Queen Victoria Hospital NHS
NHS Foundation Trust

# ANNUAL REPORT AND ACCOUNTS 2008/09

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# ANNUAL REPORT AND ACCOUNTS 2008/09

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

# WELCOME FROM THE CHAIRMAN AND CHIEF EXECUTIVE

PETER GRIFFITHS CHAIRMAN

ADRIAN BULL CHIEF EXECUTIVE

In 2008/2009 Queen Victoria Hospital NHS Foundation Trust (QVH) has had another successful year providing excellent healthcare for our patients. For the second year running, the Healthcare Commission rated us 'Excellent' for the quality of services and 'Excellent' for our use of resources.

Throughout the past year, QVH has continued to develop and extend its specialist services across the South of England, and to develop the well established local services for the East Grinstead area.

- Our telemedicine system, enabling our specialists to provide remote support to A&E departments across the counties, has improved the treatment of many patients with hand trauma, burns, and other conditions.
- We have established a new base for our reconstructive surgeons in East Kent.
- Our expert multidisciplinary facial palsy service under Mr Charles Nduka is now firmly established and attracting patients from across the country.
- We have developed our support to orthopaedic surgeons across the counties in treating people with serious trauma to their lower limbs who need reconstructive surgery to muscle and skin, preventing extended hospital stays and, in many cases, amputation.
- We have affirmed our position as a leading provider of corneas, and continue to offer our own corneal transplant service.
- We are also now firmly established as the surgical centre for skin cancer across our catchment area, working closely with the relevant cancer networks. Our major contribution to head and neck cancer services also continues.
- We have continued to develop our psychotherapeutic service, recognising the importance of the psychological trauma that accompanies many of the conditions we treat.
- As part of our continued commitment to providing local community services, our diagnostic and radiology services have continued to respond to the needs of local people, for example by providing X-Rays on Saturday mornings, and increasing the range of equipment and tests.

We have also continued to strive to meet all the NHS standards and targets set by the Government, including those that really matter to patients, such as quality of care and safety, and we have continued to invest in our estate, ensuring the patient environment is as good as it can be. Major projects have included refurbishing operating theatres and installing a new maxillofacial unit, totalling an investment of £5.3 million. Extensive site surveys and planning reviews have been undertaken in preparation for the redevelopment of the site overall.

We would like to thank those who responded to the invitation we made to the public to comment on our future plans. Your views and those of our patients, staff, Governors, members and other stakeholders have informed the development of our plans for the coming year.

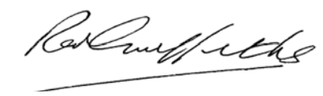
Our record in the control of hospital infection remains exemplary, with the numbers of MRSA and Clostridium Difficile below our challenging target limits.

The number of patients we diagnose and treat continues to rise, with October 2008 the busiest month ever in the hospital.

We were delighted to host several high profile visits during the year, including the Secretary of State for Health, Alan Johnson, the Under Secretary of State for Health, Lord Darzi, and Chief Executive of the NHS in England David Nicholson.

Our future plans are to grow and develop our specialist reconstructive surgery and associated therapy services. We will finalise our planning and commence a long term programme of site redevelopment in East Grinstead. We will continue to seek opportunities to take our services closer to local populations, working in partnership with other hospitals across the South East, and we will continue to provide excellent medical and rehabilitation services to our local communities.

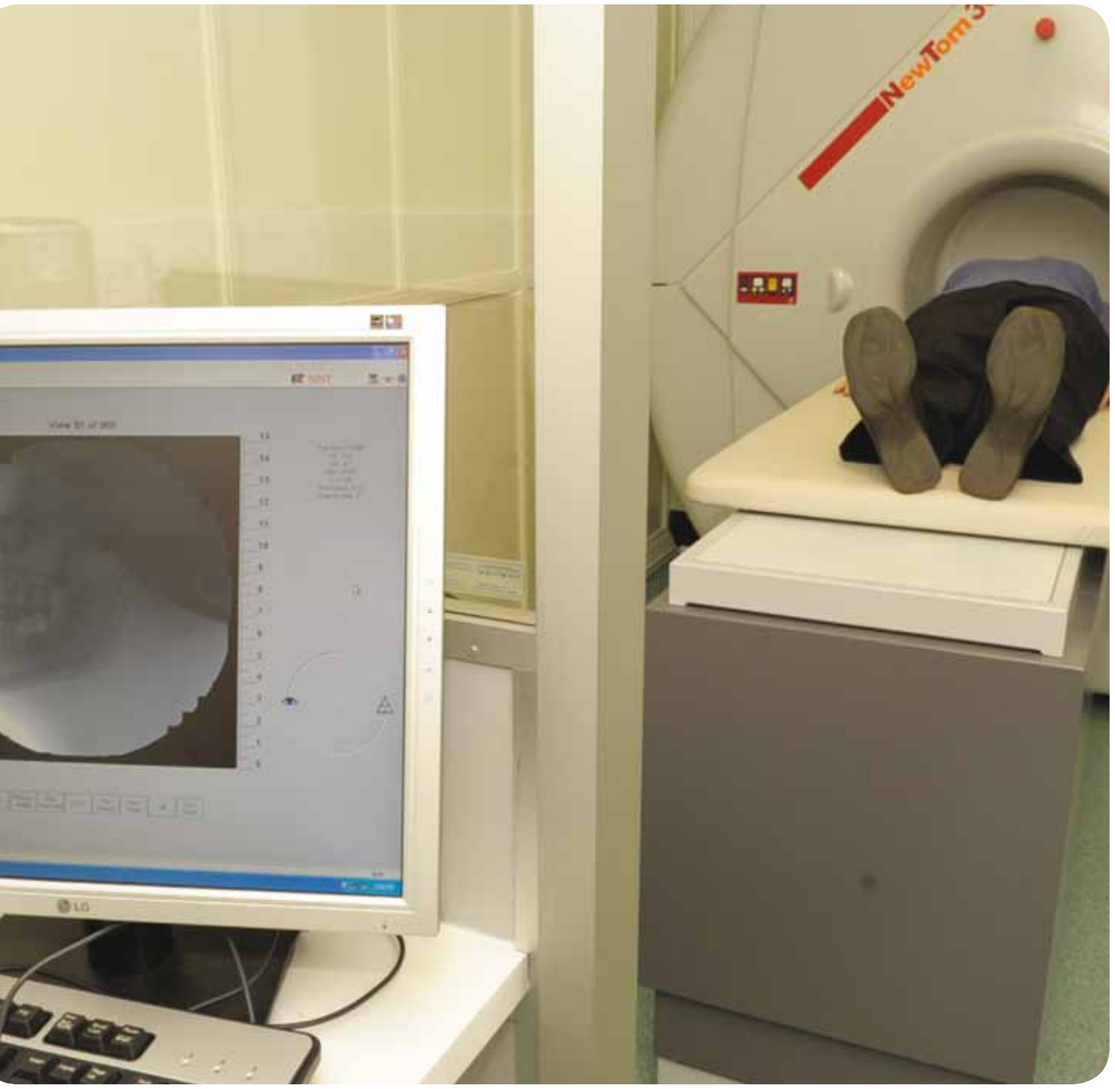
Queen Victoria Hospital continues to grow and develop. We appreciate your support and hope you will enjoy reading about the hospital's performance in this past year.



**Peter Griffiths**
**Chairman**

**Adrian Bull**
**Chief Executive**

# 1. WHO WE ARE AND WHAT WE DO




Queen Victoria Hospital became a foundation trust 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, together with 842 staff members.

Our members help us develop our services by their comments and observations. They are key to our foundation trust status, representing the local communities we serve, to whom we are accountable.

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.

As a foundation trust, we prepare a business plan for the coming year which sets out what we want to do, and how we plan to do it. This is called the Annual Plan and it is submitted to Monitor, our regulator. The Board of Directors approve the Plan and reviews the Trust's performance at each meeting. This Annual Report sets out our progress against our 2008/09 Plan.

## OUR OBJECTIVES FOR 2008/09

1. Provide outstanding clinical services and care for our patients.
2. Take our hospital services to patients closer to home, where appropriate.
3. Make the hospital environment the best we can for our patients and staff.
4. Involve and listen to our patients, staff, members, and the general public.
5. Tell everyone what we do and how well we do it.
6. Ensure that we have the right level of resources to achieve our objectives.

Revised objectives have been agreed for 2009/10

## OUR VISION

Through a fully resourced and expert team of leading clinical specialists, we will be a centre of excellence for our specialist reconstructive and rehabilitation services, which we will offer through a network of facilities across the South of England, centred on East Grinstead. We will continue to provide and extend direct access to the medical and diagnostic services we offer to our local population.

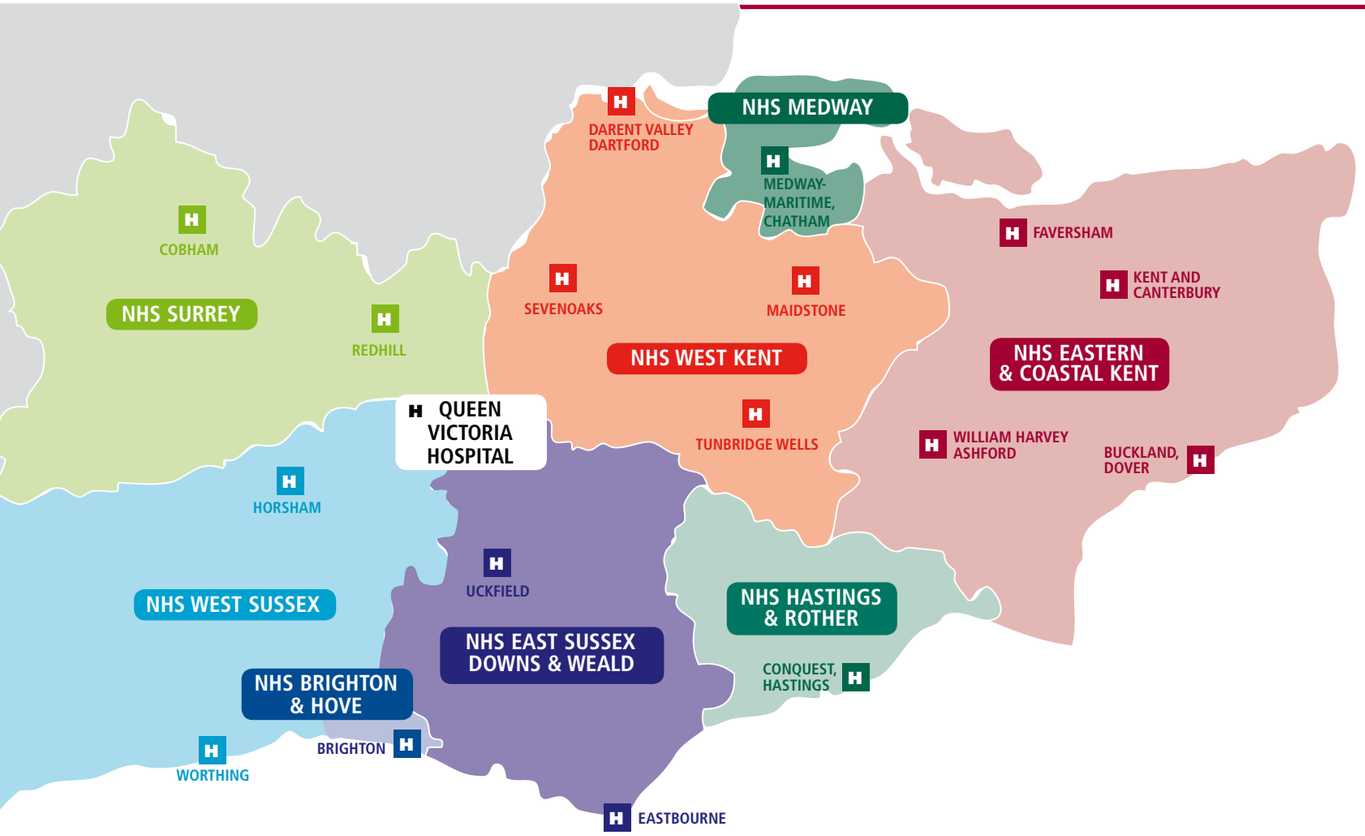
## OUR PURPOSE IS TO

provide specialist reconstructive surgery and expert rehabilitation services for the South of England, together with first class community medical services for our local population.

# PROVIDING CARE CLOSER TO YOUR HOME

## Our network of services in the South of England





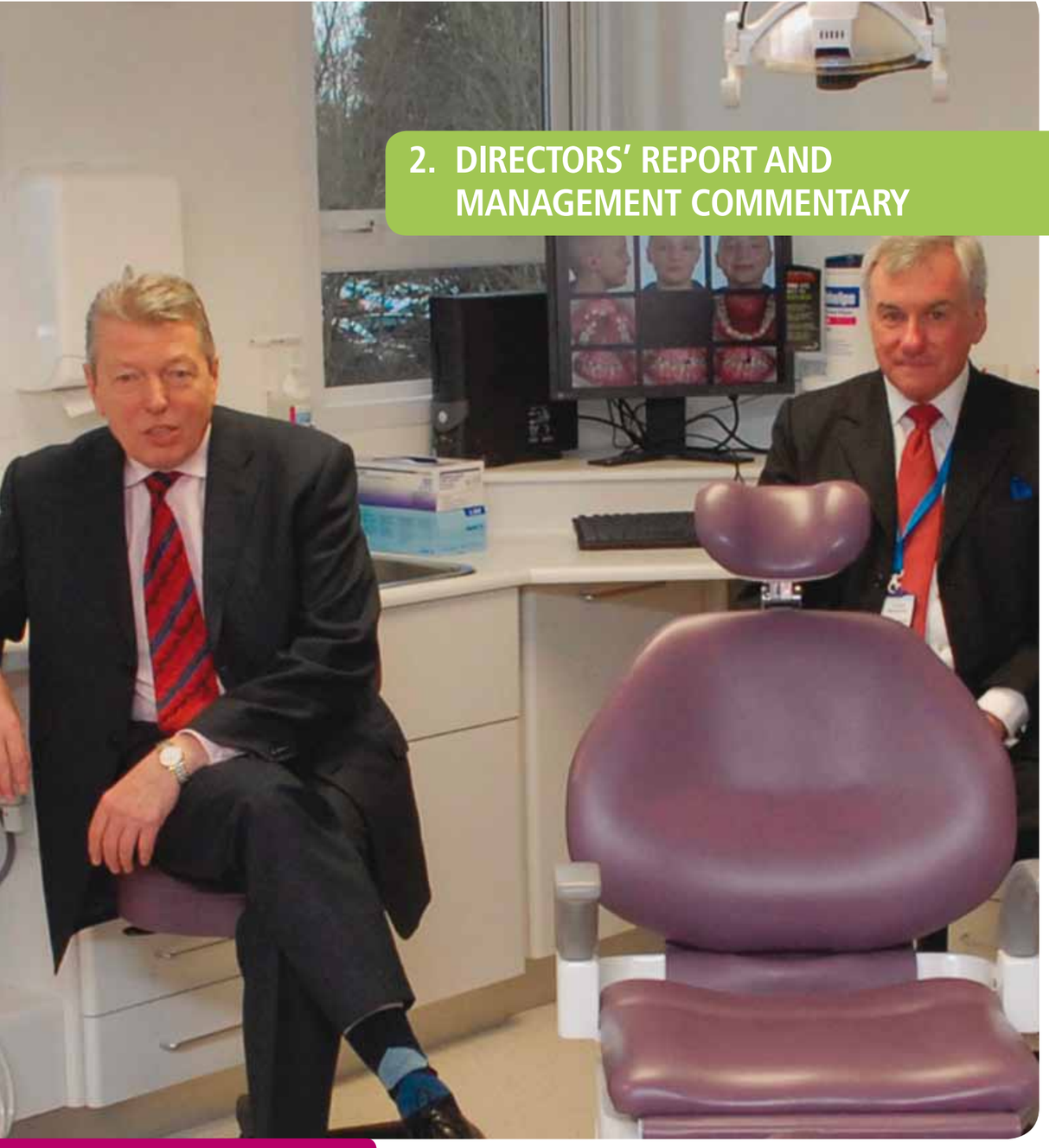

This map shows Queen Victoria Hospital in East Grinstead and also our network of services across the South East of England.

