monitoring patients physiological observations (see above) has been reviewed and a new form has been developed and trialled. It is due to roll out across the organisation in April 2010. The number of completed observations is audited fortnightly.
- **Pressure sores** – Each incident is followed up by the matron responsible for safeguarding and audited on a quarterly basis.
- **Patient falls** – A new falls assessment form has been introduced, including a system to alert all staff to patients at high risk of falling, and the actions of ward staff are reviewed following a fall.
- **Operational** – There are ongoing projects to streamline care, particularly for trauma patients.
- **Infection prevention and control** – Our measures to prevent surgical site infection are being reinforced and re-audited to ensure improvement.
- **Communication** – We have introduced the World Health Organisation (WHO) checklist and pre-list team safety briefings in theatres, as detailed below. We plan to introduce similar safety briefings for ward nursing staff. A patient safety dashboard to update all staff with progress is in development.

Priority 4

Implement a pre-theatre list safety team meeting and enhance our checklist in line with NPSA / WHO recommendations.

In January 2009, the National Patient Safety Agency (NPSA), in response to compelling evidence arising from a global pilot, issued an alert to the NHS in England and Wales to be compliant in the use of the WHO theatre checklist for all surgical procedures by February 2010.

In addition to the checklist, the Patient Safety First campaign advocates the use of two additional steps: pre-list briefings and post-list debriefings. Pre-list briefings provide an opportunity for the operating team to share information about potential safety problems and concerns about specific patients in advance of sending for and anaesthetising the first patient on the operating list. They facilitate the integration of essential reporting on safety issues into everyday work and the opportunity for proactive information exchange. The pre-list briefing enables the whole theatre team to discuss potential problems or challenges in a timely fashion.

Since November 2009 QVH has implemented a system of pre-theatre list team safety briefs, where the whole theatre team joins together at the start of the day to discuss safety issues, list order, equipment and imaging needs, antibiotic prophylaxis and staffing for the day.

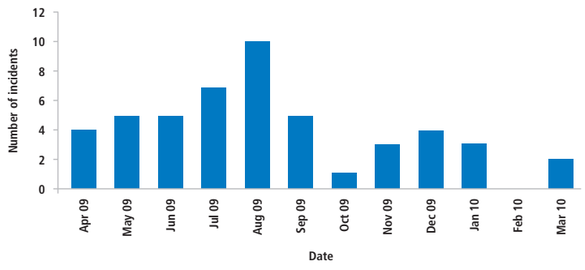
This has rapidly become part of normal practice, as demonstrated in the latest audit figures above right.

Percentage of lists that now start with a pre-list safety briefing.	91%
Percentage of pre-list briefs that have imparted knowledge that might otherwise have been missed or delayed.	70%
Percentage of team safety briefs that occur on time.	50%

The briefings contribute to smooth, incident free running of the lists, with a reduction in overruns and delayed starts.

The chart below demonstrates the reduction in clinical incidents reported that relate to poor communication in the theatre complex since the introduction of pre-list briefings in November 2009.

Poor communication incidents reported since briefings introduced



We still have some progress to make in ensuring the pre-list occurs on time. This is due to pressures of anaesthetic assessment and surgical consent and marking of patients on the morning of their surgery. We hope that the opening of the new surgical admissions unit will reduce this difficulty.

Implementation of the WHO checklist, with a 'time out' before incision to cross check the details of the patient, the operation and the site of the operation was also formalised, ahead of schedule, in November 2009.

From a previously poor use of the WHO checklist in June 2009, we are now approaching compliance of over 80%, as shown in the table below.

Safety step	Ward safety check	Pre-anaesthetic check ("sign in")	Pre-incision safety check ("time out")	Post-surgery safety check ("sign out")	Recovery handover check
June 2009	96%	56%	41%	56%	70%
Jan 2010	95%	90%	80%	70%	80%

Priority 5

Ensure all patients admitted as an emergency are reviewed by a consultant within 24 hours of admission.

All of our emergency admissions are admitted by nursing and medical staff who, with the patient, will make a plan for their care. The admitting doctor will often be a doctor in training. This is entirely appropriate for most of the patients admitted to QVH who are often otherwise well but with peripheral injuries, eg hand lacerations or minor facial trauma.

However, in 2009 the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) produced two reports. One examined the care of patients who died within four days of admission to acute care; the other looked at patients who develop acute kidney injury in hospital. Amongst other recommendations, both reports suggested that all emergency admissions to hospital, of whatever specialty, should be reviewed by a consultant within 24 hours - ideally 12 hours - of admission.

At QVH there are daily consultant-led trauma ward rounds to facilitate such review. However, the documentation of these reviews has been inconsistent.

We have made efforts to ensure that these consultant-led rounds occur, that all patients are reviewed by a consultant within 24 hours to make a senior plan for patient care, and that these reviews are documented in the patient record.

Although we have made some progress with this priority, with a 20% improvement in compliance (see table below), this will remain a priority for the forthcoming year, and continued improvements in the way junior doctors document consultant reviews are being made.

Audit period	Percentage of patients receiving **documented** consultant review within 24 hours of admission			
	Plastic surgery	Max-facial	Corneoplastics	Overall
Mar - Jun 2009	55%	32%	50%	46%
Jan - Feb 2010	71%	61%	50%	66%

Priority 6
Improve our compliance with hand decontamination (hand washing).

Effective hand hygiene is a key measure in maintaining a low hospital acquired infection rate. There is a very low rate of hospital acquired infections at QVH and there have been no outbreaks during the year:

	2008	2009
MRSA bacteraemia	2 cases	1 case
C. difficile	5 cases	1 case

Adherence to our hand hygiene policy has been a key focus during 2009/10 and we have achieved an improvement in our hand hygiene compliance across the organisation from 73% in early 2009 to 87% in 2010.

We will continue to focus on compliance during 2010/11 as our aim is to achieve a compliance score above 90% for hand washing against all five 'moments' of hand hygiene audited. These are: before patient contact; before an aseptic task; after exposure to body fluids; after patient contact; and after contact with a patient's surroundings.

6.2.2 2009/10 PRIORITIES IN CLINICAL EFFECTIVENESS

Priority 1
Ensure that all in-hospital deaths (including those in our community hospital), and deaths within 30 days of surgery, continue to be discussed within an open, multidisciplinary forum, and that concerns and actions raised from these meetings are acted upon and results monitored. We will ensure that our end of life care is recognised as an important contribution to community care, and supported as such.

Our rolling programme of multidisciplinary joint hospital clinical audit meetings has continued, with 90 minute meetings held in protected time every other month.

All deaths within 30 days of surgery are discussed at these meetings, focusing on those episodes where lessons can be learned by the multidisciplinary team. In the past 12 months we have presented information about 11 surgical deaths at QVH, 8 of which have been related to burn injuries, and a further 19 deaths that occurred away from QVH, either at other hospitals or a patient's home, but within 30 days of surgery at QVH.

Our rates of QVH non-burns related surgical deaths remain low and stable, but are continuously monitored (see table below).

Year	Non-burn related surgical mortalities	Death rate %
2006	2	0.017
2007	1	0.008
2008	3	0.022
2009	2	0.014

Non-surgical deaths in our rehabilitation service are also now formally reviewed at a separate meeting. Attended by the clinical director of community medicine and GP representatives, together with senior nursing staff and the clinical director of audit and outcomes, this quarterly meeting allows an opportunity to review all unexpected transfers out to supporting trusts and deaths at QVH. In the past 12 months, 14 deaths on Jubilee ward have been discussed, almost 60% of which were related to terminal cancer.

Identifying patients admitted for end of life care has been made a priority and the use of the Liverpool Care Pathway, a protocol for patient care in the final hours and days of life, has been encouraged for all such cases. Recent audit showed that it was correctly implemented in 80% of cases.

Lessons learned from mortality reviews are disseminated to the clinical policy committee and through the directorate structure.

Over the last year particular attention has been given to the following issues raised:

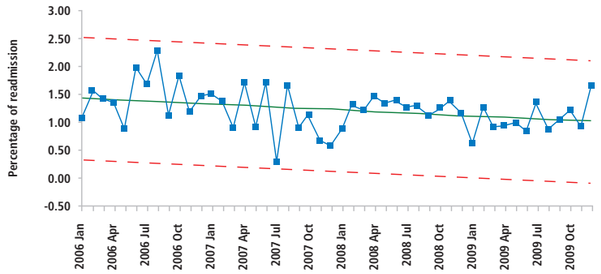
- Consultant review of emergency admissions
- Thromboprophylaxis for prevention of venous thromboembolism
- Care of patients with tracheostomies
- Medical review of high dependency unit patients
- Implementation of team brief and WHO checklist
- Availability of short-notice pre-assessment.

The joint hospital clinical audit meetings also allow review of our clinical indicator programme. In addition to monitoring deaths we also monitor and present:

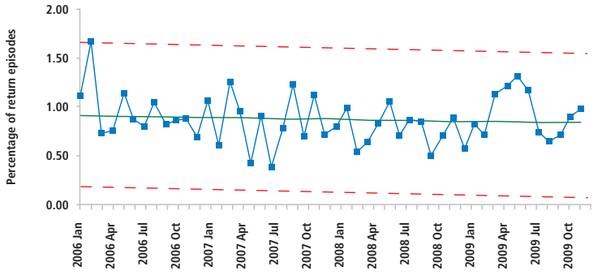
- Unexpected returns to theatre within 7 days of operation (approx 0.9%)
- Unexpected transfers out to neighbouring trusts (approx 0.5%)
- Unexpected readmission to QVH within 28 days of discharge (approx 1%)
- Infection (MRSA bacteraemia and Clostridium difficile) rates
- Clinical incident reporting rates.

The following graphs demonstrate how we monitor these numbers, and the improvement in the rates of emergency readmission.

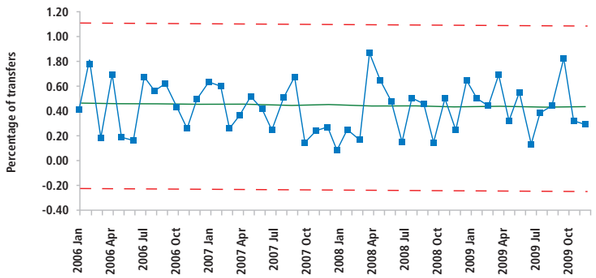
Emergency readmission within 28 days of discharge



Unexpected returns to theatre



All transfers out



It should be noted that, as a specialist surgical unit that does not provide a full range of clinical specialties, we will always have to transfer some cases out for specialist medical care. This particularly applies to our rehabilitation patients under the care of GPs, whose complex medical needs cannot always be provided by QVH.

Where there is any statistically significant change in the rates of returns to theatre, readmissions or transfers out, further audit is conducted to detect underlying causes.

Priority 2
As a major centre for skin cancer and cancer of the head and neck, we will seek to develop short and medium term specific outcome indicators for our services.

MELANOMA AND SKIN CANCER UNIT (MASCU)

The QVH MASCU has developed several markers of clinical effectiveness. Currently, data is predominately from retrospective audit. However, the development of a prospective database will mean we can monitor these outcome measures continuously in the future.

Measures of quality include:

- Incomplete excision rates in basal cell carcinoma
- Rates of complete wide local excision of melanoma, as per NICE guidance
- Complications of axillary and inguinal region block lymph node dissection
- Patient satisfaction in MASCU out-patients.

Details of the results of these outcome indicators are detailed in the skin cancer section of the 'Monitoring of clinical quality and effectiveness' section of the report page 38.

HEAD & NECK CANCER SURGERY

We provide surgical care to patients with head and neck cancer from three different cancer networks. However, survival from head and neck cancer is also dependant on oncological care, including radiotherapy and chemotherapy, received elsewhere.

Markers of clinical quality for surgery will potentially include:

- 'Free flap' (microvascular surgery) survival rates
- Length of stay
- Surgical complication rates
- Waiting time from surgery to radiotherapy
- Two- and five- year survival rates.

Collection of data for these has proved challenging as the multidisciplinary teams (Maidstone, Brighton and Guildford) all use different data collection systems. However, we have now implemented the Liverpool head and neck cancer database and intend to improve reporting on these outcome measures for 2010/11. This database will also enable us to improve our contribution to the DAHNO (data for head and neck oncology) national head and neck cancer database.

Priority 3

Microvascular surgery (free tissue transfer or 'free flap' surgery) is central to the reconstructive work. We currently have no continuous, prospective data on the outcomes, complications and failure rates of our microvascular surgery and have traditionally relied on occasional snapshot audit. A continuous, prospective multi-disciplinary database of all 'free flaps' (including head and neck, breast and lower limb and trauma work) would allow us an opportunity to demonstrate quality of service and provide an excellent opportunity to benchmark ourselves against other units willing to share results.

We now have a continuous, prospective database of all patients undergoing microvascular breast reconstruction. This has also already been populated with two years of retrospective data, and the results of this work are detailed in the 'Monitoring of clinical quality and effectiveness' section of the report page 36.

It is hoped to extend use of this database to other 'free flaps' when fully operational for breast patients.

A recent audit of 45 plastic surgery units found that only four other centres use a prospective database in this way to record their outcome data.

Priority 4

We will improve our contribution to the national head and neck oncology database (DAHNO) to demonstrate the effectiveness of head and neck cancer care.

As detailed above, we have had great difficulties in supplying comprehensive data to the DAHNO national head and neck cancer database, due to the different IT systems in use across the multi disciplinary teams that we serve.

Our reporting rate to DAHNO has been 14% (data period to November 2009). This will remain a priority for improvement in 2010/11, and the introduction of the Liverpool head and neck cancer database, from which DAHNO data can be extracted, will aid us in improving our submission.

Priority 5

We will give greater priority to lower limb trauma patients referred from surrounding hospitals, reducing time to admission and time to surgery with the aim of reducing length of stay and time to rehabilitative care.

The development of the QVH 'Outliers' service continues and, in 2009, the service won the NHS South East Coast Health and Social Care Award for Innovation in Acute Care, and was one of three finalists in the national awards.

Previously, patients were automatically brought to acute care and often spent long periods on wards waiting to be transferred to surgery or discharged home. We have provided a community-based outreach practitioner who can visit patients in their own home, pre-assess the patient's fitness for surgery, decide on treatment and discuss the benefits and risks of treatment.

A dedicated team of consultant surgeon, consultant anaesthetist and administrator support the outreach nurse. Patients appreciate the point of contact and the personal care and now have the option of, rather than surgery, using long-term dressings managed by community and district nurses supported by the outreach nurse.

Where surgery is necessary, post-surgical wound care can be provided in the community, saving on long journeys for follow up.

This approach has proved cost effective, ensuring surgery takes place as planned and has reduced inpatient stay for pre-tibial lacerations to 3.5 days.

For patients referred from the community or other acute trusts in the region we have seen a 35% reduction in the average time from referral to admission and a 23% reduction in length of stay at QVH before discharge (see table below).

Year	Average time for lower limb trauma patients referral to admission (days)	Average length of stay for lower limb trauma patients (days)
2005 - 2006	15.74	7.82
2009 - 2010	10.2	6.0

Priority 6

We will continue to review our links with Brighton and Sussex University Hospitals NHS Trust and the joint provision of care for very young children. A large proportion of the patients requiring surgery at QVH are children and we have a group of staff specialising in the care of children at QVH. In addition, we are building a formal link with the paediatric service at the Royal Alexandra Children's Hospital in Brighton to work alongside QVH practitioners and help to oversee our paediatric care.

We have had a new service level agreement (SLA) with the Royal Alexandra Children's Hospital (RACH) since May 2009. In particular, this specifies the commitment by RACH consultants to provide an on-call service and allocated resources for safeguarding children at risk. We have met twice since May 2009 to review the arrangements and have on these occasions reviewed the allocation of paediatricians' time at QVH.

The SLA is working well and there have been no clinical issues of note. Urgent referrals have been reviewed and show a similar pattern to previous years, though the process of referring a child on has become notably easier for QVH staff. Nursing staff on our paediatric unit have universally praised the service and the greater level of input from our paediatricians.

The SLA was most recently reviewed in March 2010 and the service continues to develop.

Priority 7

We will develop new outcome measures in orthognathic surgery and burns care, enabling us to benchmark and improve performance.

ORTHOGNATHIC SURGERY

Data is now being collected in orthognathic surgery which will enable us to report on the following outcomes:

- Patient satisfaction
  - Satisfaction with functional outcome
  - Satisfaction with aesthetic outcome
  - Satisfaction with the orthognathic and orthodontic services
  - Patient perception of complications
- Inferior dental alveolar nerve injury rates
- Stability data – whether the new position of the facial bones is retained.

Due to the nature of the surgery and length of orthodontic treatment, this data may take up to three years to collect. Some initial results are included in the 'Monitoring of clinical quality and effectiveness' section of the report page 41.

BURNS SURGERY

In burns surgery, the burns care team use the following markers of quality of outcome:

- Rates of burn healing within 21 days of healing
  - target is for all burns to be healed within 21 days
- Length of stay per percentage body surface area of burn
  - target is for 1 days stay per 1% BSA burn.

Initial results are presented in the 'Monitoring of clinical quality and effectiveness' section of the report page 40.

Priority 8

We will develop quality portfolios by individual clinical specialties as evidence of clinical performance.