| KEY | |
|---|---|
| ✔ | Full Service |
| OP | Out Patients |
| DC | Day Cases |
| MO | Minor Operations |

| PCTS | |
|---|---|
| **NHS EASTERN & COASTAL KENT** | **NHS HASTINGS & ROTHER** |
| Kent & Canterbury | Conquest, Hastings |
| Buckland, Dover | **NHS SURREY** |
| William Harvey, Ashford | Cobham, North Surrey |
| Faversham | East Surrey, Redhill |
| **NHS WEST SUSSEX** | **NHS EAST SUSSEX DOWNS & WEALD** |
| Horsham | Eastbourne |
| Worthing | Uckfield |
| **NHS MEDWAY** | **NHS WEST KENT** |
| Medway Maritime, Chatham | Kent & Sussex, Tunbridge Wells |
| **NHS BRIGHTON AND HOVE** | Sevenoaks |
| Brighton | Maidstone |
| | Darent Valley, Dartford |

| Services | Queen Victoria Hospital, East Grinstead | Brighton | Buckland, Dover | Conquest, Hastings | Darent Valley Dartford | Eastbourne | East Surrey, Redhill | Faversham | Horsham | Kent & Canterbury Canterbury | Kent & Sussex Tunbridge Wells | Maidstone | Medway Maritime Chatham | North Surrey, Cobham | Sevenoaks | Uckfield | William Harvey Ashford | Worthing |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Audiology | OP | | | | | | | | | | | | | | | | | |
| Burns | ✔ | | | | | | | | | | | | | | | | | |
| Cardiology | OP | | | | | | | | | | | | | | | | | |
| Care of the Elderly | ✔ | | | | | | | | | | | | | | | | | |
| Cataract | ✔ | | | | | | | | | | | | | | | | | |
| Chest Phyisician | OP | | | | | | | | | | | | | | | | | |
| Colorectal Surgery | OP | | | | | | | | | | | | | | | | | |
| Corneo-plastics | ✔ | | | | | | | | | | | | | | | | | |
| Dermatology | OP/MO | | | | | | OP/ MO | | OP/ MO | | | | | | | | | |
| Dietetics | 0P | | | | | | | | | | | | | | | | | |
| Direct Access | ✔ | | | | | | | | | | | | | | | | | |
| Ears, Nose & Throat | OP/DC | | | | | | | | | | | | | | | | | |
| General Surgery | OP/DC | | | | | | | | | | | | | | | | | |
| Gynaecology | OP/DC | | | | | | | | | | | | | | | | | |
| **Maxillofacial (jaws and face)** | ✔ | | | | OP DC MO | | OP MO | | OP MO | | OP | OP | OP DC MO | | | OP/ DC | | |
| - Head & Neck Oncology | ✔ | | | | ✔ | | | | | | | ✔ | ✔ | | | ✔ | | |
| - Lumps Clinic | ✔ | | | | | | | | | | | ✔ | ✔ | | | | | |
| - Dental Alveoli | ✔ | | | | ✔ | | ✔ | | ✔ | | ✔ | ✔ | ✔ | | | ✔ | | |
| - Orthognathic | ✔ | | | | ✔ | | | | | | ✔ | ✔ | ✔ | | | ✔ | | |
| Neurology (Sleep) | OP | | | | | | | | | | | | | | | | | |
| Medical | OP | | | | | | | | | | | | | | | | | |
| Minor Injuries | ✔ | | | | | | | | | | | | | | | | | |
| Occupational Therapy | OP | | | | | | | | | | | | | | | | | |
| Orthodontics | ✔ | | | | | | | | | | OP | | | | | | | |
| Paediatrics | OP | | | | | | | | | | | | | | | | | |
| Physiotherapy | OP | | | | | | | | | | | | | | | | | |
| **Plastic Surgery** | | | | | | | | | | | | | | | | | | |
| - Hand surgery | ✔ | OP/ DC | | ✔ | OP/DC | | | OP | ✔ | | | | OP/DC | | | | | |
| - Breast reconstructive surgery | ✔ | ✔ | ✔ | ✔ | ✔ | | | | | ✔ | | ✔ | OP | | ✔ | | ✔ | |
| - Skin cancer | ✔ | OP/ DC | ✔ | ✔ | ✔ | ✔ | ✔ | | | ✔ | | ✔ | ✔ | | ✔ | | ✔ | ✔ |
| - General plastic surgery | ✔ | OP/ DC | OP/ MO | OP/ MO | OP/ MO | OP | | | | OP/MO DC | | OP/ MO | OP/ MO | OP/DC | OP/ MO | | OP | |
| Psychotherapy | OP | | | | | | | | | | | | | | | | | |
| Rheumatology (Arthritis) | OP | | | | | | | | | | | | | | | | | |
| Sleep Studies | ✔ | | | | | | | | | | | | | | | | | |
| Speech & Language Therapy | OP | | | | | | | | | | | | | | | | | |
| Trauma & Orthopaedics (Bones, joints & muscles) | OP/DC | | | | | | | | | | | | | | | | | |
| Urology (Urinary tract disease) | OP | | | | | | | | | | | | | | | | | |
| Vascular | OP/DC | | | | | | | | | | | | | | | | | |

# 2. DIRECTORS' REPORT AND MANAGEMENT COMMENTARY



HEALTH SECRETARY OF STATE ALAN JOHNSON WITH QVH MEDICAL DIRECTOR KEN LAVERY IN OUR NEW MAXILLOFACIAL & ORTHODONTIC UNIT.

The Directors are pleased to present their report, together with the management commentary about the work and performance of the hospital over the past year.

## CHIEF EXECUTIVE AND MANAGEMENT AND GOVERNANCE ARRANGEMENTS

In December 2008, the Trust welcomed Dr Adrian Bull as Chief Executive. Dr Bull has led a management restructure, aligning the structure with the patients' pathway and putting the patient firmly at the centre of the Trust's services. This work was undertaken following a review of the clinical leadership in the Trust, the introduction of the Clinical Cabinet and a revision in the organisation's structure to reflect the emphasis on clinical leadership and organisational direction. Also reviewed were the performance management within the Trust, the top level management and governance reporting structures.

## CLINICAL QUALITY

The Board agenda ensures there is a strong focus on clinical quality and that all areas, especially Director of Infection Prevention and Control reports, are regularly received, along with a range of routine indicators designed to track performance and assure the board that the organisation's exceptionally high standards are maintained and improved.

The Board has delegated authority to the Quality & Risk Committee to scrutinise further the quality of services the Trust provided. This is supported by the Clinical Outcomes Group, led and chaired by Dr Ed Pickles, Consultant Anaesthetist and Director of Audit and Outcomes. This Group pays particular attention to locally developed outcome measures, including those involving patients, who are often best placed to assess the success of their care and treatment. This work has enriched the Trust's first Quality Accounts which are included later in this report.

## EFFECTIVE RISK AND PERFORMANCE MANAGEMENT

The organisation is committed to managing and mitigating risk whilst safeguarding patient safety and improving service quality. The Executive Lead for Risk Management is the Director of Nursing & Quality, who is supported by an experienced Risk Management Team. The Director of Nursing & Quality provides a regular risk exception report to the Board, highlighting significant risks to the organisation alongside a range of key performance indicators. Detailed analysis of risk is undertaken by the Quality and Risk Committee, which meets bi-monthly under the Chairmanship of Mr Jeremy Beech, one of the Trust's Non-Executive Directors.

## TOP ACUTE TRUST AND TOP EMPLOYER FOR NURSES

In March 2009 we were pleased to learn we had been voted Top Acute Trust in the Healthcare100 awards for staff employment, Top Employer for Nurses, and second placed employer in all categories.

## SECRETARY OF STATE, HEALTH MINISTER AND NHS CHIEF EXECUTIVE VISITS

In March 2009, we were delighted to host Alan Johnson, Secretary of State for Health who visited our newly opened Maxillofacial & Orthodontics Unit and the Burns Centre. In September 2008, Lord Darzi, Under Secretary of State for Health, and David Nicholson, NHS Chief Executive, visited the hospital as part of a regional visit looking at innovation in the NHS. They were particularly interested in the Trust's telemedicine system.

## LOCAL CONTEXT

The Trust has also taken account of changes in the local health economy led by the Strategic Health Authority which consulted on, and published Healthier People Excellent Care during 2008/09 outlining the vision for health services in the south east of England. Also drawing on this strategic document, and the principles within the national High Quality Care for All, Next Stage Review, the SHA has produced its Operating Framework within which QVH will work.

The Trust has highlighted where it could help shape services in West Sussex as part of the North East Review and where potential services strongly align with QVH's purpose and vision. In addition the Trust will also continue to explore opportunities arising from changes in national and local policy if they align to the Trust's overall strategic direction.

## GROWING A REPRESENTATIVE MEMBERSHIP

Since the approval of the Membership and Engagement Strategy in January 2008, considerable work has been done to grow a representative membership with increasing involvement by the Governors themselves. This has proved very successful and real growth in the membership is now evident. This work has been led by the membership taskforce, made up of Governors, but chaired by the Membership and Engagement Manager. Some of the actions introduced this year, focusing on a broad range of potential members were:

- Displays and roadshows in supermarkets, manned by Governors.
- Displays with Governors at libraries.
- Attendance at school career conventions.
- Invitations to members to attend local Board of Governors meetings.
- Targeting patients on discharge through exit surveys.
- Membership area on website.
- Governors accompanying senior managers on public engagement roadshows.
- Attendance at parish council meetings, local societies etc.

The public engagement exercise held during the summer 2008, **'Building our future… your hospital',** gave the Trust the opportunity to try new mechanisms in reaching the public and members (and potential members), including social media, a much better website, and roadshow meetings, attendance at which proved inconsistent depending on the part of the region held. The experience was invaluable, informing the Trust what worked and what did not.

**More information about our Governors and members can be found later in the report.**

# QUALITY OF CARE

This section outlines the Trust's achievements in providing quality care. More detailed quality information is covered in the Trust's first 'Quality Accounts', which are reproduced in full in chapter 7 page 54

## HIGHEST RESULTS IN PATIENT SURVEY

We are pleased to report that, once again, the Trust has received excellent results following the 2008 national in-patient survey published by the Care Quality Commission.

In 56 out of the 61 questions that measure the quality of patient experience, QVH scored 'better' than other trusts. In 16 of these questions, QVH received the absolute highest score of all 165 hospitals. This includes the key question about how good the overall care was that they received.

In the remaining 5 of the 61 questions, the trust's results were 'about the same' compared to other trusts. These are as follows:

- While you were in the Emergency Department, how much information about your condition or treatment was given to you?
- When you were referred to see a specialist, were you offered a choice of hospital for your first hospital?
- Were you offered a choice of food?
- Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?
- During your hospital stay, were you ever asked to give your views on the quality of your care?

In none of the questions were QVH's results 'worse' than other trusts.

Full results, in a very public-friendly format, are available at www.cqc.org.uk.

Whilst we are pleased with the overall results, there is always room for improvement. We will implement a series of actions to continually improve our services. The action plan will address those areas where further improvement can be achieved. It will also reflect the verbatim comments which provide for the Trust rich learning about the real experience of patients in our care.

In December 2008 the Trust successfully attained Level 1 of the new NHS Litigation Authority Risk Management Standards. The Trust is now working towards achieving Level 2, with a view to being assessed in 2010.

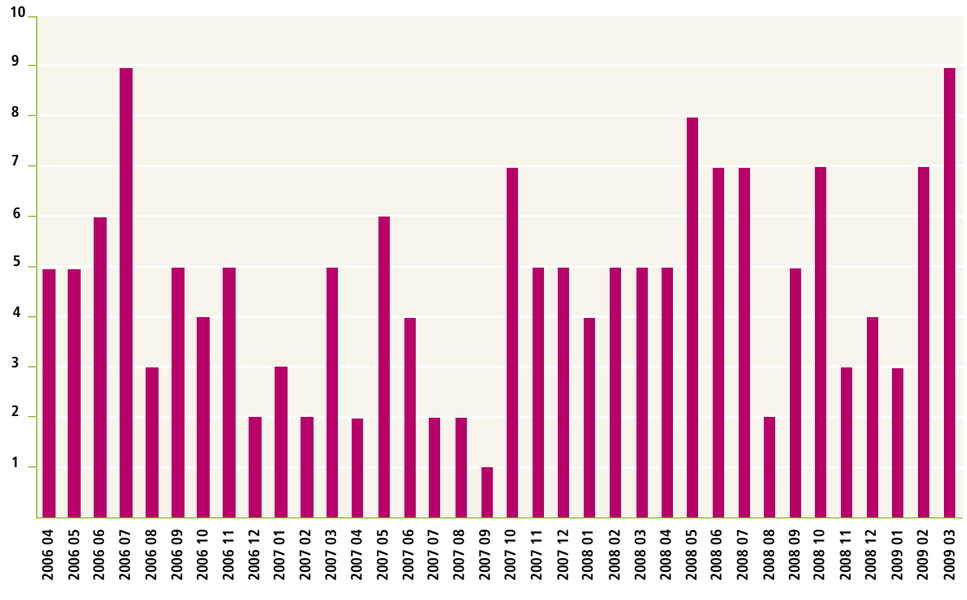
## HEALTH CARE ACQUIRED INFECTIONS (HCAIS)

QVH has an excellent reputation for infection control. During 2008/09 the Trust reported 2 cases of MRSA and 4 cases of Clostridium Difficile.

With the formation of the Care Quality Commission in April 2009 and its additional powers of enforcement, comes the crucial need during the next year to introduce systems and processes for more rigorous internal assessment and regulation to ensure compliance with the Health and Social Care Act 2008. The importance of consistently addressing the risks of patients acquiring health care associated infections has to be at the top of the agenda for all health care workers, working towards no cases of HCAIs.

During November 2008, the Healthcare Commission made an unannounced visit to the Trust to assess the organisation's compliance with the Hygiene Code (The Health Act, which will be superseded by the Health and Social Care Act 2008). The subsequent report highlighted two sub duty breaches which have been taken very seriously within the Trust. As a result of the report all actions identified including untidiness and failure to have comprehensive cleaning schedules as well as the correct policies, have already been implemented. The Trust has now set up the Environmental Risk and Hygiene Code Compliance Group to ensure future compliance and monitoring of all environmental and infection control requirements.

COMPLAINTS (MONTH AND YEAR)




## COMPLIMENTS AND COMPLAINTS

The Trust received 67 formal complaints during 2008/09, which was an increase of twenty more than the previous year. 94% of complaints were responded to within 25 working days as required by NHS guidelines.

To put this in context, below are figures showing complaints against our increasing levels of activity.

| COMPLAINTS PER 1000 SPELLS* | |
|---|---|
| 2006/07 | 3.4 |
| 2007/08 | 2.7 |
| 2008/09 | 3.6 |

* A spell is an inpatient admission or day case surgery

Although a very low number of complaints, the Trust is still concerned about the upward trend. Improvements made in response to formal complaints include information leaflets for the staff which have been produced by the Plastic Surgery Department and shared with the Dressings Clinic, advising about types of dressings and how they should be appropriately applied and removed. New changes are being implemented to improve communications between the wards and catering, when patients require meals that are not available on the menu. We also try to stagger admission times and to ensure that elderly patients do not have to come in too early.

From 1 April 2009 there is a new approach for dealing with complaints. The Healthcare Commission ceased to exist and will no longer act as the independent reviewer of complaints that have not been resolved to the patient's satisfaction. Instead more emphasis will be placed on hospitals successfully resolving complaints at a local level, with the Health Service Ombudsman acting as the 'second stage' for independent review.

## IMPROVEMENTS IN PATIENT/ CARER INFORMATION

Patient information and communication is an area that the Trust considers vitally important.

The Patient Information Group is busy, with over 300 patient information leaflets to review and update where appropriate. This is well in hand but will continue throughout the coming year, together with additional leaflets as new services come on stream. Another area of work for the Patient Information Group is the bedside folder, now being printed, that will include a whole range of information to ensure the patient's stay is as good as it can be.

2008/09 saw significant improvements to the QVH website which will continue to be updated, particularly with information about our services enabling patients, potential patients and their GPs to make an informed choice about their treatment.

# QUALITY OF CARE

Signage around the hospital requires improvement. Whilst some progress has been made, further work is needed. A Site Signage Taskforce has been formed with patients, members, governors and staff helping us with this during the coming year.

The Trust is aware that improvements could be made to the Choose and Book system within the hospital. During the coming year, the Trust will continue to improve slot availability, particularly for general surgery (visiting consultants). In addition, the role of Choose and Book Manager has recently been filled and it is expected that the new manager will lead further improvements to the service.

## Summary of Trust performance against indicators for the annual assessment ratings 2008/09 (not yet validated by Care Quality Commission)

### EXISTING COMMITMENTS

| INDICATOR | DESCRIPTION /RATIONALE | NATIONAL TARGET | TRUST'S PERFORMANCE |
|---|---|---|---|
| Cancelled operations | % of elective cancellations by hospital, for non-clinical reasons, at short notice (on day of admission or surgery). All cancelled patients are offered binding To Come In dates within 28 days | Low Value indicates good performance | 0.79% achieved |
| Data Quality on Ethnic Group | Completeness of Trust coding for ethnicity in patient datasets. | 80% | 90.90% achieved |
| Delayed Transfers of Care | Numbers of patients occupying an acute hospital bed whose transfer of care is delayed. | Low Value indicates good performance | 0% achieved |
| Number of electives waiting longer than the standard | Numbers of patients waiting 26 weeks or more at the end of each month totalled across the year. | Low Value indicates good performance | No breaches of this target |
| Number of outpatients waiting longer than the standard | Numbers of patients waiting 13 weeks or more at the end of each month totalled across the year. | Low Value indicates good performance | No breaches of this target |
| Total Time in A&E | 98% of patients should spend no more than 4 hours in A&E from arrival to admission, transfer or discharge. | 98% | 99.5% achieved |

### NATIONAL PRIORITIES

| INDICATOR | DESCRIPTION /RATIONALE | NATIONAL TARGET | TRUST'S PERFORMANCE |
|---|---|---|---|
| 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. | Admitted patients 90% Non-admitted patients 95% | Admitted patients: 93.6% achieved; Non-admitted patients: 96.5% achieved (pending confirmation) |
| All Cancers - 31 day target | One month diagnosis (decision to treat) to treatment, including new cancer strategy. | 98% | 99.5% achieved – pending confirmation |
| All Cancers - 62 day target. | Two month Urgent GP referral to treatment, including new cancer strategy. | 95% | 99.5% achieved – pending confirmation |
| All Cancers - Two week waits | % of patients with suspected cancer seen within 2 weeks of urgent GP referral | 100% | 100% achieved – pending confirmation |
| Engagment in Clinical Audits | Principles of Best Practice in Clinical Audit - NICE 2002 | | Fully met |
| Experience of Patients | Clinical Quality Domain | Results of National Survey | Excellent results achieved |
| Experience of Patients | Health & Wellbeing Domain | Results of National Survey | Excellent results achieved |
| Experience of Patients | Patient Focus & Access Domain | Results of National Survey | Excellent results achieved |
| Experience of Patients | Safety Domain | Results of National Survey | Excellent results achieved |
| Clostridium Difficile Infection | Trust must have fewer than 5 cases in year | Low value 2008.09 Plan = 5 | 4 cases reported - achieved |
| MRSA Bacteraemia | Trust must have fewer than 4 cases in year. | Low value 2008.09 Plan = 4 | 2 cases reported - achieved |
| NHS Staff Satisfaction | | Results of National Survey | Excellent results achieved |

# OUR ENVIRONMENT

## OUR OBJECTIVE 3

Make the hospital environment the best we can for our patients and staff

It has been acknowledged that the infrastructure of the Trust is becoming increasingly unfit for purpose, with 90% of the estate in poor condition. In April 2008 the Trust embarked on the development of an Outline Business Case for the development of a new hospital. This followed an extensive review of our services which was agreed by the Board of Directors in January 2008.

Our overall approach will be to retain the best areas for patient care, investing in a refurbishment and maintenance programme, but also to phase rebuilding areas of the hospital which are no longer fit to deliver 21st Century healthcare, even with refurbishment.

A number of key milestones have been achieved, building on our strategic direction as follows:

- Affordability, utilising our foundation trust status to retain surplus and borrow.
- Completion of clinical vision and models of care.
- Completion of activity and capacity model.
- Completion of workforce strategy.
- Completion of 1:500 drawings.
- Establishment of backlog maintenance costs.
- Establishment of refurbishment costs.

The other very key milestone was our first public engagement exercise – Building our Future…Your Hospital on the site and service development which prompted nearly 500 responses. We had many comments that will be fed back into the Outline Business Case for consideration by the Board in May 2009.

In summary we had overwhelming support for our proposals for site and service developments but there were some significant qualitative comments that have been highlighted which QVH will take forward:

- Parking is a problem with 61.7% of respondents commenting
- 10.6% of respondents related answers to retaining the hospital's sense of history and homely feel
- 7.3% of respondents cited green issues as a key area for consideration
- 8.5% cited public transport as being of importance

**Quantitative Analysis**
**The overall public findings show**

| | |
|---|---|
| 54.4% | Strongly supported |
| 33.9% | Support |
| 1.2% | Opposed |

Looking ahead to the new financial year and aligned to the programme objectives below we will develop our preferred options to a level of detail to support production of the Outline Business Case for agreement by the Board.

i) To provide a best in class hospital environment that enables safe, effective and efficient clinical care and a comfortable patient experience.

ii) To provide an estate strategy and site master plan that gives an affordable, flexible solution to support the delivery of excellent healthcare on the QVH site.

This will incorporate:

- Flexible design, allowing future restructuring and redevelopment.
- Improved efficiencies by enabling flexible use of theatres and patient accommodation.
- Improved efficiency & effectiveness in patient pathways.
- Improved efficiencies by facilitating key interface arrangements for patients.
- Maintained clinical operation of the site during development.
- Each phase will be self-contained thus realising maximum clinical benefit at completion of each phase.
- The development will comprise a mixture of new and refurbished accommodation.

As our plans develop we will keep the local community, members, patients and public, stakeholders and staff fully updated and we will invite feedback and comments as we progress. Keeping our staff engaged in this very significant project is absolutely paramount. There is a communications plan for the site development project which will be fully implemented during the coming year.

# OUR ENVIRONMENT

## CAPITAL INVESTMENT

The Trust embarked on a significant capital programme for 2008/09, with a planned investment of over £5m, this funding coming from retained surplus and efficiencies accrued since becoming a foundation trust. Although the Trust is planning a major redevelopment of the East Grinstead site, the plans for the year included those areas where investment was required to increase capacity to deliver patient activity or to make improvements to ensure continuity and patient safety.

The two major capital schemes undertaken during the year were ventilation and some refurbishment works to four of the Trust's oldest theatres and the provision of a new modular maxillofacial and orthodontic unit.

The new Maxillofacial Unit has significantly improved the patient experience and will enable increased activity during the coming year. In addition, the old, vacated Maxillofacial building will enable the Prosthetics Laboratory (already one of the biggest in the country) to expand, supporting the work elsewhere in the hospital and also reducing waiting times for orthodontic appliances. The larger area will also enable more prosthetics technician training.

The capital programme also included continued investment in medical equipment and information technology, with total capital expenditure in these areas of £0.88m and £0.34m respectively. It should be noted that during the year the Trust was required to upgrade its server for its Patient Administration System (PAS). This investment will now ensure that the Trust has a robust platform to host its PAS system until the implementation of a national care records system. The upgraded technology also means that the Trust is able to host off-site activity on its own server making it more self-sufficient in terms of activity and performance reporting.

## PATIENT ENVIRONMENT ACTION TEAM (PEAT)

Since 2000 the National Patients Safety Agency (NPSA) has required all trusts to undertake an audit of the level of cleanliness and standard of patient food. It is an annual self-assessment tool undertaken by clinical, non-clinical and stakeholder representatives. The objective of the PEAT assessment is to look at the environment from a patient perspective.

The year's annual PEAT inspection included Infection Prevention and Control Team members, Matrons, a Governor representative, Facilities staff, together with an external assessor from the national PEAT team. There have been changes in this year's self-assessment within the food section plus some streamlining of other sections and it is therefore difficult to compare like for like, but overall it is clear improvements had been made over the year.

| PEAT SCORES FOR 2008/09 | |
|---|---|
| Enviroment | Excellent |
| Food | Good |
| Privacy & dignity | Good |

## OTHER ENVIRONMENTAL ISSUES

- **Maintenance** – Maintenance of our old buildings is becoming an increasing and costly problem, hence the capital investment during the year and also the planned expenditure for 2009/10.
- **New main entrance** - Following comments from patients and visitors, a new main entrance was opened during 2008/09, which is well signed and lit. The main reception desk is manned by volunteers who assist with directions and enquiries, as many as 500 enquiries each month. This development has proved a great success and eased confusion around a fragmented site.
- **Signage** – Through the year signage has improved, but it is recognised further work needs to be done.

# SOCIAL RESPONSIBILITIES

For the last two years we have reported about our wider responsibilities to the community. Here is an update.

## SUPPLIES AND PROCUREMENT

Over the year we have made progress developing an e-procurement system, reducing the volume of paper records and stationery processed by the Trust. This has freed up space within the hospital. We expect further benefits to develop in the coming year following the appointment of a new Supplies and Procurement Manager.

Also freeing up space in the hospital has been the implementation of a policy about the disposal of obsolete or out of date consumables or equipment. Not only does this ensure better housekeeping on our part, we are also able to support charities that benefit from products we no longer require.

Where we can, we purchase locally, whether it is goods or services, supporting our community.

## RECYCLING AND WASTE MANAGEMENT

Last year we introduced a compactor to the site which has not only stopped three lorry collections of rubbish each week, but is also far cheaper, as we only pay for disposal by weight and not by volume. We continue to recycle large cardboard, shredded paper, tins and toner cartridges, but we acknowledge that we need to do further work to develop our recycling and waste policies. We are compliant with the Waste Electrical and Electronic Equipment Directive (WEEED) which regulates the disposal of all electrical equipment, medical and non medical.

## SMOKE FREE

Everyone is aware that smoking in public buildings is now illegal. For the NHS, smoking is also banned from all hospital grounds. There has been some difficulty in explaining this to visitors and we still have to address this issue. Better signage will help, but we acknowledge that the message is confusing particularly for patients and visitors who may be anxious. Smoking cessation support is offered for patients and staff.

## CAR PARKING AND SECURITY

Despite many additional spaces being created over the last two years, this is still a problem and one that instigates many comments. During the year, the car park bays were marked more clearly. The policy for car parking permits for staff is also being reviewed, with staff being encouraged to walk to work where it is feasible, or to share cars. It is likely that the underlying issue of sufficient parking will not be fully addressed until the conclusion of the site redevelopment.

Car parking is now being managed by security personnel who are on site 24/7. This is a new development following a pilot during 2008/09 which worked extremely well. Whilst criminal activity or disturbances are rare on site, having a security presence on site as well as at our Sleep Disorder Centre in the London Road, East Grinstead reassures patients and staff.

## PUBLIC TRANSPORT

This is an area we would wish to develop, along with our site, following conversations last year with Metrobus. It is also an area that is of importance to our visitors and staff, evidenced by the responses to our public engagement exercise.