Through the clinical audit and outcome leads, all main clinical departments have developed their own plans for their departmental quality portfolios. These have been shared with all clinicians through a series of presentations at the joint hospital clinical audit meetings.

Many of the portfolios include details of how patient reported and clinically measured outcome data is being collected, but it may take several years for this to produce validated results which can be benchmarked. Much of the outcomes work detailed in this report has been as a result of the hard work clinicians have put into the development of these quality portfolios.

Presentations have so far been received from:

- Orthodontics
- Oral and maxillofacial surgery
- Corneoplastics
- Nursing
- Burns surgery and care
- Skin cancer care.

Presentations in the coming year will include anaesthetics, hand surgery, breast surgery and rehabilitation medicine.

6.2.3 2009/10 PRIORITIES IN PATIENT EXPERIENCE AND ACCESS

Priority 1
We will partake fully in the national Patient Reported Outcome Measure (PROM) project for varicose vein and groin hernia surgery. In addition we will develop our own PROM for cataract surgery.

PROMs enable the effectiveness of procedures delivered to patients to be measured by comparing patients' self-reported health status before and after undergoing surgical procedures. It asks about symptoms specific to the condition being treated, as well as making a global assessment of health.

So far we have collected information on participation rates and patients' pre-operative condition, summarising the levels of health they reported before undergoing one of two common elective surgical procedures: groin hernia operations and varicose vein operations. Hip and knee replacements, the other two procedures covered by the national PROMs programme, are not performed at QVH.

The information collected covers the period from April 2009 to November 2009. Nationally, it includes analysis of around 87,000 questionnaires that all hospitals treating NHS patients have been asked to collect from patients undergoing these procedures who wish to participate.

Although QVH performs low numbers of these procedures (26 patients with varicose veins, 28 patients with groin hernias during the information collection period) and they are performed by visiting surgeons, the participation rates compared to the national average nonetheless reflect the commitment of our staff to supporting the audit and focusing on patient outcomes.

We are awaiting the audit outcomes from the Department of Health.

In addition, QVH have trialled the use of a cataract surgery PROM (the VF-7), the results of which are included in the 'Monitoring of clinical quality and effectiveness' section of the report page 44. We are also now developing PROMs in breast, hand and orthognathic surgery.

PROM	QVH participation rate (% eligible patients)	National participation rate (% eligible patients)	Preoperative health perception of QVH patients (visual analogue score 0 - 100)	Preoperative health perception of patients nationally (visual analogue score 0 - 100)
Varicose veins	92%	40.5%	82.5%	79.6%
Groin hernias	100%	51%	83%	79.3%

Priority 2
We will continue to measure patient experience, focusing on issues of privacy and dignity and single-sex accommodation. We will conduct a comprehensive review of our communication and interaction with patients, the materials we send them, the information we give them, and the means by which we do so.

PRIVACY AND DIGNITY

Maintaining privacy and dignity for our patients is a priority and will remain so during 2009/10. We have a plan and a statement of compliance which are available on our website. We have participated in three reviews with our commissioners and peer-review trust to provide an assurance that we are addressing adequately the privacy and dignity of our patients.

The national survey of inpatients also provides information about patients' perceptions of how we consider their privacy and dignity. Results for QVH show that when asked 'did you feel you were treated with dignity and respect while in hospital?' our scores have remained consistently high with scores in 2007 and 2008 of 95% and 96% respectively. We currently await publication of the 2009 survey information from the Care Quality Commission.

To ensure we continue to listen to patients views on our ability to provide privacy and dignity in their care, our newly revised discharge questionnaire asks specific questions about this.

Work undertaken during 2009/10 has included the building of additional single rooms, provision of ensuite facilities, and additional screening. As a result, in the last three months, no patient has needed to share accommodation with patients of the opposite sex, except for within our intensive care and high dependency facility. Information on our ability to deliver same-sex accommodation to patients is reviewed monthly and any exceptions will be investigated.

PATIENT INFORMATION

The patient information group held a workshop to discuss the information currently being given patients to ensure it is relevant, accessible and timely and we have made several changes as a result.

We recognise that patients have a lot to think about in advance of their surgery and may not remember everything they have read or been told. Therefore, a bedside guide has been written for patients to read whilst they are an inpatient covering everything they need to know about the hospital and the amenities available. A paper version has been trialled successfully and a re-usable wipe-clean version is currently being printed which has been funded by the League of Friends.

The results of our inpatient survey showed that, overall, patients were very happy with the amount of information being given to them. However, the score when asked if they were given written information about their condition or treatment, whilst not a high problem score, showed weaker than other trusts. Therefore an action to address this has been added to the patient experience action plan and will remain a priority for QVH in 2010/11.

As part of the patient information review, members of the patient information group and public engagement committee undertook a comprehensive signage review, looking at all signage from the patient's perspective. The findings have been submitted to the estates department and will feed into the business plan for next year.

6.2.4 PRIORITIES FOR 2010/2011

In order to identify our areas for improvement in 2010/11 we considered a variety of measures. This included feedback from inpatient and outpatient surveys, patient complaints, internal incidents and staff views. In addition, external stakeholders' views, including those of our local primary care trust and our governors, have been included.
The priorities identified for 2010/11 are:

1. **Our aim is that, unless clinically indicated, no trauma patient will wait more than 24 hours for their surgery**

This area for improvement was chosen because it was recognised that patients' experiences were sometimes poor, with cancellations on a number of occasions and long waits before surgery.
In 2009/10 patients waited for an average of 18 hours for their surgery but some waited up to 59 hours. This has been occurring because our resources have not been used as efficiently as possible and it affects other patients because their operations are sometimes delayed or postponed.

In order to achieve improvements, we are already working on analysing the processes that affect the admission of trauma patients and will re-design our processes of care to address this priority. We are, for example, recruiting a trauma coordinator whose role will be to support the delivery of this objective.

2. **Our aim is that 80% of patients seen at QVH will be pre-assessed for surgery on the day of their outpatient appointment.**

Moving to pre-assessment on the day of outpatient appointment was identified as a priority due to the poor experience patients have when their operation is cancelled on the day either because they are unfit for surgery or delayed into theatre, or when they have to make repeat visits for pre-assessment, causing unnecessary travel time and costs. Currently, less than 50% of surgical patients at QVH are assessed on the day of their outpatient appointment.

Conducting pre-assessments on the day of outpatient appointments means that we are able to use our resources more efficiently, avoiding wasted theatre slots that could be used for other patients, and reducing the additional administrative and clinic time needed to see the patients for separate outpatient and pre-assessment appointments.

The work for this area of improvement will concentrate on amending processes within the pre-assessment clinic specifically addressing capacity and scheduling and linking these effectively to the outpatient service.

3. **We aim to guarantee that once an outpatient appointment has been made it will not be changed, except at the patient's request.**

Several complaints have shown us that too many patients have their outpatient appointments cancelled, sometimes more than once.

The cancelling and rebooking of patients does not provide a patient with the best experience and also takes up a lot of administrative time. We will establish baseline measures and achieve continuous improvement throughout the year.

In addition, progress against this priority will also improve the patient experience in our corneoplastic service, where improved booking arrangements will reduce unnecessarily long waits which can currently lead to crowded waiting areas.

4. **No elective patient will have their surgery avoidably cancelled on the day of surgery.**

During 2009/10, 96 patients had their operations avoidably cancelled on the day of surgery. This is too many.
It impacts on the patient involved, and others whose surgery may be delayed as a result because of attempts to try and avoid the cancellation. It leads to wasted theatre slots and unnecessary overnight stays.

Plans to achieve the improvements are linked to the hospital transformation plan and activity on ensuring that patients are being pre-assessed on the day of their outpatient appointment. There are separate project plans for each contributory change mechanism and this work is being led by the director of performance.

Progress against all of these priorities will be monitored through weekly/monthly capability charts that will be reported on at trust operational meetings and to the trusts management meetings (direct reports, clinical cabinet and directorate review meetings). Reporting on improvements will take place through these meetings and quarterly to our quality and risk committee that monitors progress against our quality account objectives.

6.2.5 REVIEW OF SERVICES

Statement of assurance from the board

During 2009/10, Queen Victoria Hospital NHS Foundation Trust provided burns, general plastic surgery, head and neck surgery, corneoplastic surgery and community NHS services.

Queen Victoria NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Queen Victoria Hospital NHS Foundation Trust.

6.2.6 PARTICIPATION IN CLINICAL AUDIT

National audit and national confidential enquiries

During 2009/2010 six national clinical audits and one national confidential enquiry covered NHS services that QVH provides. During that time QVH participated in 83% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. These are set out as follows (see table 1a and 1b):

Table 1a: Eligibility and participation in national audits

National clinical audits	Eligible	Participated
PICANet: Paediatric intensive care network	X	X
VSSGBI VSD	X	X
NNAP: Neonatal care	X	X
NDA: National diabetes audit	X	X
ICNARC CMPD: adult critical care units	✓	X [1]
National elective surgery PROMs	✓	✓ [2]
NIAP: coronary angioplasty	X	X
Congenital heart disease: paediatric cardiac surgery	X	X
NJR: hip and knee replacements	X	X
Renal Registry: renal replacement therapy	X	X
NLCA: lung cancer	X	X
NBOCAP: bowel cancer	X	X
DAHNO: head and neck cancer	✓	✓
Adult cardiac surgery: CABG and valvular surgery	X	X
MINAP (inc ambulance care): AMI and other ACS	X	X
Heart failure audit	X	X
Pulmonary hypertension audit	X	X
NHFD: hip fracture	X	X
NAPTAD: anxiety and depression	Eligibility currently being assessed	Main phase of audit starts May 2010
TARN: severe trauma	X	X
NHS Blood and Transplant: intra-thoracic, liver, renal	X	X
NHS Blood and Transplant: potential donor audit	X	X
National kidney care audit	X	X
National sentinel stroke audit	X	X
National audit of dementia: dementia care	X	X
National falls and bone health audit	X	X
POMH: prescribing topics in mental health services	X	X
National comparative audit of blood transfusion	✓	✓
British Thoracic Society: respiratory diseases	X	X
College of Emergency Medicine: pain in children	X	X
National mastectomy and breast reconstruction audit	✓	✓
National oesophago-gastric cancer audit	X	X
RCP continence care audit	✓	✓

[1] Although QVH is eligible to participate in the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme, we do not currently participate. No other specialist burns units currently contribute data and, for this reason, meaningful comparator data are limited. At QVH, consultant-led review takes place for all hospital mortalities on a case-by-case basis and lessons learned are disseminated throughout the organisation. We also contribute fully to the International Burn Injury Database (IBID).
[2] QVH was eligible to participate in two of the four PROMs – varicose veins and groin hernia.

Table 1b: Eligibility and participation in national confidential enquiries

National confidential enquiries	Eligible	Participated
CMACE (formerly CEMACH): perinatal mortality	X	X
NCEPOD	✓	✓
NCISH	X	X

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2009/2010, 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 terms of that audit or enquiry (see table 2a and 2b):

Table 2a: Data submitted to eligible national audits

National clinical audits	% data submitted	Comments
National elective surgery PROMs[2]	100% and 92%[3]	Two patients declined to participate.
DAHNO: head and neck cancer	14%[4]	
National comparative audit of blood transfusion	No relevant cases	Eligible to participate in audit of the use of red blood cells in neonates and children, but no relevant cases transfused over time period identified.
National mastectomy and breast reconstruction audit	100%	
RCP Continence care audit	100%	All relevant coded cases submitted

[3] Data collection period April to November 2009, assessed against Health Episode Statistics (HES Online)
[4] Data collection period to November 2009

Table 2b: Data submitted to eligible national confidential enquiries

National confidential enquiries	Denominator data	Individual patient cases	Organisational questionnaire
NCEPOD: Parenteral nutrition study	No relevant cases	No relevant casese	✓
NCEPOD: Elective and emergency surgery in the elderly	✓	1/1(100%)	✓
NCEPOD: Paediatric surgery study	✓	Not yet requested	✓
NCEPOD: Perioperative care study	✓	87/87 (100%)	Not yet requested

QVH also participated in the following national audits during 2009/10:

- National inpatient survey
- Patient Safety First campaign
- Major complications of airway management in the UK (NAP4, Royal College of Anaesthetists): initial snapshot data submitted, followed by details of 2 cases (100%) which fulfilled audit inclusion criteria
- National diabetes inpatient audit of acute trusts (NHS Diabetes): details of 6 inpatient cases (100%) which fulfilled the audit inclusion criteria were submitted
- BIBID: we contribute fully to this ongoing national burns activity and outcome database
- SwiFT: In conjunction with the Department of Health and ICNARC, a review of H1N1 demands on national critical care bed capacity/usage. Three suspected cases (100%) were reported, two of which were subsequently confirmed as being H1N1 positive
- Infection control national audits.

The reports of three national clinical audits were reviewed by QVH in 2009/2010 and we intend to take the following actions to improve the quality of healthcare provided (see table 3a):

Table 3a: National clinical audit reports reviewed / action provider intends to take

Report	Publication date	Review by	Actions identified
National head and neck cancer Comparative audit (DAHNO)	2009	Board clinical cabinet	Recurrent theme of technical difficulties experienced in uploading data. Resources to be made available by the trust to support compliance with DAHNO requirements.
National mastectomy and breast reconstruction audit	2009	Board clinical cabinet	In response to concerns raised about the quality and completeness of data nationally, all sites asked to check integrity of their own data. QVH data double-checked against Patient Administration System (PAS) and re-submitted by December 2009 deadline. Ongoing audit/outcomes activity and development of a free-flap database in the plastic surgery department.
National audit of the organisation of services for falls and bone health of older people	2009	Board, clinical cabinet and falls prevention group	Although not eligible to take part in this audit, review has been carried out against the published public indicators, and details forwarded to the falls prevention group for identification of recommendations and implementation of actions.

In addition, the following national confidential enquiry reports published during 2009/2010 were reviewed by the clinical policy committee and actions identified. See table 3b:

Table 3b: National confidential enquiry reports reviewed / action provider intends to take

Report	Publication Date	Review By	Actions Identified
NCEPOD: Adding insult to injury	June 2009	Clinical policy committee	Review and action taken of consultant review and documentation thereof of all emergency admissions. Review and action taken to improve physiological observations, and identification, communication and review of the deteriorating patient.
NCEPOD: Caring to the end	November 2009	Clinical policy committee	Review and action taken of consultant review of emergency admissions within 24 hours. Review and action taken to improve end of life care on jubilee and burns. Review and action taken to improve physiological observations, and identification, communication and review of the deteriorating patient. Review and action taken of multidisciplinary handover, particularly with regard to hospital at night teams.

At QVH, clinical audit is seen as routine element of clinical practice, and all staff undertaking clinical outcomes and audit activity have the appropriate time, knowledge and skills available to them. There is a wealth of clinical audit/clinical outcomes work currently underway at QVH, and well-attended joint hospital clinical audit meetings are held every two months to ensure that lessons learned from this programme of work are shared across the organisation.

Clinical outcomes and audit activity at QVH is steered by the clinical outcomes group 'COG' and is chaired by Dr Edward Pickles, Clinical Director for Audit and Outcome Measurements. Clinical outcomes leads coordinate clinical audit and outcomes activity within their own departments.

Clinical audit and outcomes activity is prioritised by COG against both national and local imperatives, in order to give direction and focus on how and which clinical audit projects are supported.

The hospital operates a systematic programme of feedback concerning national and local audit activity via regular reporting to designated committees. In addition to the national audits listed above, during 2009/10 the trust board undertook a review of recommendations and actions arising from presentations given at the joint hospital clinical audit meetings.
The board also receives a quality metrics report (which includes, for example, incidence of falls, pressure ulcers and prescribing errors) on a monthly basis.
The quality and risk committee, which reports directly to the trust board, receives a quality metrics update each time it meets (which includes patient safety, clinical quality and effectiveness and patient experience and access indicators), a twice-yearly summary of the work of the clinical outcomes group, as well as a clinical audit and outcomes annual report summarising all audit activity undertaken during the preceding year. Details of all new publications arising from the three national confidential enquiries are reported to the clinical policy committee six times a year, and the same committee reviews a summary of audit activity linked to relevant National Institute for Health and Clinical Excellence (NICE) guidelines twice a year.

The reports of 108 local clinical audits were reviewed by QVH in 2009/10 and as a result we have taken, or intend to take, the following actions to improve the quality of healthcare provided:

- Following targeted trial, introduce the 'safer surgery checklist' and team safety briefings in operating theatres from November 2009
- Set up a complex case review panel to review potential moral, ethical and technical issues on an ad-hoc, case-specific basis
- Ensure emergency access to McIndoe Surgical Centre for QVH trauma team
- Clarify policy for carrying out thromboprophylaxis risk assessment for corneoplastics surgical patients
- Review trust policy on the use of tracheostomy tubes
- Review application of Hospital Standardised Mortality Ratio (HSMR) methodology to mixed cohort of surgical/non-surgical patients
- Introduce coding sheet for non-surgical mortalities to ensure co-morbidities are accurately recorded
- Support ongoing programme of teaching and monitoring of compliance with hand hygiene policy
- Continue to monitor cancellations as an indicator of performance
- Aim to reduce the number of falls via ongoing work by the falls prevention group
- Review the availability of short-notice pre-assessment slots
- Monitor the distribution of top copies of consent forms to patients undergoing procedures
- Audit timeliness of consultant review of trauma patients admitted in previous 24 hours
- Review waste disposal and recycling practices in theatre areas
- Update guidelines on the peri-operative management of diabetic patients
- Institute early intervention for slow-to-heal burns injuries and improve their documentation
- Introduce a quality of life questionnaire for patients following corneoplastic surgery
- Investigate the feasibility of launching a randomised controlled research trial of the use of venous coupler in abdominal free flap breast reconstruction surgery
- Introduce a safeguarding framework to investigate the potential link between pressure ulcer development and neglect.