## SOCIAL RESPONSIBILITIES 2008/09

### Investing in staff

- Outstanding staff survey results
- Top employer for nurses in hospitals three times running
- Investors in People
- Top Acute Trust (Healthcare 100)
- Appraisals and personal development plans implemented
- Two ticks symbol for disability awareness

### Quality of care

- Outstanding patient survey results
- Quality Accounts
- Met all national and local targets
- Excellent Healthcare Commission rating for quality of care and use of resources
- First pilot in country for a burns rehabilitation service

## OUR PATIENTS AND THEIR CARE

### Green credentials

- Introduction of compactor reducing lorries
- Recycling cardboard, shredded paper, tins and toner cartridges
- Compliant with Waste Electrical and Electronic Equipment Directive
- Talks continuing with Metrobus to reduce car journeys to site

### Public and partners

- First public engagement exercise
- 11,500+ foundation trust members
- Membership & Engagement Strategy
- Governor involvement throughout hospital
- Flourishing partnership with Brighton and Sussex University Hospitals Trust
- Closer working with Blond McIndoe Research Foundation
- Working with partners to relocate museum
- Use of volunteers throughout hospital particularly at new main entrance

# RESEARCH AND DEVELOPMENT

Research and Development is of increasing importance to the Trust and is fundamental to its aim of being a national and international reference centre with leading clinicians. The governance and management infrastructure for R&D has been consolidated in 2008/09, and a new strategy developed to strengthen our core translational research work carried out in conjunction with the Blond McIndoe Research Foundation (BMRF).

During 2008 / 09 work has continued on the longstanding programme of Wound Healing and Tissue Reconstruction, in which the Trust has a long history of developing pioneering techniques. The following investigator-led projects in this programme were underway during the year:

- Pilot study of histological and clinical variables contributing to both a long-term natural history and an estimation of time from injury for normal cutaneous scars taken at routine scar revisions at four plastic surgical units in the UK
- Extent of extra-capsular fibrosis following breast implant insertion
- Pharmacokinetics of antibiotics in burns patients
- Rapid autologous sprayed keratinocytes
- Improving wound healing: assessment of parameters at the wound surface that affect healing and the survival of skin grafts and cultured cells
- 100 consecutive split skin graft donor sites: outcomes

During 08 / 09 we have also been pursuing a new avenue of research looking at the psychosocial aspects of both trauma and elective surgery. This represents a significant new direction for the Trust, and will draw on the work of many of the Trust's renowned surgical specialties. It builds on the experience gained in previous successful projects on 'Telemedicine' and 'Return to Work following Burns', which have now been presented nationally and internationally.

This year we have specifically focussed on the appearance-related concerns of women undergoing surgery for acquired and congenital breast conditions and their impact on levels of intimacy and satisfaction with surgery, women's experiences of having breast asymmetry, and the prevalence of decision regret and its association with body image, distress and information satisfaction in women who have undergone nipple reconstruction. We are also looking at the psychosocial and support needs of men undergoing surgery for gynaecomastia.

Academics from the University of the West of England – acknowledged leaders in this area - are collaborating with us on this new suite of projects. We plan to roll out similar outcomes-related projects to our other surgical specialties in due course.

The Trust also undertakes a range of research projects other than these two main programmes, together with collaborative studies with other Trusts, and some commercially-funded research. A new partnership with Brighton and Sussex Medical School has led to ten new joint projects to be carried out with undergraduates next year.

The other main event during 2008/09 has been the recommissioning of the clean room, situated within the Blond McIndoe Research Centre. This was funded by QVH, working in partnership with BMRF. Towards the end of the year QVH appointed a Principal Clinical Scientist responsible for the management of the clean room which will ensure compliance with the Human Tissue Act and enable the Eye Bank and Tissue Engineering service to expand, underpinned by high quality research.

# WORKING IN PARTNERSHIP

## Our staff

The Trust continues to put a high priority on recruiting and retaining a motivated and skilled workforce, whilst aspiring to be an employer of excellence. Following success at the Nursing Times awards over the past two years (Top Employer For Nurses in Hospital and Secondary Care in 2007 and 2008), this year the Trust scooped three awards at the revamped Health Service Journal/Nursing Times awards – Top Acute Trust, Top Employer for Nurses, and second overall healthcare employer in the country.

The Trust was also reaccredited for the Disability 'Two Ticks' rating and this year will be evaluated for the third time for the 'Investors in People' award, having held the accreditation for 6 years to date.

### STAFF SURVEY

The results for the NHS Staff Survey 2008 have now been received, showing another good set of results for the Trust. 327 staff at QVH took part in the survey which was a response rate of 56% which is above average for acute specialist trusts in England, and compares with a response rate of 59% last year.

Four areas where QVH compared most favourably with other acute specialist trusts in England were:

- **Percentage of staff that would recommend the trust as a place to work** (87% - compared to an average of 64% for acute specialist trusts)
- **Staff intention to leave jobs** (2.15 on a scale of 1-5 – compared to an average of 3.53 for acute specialist trusts)
- **Staff job satisfaction** (3.73 on a scale of 1-5 – compared to an average of 3.53 for acute specialist trusts)
- **Percentage of staff agreeing that they understand their role and where it fits in** (71% compared to an average of 52% for acute specialists trusts)

We were particularly pleased that in several areas staff experiences have improved since the last survey, including:

- **Staff job satisfaction** which has gone up from 3.63 to 3.73, on a scale of 1-5
- **Percentage of staff receiving job-relevant training, learning or development in last 12 months** which has gone up from 79% to 85%
- **Quality of job design (clear job content, feedback and staff involvement)** which has gone up on the scale (1-5) from 3.45 to 3.57
- **Staff intention to leave jobs** where it has gone down on the scale (1-5 where lower the score the better) from 2.34 to 2.15

OUR OBJECTIVE 4

Involve and listen to our patients, staff members and the general public

# WORKING IN PARTNERSHIP

There are areas that the Trust will be taking forward during 2009/10, including:

- addressing the issue of staff working extra hours (73% compared to an average of 68%, however analysis shows that this relates to paid shifts, not unpaid hours)
- percentage of staff suffering work- related injury (14% compared to the average of 13%)
- further work is required on staff appraisals where we scored 62% compared to the average of 64%
- and staff appraised with personal development plans where we scored just 54% compared to the average of 57%.

There is one area (support from immediate managers) which has deteriorated since 2007, falling from a score of 3.79 to 3.73 in 2008. The Healthcare Commission has noted that this score is still better than average, and although it is of concern to QVH that the score has worsened, the Trust will be keeping a watching brief on this and will review the 2009 scores to see if a trend is developing.

The survey is not the only tool used by the Trust to measure success. Other measures used to ensure improvement include:

- Reasons for sickness absence, particularly stress
- Employee relations cases, particularly discrimination/ethnicity
- Occupational Health referrals and data provided on reasons for referrals, highlighting any significant increases

The Board of Directors also receives regular reports and presentations on equality and diversity and other HR issues, including learning and development and the workforce generally.

## EQUALITY & DIVERSITY

The Trust has recently appointed a part time Equality and Diversity Manager who will be focussing on ensuring that the Trust is compliant with its duties and legislation, as well as implementing best practice to achieve an inclusive organisation.

We continue to pursue the Equality Impact Assessment of our Trust services and policies and will be rolling out further training to managers this year. Equality and Diversity training in the Trust is being reviewed and we are looking at specific initiatives such as improving disabled parking and providing multi-faith facilities. We will also monitor our recruitment and selection practices to ensure equality and use the information provided in the annual staff survey to track and deal with any issues that arise.

## LEARNING AND DEVELOPMENT

To support the Trust's goal of ensuring that we have a fully trained workforce with a balanced skill mix, we will continue with our robust programme of learning and development opportunities for all staff. In addition to mandatory training covering clinical, risk, health & safety and other statutory areas such as equality and diversity, we provide a comprehensive range of personal and management development learning opportunities which provide both career enhancement for staff and underpin the Life Long Learning and Skills for Life initiatives. We have a range of NVQ and ITQ (Vocational Qualification in information technology) courses and will continue with our programme of ESOL (English as a Second Language) education.

The Trust will continue to promote appraisal and personal development plans for all staff but a priority will be to drive up completion rates so that all staff have meaningful appraisals at least annually. Appraiser and appraisee training is run by the Staff Development Centre (SDC) and appraisal activity is also monitored through the SDC. A review of the appraisal system is currently underway.

We will also be focussing on leadership and succession planning across the Trust. To support our programme of leadership development such as Transformational Leadership, Finance and Employee Relations best practice sessions and Appraisal training, we will be looking at initiatives in mentorship and shadowing to bring a more focused approach to Talent Management. We will also continue to embed the Modernising Medical Careers agenda for Doctors in training which includes continuing to train as Educational Supervisors the Consultants who supervise Doctors in training. Three of the Trust's senior managers are undertaking the aspirant directors programme led by the SHA.

## ORGANISATIONAL CULTURE AND PRIORITIES

The culture and ethos of the organisation are essential to our success and determine the type and standard of care that we offer to our patients. The behaviours that would demonstrate the professional and caring culture to which we aspire include:

- Professional integrity – such as objectivity and commitment to the patient's preferences and interests.
- Professional competence through maintaining and updating relevant expertise.
- Clear communication and explanation of clinical procedures.
- Courtesy and respect in interactions with patients, visitors, and fellow staff.
- Sensitivity to patients' needs and wants.
- Observation of behaviours and policies contributing to the overall professionalism of the organisation such as clinical record keeping, dress code and hand washing.

**We have specific priorities to develop this which are:**

- Professional communication with GPs and other community clinical staff.
- Ensure full compliance with required training of all junior medical staff.
- Professional communication with patients.
- Continued professional development of all staff, including NVQ and EFL training of facilities operatives.
- Development and implementation of a systematic approach to appraisal and personal development for all staff.
- Compliance with organisational policies, in particular policies relating to hygiene such as dress codes and hand washing.
- Transparent governance through the organisation.

# WORKING IN PARTNERSHIP

## OUR OTHER PARTNERS

**Public involvement in developing services**
One of the most visible projects undertaken was Building our Future… Your Hospital which was designed to seek the views of our patients, visitors, members and staff across south east England about our plans.

Although very early in the process we wanted to do five things:

(i) Seek views about our plans for the future, effectively testing them to see if they were relevant and acceptable.

(ii) Reinforce the hospital's reputation as a model foundation trust that genuinely involves the public in its work.

(iii) Promote the hospital, what it does and what it could do.

(iv) Reinforce the QVH's reputation as a centre of excellence.

(v) Recruit new members.

The exercise lasted two months and whilst extremely supportive about all our plans, the Trust appreciated some very constructive feedback which is being incorporated into the Outline Business Case for the hospital redevelopment.

More importantly, whilst achieving our objectives, we learnt that the hospital needs to be better at explaining its specialist services in particular, but also the community services and the proposed development of diagnostics and additional clinics. This has informed the Communications Strategy currently being developed.

## CO-OPERATION WITH NHS BODIES AND LOCAL AUTHORITIES

QVH has worked increasingly closely with its commissioners during the year and as last year, in particular, West Sussex PCT. The relationship has been enhanced because of the PCT's North East Review which looked specifically at health services in and around East Grinstead, Crawley and Horsham. The Review, a consequence of the PCT's Fit for the Future consultation, raised the profile of the hospital quite significantly, both its specialist services and in particular its community and medical services in and around East Grinstead. Several opportunities have been identified and talks continue at Chief Executive level on how to take the opportunities forward.

The Trust has also been working closely with the Health Overview and Scrutiny Committee (HOSC) regarding its plans for developing its services and site. The HOSC supported fully the early public engagement programme conducted during the summer and autumn 2008, and early in the new financial year the Board will receive the Outline Business Case which it will also take to the HOSC.

The review of the Constitution has allowed the Trust to consider its Stakeholder Governors, which now reflect the new health economy (since 2004). Brighton and Sussex University Hospitals NHS Trust is being invited to send a Stakeholder Governor, which is important as the relationship between the two Trusts was formalised during 2008 by the signing of a Memorandum of Understanding, developing closer working. A joint Board meeting took place in February 2009 with very positive outcomes.

RESEARCHER WORKING IN THE BLOND MCINDOE RESEARCH FOUNDATION

## BLOND MCINDOE RESEARCH FOUNDATION

The Blond McIndoe Research Foundation, an independent registered charity, has been on the site of the Queen Victoria Hospital since the charity was founded in 1961. The close working relationship between our two organisations is very important to both parties, bringing together strong scientific and medical expertise to identify areas of research which will result in direct patient benefit.

The charity's principal objectives are to carry out high quality research into wound healing, tissue regeneration, replacement and reconstruction, in particular for the treatment of patients suffering serious burns and those who require plastic surgery.

For further details please see their website at **www.blondmcindoe.com.**

## LEAGUE OF FRIENDS

The hospital is, as always, grateful to the support of the League of Friends. During 2008/09 they have been tremendously generous by providing the following items over £1,000 as well as many lower cost items:

| | | |
|---|---|---|
| X-ray | Cone beam CT head scanner | £60,000 |
| Staff Development Centre | Rosemary Wootton Bursary | £10,000 |
| Hospital Museum | Pledge towards museum relocation | £20,000 |
| Jubilee Centre | Therapy mattresses | £9,675 |
| Medical Photography | Video editing suite | £4,626 |
| Rehabilitation Unit | Electric plinth | £1,595 |
| Sleep Disorder Centre | Actiwatches | £1,210 |
| Surgeons' Mess | Cooker | £1,015 |

These contributions significantly improve the care of patients and working conditions of staff. The cone beam CT - head scanner has enabled QVH to undertake new and pioneering work in the treatment of head and neck cancer

There is more information about the League of Friends available through the website at www.qvh.nhs.uk/about_us/league_of_friends.html.

## OTHER DONORS

We also gratefully received several other donations for of over £1,000 including:

- £2,500 from Kingscote W.I. for the Jubilee Centre.
- £2,500 from Old B's Golf Society, Guildford, for Peanut Ward.
- £1,500 from The Childrens' Fire & Burns Trust for Peanut Ward.

We also received legacies of £79,000 for Maxillofacial research and £5,000 for the Burns Unit.

Thank you too, to Tony Grubb who replaced our 'Three Little Boys' statues during the year, following their theft from the site a while ago. Mr Grubb donated them in memory of his sister.

For all who gave to the hospital, however large or small, or supported us with staff discounts or benefits during the year, including Ashdown Park Hotel, Lingfield Race Course and Martells Department Store, **thank you.**

## SUPPORT GROUPS

We have many groups inside and outside the hospital that support us, including:

## MCINDOE BURNS SUPPORT GROUP

Provides friendship and reassurance to those who have suffered burns and to their families. Some financial support is available as appropriate. Contact the Burns Centre on 01342 414440.

## CHILDREN'S FIRE AND BURNS TRUST

Support of QVH Peanut patients during 2008 included:

- CREW - Activity weekend for 28 children who have been patients on the ward.
- Theatre tickets for patients and their families to productions in London and Brighton.
- Sponsorship of 4 children to attend the annual Summer Burns Camp at Grafham Water.

Contact Alison Tweddle on 020 7233 8333 or www.childrensfireandburnstrust.org.uk

## PARKINSON'S PALS

This is a communication and support group for patients suffering from speech and voice difficulties due to Parkinson's disease. Contact Brooke Quinteros on 01342 414526.

## HEADSTART

Is a support group for patients with head and neck cancer and their carers. Contact Brooke Quinteros on 01342 414526.

We are grateful to all these groups for their work during the year and making the patient's experience a little better; this includes our volunteers who support us so ably throughout the hospital. Thank you.



# DIRECTORS DISCLOSURES

## Statement of Disclosure to Auditors

For each individual who is a director at the time that the Annual Report is approved:

- so far as the directors are aware, there is no relevant audit information of which the auditors are unaware
- the directors have taken all of the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the auditors are 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.

### COMPLIANCE WITH NHS FOUNDATION TRUST CODE OF GOVERNANCE

As a NHS foundation trust Queen Victoria Hospital is expected to comply with the NHS Foundation Trust Code of Governance as laid down by Monitor, the Regulator for Foundation Trusts.

In section 4 of this report "Our Boards", the Trust sets out how it applies the main and supporting principles of the code.

The Trust confirms that it complies with the provision of the code.

# 3. FINANCIAL PERFORMANCE

## Overview of the year

Last year's Annual Report recognised that 2008/09 would be a challenging year for the Trust as we planned for a stepped change in costs in order to deliver the increasing levels of activity and planned the refurbishment of 4 of the Trust's 10 theatres over 12 weeks during the summer months.

**OUR OBJECTIVE 6**

**ENSURE THAT WE HAVE THE RIGHT LEVEL OF RESOURCES TO ACHIEVE OUR OBJECTIVES**

The year proved to be as challenging as predicted. During the year the Trust also started to feel the impact of the ageing estate on service delivery, together with fact that the Trust is reaching near physical capacity on the East Grinstead site to meet activity plans. The impact of the economic down turn was also reflected in the significant increase in non-pay costs. Despite these challenges the Trust was still able to deliver a surplus of £1.2m (£0.9m after the impairment of fixed assets).

As a foundation trust, Queen Victoria Hospital has a number of financial freedoms that allows it to retain any surpluses that it generates and to borrow in order to support capital investment. In this respect the surplus generated in 2008/09 will be added to the Trust's reserves and be used to support the Trust's strategy to continually improve the services and infrastructure for our patients and staff.

A summary of the forecast out-turn for 2008/09 is set out in the table below, together with an analysis for each of the income and expenditure headings.

### HEADLINE FIGURES

The headline figures for 2008/09 are set out below, with comparatives for the previous year's financial performance:-

| | 2008/09 | 2007/08 |
|---|---|---|
| Turnover | £52.4m | £48.7m |
| Surplus before impairments | £1.2m | £2.3m |
| Surplus | £0.86m | £2.07m |
| EBITDA Margin | 7.23% | 9.59% |
| Income & Expenditure Margin | 1.63% | 4.27% |
| Cash balance | £3.1m | £5.5m |
| *Financial risk rating | 4 | 5 |

* The financial risk rating is determined by Monitor, the Regulator for Foundation Trusts, the ratings are on a scale of 1 to 5, with 1 indicating high financial risk and 5 low financial risk.

### INCOME AND EXPENDITURE

Details of the Trust's income and expenditure for the year are set out in the Full Accounts However, the key messages for the year, with comparatives to the previous year are set out below:-

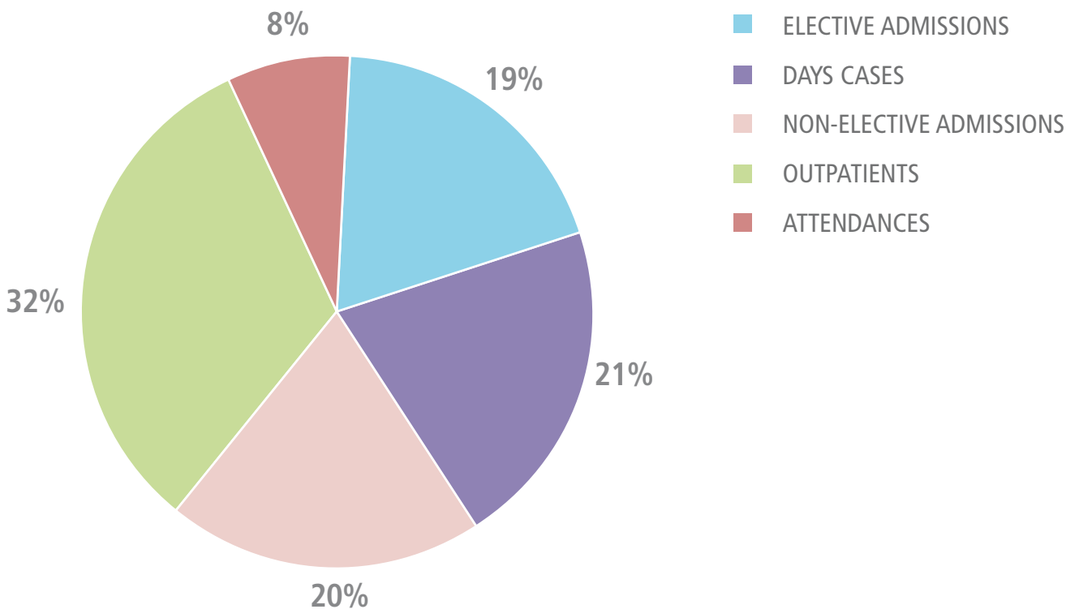
### INCOME

In line with the Trust's strategy to increase its turnover year on year, growth in income for 2008/09 was 8.0% (8.4% for 2007/08).

Clinical income grew by 9.6% during 2008/09. However, during the year the Trust saw a reverse in the shift in the move towards day cases from in-patients. This resulting change in the case mix had an impact on the Trust's financial performance for the year.

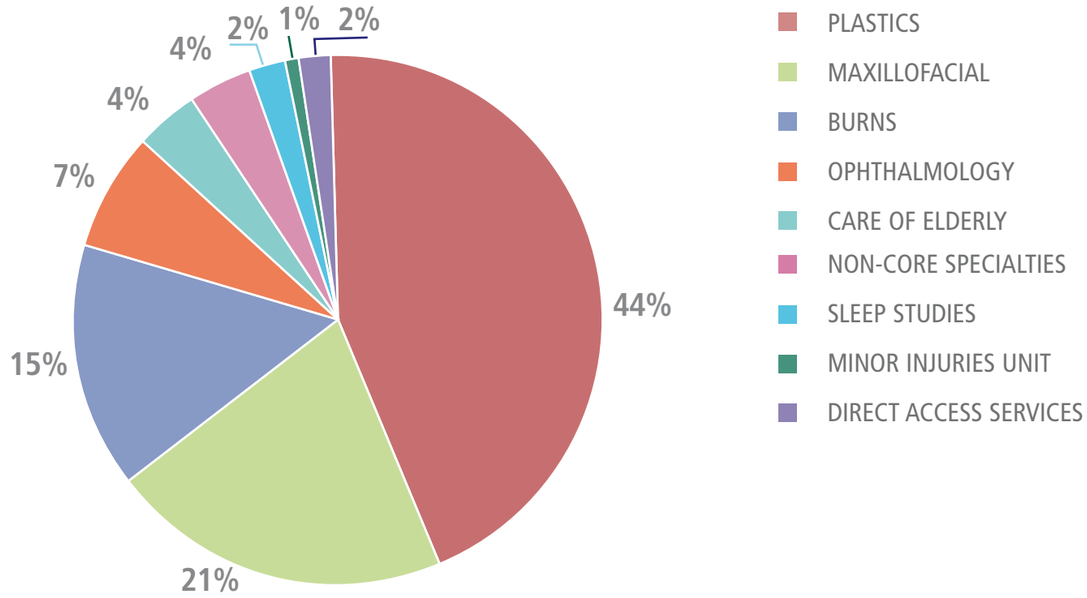
## The charts below show the Trust's clinical income analysed by type of activity and specialty.

### CLINICAL INCOME ANALYSED BY ACTIVITY TYPE




| | 2008/09 | 2007/08 |
|---|---|---|
| | % | % |
| Elective Admissions | **18.7%** | 20.5% |
| Day Cases | **21.2%** | 20.8% |
| Non-elective admissions | **20.4%** | 21.9% |
| Outpatients | **31.7%** | 29.2% |
| Attendances | **8.0%** | 7.6% |

### CLINICAL INCOME ANALYSED BY SPECIALITY




| | 2008/09 | 2007/08 |
|---|---|---|
| | % | % |
| Plastics | **43.9%** | 44.5% |
| Maxillo Facial | **20.5%** | 18.9% |
| Burns | **14.7%** | 17.1% |
| Ophthalmology | **7.4%** | 6.3% |
| Care of Elderly | **3.7%** | 3.8% |
| Non-core specialties | **4.0%** | 4.3% |
| Sleep Studies | **2.1%** | 2.1% |
| Minor Injuries Unit | **1.5%** | 1.6% |
| Direct Access services | **2.2%** | 1.4% |

It should be noted that non-core specialties are those medical and surgical specialties that the trust provides as an out-patient and day case service for its local population, for example gynaecology, urology and rheumatology.

Direct access services are services that GPs can access for therapy and diagnostics, for example physiotherapy and radiology services.

Other operating income for the year totalled £3.3m, an increase of 9.4% on the previous year.

## EXPENDITURE

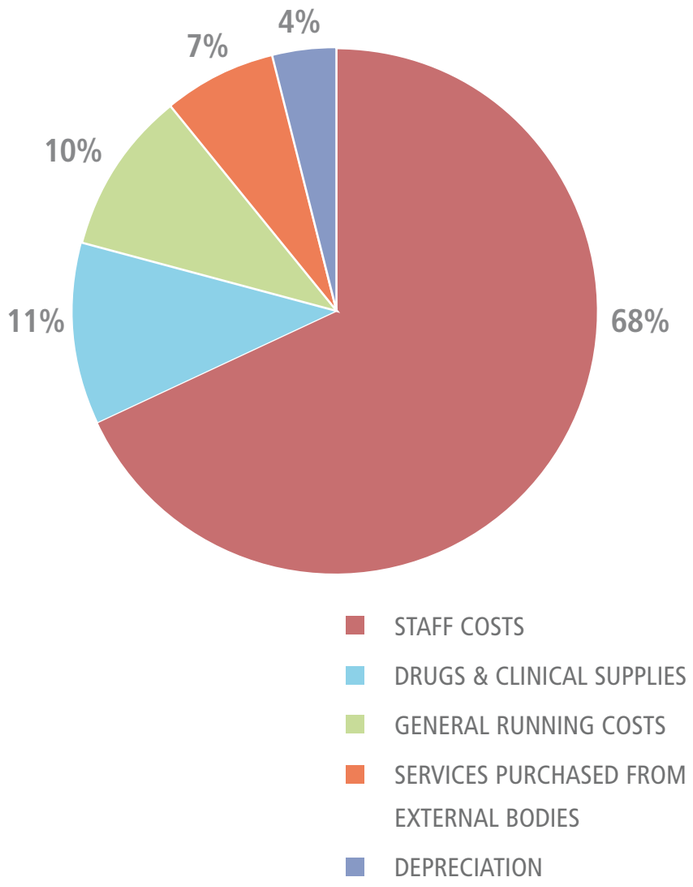
Operating expenses totalled £50.9m, an increased of 10.7% year on year, which exceeded income growth by 2.7% thereby reducing the year on year surplus.

Staff costs increased by £2.8m (9.15%). After taking into account the annual cost of living pay increase of 2.75% (£0.8m), and annual increments for Agenda for Change (£0.4m), there was a net investment in staff of £1.6m. The Trust recognised that there would be a stepped change in staffing in the year to allow for the increase in planned activity, however additional costs were incurred over and above the plan in order to deliver the additional activity.

The increase in non-pay costs was £1.7m (14.4%). The increase in non-pay mainly resulted from three areas; increase in clinical supplies, higher prices and a number of costs and initiatives over and above the plan for the year.

The table below reflects the breakdown of the Trust's cost base.

## ANALYSIS OF EXPENDITURE




| | 2008/09 | 2007/08 |
|---|---|---|
| | % | % |
| Staff Costs | **68.0%** | 69.2% |
| Drugs & Clinical Supplies | **10.7%** | 9.1% |
| General Running Costs | **10.3%** | 9.4% |
| Services purchased from External Bodies | **7.3%** | 8.7% |
| Depreciation | **3.7%** | 3.7% |

## SERVICE LINE REPORTING AND SERVICE LINE MANAGEMENT

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.

## COST IMPROVEMENT PROGRAMME

During the year the Trust delivered a cost improvement programme of £1.2m. As well as the general procurement savings made during the year, the Trust's main focus in the year included the following areas:-

- securing additional funding for non-burns ITU/HDU activity through negotiating a local price with the PCTs.
- moving towards cost per case funding for direct access referrals for diagnostics and therapies
- relocating minor surgical procedures into a treatment room setting, rather than taking up main theatre capacity
- reviewing the pre-assessment pathway in order to reduce overnight admission prior to surgery and cancellations on the day
- Continuing to focus on agency expenditure, and enhanced controls around use of administration staff from the Trust's internal bank of staff.

During the year the Trust also appointed a new procurement and supplies manager who has made good progress in re-tendering for a number of goods and services, for which the Trust will realise the savings in 2009/10. The Trust also developed its relationship with the local procurement hub to ensure that it is realising its return on investment on its annual contribution to the hub.

## PRIVATE PATIENT CAP

The Trust's private patient activity is restricted by the private patient cap, as set out in the Trust's terms of authorisation as a foundation trust, and for the Trust is 0.2%.

For a further year, in 2008/09, the level of private patient income has come close to the Trust's private patient cap, as the level of private work has increased disproportionately to the level of clinical income. The increase in private work during the year has mainly arisen the use of the mobile MRI and CT scanning facilities, which have been increased by the Trust overall to address diagnostic waiting times. As the Trust is bordering on its private patient cap it has had to be more proactive in managing its private patient activity than in previous years.