6.2.7 PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided or subcontracted by QVH in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 392.

This increasing level of participation in clinical research demonstrates our commitment to improving the quality of care we offer and making our contribution to wider health improvement.

During 2009/10 QVH was involved in conducting 22 clinical research studies. We completed recruitment for 23% of these studies in the period. Of these, 80% were completed within the agreed time and to the agreed recruitment target.

We used national systems to manage the studies in proportion to risk. Of the 11 new studies reviewed by QVH in 2009/10, all were given feedback (full approval/approval subject to amendments/request for further information) less than 30 days from receipt of a valid complete application. None of the studies were established and managed under national model agreements. There were no studies requiring the use of a research passport. In 2009/10 the National Institute for Health Research (NIHR) supported four of these studies through its research networks.

In the last three years 19 publications have resulted from our involvement in research (of which none were NIHR studies), helping to improve patient outcomes and experience across the NHS.

6.2.8 USE OF COMMISSIONING FOR QUALITY AND INNOVATION PAYMENT FRAMEWORK

A proportion of QVH's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed with commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2009/10 and for the following 12 month period are available from Amanda Parker, Director of Nursing & Quality.

2009/10 CQUINs

Two specific measures were identified for achievement during 2009/10 in order to improve the quality of care delivered to patients.

Within our community ward we were unable to offer a variable admission time and were restricted to receiving admissions before 11am. Our CQUIN goals were to:

- extend the admission time for community patient admissions so admission could occur between 09.00 and 17.30
- introduce nurse-led admission.

Attached to this goal was 0.25% of the 0.5% CQUIN allocation.

During 2009/10, by working with our community colleagues, we have been able to extend the admission time for patients and have not remained restricted to early morning admissions. In addition, we appointed a nurse with assessment and prescribing qualifications into our admission nurse role so that we could begin nurse led-admission.

Our second CQUIN goal was to introduce electronic discharge notification to GPs, and a further 0.25% of the 0.5% CQUIN allocation was attached to this initiative. During March, having completed the information technology infrastructure requirements, we were able to commence electronic discharge notification to GPs and this will now be rolled out across the trust.

The monetary value attached to achieving the CQUINs for 2009/10 was £190,000. Activity to achieve the CQUINs was completed and payment is pending.

6.2.9 STATEMENT FROM THE CARE QUALITY COMMISSION

Queen Victoria Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without compliance conditions.

The Care Quality Commission has not taken enforcement action against the Queen Victoria Hospital NHS Foundation Trust during 2009/10.

Queen Victoria Hospital NHS Foundation Trust is not subject to periodic reviews by the Care Quality Commission.

Queen Victoria Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

6.2.10 DATA QUALITY

QVH submitted records during 2009/10 to the secondary uses service 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:

- 95.1% for admitted patient care
- 97.3% for outpatient care
- 89.7% for accident and emergency care.

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

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

6.2.11 INFORMATION GOVERNANCE TOOLKIT ATTAINMENT LEVELS

The QVH score for 2009/10 for information quality and records management, assessed using the information governance toolkit, was 73%.

6.2.12 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 49.5%
- Secondary diagnoses incorrect 23.0%
- Primary procedures incorrect 12.2%
- Secondary procedures incorrect 2.8%.

The results should not be extrapolated further than the actual sample audited; the services reviewed within the sample were:

- Speciality 130 – ophthalmology
- Sub chapter BZ – eyes and periorbita procedures and disorders
- HRG HA51Z – major hand procedures for trauma category 2.

The 2009/10 PbR admitted assurance framework audit shows the trust's healthcare resource group (HRG) error rate as 4.0%. Both the national average and the Strategic Health Authority average error rate in 2008/09 was 8.1%.

6.3 REVIEW OF QUALITY PERFORMANCE

The trust board reviews the quality of services on a monthly basis. The metrics reviewed during 2009/10 include measures related to safety, effectiveness and experience for patients.

Our board metrics have recently been reviewed and expanded to ensure a more consistent approach to our review of specialist service outcome measures for patients.

6.3.1 SUMMARY QUALITY DASHBOARD

	Monthly activity (HES)	Optimal score	2009/10	2008/09
CQUINS	To improve responsiveness to personal needs of patients (national survey)	High	Awaiting results	82.12%
	VTE risk assessment	High	79.5%	70%
	Discharge planning on admission for elective care	High	New	
	Nutritional assessment within 24 hours of admission (all patients)	High	84%	75%
	Patient experience ophthalmology (quality account)	High	New	
	Increase in reporting of non-PbR drugs	High	New	
Clinical outcomes	Incidence of MRSA bacteraemia (whole numbers)	Low	1	2
	Incidence of Clostridium difficile (whole numbers)	Low	1	5
	Patient return to theatre within 7 days whole number (per 1,000 spells)	Low	145 (1.01%)	113 (0.81%)
	Surgical mortality (whole numbers)	Low	11	11
	Non-surgical mortality (whole numbers)	Low	12	22
	Breast free flap survival rate	High	98.70%	Score 2007/09
	Rupture rate following repair of flexor tendon	Low	6-7%	NA
	Melanoma excision rate	High	83%	NA
	Mean number of days required for burn healing	Low	10	NA
	Rate of general anaesthetic recovery requiring no intervention	High	83%	NA
	Third molar wisdom tooth injury rate – • Temporary numb lip • Temporary numb tongue	Low	2% 4%	NA
	Orthodontic mean PAR score	High	94.75%	NA
	% of patients (without other eye disease) achieving vision better 6/12 after cataract surgery	High	96%	NA
	% of patients (with other eye disease) achieving vision better 6/12 after cataract surgery	High	84%	NA

Summary quality dashboard continued

	Monthly activity (HES)	Optimal score	2009/10	2008/09
Patient / staff experience	Complaints per 1,000 spells	Low	5	4
	Mixed sex accommodation breach resulting in fine	Low	New	NA
	Staff incidents causing harm	Low	0.8	0.8
	RIDDOR (patients and staff) whole number	Low	5	7.0%
	Number of patient safety incidents reported per 1,000 spells		46	46
	Percentage of patient safety incidents causing harm	Low	27%	35.5%
	Number of patient falls per 1,000 spells	Low	7.3	9.5
	Percentage of patient falls resulting in injury	Low	New	32.1%
	Pressure ulcer development grade 2 or over	Low	0.5	0.8
	Serious untoward incidents (whole number)	Low	3	2
	Number of medication errors (including, prescribing, administration, dispensing, controlled drugs and reaction)	Low	7.5	7.2
	Trust hand hygiene compliance	High	87%	73%

6.3.2 PATIENT EXPERIENCE

QVH is committed to seeking the views of its patients and visitors, listening to feedback and making changes to further improve their experience of our hospital. Every aspect of a patient's experience of our services is important to us – from the moment they are referred to us by their GP, through to their appointments, treatment and follow-up care.
We specifically use the term 'patient experience' to describe emotional experience; what it feels like to be a patient at QVH.

In 2009/10 we developed our first patient experience action plan to tackle the key issues that patients tell us affect their experience of our hospital. All sources of patient feedback were collated, including PALS enquiries, formal complaints, national inpatient and outpatient survey results, internal survey results, comments left online at www.nhs.uk and feedback from our volunteers and public governors. These were reviewed by a patient experience taskforce - a working group comprising staff, governors and patients - who identified themes and prioritised actions.

Each action has an executive lead sponsor and is owned by a senior manager, responsible for implementation.
The action plan is being implemented following approval by the trust board in February 2010.

Alongside the development of the action plan, we have been making changes that had already been identified as necessary to improve patient experience, including:

- New wheelchairs for use at our main entrance and by our porters
- Developing an in inpatients' bedside guide. Trialled as a disposable booklet, a re-usable, laminated (wipe-clean) version will be available shortly, thanks to support from the League of Friends
- Making toiletries available to buy in our restaurant, since we no longer have an on-site shop
- Reviewing the tests performed on patients waiting for eye clinic appointments, reducing waiting times.

In 2009/10 we also initiated a programme of streamlining to improve the efficiency of our processes and make our services even more convenient for patients by minimising cancellations, late bookings and the need for several visits to the hospital for tests and scans. While many of the benefits of this work are expected to be realised in 2010/11, there have already been some significant improvements. For instance, we have reduced the average time from referral for plastic surgery outpatients appointments to booking an appointment from 40 days to just five.

To support our patient experience action plan, we are also changing the way that we encourage feedback and improving the opportunities for patients and visitors to leave feedback in real-time. We will also improve the way that we analyse feedback and let people know what we do with it. In 2010/11 we will:

- Ensure that ward exit surveys are available in all wards so patients can tell us about their experience while staying with us
- Increase the number of general comment boxes and comment cards available across the hospital site for patients and visitors to tell us about their experience
- Collate and analyse as much feedback as possible at regular and frequent intervals to provide real-time analysis of our patients' experiences
- Improve the way we communicate the changes we make in response to feedback.

6.3.3 INFECTION CONTROL

Bare below the elbows
Posters have been distributed around the trust to highlight the need to be 'bare below the elbows' for all clinical activity. The hand hygiene policy was revised to include this directive and compliance has been regularly monitored.

Increased MRSA screening – monthly instead of quarterly
From April 2009, the DH introduced mandatory screening of all elective patients. This is undertaken at the pre-assessment or outpatient clinics prior to admission. Patients testing positive are contacted and given an eradication protocol in the week leading up to their admission date.

At QVH, emergency and trauma patients are also screened on admission although this will not be mandatory nationally until December 2010.

Increasing involvement in estates projects
The infection prevention and control team (IPACT) have been involved increasingly in the many estates projects being undertaken or planned, including the Peanut assessment unit, admissions lounge, x-ray refurbishment and Peanut ward refurbishment.

Flu arrangements / swine flu
During 2009/10 the IPACT has supported the managment of flu including:

- Vaccination of staff within the annualflu vaccination programme
- Swine flu vaccination programme and mask fit testing requirements
- Support in the form of checklists, advice on the management of patients and general support to the processes of caring for affected patients
- Participating in national and local exercise arrangements to ensure the effectiveness of local emergency planning arrangements.

6.3.4 SURGICAL SITE INFECTION SURVEILLANCE

Surgical site infections (SSIs) account for approximately 15% of all healthcare associated infections. The aim of SSI surveillance is to improve quality of care and patient outcomes by incorporating the best practice standards as set out by the Department of Health Saving Lives initiative and the Health Protection Agency's Patient Safety First campaign.

The data collected will enable a comparison of infection rates over time within QVH and between specialties. This will highlight areas where practice and improvements in care are required.

Major head and neck patients – audited May/June 2009

- Twelve patients undergoing major head and neck surgery were included
- The average length of stay was 10 days and none of the patients were readmitted. This was confirmed with the head and neck specialist nurse
- Prophylactic antibiotics were given to all patients in the study
- 30-day post-discharge questionnaires were returned by five patients. Of those who did not return questionnaires, one had died, one was illiterate and one was receiving radiotherapy. Two reported having seen their GP – one because their wound was 'leaking' and the other with inflammation around the wound. Neither required antibiotics.

Breast care patients – audited July/August 2010

- Fifty one patients undergoing breast surgery were included
- The length of stay ranged from two to eight days
- Prophylactic antibiotics were given to all patients in the study
- 30 day post-discharge questionnaires were returned by 33 patients
- Four patients were readmitted to QVH - two with fat necrosis, one with a haematoma and one with confirmed wound infection
- Eight others reported, in the questionnaires, that they had had problems with wound healing. Of these, three reported attending their GP and being prescribed antibiotics, three attended their local NHS hospital, and two are currently attending outpatients at QVH.

A 66% return rate from a postal survey is high. Readmission to QVH with confirmed infection is 2% (1 out of 51) which is much lower than QVH data from coding. If those who reported having attended their GP and being prescribed antibiotics were included this would result in a 6% infection rate.

6.3.5 MONITORING OF CLINICAL QUALITY AND EFFECTIVENESS

In addition to regularly collected trust-wide data on patient safety and patient experience, we aim to demonstrate our clinical effectiveness with a range of clinical audit and outcome measures.

However, where many frequent procedures, such as hip replacements, or treatments for common diseases such as heart attacks or strokes, have nationally agreed indicators of quality, much of the work at QVH is so specialised there are not centrally agreed outcome measures.

Clinicians at QVH have therefore been working hard on their own indicators of quality and effectiveness. Some of this work is detailed below by specialty.

PLASTIC SURGERY - BREAST RECONSTRUCTION SERVICE.

QVH is a major centre for patients undergoing either immediate or delayed breast reconstruction. It is an integral part of the Kent and Medway cancer network and has links to surrounding cancer networks. There is an onsite team comprising of consultant plastic surgeons, breast care nurses, pain control nurse and recovery and ward staff, all very experienced in delivering the highest possible care.

Our consultants offer a wider variety of reconstructive options and flexibility compared to other hospitals, using a comprehensive range of surgeons and surgical skills.

Our breast care team also undertake surgery to correct asymmetry where one breast is larger than the other (by at least one bra cup size) and where there is breast shape deformity.

Patient safety
Developments in the last 12 months include a step-down unit on the Canadian Wing of the hospital. Many microvascular breast reconstruction operations may take up to 10 hours, and patients require close monitoring to ensure the best recovery of their new breast tissue.

The development of a step-down unit has provided an ideal, safe environment for this monitoring, giving reassurance to the patents, nursing and medical staff alike. It also provides level 1 nursing care to other surgical patients requiring higher dependency care.

Clinical effectiveness
The gold standard for breast reconstruction following mastectomy for breast cancer is using free tissue transfer ('free flap') surgery. This involves taking excess tissue, usually from the tummy, and using it to reconstruct a new breast. It requires complex microvascular surgical techniques, and there is a small risk that the new tissue will not survive.
In 2009 we introduced a breast free-flap reconstruction database, to monitor this survival rate, and enable us to benchmark our performance against other plastic surgery units. At present only four of 45 plastic surgery units surveyed collect data in this way.

The database also allows us to identify which patients are at risk of free-flap failure, and allows us to quantify risk and eligibility criteria.

QVH breast free-flap survival rates (2007-2009 incl)	98.7%
National and international published breast free-flap survival rates (multiple sources)	95-98%

Additional plans for outcome measurement
The department has recently reappointed a research psychologist. Studies proposed include the use of PROMs (patient reported outcome measures) in breast surgery. This would measure improvements in such outcome measures as;

- intimacy scores
- self-esteem scale
- anxiety and depression scores
- appearance scores.

These measures could be used for reconstructive operations post cancer surgery and other types of breast surgery, demonstrating improvement in areas that really affect quality of life in this group of patients.

Contribution to national audit
The national mastectomy and breast reconstruction audit commenced in January 2007, and data submission continued until late 2009. Its task is to look at the provision of breast reconstruction post-breast cancer in women living in England. It was also set up to look at the determinants and outcomes in both ladies that chose reconstruction post mastectomy and those that did not.

QVH had a 100% data submission rate to this audit compared to a national average of 74%.

QVH has assessed and ensured compliance against the six principle recommendations of the Second Report of the National Breast Reconstruction Audit (December 2009).

PLASTIC SURGERY - HAND SURGERY SERVICE

The hand surgery department at QVH manages approximately one third to one half of elective plastic surgical operations. It also comprises a majority (approximately 80%) of the trauma workload at the hospital.

Hand surgery at this hospital has a long history and the hospital gained fame for this when the first toe to hand transfer was carried out.

The geographical intake for the acute trauma comes from most of the south east of England and south east London. Besides acute trauma, elective work comprises secondary reconstruction following trauma, paediatric hand surgery, arthritis and neurological conditions. In addition, vascular problems are also handled.

Rolling audit to demonstrate quality

	QVH result in 2009	National average (published data)
Rupture rate following repair of flexor tendon injuries.	6-7%	9-13%
Successful (resolution of pain) outcome following trapeziectomy.	92%	85-88%

How do we improve and measure quality?
Ongoing monthly audit, where all therapists and hand consultants are present, takes place at the monthly business meeting of the hand team. Complications are collated both in the therapy department and through a trauma database.

The trauma database gives us the ability to include complications from all locations. Nurses, therapists and junior doctors can add complications seen to the database. The head therapist and the Hand Fellow, with the help of the consultants, then access these.
Each complication is investigated to ensure that there is no disturbing trend. Any difficult cases or new procedures are also discussed at these monthly business meetings.

Patient reported outcomes
We have developed a new tool to assess the subjective impact of surgery on patients, allowing a visual representation of the severity of a hand problem.

In the first phase, which is completed, the impact on patients of a range of hand conditions is assessed on three critical parameters: pain, appearance and function. The next phase, which is currently underway, is to assess the same parameters after surgery to allow us to measure the outcome. The ideal is for surgery to effect a return of the scores back to zero, indicating normal appearance and freedom from symptoms.