## BALANCE SHEET AND CASHFLOW

Over the year the Trust's asset base increased by £0.2m (0.6%). Working capital decreased by £2.46m over the year, with the Trust's cash position falling by £2.4 to fund the capital programme.

The Trust closed the year with a cash balance of £3.1m. This was £1.0m under the plan for the year. However the Trust made prepayments during the year totalling £0.8m in order to obtain significant discounts.

During the year the Trust continued to focus on debtor management, particularly around quarterly over-performance payments from the PCTs. For 2009/10 the Trust has agreed in their contracts that over-performance will be paid monthly. This will significantly improve the Trust's cashflow.

The Trust has also continued to maintain its strong track record of prompt payment to creditors, and has been mindful of the Government's initiative to pay creditors more promptly within 10 days whereever possible.

The Trust was not required to use any of its £3m working capital facility or prudential borrowing limit during the year.

## CAPITAL PROGRAMME

The Trust embarked a significant capital programme for 2008/09, with a planned investment of over £5m. Although, the Trust is planning a major redevelopment of the East Grinstead site the plans for the year included those areas where investment was required to increase capacity to deliver patient activity or to make improvements to ensure continuity and patient safety. The two major capital schemes undertaken during the year were the refurbishment of four of the Trust's oldest theatres and the provision of a modular new maxillofacial and orthodontic unit.

During the year the Trust also made considerable progress on its site redevelopment plans. The Trust now has a long term development plan for the site, which will commence with a new surgical centre, hosting theatres, surgical beds and a day surgery unit, followed by a period of major refurbishment of its existing buildings to bring these up to modern day standards, the overall development plan spanning a period of 10 years. The Trust will have completed the outline business case for the redevelopment by May 2009.

The capital programme also included continued investment in medical equipment and information technology, with total capital expenditure in these areas of £0.88m and £0.34m respectively.

At the year end the Trust was required to revalue its assets to a modern equivalent asset (MEA) value. This resulted in fixed asset impairments of £0.3m and a reduction in the land value of £2.3m. Apart from the impairments, the value of buildings increased overall by £0.7m.

### International Financial Reporting Standards

The Trust will be re-stating its 2008/09 accounts during the year in preparation for 2009/10 when the Trust is required to be compliant with International Financial Reporting Standards (IFRS).

### Internal Audit and Counter Fraud

During the year the Trust's internal auditor service was provided by Chantrey Vellacott, and the Trust's local counter fraud service was provided by South Coast Audit.

## LOOKING FORWARD

2008/09 has been a challenging year for the Trust with the impact of the ageing estate starting to impact on service delivery, together with fact that the Trust is reaching near physical capacity on the East Grinstead site to meet activity plans. The impact of the economic down turn has also been reflected in the significant increase in non-pay costs.

However, these challenges have prompted the Trust to undertake a substantial review of its operational systems and processes to ensure that it makes better use of its estate ahead of investing in its new development to ensure it maximises its return on assets. The Trust's awareness of the impact of the current economic climate has also been raised, and has allowed it to plan for more difficult years ahead as public sector funding is significantly reduced.

Based on the financial performance for 2008/09, the Trust's Financial Risk Rating (FRR) will drop to a 4. However, this reflects the FRR over the next few years as the Trust moves into its site redevelopment phase. It should be noted that a FRR of 4 still gives the Trust an excellent rating for "use of resources" in the Annual Healthcheck.

**Sally Flint**
**Director of Finance**



# 4. OUR BOARDS


## Board to Board

During the five years since becoming a foundation trust, we have developed several ways of ensuring that the views of Members and Governors are heard, in particular by the Board of Directors, to ensure that the relationship is as good as it can be, to drive forward improvements in delivery of care.

# BOARD TO BOARD

## OUR OBJECTIVE 4

## INVOLVE AND LISTEN TO OUR PATIENTS, STAFF MEMBERS AND THE GENERAL PUBLIC

The most significant was the appointment in 2006 of a Governor Representative who attends the Board of Directors, including informal meetings of the Board. The primary role of this appointment is communication and liaison between the Directors and Governors and assisting the Chairman of the Trust, where appropriate, in developing the Governors' governance system. It has worked very successfully, with the Governor Representative writing a Governor Update each month and reporting on the Board of Directors at each meeting of the Governors. The Governor Representative also feeds back to the Board of Directors the views of Members and Governors, and this has proved invaluable, not least in early 2009, confirming the need for the Board of Directors to review the Trust's vision and purpose.

In addition to this, all Directors attend the Board of Governors meetings in public and are aware of the standing item on the agenda of Members' views and feedback when feedback from either the Trust, Governors and Members can be discussed freely.

Also, there are joint meetings with both Boards, particularly in August when discussion takes place on strategy for the coming year that informs the Annual Plan.

Above all, the Governors are welcome to meet Directors and senior managers on any matter, and have regular meetings with both the Chairman and Chief Executive

## The Board of Governors

The Board of Governors represents and is elected by the public membership which consists of almost 11,000 members across Kent, Surrey and Sussex. The Board holds four public meetings a year, including the AGM, which are held in various parts of the catchment area. Members who live nearby are invited specifically to attend, which has been very successful in engaging a wider and more representative range of members.

The Board of Governors is represented at the Board of Directors by the Governor Representative, who plays a significant role in the communication between both Boards. The Board of Governors works through a Governors Steering Group, which supports and facilitates the work of the Board of Governors.

The Board of Governors has important powers, for instance to appoint or remove the Chairman of the Trust and other Non-Executive Directors. It can also decide how much they will be paid and other conditions of service. The Board also approves the appointment of the Chief Executive. Through this line of accountability the Board of Directors is accountable to the Board of Governors. Governors do not hold an operational role, but their views are vital.

### HOW THE BOARD OF GOVERNORS IS MADE UP

**Stakeholders (9 with 2 vacancies)**

**Ricky Banarsee**
Imperial College (removed due to lack of attendance - May 2008)

**Tom Cochrane**
Guinea Pig Club (renewed to 2010)

**Sarah Creamer**
West Sussex Primary Care Trust (Appointed 2008 to 2011)

**Roy Daisley**
University of Brighton (2007 to 2010)

**Peter Evans**
West Sussex County Council (2006 to 2009)

**Derek Pocock**
League of Friends (2006 to 2009)

**Chris Rolley** East Grinstead Town Council (renewed to 2010)

**Staff (3)**

**Maureen Adams**
term of office ended June 2008

**Mabel Cunningham**
July 2008 to June 2011

**Tony Josling**
resigned from Trust October 2008

**Carol Lehan**
July 2008 to June 2011

**Amanda Wood**
Term of office ended June 2008

**Vacant position**
November 2008 onwards

**Public (24)**

**Re-elected July 2006 to June 2009**
Bernard Atkinson, Leonard Barlow, Stuart Barnett, Caroline Hitchcock.

**July 2006 to June 2009**
Edward Belsey, Gillian Brack, Howard Matthews, Andrew Robertson, Manya Sheldon

**July 2007 to June 2010:**
Ann Horscroft, Alison Tweddle, Sharon Watkinson.

**Re-elected July 2008 to June 2011**
John Bowers, Peter Dingemans, Bill Hatton, Valerie King, Shirley Mitchell, Martin Plimmer.

**Elected 2008 to 2011**
Adrian Fuchs, Sue Hull, Gillian Baxter, Jill Walker, Ian Stewart, Peter Harper.

Public governor elections took place in 2008 with 10,723 election forms being sent and 2,577 forms being received, a 24% turnout.

# BOARD OF GOVERNORS

Staff elections were uncontested.

Five meetings of the Board of Governors took place between 1 April 2008 and 31 March 2009. Apart from sickness, attendance at meetings was good.

| Name | Attendance |
|---|---|
| Bernard Atkinson | 5 |
| Leonard Barlow | 5 |
| Stuart Barnett | 5 |
| Gill Baxter | 4 |
| Edward Belsey | 5 |
| John Bowers | 4 |
| Gill Brack | 5 |
| Tom Cochrane | 4 |
| Sarah Creamer | 2 |
| Mabel Cunningham | 4 |
| Roy Daisley | 5 |
| Peter Dingemans | 3 |
| Peter Evans | 3 |
| Adrian Fuchs | 4 |
| Peter Harper | 4 |
| Bill Hatton | 4 |
| Caroline Hitchcock | 4 |
| Ann Horscroft | 4 |
| Sue Hull | 3 |
| Valerie King | 4 |
| Carol Lehan | 3 |
| Howard Matthews | 5 |
| Shirley Mitchell | 5 |
| Martin Plimmer | 5 |
| Derek Pocock | 5 |
| Andrew Robertson | 4 |
| Chris Rolley | 4 |
| Manya Sheldon | 5 |
| Ian Stewart | 3 |
| Alison Tweddle | 4 |
| Jill Walker | 4 |
| Sharon Watkinson | 3 |
| Amanda Wood | 0 |

Any member of the public aged 18 or over and living in the Trust's catchment area of Kent, Surrey and Sussex can become a public member.

Any member of staff who is a member, either part time or full time (with a contract of longer than one year) can become a staff governor. Staff who have 'opted out' can become members. See the Trust Constitution for further details.

Governors are actively encouraged to recruit public members. The focus of the membership strategy is to have a meaningful membership who are interested in the future of the hospital and who widely represent the population the hospital serves. We aim to ensure the membership has real influence over the quality and type of services delivered by the hospital. A representative membership is sought by governors attending school career evenings, public libraries, supermarkets to speak to the public and recruit members. Links are continually being developed with the community and all stakeholders, whether or not they are members of the trust. Through the membership database, the membership taskforce endeavours to identify under represented groups and to seek more members. All this Governor activity is supported by the Trust.

Members of the public can view the Register of Governors' Interests by contacting the Head of Corporate Affairs (address on inside back cover).

# GOVERNORS` CORNER

BY BERNARD ATKINSON GOVERNOR REPRESENTATIVE

QVH Governors have two primary overall functions:

- to hold the Directors to account for the activities, plans and strategy of the hospital, as required by the Constitution and
- to be supporters of the hospital, in the broadest sense, on behalf of members and the community at large.

Since the creation of Queen Victoria Hospital NHS Foundation Trust in 2004 the Governors have been developing mechanisms whereby they can carry out these tasks effectively and economically. During this time it has become clear that there is need for a range of personalities, from those with the skills and personal characteristics necessary to relate to members of the public and to elicit their concerns and then to articulate these latter as a coherent whole, to those with the experience and knowledge of how large organisations function at the human, organisational and process levels. Fortunately the QVH Board of Governors has contained these characteristics, to varying degree, within each of its individual members.

Initially the QVH Governors were concerned with developing their own Governance systems and benchmarking their activities on an ad-hoc basis, using such mechanisms as attendance at meetings of the Foundation Trust Governors Association. More recently a short–term working party was established to carry out an Audit of QVH Governor Activity with the objective of establishing `where we are` and `how we compare`, by formally benchmarking QVH with six well-established FTs, ranging from small to large.

The working party found;

- no evidence of more elaborate or more sophisticated ways of working than at QVH
- that QVH had the greatest level of Governor involvement
- that no other Trust had either a Governor Representative or a Governors Steering Group and
- that a Governor Representative on the Board of Directors and a Governors Steering Group attended by the Executive Directors and Chairman is clearly more influential than seats on Committees.

Queen Victoria Hospital is a regional provider of world–class reconstructive surgery, rehabilitation and community services, which it offers for patients across Kent, Surrey and Sussex and beyond. To continue this work for the foreseeable future the hospital needs new facilities and Governors have been deeply involved in the development of plans for a programme of new build, refurbishment and backlog maintenance. To this end the normal channels involving the Governor Representative, the Governors Steering Group, and the Board of Governors, have been enhanced, because of the importance of these issues. This has been achieved by Governor participation in the Project Steering Group, by the creation of a Governors Refurbishment Advisory Group, and by developing a Governors` list of maintenance issues.

Governors hold the view that by any measure QVH performance and the commitment of its staff is exemplary and demonstrably so. The challenge is not one of performance but of sustaining performance day-by-day, month-by-month, year-by-year. This latter challenge is exacerbated by the fact that the estate is old and plans are both in hand and in action for a significant new build/high level refurbishment programme(see above). The fact that the physical facilities are in a state of transition does, of itself, present a further challenge to QVH and its staff, which will remain so for the foreseeable future.

The Governors have debated these issues and asked themselves what they can contribute to maintain and even enhance QVH performance. This, over time, has led to a matrix of actions with the complete support of the Board of Directors and the hospital staff; examples include:

- A regular presentation at all Board of Governors (BofG) meetings by the Chief Executive covering all aspects of performance and finance.
- A regular presentation at all BofG meetings by the Director of Infection Prevention & Control on the current infection status, challenges and future actions.
- Frequent programmed visits by Governors, with written reports, to every area of the hospital from wards to the eye bank to the waste collection facilities.
- Extensive interaction between Governors and staff of every kind and level.
- A short term working party of Governors tasked with assessing the QVH Healthcare Declaration by study, by visits and by drilling deep.
- Governor involvement in the hospital structure through such committees as the Quality and Risk Committee, the Patient Engagement Committee, etc.

Governors recognise that issues occur even in the processes of very well run organisations and that the robustness of such organisations lies in the fact that they are quickly identified, are minor, and their effects constrained. Also that in such organisations, even when achieving the highest levels of performance, the processes are inspected and refreshed to ensure sustainability. To this end, in the healthy governance environment that is QVH, the Governors are in dialog with the Directors having posed recently a series of questions, challenging to all, covering demanding issues such as.

- Is there any danger of an excess of inspections, but a lack of ownership?
- Is there any danger of an excess of process, but lack of responsibility and 'power'?
- Does the understandable pride in coping in difficult circumstances present any dangers?
- Is QVH overly parochial, perhaps because of its success, and not focused on the best in-class experience of others?
- Does QVH, even the NHS at large, have knowledge of the Safety Management Systems of others, for example in the aviation and nuclear industries?
- Could monitoring and assessing reputational risk be used as a useful tool?

It is a strength of the QVH Governance system that Directors and Governors can participate together in the professional discussion of complex topics such as these and it reflects well on how the FT concept has matured and on how knowledgeable the Governors have become. Furthermore it stands QVH in good stead, since undoubtedly the next five years will be more difficult for the NHS as a whole than those experienced since the Foundation Trusts were first introduced.