We will report progress with this new measure in 2010/11.

Patient satisfaction
Patient satisfaction is audited on a rolling basis. In 2009, patient satisfaction with the QVH hand trauma service, which serves the south east of England, was examined by surveying 182 patients.

	Yes	No
Were you given clear directions to reach QVH?	78%	20%
Did you receive a clear explanation of your injury?	99%	1%
Were you warned of the potential complications?	91%	9%
Was your operation cancelled from its scheduled time?	95%	5%
Were you seen by a consultant? (inpatients)	100%	0%
Were you seen by a consultant? (outpatients)	75%	25%

Overall satisfaction with the hand trauma service		
Excellent	Good	Satisfactory
87%	11%	2%

It was noted that a cancelled operation time was the biggest factor in reduced satisfaction with the service. This will be addressed through the 2010/11 priorities for streamlining care.

Other ongoing audit and research
Ongoing audits are taking place in:

- Pyrocarbon implants
- Joint fusions
- Referrals to trauma clinics
- Use of x-rays for nail bed lacerations in patients under age five
- Miniature dynamic traction devices for comminuted digital fractures.

Ongoing research projects include:

- Zone 1 EPL tendon repairs
- Tendon adhesion following Zone II flexor tendon repair
- Growth of Schwann cells (with the Blond McIndoe Centre).

PLASTIC SURGERY – SKIN CANCER SERVICE

QVH is now firmly established as the surgical centre for skin cancer across the south east of England, working closely with the relevant cancer networks.

The Melanoma and Skin Cancer Unit (MASCU) deals with patients requiring surgical treatment of all skin cancers, including basal and squamous cell carcinoma and melanomas.

Serving Kent and Sussex, the MASCU has recently undergone an extensive peer review process which supported all aspects of its service provision.

How do we improve and measure quality?
Extensive audit in 2009 has developed four key measures of quality, data on which can now be collected prospectively through use of the new MASCU database.

1. Patient satisfaction

In February 2010 a patient satisfaction survey of 50 patients treated by the MASCU was carried out. Questions focused on the verbal and written information given to patients, their waiting times, their involvement in the decision making process, and the patients understanding of the Macmillan nursing and key worker service.

Overall, 96% of patients rated their treatment as excellent or very good.

The survey has prompted focus on patients' understanding of their key worker, and providing patients' contact numbers for the Macmillan nursing team and providing them with copies of their clinic letters.

This survey will be repeated to ensure progress.

2. Melanoma excision rates

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.

NICE suggest that 75% of excisions should fulfil these guidelines. There is little published outcome data of this type.

2009 audit of 108 cases showed that the excision margins were achieved as per local guidelines in 83% of cases. If all the patients discussed under the auspices of the MDT during this period and treated according to their recommendations are included we achieve a compliance of 97%.

3. Incomplete excision rates in basal skin carcinoma (BCC)

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.

In 2009 a retrospective audit of 2,586 primary excisions of BCCs was carried out, examining rates of incomplete excision, the rate of re-excision, and the presence of tumour in the secondary excised sample.

This demonstrated:

- 7.1% incomplete excision rate (published rates 4.7 – 11.1%)
- 33.7% of these lesions were re-excised
- 63% of the secondary samples contained residual tumour.

Our results are consistent with national rates and will continue to be monitored.

4. Complications in axillary and inguinal lymph node block dissections

These difficult procedures for metastatic cancer are well recognised to be associated with a high morbidity or complication rate, particularly associated with wound infection, wound dehiscence, seroma formation and the requirement for re-operation.
QVH outcomes are compared with national published outcomes below:

	QVH MASCU	Published rates
Seroma formation	41%	40%
Wound dehiscence	6%	24%
Wound infection	6% (patients readmitted for treatment)	20%

Our rate of post-operative seroma formation (higher in axillary block dissection) is in line with published standards. Our wound infection and dehiscence rates compare very favourably. New strategies to reduce seroma formation are being trialled, with the use of fibrin glue, and these will be re-audited.

PLASTIC SURGERY - BURNS SURGERY SERVICE

The QVH burns centre provides specialist burns care treatment for people living in the south east of England. It has 11 treatment beds including:

- Three single-patient intensive therapy rooms
- Two intensive therapy/high dependency areas for ITU patients
- Two single side rooms for patients needing close supervision or segregation for infection control management
- Four single beds
- Burns assessment / outpatient clinic
- Operating theatre.

A large number of our nurses specialise in burns and/or ITU and, with our three consultant plastic surgeons who specialise in burns treatment, consultant anaesthetists, physio and occupational therapists, auxiliary and administration staff, we provide a multidisciplinary team approach to patient care. This provides systematic problem solving and reflects the concept of holistic care, emphasising human values and maintaining the dignity and identity of each individual patient.

How do we improve and measure quality?

There has been much discussion by the national burn care group about defining appropriate outcome measures for burns and this has yet to be agreed at a national level. A validated score for outcomes agreed by all is on the horizon. We looked to our patients to help define quality measures and it became clear that getting our patients healed as quickly as possible, and out of hospital in a safe and timely manner, had the biggest impact on patient wellbeing. Length of stay is a good measure of rapid treatment, excellent aftercare and outstanding support services.

1. Length of stay per percentage of body surface injury burn

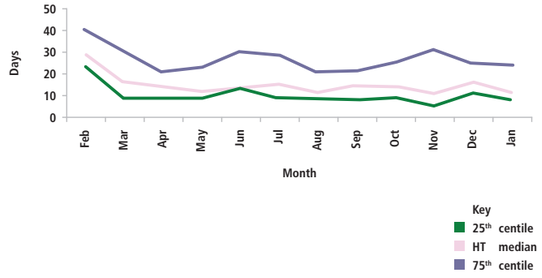
This indicator is a work in progress and will be formally presented in next year's quality account. Known outcome work suggests that on average one day of inpatient stay is required for every one percent of body area that is burnt or scalded in children or young adults while it is one to two days per percent of body area burned for the elderly or medically unfit. A young patient with 20% burns would be expected to require a 20 day stay at the QVH. In 2010/11 we will see how our rates compare to this standard.

2. Number of days required for burn healing

We believe that with excellent, timely treatment an uncomplicated burn should be healed within approximately 21 days. Research from one of our own consultants has shown that there is reduced scarring in those who heal within three weeks. We believe we are one of the only units in the country to have an ongoing measure of burn wound healing. This has already led to a significant improvement in healing times with earlier operations, reduced infection rates and ultimately reduced costs. We can now use this approach for assessing new innovations as we have now built a bank of historical data.

A graph of the average number of days required for healing is detailed below. The reduction in healing times has been achieved by a bundle of care aimed at reducing potential infection.

Healing time



PATIENT SAFETY IN THE BURNS INTENSIVE CARE

'Matching Michigan'

Ninety seven per cent of acute trusts in England are participating in 'Matching Michigan'. This is a quality improvement project based on a model developed in the United States which, over 18 months, saved around 1,500 patient lives. It took place at Intensive Care Units (ICUs) in Michigan and introduced data definitions, technical interventions (changes in clinical practice) and non-technical interventions (linked to leadership, teamwork and culture change). When these interventions are applied together they have been shown to reduce central venous catheter bloodstream infections (CVC-BSIs).

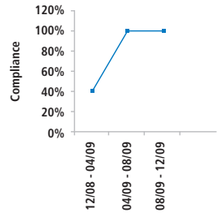
QVH started collecting Matching Michigan data in December 2009. Monthly data is submitted on the number of patients with CVCs, number of CVCs and number of CVC-BSIs.

QVH ITU has had a zero incidence of CVC-BSIs. We remain fully committed to ensuring that patient care relating to CVCs is fully compliant with the Matching Michigan interventions.

Saving lives – ventilator care bundle

This aims to provide a bundle of care to prevent patients on ventilators from acquiring ventilator acquired pneumonia (VAP). Our rate of VAP is difficult to establish, as many of our long term ventilated patients are admitted with inhalational burn injuries which predispose to pneumonia. However, the care bundle, which includes gut protection to avoid gastric ulceration and micro-aspiration, patient positioning and breaks in sedation regimes, has been fully implemented, with a compliance of 100% (see graph below).

Ventilator care bundle compliance



PLASTIC SURGERY – NON-ELECTIVE

Trauma surgery will form part of our priorities for the forthcoming year, with the aim of reducing time from injury to operative repair, and reducing trauma cancellations through the streamlining of care. The award winning work of the QVH 'Outliers' team has been detailed in the section on progress made against the 2009/10 priorities on page 19.

ORTHODONTICS, ORAL AND MAXILLOFACIAL SURGERY

The QVH maxillofacial department is one of the busiest in the UK. It comprises seven consultant surgeons, supported by trainee surgical staff, specialist nurses, dieticians, physiotherapists and speech therapists. It has an international reputation as a training and teaching unit.

Our staff have particular expertise in a number of areas including facial trauma, head and neck cancer, orthognathic surgery, salivary gland disease, face and jaw reconstruction and developmental facial deformity.

In addition to our hospital site in East Grinstead, our consultant maxillofacial surgeons also have regular operating schedules and clinics at hospitals run by other trusts across the south of England, including Medway, Dartford, Maidstone, Horsham and Redhill.

The specialist, consultant led orthodontic team advises and treats children and adults with complex orthodontic problems. This can involve a range of conditions from positional problems of the teeth, to malalignment of the jaws. We work closely with our maxillofacial and plastic surgery colleagues as well as our local, dental practice based colleagues and work with a team approach to solving clinical problems.

How do we improve and measure quality?

Head and neck cancer service

In 2009 we introduced use of the Liverpool head and neck cancer database which is now being populated with details of operative cases. This will enable us to improve our contribution to the DANHO national head and neck cancer database and report next year on indicators of clinical quality such as length of stay and free flap survival. Longer term measures, such as five year survival will then be developed.

A development in quality in 2009/10 has been a revision in our ordering of blood products. Major head and neck surgery occasionally involves substantial blood loss requiring transfusion. Modern surgical techniques and updated transfusion protocols have reduced the transfusion requirements.

We have conducted an audit of blood transfusion of 76 patients undergoing major head and neck surgery confirming that no patient has required transfusion following an isolated neck dissection. Our cross matching protocols are being appropriately adjusted, saving the precious resource of donated blood (see table below).

	Traditional provision of blood products	Actual maximum blood products used	New protocol for blood provision
Neck dissection for head and neck cancer	2 units	0	Group save only
Neck dissection with free radial forearm flap	4 units	2 units	2 units
Neck dissection with bone containing free flap or extensive resection	4 units	4 units	4 units

Orthognathic and non-oncological head and neck surgery

We have an ongoing audit of nerve injury rates following third molar surgery that has shown only temporary nerve injury in a minority of cases (see following table).

Third molar (wisdom tooth) nerve injury data 49 consecutive patients		
	QVH rate	Rate in published literature
Temporary numb lip	2%	5-10%
Temporary numb tongue	4%	2-8%

We also have ongoing facial nerve injury monitoring following open fixation of mandibular fractures. We continue to have a zero permanent nerve injury rate for this procedure (see following table).

Condylar fracture facial nerve injury rate (2008 – 09) 48 fractures, 41 patients		
	QVH rate	Rate in published literature
Temporary nerve injury	12.5%	17%
Permanent nerve injury	0%	Rare

In terms of clinical effectiveness, we have ongoing audit to look at the injury to treatment time for orbital fractures. Currently we treat a number of fractures over 10 days following injury. It is our intention to improve this in 2010/11 so that the majority are treated within 10 days.

We also have ongoing patient satisfaction surveys looking at the outcome following orthognathic surgery. The initial results show a good level of patient satisfaction and we are aiming for improved data collection and accuracy during 2010/11.

Orthodontics

The PAR (peer assessment rating) index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. It is primarily designed to look at the results of a group of patients, rather than an individual patient, as there are always a small number of patients where the index does not really represent the result obtained. The index is, however, generally accepted by the British Orthodontic Society as a useful tool in this area.

When interpreting the results, a mean PAR score improvement of greater than 70% represents a very high standard of treatment. Less than 50% shows an overall poor standard of treatment and less than 30% means the patient's malocclusion has not been improved by orthodontic intervention. It must be stressed, however, that the index is designed to look at a large group of patients rather than an individual patient's outcome.

QVH orthodontic PAR scores for 2009/10:

- Mean PAR score improvement 94.75% (very high standard), of which:
  - Greatly improved 47.8%
  - Improved 46.9%.

DNA (did not attend) rates

Orthodontic patients often have courses of treatment extending over several years, with multiple attendances required at clinic. This sometimes means patients forget their appointment dates, leading to a relatively high non-attendance (DNA) rate.

A new initiative in 2009/10 has been the introduction of a SMS or texting service to remind patients of their appointments. The effect on the rate of DNAs is detailed below.

Clinic type	DNA rate pre-texting reminder service	DNA rate with texting reminder service
Operating clinics	9.3%	8.3%
New and review clinics	13.5%	9.6%
Orthognathic MDT clinics	8.7%	8.1%

Patient satisfaction in orthodontics

In 2008 86% of patients were completely satisfied with the combined orthodontic / orthognathic service, compared to 79% in 2002. This work on patient satisfaction will be repeated in 2010.

CORNEOPLASTIC SURGERY

The ophthalmic department provides specialist care, mainly cornea and oculoplastics. However, the department does also provide other ophthalmic services to the same standard as its specialty services. The department is amongst the most technologically advanced in the UK.

We believe that our ethos of providing the highest quality care and experience available accounts for our good reputation and patients are referred both nationally and internationally. Our consultants are highly respected and present their work internationally.

Our specialist cornea services include:

- High risk corneal transplantation
- Stem cell transplantation for ocular surface rehabilitation
- Innovative partial thickness transplants (lamellar grafts)
- Vision correction surgery in liaison with Centre for Sight.

Specialist techniques in oculoplastic surgery offered include:

- Mohs micrographic excision for eyelid tumour management
- Modern techniques for facial palsy rehabilitation
- Endoscopic DCR and modern orbital decompression techniques for thyroid eye disease.

The unit also offers treatment for conditions including:

- Cataract
- Glaucoma
- Refractive problems
- Ocuplastic, orbital and lacrimal disorders.

How do we improve and measure quality?

The cataract service
QVH provides a modern phacoemulsification small incision high throughput cataract surgery service for its local community. In addition, cataract surgery is performed on a large cohort of patients with complex anterior segment conditions as part of our specialist surgery service which are not comparable to other units.

Activity for April 2009 – April 2010

Total cataract operations performed	Carried out as daycase surgery (%)	Post-operative infection rate (%)	Emergency transfers out to other trusts for specialist medical care
1,336	99%	0%	6 cases (<0.5 %)

Outcome figures (2009 Audit)

	QVH	National comparator data (UK EPR UK 8 Audit 2002-2003)
% of patients (without other eye disease) achieving vision better 6/12 after cataract surgery	96%	96%
% of patients (with other eye disease) achieving vision better 6/12 after cataract surgery	84%	78%

The tables above show that quality of outcome for QVH cataract patients is in line with national outcomes with uncomplicated cataracts. Our outcome figures exceed national outcomes in patients who have other eye diseases in addition to the cataract being treated.

Patient reported outcome measures in cataract surgery
We have trialled a PROM for cataract surgery, called the VF-7. It specifically asks about changes in the ability to perform tasks that a patient with cataracts might find difficult (see table below).

	% improved	% no change	% worse
Night driving	86	14	0
Reading small print	59.5	32.4	8.1
Watching TV	37.9	59.4	2.7
Climbing steps	16.7	68.6	2.9
Traffic signs	28.6	68.6	2.9
Cooking	12.9	87.1	0
Fine hand work	42.3	53.8	3.8

Cataract surgery with a monofocal lens improves vision for most tasks. By eliminating glare, night vision tasks are particularly improved. Those tasks that involve peripheral vision such as climbing steps were improved less. Near vision tasks are less likely to be improved as the NHS provides only monofocal lenses (not accommodating or multifocal lenses). These monofocal lenses mainly have a distance focal point with supplementary reading spectacles required for reading.

These results are in line with published figures on which use of the VF-7 is based (Department of Ophthalmology, Helsinki University Central Hospital, Helsinki, Finland).

The cornea, anterior segment and keratorefractive service
QVH provides a tertiary level care service for patients with cornea and ocular service diseases. The case mix is not typical and most patients are referred from experienced corneal surgeons for further care. Most cases are high risk, and are patients requiring regrafts.

Historical data from 2006 is provided as comparison.

In 2009/10 102 corneal transplants were performed at QVH.

Penetrating keratoplasty (full thickness corneal transplant)

Table 1 Three year graft survival rates for national outcome data (UKT) and QVH

Diagnosis	UKT 3 year graft survival rates (%)	QVH 3 year graft survival rates (%)	p Value
Keratoconus	93	98	0.019
PBK	65	90	0.00003
Fuchs' dystrophy	87	90	0.47
Viral keratitis	77	95	0.002
Regrafts	57	67	0.002
Total	79	81	0.15

Ex vivo ocular stem cells (EXVSCALT)
Patients are referred to QVH for reconstruction of their ocular surface secondary to burns, or damaging immunological conditions. Prior to any attempt at corneal grafting for optical correction, a satisfactory corneal epithelium must be produced or any secondary corneal graft will inevitably fail. At QVH we have the longest history of this technique in the UK.