# THE BOARD OF DIRECTORS

## An introduction

The Board of Directors consists of the Chairman, five Non-Executive Directors and five Executive Directors. The Directors are listed below, together with their responsibilities. Also attending the meetings which are held in private, are the Governor Representative, the Programme Director, Deputy Medical Director and Head of Corporate Affairs and during interim arrangements in 2008/09, the Head of Finance.

### THE CONSTITUTION

Since becoming a Foundation Trust, QVH had not undertaken a review of its Constitution, but a revised and updated Constitution was agreed in July 2008 and endorsed by Monitor. This is considered the first phase of a longer term review of the document which needs to reflect the Trust's vision and purpose. At that time consideration will also be given to the appointment of a Governor as Deputy Chairman of the Board of Governors and the catchment area of the Trust. Further work is also required to align Standing Orders with the revised Constitution and Standing Financial Instructions.

### THE BOARD

During the course of the year, there have been vacancies at both executive and Non-Executive director level. The new role of Director of Performance, Technology and Innovation has recently been appointed and it is anticipated that the Non-Executive director role will be filled once the executive director has been appointed and an overall evaluation of the Board's effectiveness and future requirements undertaken.

### COMPLIANCE WITH THE CODE OF GOVERNANCE

As a foundation trust, the hospital has more freedoms than other NHS organisations but we still have to have a clear framework within which the Trust operates, reporting to Monitor twice a year.

The Trust considers that it complies with the main and supporting principles of Monitor's Code of Governance.

# EXECUTIVE DIRECTORS

## Adrian Bull
### Chief Executive

Adrian Bull 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.

Adrian joined QVH in December 2008.

## Caroline Becher
### (Director of Nursing and Quality)

Was appointed in September 2003. She trained at Guy's Hospital in London where she held two Senior Nursing posts and then gained further Senior Nursing posts within the NHS and BUPA. Her style of management is to be highly visible and she enjoys her regular interaction with patients and staff as her valuable quality check on the provision of care.

Caroline has been requested to speak at national conferences on privacy & dignity for patients where the Healthcare Commission has recognised QVH as an exemplar.

## Sally Flint
### (Director of Finance)

Was appointed in October 2002 and made a significant contribution to the trust's Foundation Trust application. She was previously Group Financial Controller of Housing 21, a large national housing association and she has held a number of other senior finance roles.

## Ken Lavery
### (Medical Director)

Came into post in April 2008. A Consultant in Oral and Maxillofacial Surgery, Ken trained in dentistry and medicine at the University of Dundee. Subsequent to 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 the Queen Victoria Hospital and Guy's Hospital.

## Sharon Colclough
### (former Chief Executive)

Joined QVH in November 2006 from East Devon PCT where she was Chief Executive. Originally trained as a nurse and then a midwife, Sharon has an MBA from Henley Management College. She was previously Director of Operations at Royal Berkshire and Battle NHS Trust and Wycombe PCT. Sharon left the Trust in December 2008.

There were 11 meetings during 2008/09 with the following attendance:

#### EXECUTIVE DIRECTORS

| | |
|---|---|
| Caroline Becher | 11 |
| Adrian Bull | 2 (part year) |
| Sharon Colclough | 6 (part year) |
| Sally Flint | 11 |
| Ken Lavery | 8 |

#### NON-EXECUTIVE DIRECTORS

| | |
|---|---|
| Jeremy Beech | 9 |
| Peter Griffiths (Chairman) | 10 |
| Rachael Hoey | 6 (part year) |
| Renny Leach | 11 |
| Hugh Ure (Deputy Chairman) | 9 |
| Shena Winning | 11 |

All appointments and termination of appointments are conducted within the terms of the QVH's Constitution.

The Board of Directors reflected a wide range of experience both within the public and commercial sectors. Vacancies have been promptly filled and at all times the completeness and appropriateness of Board membership considered in line with the requirements of Queen Victoria Hospital NHS Foundation Trust, its Terms of Authorisation and Constitution.

It is not felt that the independence of the Board has been undermined because of lengthy terms in office. The independence of the Non-Executive Directors is also assured, supported by the appointment of a Senior Independent Director (Hugh Ure) who was also appointed Deputy Chairman of the Trust.

#### REGISTER OF DIRECTORS' INTERESTS

A register of Directors' interests is kept by the Trust and is available on request by contacting the Head of Corporate Affairs (details on inside back cover).

# NON EXECUTIVE DIRECTORS

## Jeremy Beech CBE, QFSM

From Frittenden in Kent, Jeremy is a Chartered 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. He is also Non-Executive Chairman of MKC Training Services Ltd, a Governor of Mid-Kent College and a Trustee of the Kent Foundation.

Appointment: 1 October 2005 to 30 September 2009

Committees: Quality and Risk (Chairman), Nomination & Remuneration

## 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 he 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.

Appointment: 1 April 2005 – 31 March 2012
Committees: Nomination & Remuneration

## Dr Renny Leach

Dr Leach lives in Forest Row. He is Chief Executive of a clinical research organisation working with a number of public and venture capital funded companies developing new clinical treatments for common conditions including cancer. Renny's career has focussed 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 held senior positions with the UK Medical Research Council and the Horsham-based charity Action Medical Research.

Appointment: 1 January 2007 – 31 December 2010

Committees: Nomination & Remuneration, Research & Development (Chairman),

## Hugh Ure (Deputy Chairman)

Mr Ure is from Haslemere in Surrey, and was appointed to the Board in December 2000. He was appointed Deputy Chairman and Senior Independent Director in April 2007. A former company director he enjoyed a 32 year international career with consumer goods company Reckitt Benckiser during which his postings included Australia, Papua New Guinea, South Africa, Sri Lanka, Ireland and the UK. He was for six years Chairman of a private sector Pension Fund, and he has just completed a four year term as a Non-Executive director in the Ministry of Defence. He is a former council member of the Rotary Club of London, and is currently a trustee of its charitable fund.

Appointment: 1 October 2005 to 30 September 2011

Committees: Nomination & Remuneration (Chairman), Audit

## Shena Winning

Shena, from Elham, near Canterbury, is a Chartered Accountant. Formerly Finance Director of CarpetRight plc, Shena has over 20 years experience within the retail sector. She is Non-Executive Chairman of Swallowfield plc and was also a Non-Executive Director of South East Kent Community Health Trust from July 1996 - January 1998.

Appointment: 1 October 2005 to 30 September 2009

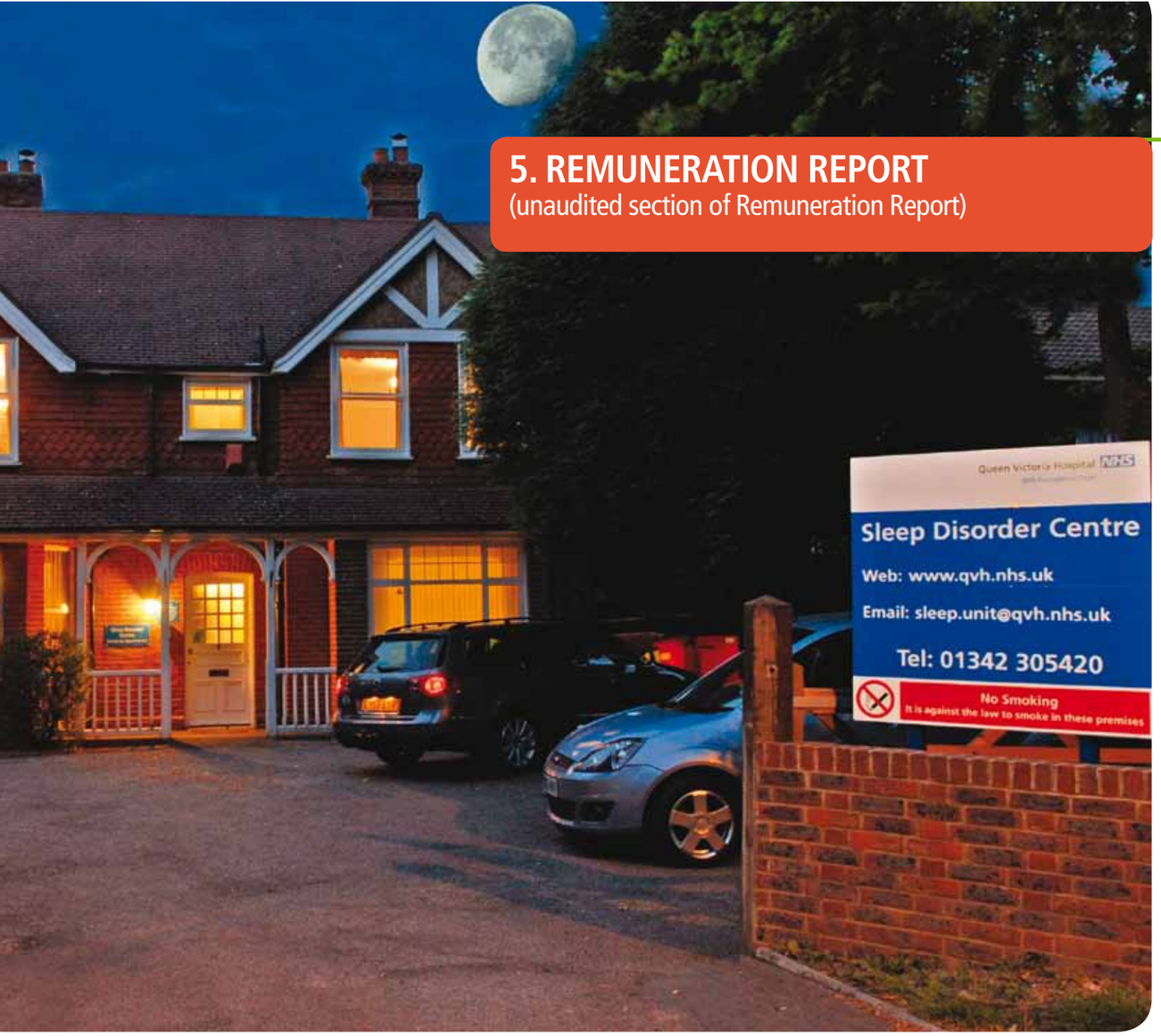
Committees: Nomination & Remuneration, Audit (Chairman)

## Rachael Hoey

Rachael, from Groombridge, is currently Director and global head of relationship management and product management for CLS Bank where she leads a team responsible for the strategic development of the bank and its global relationships. Other positions held by Ms Hoey include a period as a trustee of a corporate pension plan. Mrs Hoey left the Trust at the end of September 2008.

Appointment: 1 October 2005 to 30 September 2008

Committees: Nomination & Remuneration, Audit




# 5. REMUNERATION REPORT
(unaudited section of Remuneration Report)

The Nomination and Remuneration Committee was formed on 1 April 2007, replacing the former Remuneration Committee. Its purpose 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.

Hugh Ure, Deputy Chairman of the Trust, is Chairman of the Nomination and Remuneration Committee. The Chairman, Chief Executive and all Non-Executive Directors are members of the Nomination and Remuneration Committee. The Head of Human Resources is Secretary and advisor to the Committee and the Head of Corporate Affairs attends as advisor to the Committee. The terms of reference are reviewed annually.

During 2008/09 the Trust continued with an agreed rolling work programme but due to the long term sickness absence of the Head of Human Resources (who is secretary to the committee) only 2 meetings took place. However, written communication took place outside of the meetings to enable decisions to be made where needed. A new Chief Executive was appointed, taking up post in December 2008 and one of the Non-Executive Directors stood down on 30 September 2008. The committee made decisions or recommendations on the following issues:

- Reviewing the effectiveness of the Board.
- Standards of Business Conduct.
- The 2008 national pay award.
- Recruitment of and Job Description for a new Executive Director post.
- Amendments to the Director of Finance's role and Job Description.
- Hay Group Job Evaluation of Executive Directors and other Very Senior Managers.
- Pay for Executive Directors and other Very Senior Managers.
- Benchmarking performance pay arrangements in foundation trusts.
- Work plan for 08/09.

Attendance record of members (out of a possible 2 meetings)

| MEMBER | | MEETINGS |
|---|---|---|
| Hugh Ure | **(Chairman, Non-Executive Director)** | 2 |
| Jeremy Beech | **(Non-Executive Director)** | 2 |
| Sharon Colclough | **(Chief Executive, left 12/12/09)** | 1 |
| Adrian Bull | **(Chief Executive, joined 15/12/08)** | 1 |
| Peter Griffiths | (**Non-Executive Director)** | 2 |
| Rachel Hoey | **(Non-Executive Director, left 30/9/08)** | 1 |
| Renny Leach | **(Non-Executive Director)** | 2 |
| Shena Winning | **(Non-Executive Director)** | 2 |

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.

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. Bethan Douglas from the Hay Group undertook the external benchmarking through a job evaluation assessment of the Executive Directors and other Very Senior Manager posts which informed the committee's final decision on pay for the 2008/09 Financial Year.

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.

Through the Board the trust also reviewed the Trust's sickness absence rate, which was an average of 3.58% for the year (3.57% for 2007/08).

## Salary and Pension Entitlements of Senior Managers

(AUDITED SECTION OF REMUNERATION REPORT)

The salary details of the Trust's Chairman, Executive and Non-Executive Directors are set out below.
The Trust made one post redundant, effective in April 2008 and therefore

| NAME AND TITLE | 1 APRIL 2008 TO 31 MARCH 2009 | | | 1 APRIL 2007 TO 31 MARCH 2008 | | |
|---|---|---|---|---|---|---|
| | Salary (bands of £5,000) £000 | Other Remuneration (bands of £5,000) £000 | Benefits in Kind Rounded to the nearest £100 | Salary bands of £5,000 £000 | Other Remuneration bands of £5,000) £000 | Benefits in Kind Rounded to the nearest £100 |
| P. Griffiths (Chairman) | 40-45 | | | 35-40 | | |
| J. Beech (Non-executive director) | 10-15 | | | 10-15 | | |
| R.Hoey (Non-excutive director) | 5-10 | | | 10-15 | | |
| R. Leech (Non-executive director) | 10-15 | | | 10-15 | | |
| H. Ure (Non-executive director) | 15-20 | | | 10-15 | | |
| S. Winning (Non-executive director) | 10-15 | | | 10-15 | | |
| S. Colclough (nee Kearns) (Chief Executive) | 95-100 | | | 120-125 | | |
| A. Bull (Chief Executive) | 35-40 | | | | | |
| C.Becher (Director of Nursing & Quality) | 90-95 | | | 80-85 | | |
| K Lavery (Medical director) | 10-15 | 165-170 | | 0-5 | 170-175 | |
| M. Middleton (Director of Operations) | | 70-75 | | 80-85 | | |
| S. Flint (Director of Finance) | 100-105 | | | 85-90 | | |

P. Griffiths joined the board on 1 April 2005.
A. Bull joined the board on 15 December 2008.
J. Beech joined the board on 1 October 2005.
S. Colclough (nee Kearns) joined the board on 20 November 2006 and left on 4 January 2009
R. Hoey joined the board on 1 October 2005 and left on 30 September 2008
C. Becher joined the board on 1 September 2003
R. Leach joined the board on 1 January 2007.
S. Flint joined the board on 7 October 2002
H. Ure joined the board on 11 December 2000.
S. Squires was Medical Director from 1 April 2007 to 31 October 2007
S. Winning joined the board on 1 October 2005.
K. Lavery was Medical Director from 1 November 2007
M. Middleton joined the board on 1 February 2006 and left on 1 April 2008.