The primary outcome of surgery is to provide a stable corneal epithelial surface.

EXSCALT	QVH	Others
Stable surface	74%	60%
Visual acuity improved	20/37	

Patient reported outcomes
When the corneal phenotype is restored, patient reported symptoms decrease as the new surface is less likely to break down causing pain and inflammation. These results are taken from 47 patients, who reported the severity of their symptoms on a subjective scale of 0-10, where 10 is the most severe.

	Pre-operative score (0 - 10)	Post-operative score (0 - 10)
Inflammation	2	0.75
Conjunctivitis	4	1
Epithelial defect	0.75	0.5
Vascularity	3.5	1.75
Photophobia	0.75	0.5
Pain	0.75	0.4

ANAESTHETICS

A specialist surgical hospital depends on the anaesthetists' role as perioperative physicians to enable it to function safely. There are 18 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, regional nerve blocks using ultrasound guided methods, and techniques to lower blood pressure and reduce bleeding during delicate surgery.

How do we improve and measure quality?
Few benchmarks and markers of quality in anaesthetics are available. Attempts to link quality of anaesthesia to surgical outcome have proven difficult.
The emphasis has turned to attempts to quantify the quality of the perioperative care by patients and with validated outcome figures variably based on incident reporting or incidents, events and complications (IEC) during the perioperative period and by patient reported scores or quality of recovery (QOR) scores.

Patient safety
In close collaboration with the risk management team, we have monitored the development of a speciality based incident reporting system by the Royal College of Anaesthetists and the NPSA. In line with this we have developed our own anaesthetic reporting system, which works within the present Datix software. This was discussed at several meetings with the NPSA and it appears it will work well alongside the national reporting system. Other hospitals have enquired about our approach, as it appears to give some advantages over the new national system. This will be launched in the near future.

Clinical effectiveness
Outcome audits have included:

- Rolling audit of anaesthetic records for compliance with national standards
- Audit of brachial plexus anaesthesia in 1,035 patients undergoing hand and forearm surgery
- Database development of mortality and outcome in burns patients
- Database of performance indicators in day surgery patients.

Following on from several audits of key anaesthetic performance indicators in the Russell Davis Recovery Unit (RDU) 2005-2009, we have developed an audit of complications in RDU.

This has been developed in close collaboration with the management of RDU along the lines of the IEC and QOR scores that have featured in attempts to quantify anaesthetic outcomes. It has successfully been embedded in their data collection.

We have now collected three months worth of figures and hope to provide a simple metric indicator of performance in the near future. There is a possibility that this data collection, presently done and collated on paper, could be used to trial a new computer based data collection. This would then integrate it into the hospital quality portfolio.

Initial RDU outcome results (Oct 09 – Jan 10; 1,262 patient episodes)

Rate of uncomplicated GA recovery requiring monitoring, but no specific intervention	83%
"Prolonged" recovery period (most commonly secondary to the requirement for IV opiate analgesia)	11%
Unplanned admissions to step-down or HDU care	0.87%
Normothermia achieved on admission	99%
Excessive sedation	1.6%
Reversal of residual paralysis	0.47%

Patient satisfaction
The department has attempted in the last year to develop an appropriate means to collect meaningful data on patient satisfaction with the service. This has proved difficult, as validation of the approach is difficult. We have recently trialled our latest form and are presently receiving the first set of data. Initial results suggest an almost 100% satisfaction rate with the anaesthetic service.

Although much of this data collection is in its early stages, we believe that this reflects a national and specialty wide difficulty in benchmarking anaesthetic services. We have based our approach on the best research available and hope to contribute to this research base in the future.

6.3.6 PERFORMANCE AGAINST KEY NATIONAL PRIORITIES AND NATIONAL CORE STANDARDS

Target met

Summary of trust performance against indicators for the annual assessment ratings 2009/10

Not met/failed

Indicator	Description / rationale	Target	2008/09	2009/10
18 week referral to treatment times	90% of admitted patients must be treated within 18 weeks. 95% of non-admitted patients must be treated within 18 weeks	IP = 90% OP = 95%	IP = 93.6% OP = 96.5%	IP = 94.38% OP = 97.6%
All cancers - two week waits	% of patients with suspected cancer seen within two weeks of urgent GP referral	93%	100%	96.70%
All cancers - 31 days to first treatment	One month diagnosis (decision to treat) to treatment, including new cancer strategy	96%	99.50%	90.00%
NEW INDICATOR 09/10 All cancers - 31 days to subsequent treatment	One month diagnosis (decision to treat) to treatment, including new cancer strategy		N/A	96.60%
All cancers - 62 day target	Two month urgent GP referral to treatment, including new cancer strategy	85%	99.50%	94.40%
Engagement in clinical audits	Principles of Best Practice in Clinical Audit - NICE 2002		Fully met	Fully met
Experience of patients	Clinical quality domain		Achieved	Achieved
Experience of patients	Health and wellbeing domain		Achieved	Achieved
Experience of patients	Patientfocus and access domain		Achieved	Achieved
Experience of patients	Safety domain		Achieved	Achieved
Clostridium difficile infection	2008/09 plan = maximum of 5 cases 2009/10 plan = maximum of 4 cases	Low value 2009/10 plan = 4	4	1
MRSA bacteraemia	2008/09 plan = maximum of cases 2009/10 plan = maximum of 1 cases	Low value 2009/10 plan = 4	2	1
Infant health and inequalities	Hospitals with maternity unit	N/A	N/A	N/A
Maternity hospital episodes statistics	Hospitals with maternity unit	N/A	N/A	N/A
NHS staff satisfaction			Fully met	Fully met
Participation in heart disease audits	To reduce mortality rates from heart disease and stroke and related diseases		N/A	N/A
Stroke care	N/A	N/A	N/A	
NEW INDICATOR 09/10 Access to healthcare for people with learning disability	New NON scoring indicator for 2009/10. Six questions to be answered - results of which will be published with annual score			met

6.3.7 HEALTHCARE COMMISSION / CARE QUALITY COMMISSION DECLARATIONS AGAINST STANDARDS

In November 2009, Queen Victoria NHS Foundation Trust declared itself to be compliant against 44 of the 44 core standards within our declaration.

In January we declared ourselves to be complaint with the 16 regulations for all activities when applying for registration with the Care Quality Commission from April 2010.

6.4 STATEMENTS FROM PRIMARY CARE TRUST, LOCAL INVOLVEMENT NETWORK, OVERVIEW AND SCRUTINY COMMITTEE AND BOARD OF GOVERNORS

During April 2010 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 to the final document include editing of text and updating of graphs, inclusion of NHS number data for the full year rather than part year, an expansion on coding accuracy and inclusion of additional metrics data as per 1,000 spells to allow for comparison to other organisations to be made.

STATEMENT FROM PRIMARY CARE TRUST (PCT)

Statement from John Winderspin, Chief Executive, NHS West Sussex:

The PCT has reviewed the QVH quality account and can confirm that the quality account complies with the guidelines and demonstrates progress against its priorities identified for 2009/10.

The PCT 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.

Areas reviewed include:

- National priorities relating to cancer access, 18 weeks
- Local priorities for patient safety incident reporting, improved access to the Jubilee community unit and improvements in discharge summary information, monitoring of infection control processes.

A comprehensive set of CQUINS for 2010/11 have been agreed including:

- To improve responsiveness to personal needs of patients
- To reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE)
- To improve patient safety by development of a discharge plan within 24 hours of admission for elective care
- To improve patient clinical outcome by early detection of any nutritional issues
- Patient experience opthalmology
- To increase use of templates based on NICE recommendations by consultants during assessment of patients when prescribing complex non-PbR drugs
- Improving patient safety culture.

Overall, 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 2010/11. An increasing focus on patient experience and on improving health outcomes during 2010/11 will continue to work to the benefit of patients.

STATEMENT FROM LOCAL INVOLVEMENT NETWORK (LINK)

Statement from Chris McCrory, member of the West Sussex LINk Stewardship Group and the nominated representative for liaison activity between the West Sussex LINk and QVH:

I confirm that to the best of my knowledge the QVH quality accounts contain accurate information.
QVH should be congratulated for the extensive work carried out to improve the following services:

2009/10 priorities in patient safety
The introduction of After Action Review has contributed to improved levels of patient safety. The introduction of the Early Warning Score and the SBAR (situation, background, assessment, recommendation) communication tool will be an effective help in preventing patient deterioration. The Global Trigger monitoring method together with the ongoing work streams should lead to a reduction in adverse event rates. Much work has been put into implementing the World Health Organisation checklist. Steps have been taken to ensure the pre-list occurs on time.

2009/10 priorities in clinical effectiveness
Work carried out has led to an improvement in the rates of emergency readmission. The implementation of the Liverpool Head and Neck Cancer database will lead to improved outcome indicators and improve contribution to the national head and neck cancer database.

The outreach services have contributed to a reduction in inpatient stay and have been well received by the wider population of Kent, Surrey and Sussex. The service level agreement with the Royal Alexandra Children's Hospital continues to be developed as does the development of outcome measures in orthognathic surgery.

Patient experience and access
The development of PROMs (patient reported outcome measures) is continuing, however the participation rates so far are encouraging. Much work has been carried out on the patient experience especially on privacy and dignity issues.

Priorities for 2010/2011
The priorities for 2010/2011 demonstrate that QVH is taking account of patients, staff and stakeholders in identifying service improvements for 2010/11. These priorities include the recruitment of a trauma coordinator to facilitate no patient waiting more than 24 hours for surgery, amending processes for pre-assessment, guaranteeing an outpatient appointment, and no elective patient having their surgery avoidably cancelled.

Tables and statistics
I have taken the figures quoted as read as I have not checked them for accuracy.

STATEMENT FROM HEALTH OVERVIEW AND SCRUTINY COMMITTEE (HOSC)

Satement from Christine Field, Chairman, West Sussex HOSC:

As quality accounts were only introduced this year, the process for HOSC involvement has not been fully established, and it is clear that this first year will be very much a developmental stage. Given the short timescales which NHS trusts have had to meet in preparing this year's accounts, there has clearly not been the opportunity to involve HOSCs in the way the guidance seems to intend (e.g. involving HOSCs at an early stage as part of year-round ongoing discussions). In terms of this year's process, I'm sorry that the HOSC is unable to provide a written statement to confirm whether we consider the quality accounts to contain accurate information.

STATEMENT FROM THE QVH BOARD OF GOVERNORS

Statement from Ian Stewart, Governor Representative:

The board of governors takes a very close interest in all aspects of the quality of the services QVH provides. A governor representative attends all board of director meetings and reports back to governors on the board activities. A governor attends all meetings of the quality and risk committee which oversees all quality and risk activities on behalf of the board. The governors' steering group takes monthly reports from the executive. Governors attend meetings of the patient experience taskforce which is reviewing all aspects of the patient experience and making recommendations for improvement. Governors attend the patient information group which aims to ensure that the information given to patients is clear and easy to understand. There are many other areas of interaction including governor tours and governor involvement in the PEAT inspections. There are also staff governors on the governing body which help provide a balanced view and understanding of the hospital.

This gives the governing body a clear and comprehensive view of the activities within QVH and of the quality of the patient experience in its most general terms and, more specifically, with regard to patient safety and clinical effectiveness. We have reviewed the quality accounts produced for 2009/10 and, from our knowledge of all that has been reported during the year and from our involvement in many of the activities, we are fully confident that the information in the quality accounts is accurate. We are further confident that QVH pays close high level attention to the general patient experience, patient safety and clinical effectiveness and has, as a priority, the improvement of these areas from the current excellent performance.

7.0 FINANCIAL ACCOUNTS

7.1 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 accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the 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 Financial Reporting Manual and in particular to:

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

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

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

Dr Adrian Bull
Chief Executive

7 June 2010

7.2 STATEMENT OF INTERNAL CONTROL

7.2.1 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and 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 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 Trust's Standing Orders and Scheme of Delegated Authority outline the accountability arrangements and scope of responsibility of the Board and the Trust's executive members and the organisation's officers. The Executive Team and Board have been fully involved in agreeing the strategic priorities for the Trust, with the most critical priorities being those set out in the Trust's Business Plan 2009/10.

The Board receives regular minutes and reports from each of its nominated committees. The terms of reference for Trust committees were also fully reviewed and updated in conjunction with all governance arrangements.

As Chief Executive I chair the Clinical Cabinet, which is responsible for all aspects of performance and development, including quality and risk, financial management and governance. The Trust has also undertaken a management restructure, aligned to the patient pathways, which puts the patient firmly at the centre of the Trust's services. The new Clinical Directorates are headed up by a Clinical Director supported by a Divisional Manager and Matron, and are fully accountable for the quality, service delivery, governance and financial performance for their area. Quality and risk management is high in their agenda and is reviewed at their monthly meetings. The new structure became fully operational in February 2009.

As Accounting Officer I am also a member of the Trust's Quality and Risk Committee, which is a sub-committee of the Board. The purpose of the Quality and Risk Committee is to assure the Board that all reasonable steps are being taken to identify, manage and mitigate risk and monitor and improve quality and patient safety.

All Directors also report to me through regular one to one meetings.

The Trust's Assurance Framework has been in place for the year. In line with national guidance it is structured around the high level risks which were deemed to be the most significant risks to prevent delivery of the corporate objectives set out in the Trust's Business Plan 2009/10. Following the organisational restructure and amendment to the key strategic objectives, the board assurance framework was overhauled. There is now a direct link with all risks recorded on the risk register and the key strategic objectives with those rated above 12 being included within the Board Assurance Framework. Risks are now more explicitly identified along with the related controls, assurances and specific actions required. The Assurance Framework has been reviewed by the Board, the Quality and Risk Committee and the Audit Committee throughout the year.

Risk is a standing agenda item on monthly business review meetings and is addressed more formally at the quarterly Clinical Directorate meetings, chaired by myself and attended by other executive directors. Risk management is also a standing item at the Audit Committee, whose remit is to review the systems of control surrounding risk.

In order to determine the Trust's foundation trust Governance Risk Rating, the Board makes a self certification to Monitor, the Independent Regulator for Foundation Trusts on a quarterly basis. The self certification confirms that all targets have been met over the period (after application of thresholds) and that sufficient plans are in place to ensure that all known targets which will come into force will also be met. The Trust also provides Monitor with a Self Certification Framework to support its declaration. The Trust is also required to report on any changes that may affect its mandatory service risk rating.

In 2009/10 the Trust submitted a mid year declaration of compliance against Standards for Better Health and declared compliance with Care Quality Commission regulations to support registration from April 2010.

In December 2008 the Trust successfully attained Level 1 of the National Health Service Litigation Authority's Risk Management Standard. The Trust was compliant with 47 out of 50 standards. The areas where the Trust was assessed as being non-compliant were:

- Medical Devices Training;
- Resuscitation;
- Blood Transfusion.

The above areas required minimal changes to Trust policy, all of which were completed prior to the end of the financial year. The Trust identified that the organisational changes it had made had a significant impact on its policies and, following review, passed an assessment against Level 1 criteria by the National Health Service Litigation Authority in May 2010.

7.2.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2010 and up to the date of approval of the annual report and accounts.

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 in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

7.2.3 CAPACITY TO HANDLE RISK

Risk Management is a corporate responsibility and, accordingly, the Trust Board 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 & 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.

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 risks and all other forms of risk.
This implementation requires varying levels of training across the Trust.

The Trust's Risk and Incident Management Policy is available to all staff and training is in place to ensure staff are fully briefed on the policy.

In the new management structure divisional managers and matrons also have responsibility for service areas as well as patient pathways.
This matrix structure allows for transfer of good practice between the Clinical Directorates.

7.2.4 THE RISK AND CONTROL FRAMEWORK

The Trust is dedicated to establishing an organisational philosophy that ensures risk management is integrated as part of corporate objectives, plans and management systems. The ten key principles set out in the Trust's risk management strategy are as follows:

- Board and management commitment to risk management
- The ongoing development of integrated governance, including the formal application of the risk management assessment of clinical and non-clinical practices
- Employee participation and accountability in risk management processes
- To ensure that formal mechanisms are in place to measure the effectiveness of risk management strategies, plans and processes against NHS standards
- To ensure a mechanism is in place for all incidents to be immediately reported, categorised by their potential consequences and investigated to determine system failures in an open way
- Preventative maintenance risk management processes must be applied to the management of facilities, amenities and equipment
- To ensure systems are designed to reduce the likelihood of error occurring
- To ensure that risk management processes are applied to contract management especially when acquiring, expanding or outsourcing services so that only reasonable risks are accepted and that such risks are identified and managed
- To ensure safe systems of work are in place for the safety of patients, visitors and staff
- To ensure the Trust has plans for emergency preparedness, emergency response and with contingency plans in place to support business continuity.

The Trust's risk management strategy is executed via the Trust's Risk Identification and Management Policy, which:-

- Provides information and guidance to staff to enable them to assist the Trust in proactively identifying and managing risk effectively.
- Informs staff of the agreed Trust procedures to follow and actions to take when a risk has been identified.
- Highlights that mitigating actions must be identified and implemented following the identification of a risk and that the risk is communicated to those affected and escalated as appropriate.

Risk management is embedded in the activity of the organisation with the Clinical Directorates required to identify the risks in not meeting their objectives. These risks are logged on the risk register, together with any risks identified from external assessments. Risk management is also integral to the Trust's business planning process and investment in addressing the risks identified is given a high priority and profile within the Trust.

Over the last two years the Trust has focused heavily on its Risk Management agenda, establishing a core team to take the lead on risk but ensuring that risk is on everyone's agenda. The Trust's appetite for risk management has also been heightened given the nature of a number of high profile failures to manage risk across the NHS.

The Trust has an Assurance Framework in place that is designed to map the organisation's key strategic objectives against active risks and to establish controls to mitigate against these risks in order to provide a source of assurance to the Board.

The Assurance Framework comprises the following elements:

Principal risks – currently the framework incorporates the Trust's six key strategic objectives in individual sections, with the specific risks set out under each key strategic objective. Risks are scored using the 5 by 5 matrix, with all risks rated 12 or above being reported to the Board on a monthly basis.

Key controls – the internal and external key controls that are currently in place to mitigate against the risks identified. Any gaps in control and also identified and referenced to specific risks on the Trust's Risk Register. The updated document during 2009/10 has included actions required where any gaps in controls are identified.

Sources of Assurance – these are the sources of assurance currently available for each area of risk. Any gaps in assurance are also identified.

The Assurance Framework also identifies the key performance indicators for each principle risk and the residual risk for each risk.

The Trust also has a comprehensive risk register in place that supports the Assurance Framework. The register includes both clinical and non-clinical risks, with action plans and timescales in place for addressing the risks. The risk register is managed by the Trust Risk and Security Manager and is reviewed regularly by the Clinical Directorates and Quality and Risk Committee.

During the year the Assurance Framework is reviewed and updated by the executive leads responsible, and is reviewed by the Quality and Risk committee, Audit Committee and the Board.

Public stakeholders are also involved in managing risks through the risks identified by external assessors, complaints and other external bodies. Also, during 2009/10 the Trust has invited a public governor to attend the Quality and Risk Committee.

The Risk Management Policy and associated procedures set out the framework and systems for implementation of risk and governance in the Trust. These processes are evidenced within the Healthcare Commission Core Standards declaration and subsequently the Care Quality Commission Regulations.

The Integrated Risk Management agenda reflects the organisation's core business. The Trust seeks to learn from issues raised and implement good practice at all levels. The Board receives regular reports on Quality and Risk, including trends analysis and benchmarking (e.g. Healthcare Commission Standards). Adverse events are reviewed, investigated, analysed and reported back throughout the organisation. Learning from complaints and claims is also shared across the organisation.

The Trust has a fully developed, maintained and comprehensive Risk Register based on the Datix Risk Management System; it is one of the key elements of the Trust's risk management strategy and for future business and strategic planning. This Risk Register is a Trust-wide database recording patient safety, staff safety, environmental, financial and compliance risks identified from whatever source, the assessed level of current risk and details of control measures or an action plan to reduce the risk to the lowest practicable level or to a level determined as acceptable by the Board (or its committees).

In respect of Standards for Better Health, the Trust was required to submit a mid year declaration, in November 2009,

as to its compliance with the core standards self-assessment for the year ended 31 March 2010. The Trust involved all Trust Directors in undertaking the final assessment, which is reviewed by a number of sub-committees before being presented to the Board. Based on this assessment the Board's declaration for 2009/10 was fully complaint with all standards. In January 2010 the Trust was also then required to declare compliance with the Care Quality Commission Regulations in order for registration to be in place from April 2010. Following the Hygiene Code visit undertaken by the Healthcare Commission visit in November 2008, the trust received an enhanced visit in January 2010 the outcome of which was that the CQC had found 'no evidence that the trust had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare associated infection'.

Since the adoption of the Assurance Framework, the Executive Team has fully embedded risk management in the activities of the organisation. Directors and managers have been required to identify risks within their areas of responsibility and to establish, in conjunction with the relevant managers, effective control measures and/or systems. The Risk Register is managed by a dedicated Risk Manager and has involved Board members and staff in its development to ensure it represents an accurate assessment of the risks facing the organisation.

The following actions have been taken to address gaps in Control identified in the Assurance Framework:

- Corporate objectives are assigned to an Executive Director, and performance against these is assessed on a regular basis
- the Assurance Framework is reviewed regularly through the Quality & Risk Committee, Audit Committee and the Board

The following actions have been taken to ensure that there are no gaps in assurance in the Assurance Framework:

- The Assurance Framework linked the main elements and aims of the Trust's internal control and governance policies. The Framework consists of the following key elements:
- Principal Risks: the risk management policies sought to identify the main risks which might impede the Trust in achieving its objectives and to keep these under review by the Trust Board.
- Key Controls / Treatments: these were the mechanisms for controlling the risks that have been identified.

The Board also gets its assurances from the internal auditors, external auditors, independent review bodies and Audit Committee, which has reviewed the Trust's management of risk through the Quality & Risk Committee.

The Trust has put in place control measures to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. These include an Equality, Diversity and Human Rights steering group that meets regularly; regular monitoring of data; the role out of a programme of impact assessments and the associated training; equality and diversity reports, presentations and training for the Trust Board.

The Trust has undertaken risk assessments and is putting in place Carbon Reduction Delivery Plans in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the organisation's obligations under the Climate Change Act and Adaptation Reporting requirements are complied with.

The Trust's Information Governance Strategy sets out a number of high level information governance principles with particular regard to confidentiality, integrity and availability of information. During the year the Trust has established a new Senior Information Risk Owner (SIRO) role and has introduced enhanced requirements for encryption. Information governance is delivered through the Trust's Information Security Policy.

7.2.5 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

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

The Trust has a robust business planning process that involves comprehensive meetings with the Clinical Directorates to determine the business plans for the coming year. For 2009/10 the emphasis continued to focus on the planning of clinical activity and the establishment of the activity plans for the next three years and had far more involvement from the clinicians than in previous years.

The Trust has strong financial management arrangements in place with a comprehensive Finance and Performance Report presented to the Board on a monthly basis. Key performance indicators for productivity and efficiency gains are included in the monthly Finance and Performance Report to the Board. Following the review of the Trust's management structure monthly business review meetings and quarterly performance review meetings with the Clinical Directorates have been introduced.

During the year the Trust 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 out-come of service line reporting.

During the year the Trust focused on the delivery of clinical activity which highlighted the need to review the Trust's efficiency, as a result the Trust is also undertaking a comprehensive review of its efficiency to deliver clinical services, with a view to re-engineering its systems processing.

The Trust continues to undertake value added reviews which are reported to the Audit Committee. The main review undertaken during 2009/10 was the review of utilisation of the Trust's out-patient department.

During the year the Trust has also developed a number of key performance indicators and a score card to assist the Clinical Directorates in monitoring their performance. The Trust also continues to undertake weekly activity reporting.

The Trust is reviewing its use of natural resources and is developing a strategy to reduce its carbon footprint. This Strategy will introduce four key actions to address a Sustainable Development Management Plan, ensure sign up to best practice models, ensure close monitoring of carbon usage and promote awareness within the organisation.

7.2.6 ANNUAL 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 in the NHS Foundation Trust Annual Reporting Manual.

The Trust has prepared its Quality Accounts with strong clinical and managerial input including:

- Quarterly updates to Quality and Risk Committee on progress against priorities identified in the 2008/09 Quality Account;
- Monthly updates to Clinical Cabinet and Board of Directors on metrics (including MRSA, Cancer 62 days, RTT18);
- Clinical Outcomes group receives speciality information/audit and national audit outcome data.

7.2.7 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive mangers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of the Trust's internal and external auditors, the self assessment declaration on the core standards for Standards for Better Health and declaration to the CQC for registration purposes.

This evidence also gives assurance on the effectiveness of internal controls in relation to the production of the Quality Accounts. In line with Monitor's recent guidance the Trust will be undertaking a specific review on the Quality Accounts processes in July 2010 and will ensure any resulting actions are addressed.

I have been advised on the implications of the results of the effectiveness of the systems of internal control by the Board, Audit Committee, membership of the Quality and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

A robust assessment process has been implemented this year to enable the Board to reach its declaration against the core standards including assignment of each standard to an Executive Director, regular updates to the Board, the governors conducting a robust process to arrive at their Annual Health declaration and the involvement of the Internal Auditors throughout the entire process.

During the year the effectiveness of internal control has also been demonstrated by the following:

- The Trust met all performance and waiting list targets;
- Financial performance delivered a surplus of £0.98m (a loss of £1.045m after impairments of fixed assets);
- The number of claims and complaints received by the Trust remains low and consistent with previous years;
- Monthly Board performance and financial performance reports.
- A rating of significant assurance given in the Head of internal Audits Opinion on the effectiveness of the systems of internal control;
- Minutes of Quality and Risk Committee and Audit Committee reported to the Board
- Ongoing update and approval of the Assurance Framework;
- Regular review and reports on the position of the Corporate Risk Register;
- Review of the Trust's governance and management arrangements.

The Assurance Framework is continually reviewed and updated by the Trust throughout the year to ensure that it reflects the key risks currently relevant to the Trust.

7.2.8 CONCLUSION

Based on this assessment the Board's declaration for 2009/10 was fully complaint with all Standards for Better Health. In January 2010 the Trust declared compliance with the Care Quality Commission Regulations in order for registration to be in place from April 2010. At the end of the year there are no known significant internal control issues for the Trust.

Dr Adrian Bull
Chief Executive (on behalf of the Board)

8 June 2010

It should be noted that from 1 April 2009 the Healthcare Commission has been replaced by the Care Quality Commission.

7.3 INDEPENDENT AUDITORS' REPORT TO THE BOARD OF GOVERNORS OF QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

RESPECTIVE RESPONSIBILITIES OF DIRECTORS AND AUDITORS

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer set in section 7.1 the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of Queen Victoria Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the Queen Victoria Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

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 NHS foundation trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS foundation trust; and the overall presentation of the financial statements.

OPINION ON FINANCIAL STATEMENTS

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS foundation trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year then ended ; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

OPINION ON OTHER MATTERS PRESCRIBED BY THE AUDIT CODE FOR NHS FOUNDATION TRUSTS

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- 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 in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

CERTIFICATE

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

S Isted

Sarah Isted
(Senior Statutory Auditor)

For and on behalf of
PricewaterhouseCoopers LLP
Chartered Accountants and
Statutory Auditors
London

7 June 2010

7.4 FOREWORD TO THE ACCOUNTS QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

THESE ACCOUNTS FOR THE YEAR ENDED 31 MARCH 2010 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

7 June 2010

7.5 STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Notes	2009/10	2008/09
		£000	£000
Operating income	3,4	**54,536**	52,419
Operating expenses excluding impairments	5	**(52,622)**	(50,603)
Impairments of property, plant and equipment	5,15	**(1,999)**	(366)
Operating (deficit) / surplus		**(85)**	1,450
Finance costs			
Finance income		**14**	194
Finance expense - unwinding of discount on provisions	21	**(12)**	(12)
PDC dividends payable		**(961)**	(824)
Net finance costs		**(959)**	(642)
(DEFICIT) / SURPLUS FOR THE YEAR		**(1,044)**	808
Other comprehensive income:			
Revaluation losses on property, plant and equipment		**(1,388)**	(532)
Increase in the donated asset reserve due to receipt of donated assets		**13**	194
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		**(257)**	(283)
TOTAL COMPREHENSIVE (EXPENSE)/INCOME FOR THE YEAR		**(2,676)**	187

The notes in section 7.9 form part of these financial statements.

7.6 STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Notes	31 March 2010	31 March 2009	1 April 2008
		£000	£000	£000
NON-CURRENT ASSETS:				
Intangible assets	14	**87**	65	80
Property, Plant and Equipment	15	**32,128**	33,684	31,022
Trade and other receivables	18	**48**	62	68
Total non-current assets		**32,263**	33,811	31,170
CURRENT ASSETS:				
Inventories	17	**319**	346	271
Trade and other receivables	18	**3,339**	4,350	3,633
Cash and cash equivalents	19	**4,801**	3,110	5,510
Total current assets		**8,459**	7,806	9,414
CURRENT LIABILITIES:				
Trade and other payables	20	**(4,590)**	(4,503)	(3,320)
Provisions	21	**(38)**	(37)	(40)
Tax payable	20	**(803)**	(782)	(713)
Other liabilities	20	**(2,185)**	(518)	(915)
Total current liabilities		**(7,616)**	(5,840)	(4,988)
NON-CURRENT LIABILITIES:				
Provisions	21	**(522)**	(517)	(523)
TOTAL ASSETS EMPLOYED		**32,584**	35,260	35,073
TAX PAYERS' EQUITY:				
Public dividend capital		**12,212**	12,212	12,212
Revaluation reserve		**14,075**	15,769	17,450
Donated asset reserve		**2,326**	2,692	2,185
Income and expenditure reserve		**3,971**	4,587	3,226
TOTAL TAX PAYERS' EQUITY		**32,584**	35,260	35,073

Signed on behalf of the Board:

Dr Adrian Bull
Chief Executive

7 June 2010

7.7 STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Notes	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve
		£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2009		**35,260**	12,212	15,769	2,692	4,587
Total comprehensive income for the year		**(1,044)**	0	0	0	(1,044)
Revaluation losses and impairment losses property, plant and equipment	15	**(1,388)**	0	(1,266)	(122)	0
Increase in the donated asset reserve due to receipt of donated assets	15	**13**	0	0	13	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	15	**(257)**	0	0	(257)	0
Transfers to the Income and Expenditure reserve in respect of disposed assets	15	**0**	0	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciationto the Income and Expenditure reserve		**0**	0	(428)	0	428
Taxpayers' equity at 31 March 2010		**32,584**	12,212	14,075	2,326	3,971
Taxpayers' equity at 1 April 2008		**35,073**	12,212	17,450	2,185	3,226
Total comprehensive income for the year		**808**	0	0	0	808
Revaluation losses and impairment losses property, plant and equipment	15	**(532)**	0	(1,128)	596	0
Increase in the donated asset reserve due to receipt of donated assets	15	**194**	0	0	194	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	15	**(283)**	0	0	(283)	0
Transfers to the Income and Expenditure reserve in respect of disposed assets	15	**0**	0	(125)	0	125
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure reserve		**0**	0	(428)	0	428
Taxpayers' equity at 31 March 2009		**35,260**	12,212	15,769	2,692	4,587

7.8 STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	Notes	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Cash flows from operating activities		**(85)**	1,450
Non-cash income and expense			
Depreciation and amortisation	5,14,15	**1,833**	1,903
Impairments	5,15	**1,999**	366
Loss on disposal of property, plant and equipment	5	**0**	65
Transfer from the donated asset reserve	4	**(212)**	(283)
Decrease/(Increase) in trade and other receivables	18	**1,025**	(711)
Decrease/(Increase) in inventories	17	**27**	(75)
Increase in trade and other payables	20	**1,775**	893
Increase/(Decrease) in provisions	21	**6**	(9)
Net cash inflow from operations		**6,368**	3,599
Cash flows from investing activities			
Interest received		**14**	194
Payments to acquire property, plant and equipment	15	**(3,607)**	(5,353)
Payments to acquire intangible assets	14	**(47)**	(16)
Net cash used in investing activities		**(3,640)**	(5,175)
Cash flows from financing activities			
PDC dividends paid		**(1,037)**	(824)
Increase in cash		**1,691**	(2,400)
Cash and cash equivalents at 1 April 2009	19	**3,110**	5,510
Cash and cash equivalents at 31 March 2010	19	**4,801**	3,110

7.9 NOTES TO THE FINANCIAL STATEMENTS

1.0 ACCOUNTING POLICIES

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 2009/10 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 Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. 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.

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.

All assets are measured subsequently at fair value.

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 2010 as at the prospective valuation date of 31 March 2010 and have been accounted for in the 2009/10 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. Revaluations are never less than triennial. 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
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'.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;

- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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

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 GOVERNMENT GRANTS

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

1.7 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.

1.8 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.

1.9 FINANCIAL INSTRUMENTS AND FINANCIAL LIABILITIES

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

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.

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 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.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

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.

1.10 LEASES

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as 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. Leased land is treated as 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.

1.11 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 2.2% 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 21. The Trust does not carry any amounts relating to these cases in its own accounts.

Non-clinical risk pooling
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.

1.12 CONTINGENCIES

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

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

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

1.13 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 NHS foundation 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 NHS foundation 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 Services 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.

1.14 VALUE ADDED TAX

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

1.15 CORPORATION TAX

HM Revenue and Customs has advised that no Corporation Tax will be charged to NHS foundation trusts for the financial year ending 31 March 2010.

1.16 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.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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.

1.17 THIRD PARTY ASSETS

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them.

However, if significant, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 ACCOUNTING STANDARDS ISSUED BUT NOT YET APPLIED

The following standards and interpretations issued by the IASB or IFRIC have not been adopted by the Trust as these were not effective for the year 2010.

The following standards or revisions to standards are not relevant to the Trust:

- IFRS3 (revised) – Business combinations (effective for accounting periods beginning on or after 1 July 2009). IFRS3 (revised) has been endorsed for use in the EU
- IFRIC17 - 'Distributions of Non cash Assets to Owners' (effective for accounting periods beginning on or after 1 July 2009). This IFRIC has been endorsed for use in the EU. IFRIC17, 'Distributions of Non-cash Assets to Owners' (effective for accounting periods beginning on or after 1 July 2009). This IFRIC has been endorsed for use in the EU
- IFRIC18 - 'Transfers of Assets from Customers' (effective for accounting periods beginning on or after 1 July 2009). This IFRIC has been endorsed for use in the EU
- Amendment to IAS32 - 'Classification of Rights Issues' (effective for accounting periods beginning on or after 1 February 2010). This amendment has been endorsed for use in the EU
- Amendment to IFRS1 - 'Additional Exemptions for First-time Adopters' (effective for accounting periods beginning on or after 1 January 2010). This amendment has not yet been endorsed for use in the EU
- IFRIC19 - 'Extinguishing Financial Liabilities with Equity Instruments' (effective for accounting periods beginning on or after 1 July 2010). This interpretation has not yet been endorsed for use in the EU
- Amendment to IFRIC14 - 'Prepayments of a Minimum Funding Requirement' (effective for accounting periods beginning on or after 1 January 2011). This amendment has not yet been endorsed for use in the EU
- IFRS2 (amended) - 'Group Cash-settled Share-based Payment Transactions' (effective for accounting periods beginning on or after 1 January 2010). This was endorsed by the EU on 23 March 2010
- IFRS1 (amended) - 'Limited exemption from Comparative IFRS7 Disclosures for first time adopters' (effective for accounting periods beginning on or after 1 July 2010). This amendment has not yet been endorsed for use in the EU
- IAS27 (revised) - 'Consolidated and separate financial statements' (effective for accounting periods beginning on or after 1 July 2009). This will become applicable in 2010/11. HM Treasury has deferred the implementation of IAS27 (revised) in respect of NHS charitable funds until the financial year commencing 1 April 2011.

The following standards or revisions to standards are relevant to the Trust. None of the below are anticipated to have any material impact on the recognition or measurement but may result in additional disclosure:

- Amendment to IAS39 - 'Reclassification of Financial Assets: Effective Date and Transition' (effective for accounting periods starting on or after 1 July 2009). This amendment has been endorsed for use in the EU
- Amendment to IAS39 - 'Financial Instruments: Recognition and Measurement: Eligible Hedged Items' (effective for accounting periods starting on or after 1 July 2009). This amendment has been endorsed for use in the EU

- Amendments to IFRIC9 and IAS39 - 'Embedded Derivatives' (effective for accounting periods starting on or after 1 July 2008). This amendment has been endorsed for use in the EU

- Revised IAS24 - 'Related Party Disclosures' (effective for accounting periods beginning on or after 1 January 2011). This revision has not yet been endorsed for use in the EU.
  This revision will only impact disclosure and have no effect on the net assets or result of the Trust

- IFRS9 - 'Financial Instruments' (effective for accounting periods beginning on or after 1 January 2013). This standard has not yet been endorsed for use in the EU.

The IASB2009 annual improvement project includes further minor amendments to various accounting standards and is effective from various dates from 1 January 2010 onwards. This was endorsed by the EU on 23 March 2010.

The Trust has early adopted the amendment to IFRS8, included within the IASB 2009 improvement project above, which exempts entities from disclosing assets by segment if they are not regularly reported to the Chief Operating Decision Maker.

1.19 PROFIT-SHARING AGREEMENT

The Trust has an agreement with a private company under which it is entitled to receive a proportion of the company's profits. It is the Trust's policy not to account for this income until there is a reasonable certainty that it will be received.

1.20 CRITICAL ACCOUNTING ESTIMATES AND ASSUMPTIONS

The Trust makes estimates and assumptions concerning the future. The resulting accounting estimates will sometimes not equal the related actual results. The most significant such estimates are:

- 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

- 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

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 actuarial assessments of the expected remaining lives of those concerned

- Property valuation - Property forms a large proportion of the Trust's asset value and its valuation can therefore have a critical effect on the Trust's accounts. As noted above, regular valuations are carried out by professional valuers, on whose opinion the Trust places reliance.

1.21 CRITICAL JUDGEMENTS IN APPLYING THE TRUST'S ACCOUNTING POLICIES

Impairment of site development costs - The Trust has concluded that the funding required to develop the hospital site as originally intended is unlikely to be available in the foreseeable future. It has therefore treated all the costs that were being carried in its accounts up to the end of 2009/10 as an impairment in the Statement of Consolidated Income.

2.0 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 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. Financial performance against budget for each segment is presented on a monthly basis. All accounting during the year is done on an IFRS basis.

The financial results for each segment were as follows:

	2009/10	
	Income £000	Expenditure £000
Reconstructive surgery	42,110	27,142
Other specialties	12,307	6,205
Total of reportable segments	**54,417**	**33,347**
Corporate (see note below)		17,323
Depreciation		1,833
Impairment of Property, Plant and Equipment		1,999
Finance income		(14)
Finance expense - unwinding of discount on provisions		12
PDC dividends payable		961
(Deficit) for the year		**(1,044)**

Prior to 2009/10 the Trust board reviewed the financial performance of the Trust on a global basis rather than by activity segments. Comparative figures for 2008/09 are not therefore available.

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

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, current liabilities are also managed centrally and are therefore not analysed or reported by segment.

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.

The majority of the Trust's income is derived from Primary Care Trusts (PCTs). During the year, income from the following PCTs exceeded 10% of total income:

	2009/10 £000
West Sussex PCT (acting on behalf of all Sussex PCTs)	**19,973**
West Kent PCT	**10,228**

Each of these PCTs purchased services in both of the operating segments identified above.

External commissioners for the Trust are NHS bodies in Wales and Scotland. The total funding received was:

	2009/10 £000
Wales	**33**
Scotland	**5**

3.0
INCOME FROM PATIENT CARE ACTIVITIES

	2009/10 £000	2008/09 £000
NHS trusts	**72**	22
Primary care trusts	**50,779**	44,005
Department of Health	**20**	4,547
NHS other	**76**	73
Non-NHS:		
Private patients	**95**	89
Injury costs recovery	**235**	212
Other	**185**	181
	51,462	49,129

Injury cost recovery income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

Private patient income

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year. This proportion is 0.2%.

Performance:	2009/10 £000	2008/09 £000
Private patient income	**95**	89
Total patient-related income	**51,462**	49,129
Proportion	**0.18%**	**0.18%**

4.0
OTHER OPERATING INCOME

	2009/10 £000	2008/09 £000
Education, training and research	**1,960**	1,865
Charitable and other contributions to expenditure	**119**	187
Transfers from Donated Asset Reserve	**212**	283
Non-patient care services to other bodies	**122**	366
Rental income	**12**	22
Other income	**649**	567
	3,074	3,290

Other income includes income from catering, car parking, room rentals, sale of drugs and recharges to a housing association.

5.0
OPERATING EXPENSES

	2009/10 £000	2008/09 £000
Services from NHS foundation trusts	**733**	527
Services from other NHS trusts	**2,848**	2,947
Services from other NHS bodies	**69**	174
Purchase of healthcare from non NHS bodies	**196**	38
Executive directors' costs	**598**	417
Non-executive directors' costs	**119**	129
Staff costs	**35,498**	34,033
Drugs	**890**	1,023
Supplies and services - clinical (excluding drugs)	**4,716**	4,430
Supplies and services - general	**705**	638
Establishment	**1,066**	992
Research and development	**7**	0
Transport	**248**	127
Premises	**1,657**	2,180
Provision for impairment of receivables	**113**	(7)
Depreciation	**1,808**	1,872
Amortisation	**25**	31
Impairments of property, plant and equipment	**1,999**	366
Audit fees - statutory audit	**88**	88
Other auditor's remuneration - consultancy	**74**	24
Clinical negligence	**354**	128
Loss on disposal of buildings	**0**	58
Loss on disposal of plant and equipment	**0**	7
Other	**810**	747
	54,621	50,969

Impairments of property, plant and equipment resulted from:

1. Impairment due to a project being discontinued due to current funding issues (£1,092,000).

2. The revaluation of the hospital buildings (£907,000).

Key management personnel are considered to be the directors. Directors' remuneration totalled £791,000 (2008/09 £628,000). Employer's pension contributions in respect of directors totalled £49,000 (2008/09 £48,000).

The contract between the Trust and its auditors provides for the latter's liability to be limited to £1,000,000.

Other expenditure includes training, car parking, security, payroll service, patients' travel, consultancy and legal fees.

6.0 OPERATING LEASES

6.1 AS LESSEE

Operating leases relate to buildings, heating systems, medical equipment and vehicles.

Buildings are leased for periods of five or ten years.

The agreement relating to the heating systems ends in 2011, at which point the trust has the option of terminating the lease, negotiating a renewal or purchasing the equipment for an amount to be agreed at the time. The agreement provides for cash settlements between the parties in respect of over- or under-achievement of energy-saving targets.

Medical equipment and vehicles are leased for periods of between two and five years.

Payments recognised as an expense	2009/10 £000	2008/09 £000
Minimum lease payments	**696**	492

Total future minimum lease payments Payable:	2009/10 £000	2008/09 £000
Not later than one year	**672**	544
Between one and five years	**175**	1,125
After 5 years	**60**	94
Total	**907**	1,763

6.2 AS LESSOR

Premises were leased to a private healthcare body for a period which ended in 2009/10.

Rental Revenue	2009/10 £000	2008/09 £000
Minimum payments	12	22

Total future minimum lease payments Receivable:	2009/10 £000	2008/09 £000
Not later than one year	0	2

In 2008/09 it was known that a lease would terminate in 2009/10. In the event, the termination was later in the year than expected, with the result that payments received were higher than the future minimum lease payment disclosed in the 2008/09 accounts.

7.0 EMPLOYEE BENEFITS AND STAFF NUMBERS

7.1 EMPLOYEE BENEFITS

	2009/10 Total	Permanently Employed	Other	2008/09 (restated)
	£000	£000	£000	£000
Salaries and wages	**28,460**	**28,460**	**0**	27,578
Social Security Costs	**2,536**	**2,536**	**0**	2,385
Employer contributions to NHS Pension scheme	**3,433**	**3,433**	**0**	3,200
Agency/contract staff	**1,667**	**0**	**1,667**	1,287
Employee benefits expense	**36,096**	**34,429**	**1,667**	34,450
Non-executive directors benefits not included above	119	119	0	129

The 2008/09 figures have been restated to show agency medical staff costs with other agency costs rather than in salaries and wages.

7.2 AVERAGE NUMBER OF PEOPLE EMPLOYED

	2009/10 Total	Permanently Employed	Other	2008/09 Total
	Number	Number	Number	
Medical and dental	**125**	**120**	**5**	119
Administration and estates	**209**	**208**	**1**	205
Healthcare assistants and other support staff	**137**	**137**	**0**	131
Nursing, midwifery and health visiting staff	**204**	**198**	**6**	199
Scientific, therapeutic and technical staff	**143**	**142**	**1**	132
Bank and agency staff	**41**	**41**	**0**	55
Total	**859**	**846**	**13**	**841**

8.0 PENSION COSTS

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

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

a) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation
A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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

c) Scheme provisions
In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

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

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

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance
A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement
Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits
A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

9.0 RETIREMENTS DUE TO ILL-HEALTH

During the year there were no early retirements due to ill health (2008/09, none). (This information has been supplied by NHS Pensions.)

Transfer between Funds
Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

10.0 BETTER PAYMENT PRACTICE CODE

	2009/10		2008/09	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	13,597	12,711	15,219	17,947
Total Non NHS trade invoices paid within target	7,823	7,903	14,215	15,359
Percentage of Non-NHS trade invoices paid within target	**58%**	**62%**	93%	86%
Total NHS trade invoices paid in the year	1,131	7,379	958	5,385
Total NHS trade invoices paid within target	117	585	331	2,032
Percentage of NHS trade invoices paid within target	**10%**	**8%**	35%	38%

Due to tighter cash flow management during the year performance fell below target.

11.0
THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

No claims against the Trust were made under the Late Payment of Commercial Debts (Interest) Act 1998, (2008/09 none).

12.0
FINANCE REVENUE

	2009/10 £000	2008/09 £000
Interest revenue from bank accounts	14	194

13.0
OTHER GAINS AND LOSSES

	2009/10 £000	2008/09 £000
Loss on disposal of non-protected property, plant and equipment	**0**	(65)

14.0
INTANGIBLE ASSETS

14.1
SOFTWARE LICENCES

	2009/10 £000	2008/09 £000
Gross cost at 1 April	**167**	151
Additions	**47**	16
Gross cost at 31 March	**214**	167
Amortisation at 1 April	**102**	71
Provided during the year	**25**	31
Amortisation at 31 March	**127**	102
Net book value		
- Purchased assets at 1 April	**65**	80
- Purchased assets at 31 March	**87**	65

14.2
FULLY AMORTISED INTANGIBLE ASSETS

Fully depreciated assets with an aggregate gross carrying value of £42,000 are still in use.

15.0
PROPERTY, PLANT AND EQUIPMENT

15.1
PROPERTY, PLANT AND EQUIPMENT AT 31 MARCH 2010

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	9,229	18,901	592	9,248	7	2,219	662	**40,858**
Additions - purchased	0	1,745	1,255	606	0	64	0	**3,670**
Additions - donated	0	7	0	6	0	0	0	**13**
Impairments recognised in operating expenses	0	(902)	(1,092)	0	0	0	(5)	**(1,999)**
Reclassifications	0	411	(427)	0	0	16	0	**0**
Revaluation gain/(loss)	284	(2,373)	0	0	0	0	(70)	**(2,159)**
Disposals	0	0	0	(44)	0	0	0	**(44)**
At 31 March 2010	**9,513**	**17,789**	**328**	**9,816**	**7**	**2,299**	**587**	**40,339**
Depreciation at 1 April 2009	0	20	0	5,766	4	1,384	0	**7,174**
Provided during the year	0	757	0	818	1	207	25	**1,808**
Revaluation gain/(loss)	0	(746)	0	0	0	0	(25)	**(771)**
Disposals	0	0	0	0	0	0	0	**0**
Depreciation at 31 March 2010	**0**	**31**	**0**	**6,584**	**5**	**1,591**	**0**	**8,211**
Net book value								
- Purchased assets as at 1 April 2009	9,229	16,680	592	3,039	3	824	625	**30,992**
- Donated assets as at 1 April 2009	0	2,201	0	443	0	11	37	**2,692**
Total at 1 April 2009	**9,229**	**18,881**	**592**	**3,482**	**3**	**835**	**662**	**33,684**
- Purchased assets as at 31 March 2010	9,513	15,774	328	2,933	2	699	553	**29,802**
- Donated assets as at 31 March 2010	0	1,984	0	299	0	9	34	**2,326**
Total at 31 March 2010	**9,513**	**17,758**	**328**	**3,232**	**2**	**708**	**587**	**32,128**

15.1 PROPERTY, PLANT AND EQUIPMENT AT 31 MARCH 2009 CONT.

	Land	Buildings excluding dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	11,533	15,526	329	8,033	7	1,754	287	**37,469**
Additions - purchased	0	1,029	2,832	1,042	0	400	0	**5,303**
Additions - donated	0	0	0	183	0	11	0	**194**
Impairments recognised in operating expenses	0	(366)	0	0	0	0	0	**(366)**
Reclassifications	0	2,379	(2,569)	136	0	54	0	**0**
Revaluation gain/(loss)	(2,304)	403	0	0	0	0	375	**(1,526)**
Disposals	0	(70)	0	(146)	0	0	0	**(216)**
At 31 March 2009	**9,229**	**18,901**	**592**	**9,248**	**7**	**2,219**	**662**	**40,858**
Depreciation at 1 April 2008	0	13	0	5,214	3	1,217	0	**6,447**
Provided during the year	0	976	0	696	1	167	32	**1,872**
Revaluation gain/(loss)	0	(962)	0	0	0	0	(32)	**(994)**
Disposals	0	(7)	0	(144)	0	0	0	**(151)**
Depreciation at 31 March 2009	**0**	**20**	**0**	**5,766**	**4**	**1,384**	**0**	**7,174**
Net book value								
- Purchased assets as at 1 April 2008	11,533	13,712	329	2,453	4	537	279	**28,847**
- Donated assets as at 1 April 2008	0	1,801	0	366	0	0	8	**2,175**
Total at 1 April 2008	**11,533**	**15,513**	**329**	**2,819**	**4**	**537**	**287**	**31,022**
- Purchased assets as at 31 March 2009	9,229	16,677	592	3,039	3	824	628	**30,992**
- Donated assets as at 31 March 2009	0	2,204	0	443	0	11	34	2,692
Total at 31 March 2009	**9,229**	**18,881**	**592**	**3,482**	**3**	**835**	**662**	**36,684**

15.2 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 2010, £1,753,000 at 31 March 2009 and £2,191,000 at 1 April 2008, which is included within the totals.

15.3 REVALUATION OF ASSETS

Land and buildings (including furniture and fittings) were revalued as at 31 March 2010 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 International Valuation and RICS 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 materialy.

15.4 ASSET LIVES

The lives of the various elements of buildings have been determined by the same independent valuer who carried out the revaluation referred to in Note 15.3. They vary between two and eighty five years.

15.5 FULLY DEPRECIATED ASSETS

Fully depreciated assets with an aggregate gross carrying value of £4,164,000 are still in use.

15.6 PROPERTY, PLANT AND EQUIPMENT DONATED DURING THE YEAR

During the year, medical and information technology equipment with a value of £13,000 was donated to the trust by the Queen Victoria Hospital NHS Trust Charitable Fund.

16.0 CAPITAL COMMITMENTS

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

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Property, plant and equipment	**114**	346	273

17.0 INVENTORIES

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Drugs	**101**	124	101
Clinical consumables	**211**	206	150
Other	**7**	16	20
Total	**319**	346	271

18.0 TRADE AND OTHER RECEIVABLES

18.1 TRADE AND OTHER RECEIVABLES COMPRISE:

	31 March 2010		31 March 2009		1 April 2008	
	Current £000	Non-current £000	Current £000	Non-current £000	Current £000	Non-current £000
NHS receivables	**2,095**	**48**	2,399	62	2,673	68
Other trade receivables	**252**	**0**	355	0	316	0
VAT	**53**	**0**	72	0	52	0
Accrued income	**494**	**0**	520	0	331	0
Provision for the impairment of receivables	**(185)**	**0**	(75)	0	(82)	0
Prepayments	**630**	**0**	1,079	0	343	0
Total	**3,339**	**48**	4,350	62	3,633	68

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.

18.2 RECEIVABLES PAST THEIR DUE DATE BUT NOT IMPAIRED

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
By up to three months	**355**	413	584
By three to six months	**63**	154	84
By more than six months	**133**	79	12
Total	**551**	646	680

18.3 PROVISION FOR IMPAIRMENT OF NHS RECEIVABLES

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance at 1 April	**(28)**	(41)	(41)
Amount recovered during the year	**0**	41	0
Increase in receivables impaired	**(110)**	(28)	0
Balance at 31 March	**(138)**	(28)	(41)

The closing balance represents a group of invoices raised to Welsh NHS bodies. These bodies have implemented a policy of not paying for the treatment of their patients in other parts of the UK unless they have given prior approval.

In the early days of the policy a number of patients were treated without this approval having been given and there is therefore a possibility that payment will not be received though the trust believes the invoices to be valid and continues to pursue payment in full.

18.4
PROVISION FOR IMPAIRMENT OF NON-NHS RECEIVABLES

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance at 1 April	**(47)**	(41)	(17)
Amount utilised during the year	**3**	0	0
Increase in receivables impaired	**(3)**	(6)	(24)
Balance at 31 March	**(47)**	(47)	(41)

£38,000 of the closing balance represents the probable non-recovery of costs of treating the victims of road traffic and other accidents.

The recovery of costs is handled through the NHS Injury Scheme which recommends a provision for non-recovery of 7.8%.

The trust has followed this advice.

19.0
CASH AND CASH EQUIVALENTS

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Balance at 1 April	**3,110**	5,510	3,167
Net change in year	**1,691**	(2,400)	2,343
Balance at 31 March	**4,801**	3,110	5,510
Comprising:			
Cash with the Office of the HM Paymaster General	**4,772**	3,084	5,480
Commercial banks and cash in hand	**29**	26	30
Cash and cash equivalents as in statement of cash flows	**4,801**	3,110	5,510

20.0
TRADE AND OTHER PAYABLES

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
NHS payables	**2,276**	2,543	1,578
Trade payables - capital	**181**	112	121
Other payables - revenue	**546**	971	988
Tax and social security costs	**803**	782	713
Accruals	**1,587**	877	633
Deferred income	**2,185**	518	915
Total	**7,578**	5,803	4,948

Other payables include £455,000 outstanding pensions contributions at 31 March 2010 (2008/09 £405,000).

21.0
PROVISIONS

	Current 31 March 2010 £000	Non-current 31 March 2010 £000	Current 31 March 2009 £000	Non-current 31 March 2009 £000	Current 1 April 2008 £000	Non-current 1 April 2008 £000
Pensions relating to staff	**26**	**522**	25	513	25	499
Legal claims	**10**	**0**	12	0	15	0
PAYE	**2**	**0**	0	4	0	24
Total	**38**	**522**	37	517	40	523

21.0 PROVISIONS CONT.

	Pensions relating to staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2008	524	15	24	563
Arising during the year	25	7	0	32
Used during the year	(23)	(10)	0	(33)
Reversed unused	0	0	(20)	(20)
Unwinding of discount	12	0	0	12
At 1 April 2009	**538**	**12**	**4**	**554**
Arising during the year	**24**	**1**	**0**	**25**
Used during the year	**(26)**	**(3)**	**0**	**(29)**
Reversed unused	**0**	**0**	**(2)**	**(2)**
Unwinding of discount	**12**	**0**	**0**	**12**
At 31 March 2010	**548**	**10**	**2**	**560**
Expected timing of cash flows:				
Within one year	26	10	2	**38**
Between one and five years	111	0	0	**111**
After five years	411	0	0	**411**

The provision for pensions relating to staff comprises £474,000 in respect of injury benefit (31/3/2009 - £463,000) and £75,000 in respect of early retirements (31/3/2009 - £75,000). 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. Where the NHSLA's assessment is that there is unlikely to be a loss, the value of the claims is disclosed as a contingent liability in Note 22.

Other cases within 'Legal Claims' relate to pensions paid to former employees as a result of early retirement. In one case some of the cost is recovered from PCTs until a maximum cumulative sum is reached.

£734,000 is included in the provisions of the NHS Litigation Authority at 31/3/2010 in respect of clinical negligence liabilities of the foundation trust (31/03/2009 - £812,000).

22.0 CONTINGENCIES

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Contingent liability - gross value	**0**	(7)	(5)

Contingencies relate to the provision for Legal Claims described in Note 21.

They represent the value of claims against the trust which the NHSLA considers to be unlikely to result in a loss.

There are no contingent assets.

23.0 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 1.9.

23.1 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY

All financial assets and liabilities are denominated in sterling.

Financial assets	31 March 2010 Loans and receivables £000	31 March 2009 Loans and receivables £000	1 April 2008 Loans and receivables £000
NHS Debtors	**2,067**	2,433	2,324
Accrued income	**11**	70	208
Other debtors	**305**	262	260
Cash at bank and in hand	**4,801**	3,110	5,510
Total	**7,184**	5,875	8,302

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".

23.1 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY CONT.

Financial Liabilities	31 March 2010 Carrying Value £000	31 March 2009 Carrying Value £000	1 April 2008 Carrying Value £000
Trade and other payables	3,003	3,008	2,150
Accrued expenditure	1,587	1,010	759
Total	**4,590**	4,018	2,909

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 £803,000 (2008/09 £782,000) and deferred income of £2,105,000 (2008/09 £877,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

23.2 MATURITY OF FINANCIAL ASSETS

All of the foundation trust's financal assets mature within one year with the exception of £48,000 NHS debtors which are expected to mature in annual amounts of approximately £9,000 subject to inflation until the balance is exhausted.

23.3 MATURITY OF FINANCIAL LIABILITIES

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

23.4 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.

23.5 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 2010 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.

24.0 PRUDENTIAL BORROWING LIMIT

The NHS foundation trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:

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

Further information on the NHS foundation trusts Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust has a maximum long-term borrowing limit of £11,500,000 (2008/09 £11,200,000). During the year the Trust made no borrowings (2008/09 none).

The Trust has an approved working capital facility of £3,000,000 (2008/09 £3,000,000). During the year the Trust drew down none of its working capital facility (2008/09 none).

25.0 RELATED PARTY TRANSACTIONS

During the year the Trust undertook transactions with Bolt Partners LLP, a firm associated with one of its Directors. No other board members or members of the key management staff or parties related to them has undertaken any material transactions with Queen Victoria Hospital NHS Foundation Trust.

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 foundation 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.

	2009/10		2008/09	
Private sector and charitable organisations	Income £000	Expenditure £000	Income £000	Expenditure £000
Bolt Partners	0	162	0	0
The Queen Victoria Hospital NHS Trust Charitable Fund	24	0	339	0
McIndoe Surgical Centre	142	29	132	16

	31 March 2010		31 March 2009		1 April 2008	
	Debtor £000	Creditor £000	Debtor £000	Creditor £000	Debtor £000	Creditor £000
Bolt Partners	0	40	0	0	0	0
The Queen Victoria Hospital NHS Trust Charitable Fund	0	0	31	0	0	0
McIndoe Surgical Centre	7	0	12	0	11	3

25.0
RELATED PARTY TRANSACTIONS CONT.

Whole of Government Accounts bodies

Bodies with whom either income or expenditure exceeded £150,000 during the year:

	2009/10		2008/09	
	Income £000	**Expenditure £000**	Income £000	Expenditure £000
West Sussex PCT	**19,973**	**10**	11,632	3
West Kent PCT	10,228	17	8,516	21
Eastern & Coastal Kent PCT	**5,168**	**0**	3,468	3
Surrey PCT	**4,526**	**21**	3,285	0
Medway PCT	**4,235**	**53**	3,398	52
Tower Hamlets PCT	**3,071**	**0**	3,529	0
South East Coast Strategic Health Authority	**1,641**	**0**	1,702	22
Bromley PCT	**721**	**0**	600	0
Bexley Care Trust	**687**	**0**	579	0
Croydon PCT	**402**	**0**	359	0
Hampshire PCT	**210**	**0**	341	0
Greenwich PCT	**190**	**0**	160	0
London Strategic Health Authority	**171**	**0**	27	0
NHS Business Services Authority	**0**	**1,176**	0	989
Maidstone And Tunbridge Wells NHS Trust	**29**	**974**	2	1,173
East Sussex Hospitals NHS Trust	**0**	**739**	1	736
Medway NHS Foundation Trust	**0**	**637**	0	488
Dartford And Gravesham NHS Trust	**1**	**545**	2	454
South East Coast Ambulance Service NHS Trust	**1**	**396**	0	421
Brighton And Sussex University Hospitals NHS Trust	**35**	**208**	25	57
NHS Litigation Authority	**0**	**389**	3	160

	31 March 2010		31 March 2009		1 April 2008	
	Receivables £000	**Payables £000**	Receivables £000	Payables £000	Receivables £000	Payables £000
West Sussex PCT	**324**	**0**	844	362	197	22
West Kent PCT	**0**	**458**	253	0	403	0
Eastern & Coastal Kent PCT	**584**	**0**	52	6	127	0
Surrey PCT	**311**	**5**	144	0	315	0
Medway PCT	**3**	**89**	61	79	84	53
Tower Hamlets PCT	**0**	**0**	15	0	0	105
South East Coast Strategic Health Authority	**2**	**0**	27	11	103	18
Bromley PCT	**1**	**0**	0	5	11	0
Bexley Care Trust	**0**	**20**	0	1	18	0
Croydon PCT	**0**	**0**	14	0	15	0
Hampshire PCT	**107**	**0**	260	0	92	0
Greenwich PCT	**0**	**0**	4	0	5	7
London Strategic Health Authority	**66**	**0**	0	0	0	0
Maidstone And Tunbridge Wells NHS Trust	**10**	**325**	1	622	1	430
East Sussex Hospitals NHS Trust	**1**	**176**	26	186	8	157
NHS Business Services Authority	**0**	**86**	0	204	0	0
Medway NHS Foundation Trust	**0**	**85**	0	167	0	129
Dartford And Gravesham NHS Trust	**2**	**31**	0	51	0	77
South East Coast Ambulance Service NHS Trust	**0**	**43**	0	44	0	130
Brighton And Sussex University Hospitals NHS Trust	**160**	**101**	11	55	8	44
NHS Litigation Authority	**0**	**0**	0	35	0	8

26.0 INTRA-GOVERNMENT AND OTHER BALANCES

At 31 March 2010	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 other central government bodies	1,893	48	2,101
Balances with NHS trusts and foundation trusts	297	0	976
Balances with bodies external to government	1,149	0	2,316
	3,339	**48**	**5,393**

At 31 March 2009	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 other central government bodies	2,360	62	2,185
Balances with NHS trusts and foundation trusts	130	0	1,583
Balances with bodies external to government	1,860	0	2,035
	4,350	**62**	**5,803**

At 1 April 2008	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 other central government bodies	2,144	68	1,348
Balances with NHS trusts and foundation trusts	583	0	1,319
Balances with bodies external to government	906	0	2,281
	3,633	**68**	**4,948**

27.0 LOSSES AND SPECIAL PAYMENTS

There were 38 cases of losses and special payments totalling £13,000 approved during 2009/10.

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

Losses and special payments are calculated on an accruals basis.

28.0 TRANSITION TO IFRS

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000
Taxpayers' equity at 31 March 2008 under UK GAAP:	**12,212**	**4,845**	**15,957**	**2,185**
Adjustments for IFRS changes:				
Holiday pay accrual	0	(126)	0	0
Elimination of negative balances in revaluation reserve	0	(1,493)	1,493	0
Taxpayers' equity at 1 April 2008 under IFRS:	**12,212**	**3,226**	**17,450**	**2,185**
Taxpayers' equity at 31 March 2009 under UK GAAP:	**12,212**	**6,074**	**14,415**	**2,692**
Adjustments to UK GAAP balances (see note below)	0	83	(83)	0
Taxpayers' equity under UK GAAP, restated	**12,212**	**6,157**	**14,332**	**2,692**
Adjustments for IFRS changes:				
Holiday pay accrual	0	(133)	0	0
Elimination of negative balances in revaluation reserve	0	(1,437)	1,437	0
Taxpayers' equity at 1 April 2009 under IFRS:	**12,212**	**4,587**	**15,769**	**2,692**

Note: Relates to the revaluation of a building and balances relating to disposed assets.

	£000
Surplus for 2008/09 under UK GAAP	**857**
Adjustments for:	
Impairment of property (adjustment to UK GAAP accounts)	**(42)**
Holiday pay	**(7)**
Surplus for 2008/09 under IFRS	**808**

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £(2,400,000).

This net movement is included in the bottom line cash and cash equivalents figure in the 2008/09 statement of cash flows under IFRS.

ANNEX A

GLOSSARY

Axillary and inguinal region block lymph node dissection	An operation to remove all the lymph nodes from the armpit or groin, which is the first area affected when a melanoma skin cancer starts to spread from the arm or leg.
Basal cell carcinoma	The most common form of skin cancer.
Brachial plexus anaesthesia	Local anaesthetics injected around the nerves supplying the forearm, either in the armpit or the neck. Frequently used in hand surgery to avoid the necessity of a general anaesthetic.
Comminuted digital fractures	A broken finger where the bone has fractured into several pieces.
Corneoplastics	A group of treatments and procedures to modify the cornea – the front part of the eye.
Curettage	A process for removing tissue.
Fat necrosis	A build up of dead fat tissue.
Free flap or free tissue transfer	The process of moving tissue from one part of the body to the other, requiring microvascular surgery to reconnect its blood supply.
Haematoma	A collection of blood (usually a blood clot) in body tissue, caused by bleeding from a damaged blood vessel.
Histology	Microscopic analysis of cells, used to diagnose cancer and other conditions.
Immuno-modulators	Natural or synthetic substances that help regulate or control the immune system.
Keratoplasty	A transplant to replace damaged tissue on the eye's clear surface.
Keratorefractive surgery	A procedure to change the shape of the cornea at the front of the eye to improve vision.
Lacrimal disorders	Eye problems related to the gland that produces tears.
Lamellar grafts	A type of corneal transplant using tissue from a donor eye.
Maxillofacial	Diseases affecting the mouth, jaws, face and neck.
Melanoma	A form of skin cancer.
Metastatic cancer	A cancer that spreads from its initial site to other areas of the body.
Microvascular surgery	Microscopic surgery on the smaller blood vessels in the body.
Mohs micrographic excision	Microscopically controlled surgery used to remove skin cancer

Oculoplastic	A wide variety of surgical procedures that deal with the eye socket, eyelids, tear ducts, and the face.
Oncology	The diagnosis and treatment of cancer.
Ophthalmic	The branch of medicine which deals with the anatomy, functions, and diseases of the eye.
Orthognathic surgery	Surgery to correct conditions of the jaw and face or to correct orthodontic problems that cannot be easily treated with braces.
Perioperative	Relates to the whole period of a patient's surgery, from ward admission, through anesthesia and surgery, to recovery.
Periorbita	The tissue surrounding the eye-socket.
Phacoemulsification	A surgical procedure to remove cataracts.
Pre-tibial lacerations	Damage or cuts to the front of the lower leg, which often fail to heal spontaneously.
Schwann cells	Cells that produce a protective substance surrounding nerve fibres.
Seroma formation	A common complication after breast surgery, in which a pocket of liquid forms.
Squamous cell carcinoma	A form of cancer.
Thromboembolism	A blood clot, which breaks off from where it forms, travels in the blood and lodges somewhere else in the body, for example, a deep vein thrombosis, causing a pulmonary embolism.
Thromboprophylaxis	The prevention of blood clots from forming, growing or spreading.
Tracheostomy	A procedure to create an opening in the neck leading directly to the wind pipe to bypass an obstruction, clean the airway or more easily deliver oxygen to the lungs.
Trapeziectomy	Removal of a small bone from the thumb joint to relieve the pain of arthritis.
Venous coupler	A device for re-connecting the blood supply to tissue moved through free flap transfer.
Wound dehiscence	A wound which unintentionally opens up after surgical closure.

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