## B) Pension Benefits

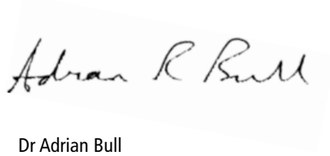
| NAME AND TITLE | Real increase in pension at age 60 (bands of £2,500) | Lump sum at age 60 related to real increase in pension (bands of £2,500) | Total accrued pension at age 60 at 31 March 2009 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2009 (bands of £5,000) | Cash Equivalent Transfer Value at 31 March 2009 £000 | Cash Equivalent Transfer Value at 31 March 2008 £000 | Real Increase in Cash Equivalent Transfer Value funded by QVH £000 |
|---|---|---|---|---|---|---|---|
| S. Colclough (Chief Executive) | 0-2.5 | 5-7.5 | 25-30 | 80-85 | 562 | 393 | 100 |
| A. Bull (Chief Executive) | 2.5-5 | 10-12.5 | 10-15 | 35-40 | 237 | 78 | 98 |
| C. Becher (Director of Nursing & Quality) | 2.5-5 | 12.5-15 | 35-40 | 110-115 | 801 | 538 | 156 |
| S. Flint (Director of Finance) | 2.5-5 | 10-12.5 | 25-30 | 75-80 | 418 | 274 | 86 |
| K. Lavery (Medical Director) | 0-2.5 | 0-2.5 | 60-65 | 180-185 | 1,505 | 1057 | 263 |

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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



Dr Adrian Bull
Chief Executive 2009

# 6. AUDIT COMMITTEE REPORT

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 three non-executive directors. Shena Winning, the non-executive director 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 2008/09 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 monitored 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 also commissioned three significant pieces of work as set out below.

The Committee commissioned a review of the Trust's hub and spoke business model. This work was undertaken by the Trust's external auditors with the brief to review the financial, governance and clinical risks arising from this business model. As a result of this piece of work the Audit Committee was able to recommend to the Board that this was a sound business model by which to deliver specialist tertiary services across a distributed network. It also recommended that the Trust should continue to develop the model as part of its overall strategy.

The report also identified further work to be undertaken to ensure complete robustness of this business model. As a result the Trust's new organisational management structure has identified a divisional manager and matron who have responsibility for the work undertaken at the spokes and for identifying and addressing any areas of risk. This will also ensure that patients treated at the spokes receive the same high quality care as they would if they were treated at the Trust's main site in East Grinstead.

Secondly, the Committee commissioned the internal auditors to undertake a review of the efficiency of the Trust's out-patient department. This work will enable the Trust to make better use its resources in respect of both staffing and fixed assets. It will also help to ensure that the out-patient department is run more efficiently in order to meet the increasing demand for our services.

The third significant piece of work was a review of the impact of the current economic climate on the Trust. This work was undertaken by the Trust's Head of Finance who provided the Committee with a comprehensive review of the risks facing the Trust and the mitigating actions the Trust was taking in order to maintain its sound financial performance.

During the year the Committee was also pleased to receive reports from the Trust's internal and external auditors that provided the Committee with a review of the Trust's internal controls and risk management systems. The internal auditors were able to report full or significant assurance for 95% of the areas reviewed, resulting in a Head of Internal Audit Opinion of significant assurance.

The Audit Committee meets four times a year and is attended by the Trust's 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 2008/09 is set out below:-

## MEMBERS

| | |
|---|---|
| Shena Winning (Non-executive director and Chair) | - 4 meetings |
| Rachael Hoey (Non-executive director) | - 2 meetings |
| Hugh Ure (Non-executive director) | - 4 meetings |

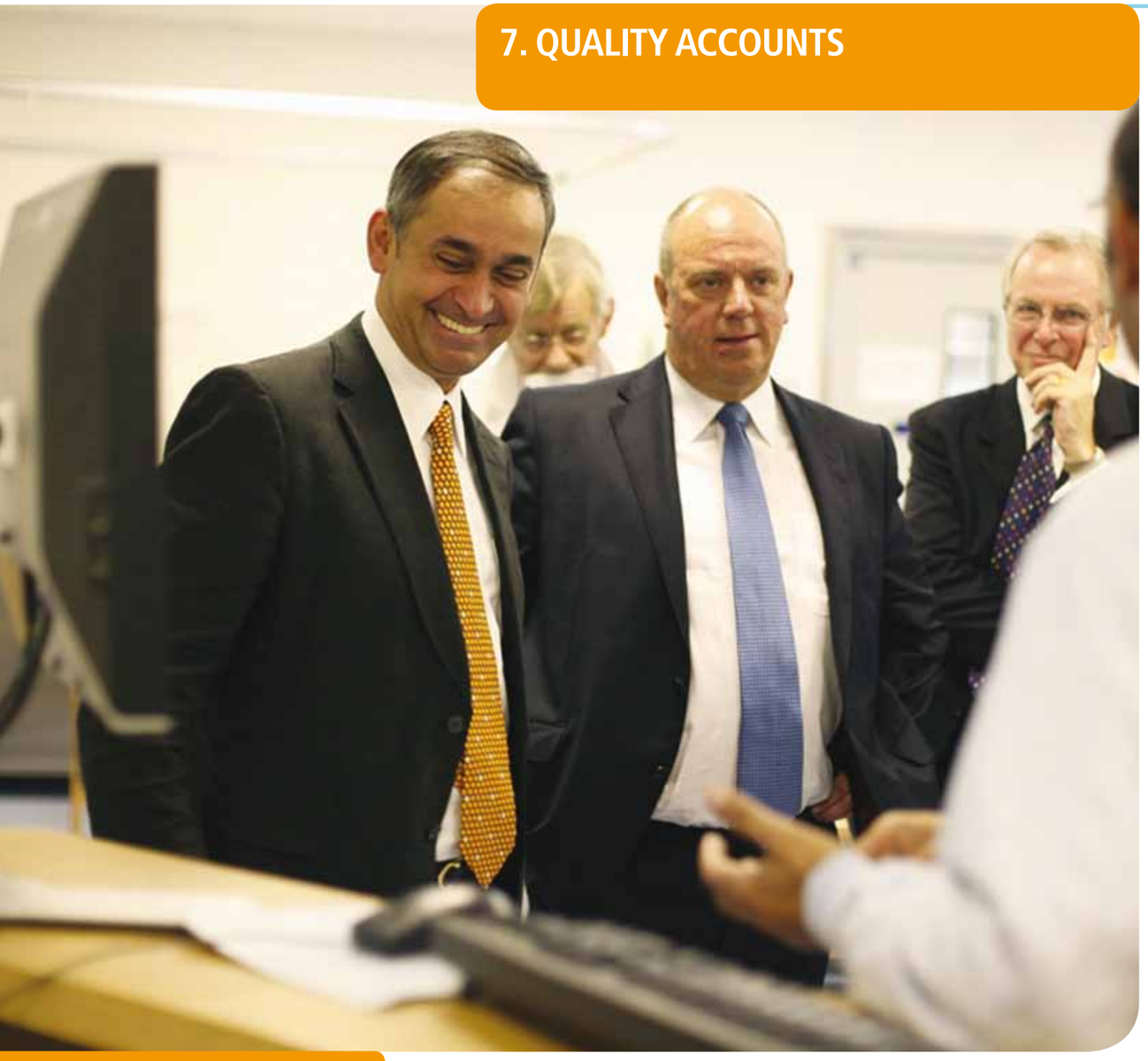
## IN ATTENDANCE

| | |
|---|---|
| Sally Flint (Director of Finance) | - 4 meetings |
| Keith Soper (Head of Integrated Risk Management) | - 4 meetings |
| PricewaterhouseCoopers LLP (External Auditors) | - 4 meetings |
| Chantrey Vellacott (Internal Auditors) | - 4 meetings |
| South Coast Audit (Local Counter Fraud) | - 4 meetings |

The Chief Executive is also able to attend the Audit Committee.

It should be noted that Rachael Hoey stepped down as non-executive director at the end of September 2008. This non-executive vacancy will be filled in due course.

# 7. QUALITY ACCOUNTS



LORD DARZI (UNDER-SECRETARY OF STATE FOR HEALTH) AND DAVID NICHOLSON (NHS CHIEF EXECUTIVE) VISITING QVH IN SEPTEMBER 2008. ON THE RIGHT IS TRUST CHAIRMAN PETER GRIFFITHS.

The requirement that all NHS Trusts produce Quality Accounts was introduced by Lord Darzi's 2008 Next Stage Review report – High Quality Care for All. QVH has produced our 2008/09 Quality Account for the first time, as required by Monitor. It is reproduced in full here.

## INTRODUCTION FROM THE CHIEF EXECUTIVE

Queen Victoria Hospital NHS Foundation Trust is a specialist centre for reconstructive surgery, treatment of burns, and expert rehabilitation services. Reconstructive surgery techniques are applied in a number of subspecialties, including corneo-plastics, head and neck (maxillofacial), burns, hand, and breast. We treat patients suffering significant damage and loss of function through trauma, cancer, or congenitally. Queen Victoria Hospital provides medical in-patient care for the local community under physician and general practice supervision, and rehabilitation and therapy services for patients suffering neuromuscular conditions such as stroke or Parkinson's disease.

Through the past year, QVH has continued to develop and extend its services, working with district general hospitals across the South East of England. Our telemedicine system, enabling our specialists to provide remote support to A&E departments across the counties, has improved the treatment of many patients with hand trauma, burns, and other conditions.

We have established a new base for our reconstructive surgeons in East Kent. Our expert multidisciplinary facial palsy service under Mr Charles Nduka is now firmly established and attracting patients from across the country. We have developed our support to orthopaedic surgeons across the counties in treating people with serious trauma to their lower limbs who need reconstructive surgery to muscle and skin, preventing extended hospital stays and, in many cases, amputation.

We have affirmed our position as a leading provider of corneas, and continue to offer our own corneal transplant service. We are also now firmly established as the surgical centre for skin cancer across our catchment area, working closely with the relevant cancer networks. Our major contribution to head and neck cancer services also continues. We have continued to develop our psychotherapeutic service, recognising the importance of the psychological trauma that accompanies many of the conditions we treat.

We strive hard to ensure we deliver the best care possible and were therefore delighted to be rated 'excellent' by the Healthcare Commission for both the quality of our services and the use of our resources. This is for the second year running, one of only eleven hospitals to achieve this accolade.

Patient care is at the centre of all that we do, and delivering effective and personalised care depends on every individual working in the organisation. We were delighted that, at the Health Service Journal and Nursing Times Awards, we were voted best acute trust for employment of staff, best organisation overall for employment of nursing staff, and runner up of all organisations as an overall employer. This is a credit to the common purpose, team spirit, and multidisciplinary working that are at the heart of the hospital and there is no doubt that this is a critical factor in the quality of services that we provide to our patients.

Our record in hospital infection remains exemplary, with the numbers of MRSA and Clostridium Difficile within our challenging targets. An unannounced Health Care Commission visit in November identified several areas for further improvement. These have all been fully addressed and are further detailed within this account.

In 2008/09, the hospital undertook an unprecedented amount of building work. Major projects have included refurbishing operating theatres and installing a new maxillofacial unit, totalling an investment of some £5 million. Extensive site surveys and planning reviews have been undertaken in preparation for the redevelopment of the site overall.

As further evidence of our commitment to improving quality the Trust signed up to the Patient Safety First Campaign in June 2008. The Campaign is supported by the National Patient Safety Agency, NHS Institute for Innovation and Improvement, and The Health Foundation.

**The Campaign cause is:**

To make the safety of patients everyone's highest priority.

**The aim is:**

No avoidable death, and no avoidable harm.

The Trust has decided to focus on the following initiatives as part of the Campaign:

- Reducing Harm from Deterioration - aim of ensuring all patients receive the required number and quality of basic observations and that an appropriate response is initiated following agreed early warning criteria. This is a critical issue for many of our patients who undergo extensive reconstructive surgery with microvascular repair, free flap transplants, and propellor flap repair;
- Leadership – aim to provide demonstrable leadership, develop explicit strategic priorities and goals and monitor progress during the campaign following audit of harm events and compliance to implementation of initiatives;
- Perioperative Care – aim of ensuring patients receive appropriate antibiotics, correct hair removal methods, effective glycaemic control for diabetic surgical patients, maintain correct body temperature following surgery and introduction of the Surgical Safety Checklist;

## CURRENT VIEW OF THE TRUST'S POSITION AND STATUS FOR QUALITY

- Rated as 'Excellent' for Quality by the Healthcare Commission for the second year running, the Trust is rightly proud of its record on delivering high quality services. However, we recognise the importance of maintaining our standing as a centre of clinical excellence and, over the past year, have sought to develop further measures of quality, along with a clear strategy for measuring and improving clinical outcomes, which will demonstrate performance and progress in a range of areas.
- A Clinical Director for Audit & Outcomes has been appointed to ensure there is senior clinical leadership in the prioritisation of clinical quality developments.
- The Trust continues to perform particularly well in the area of infection prevention and control, with exceptionally low number of patients acquiring infections during their hospital stay.

## OVERVIEW OF ORGANISATIONAL EFFECTIVENESS INITIATIVES

The Trust has a series of ongoing initiatives designed to ensure quality is at the top of the agenda and regularly scrutinised. Examples of the internal review arrangements are:

- **Clinical Directorate Reviews:** Regular quarterly reviews by the chief executive, medical director, and director of nursing, focusing on specific areas of the hospital to ensure service line accountability for quality and patient safety.
- **Clinical Outcomes Group:** Chaired by the Clinical Director for Audit & Outcomes, this group has responsibility for stimulating the development of quality portfolios within clinical departments and agreeing quality priorities for the Trust.
- **Joint Hospital Audit Meetings:** Multidisciplinary bi-monthly meetings are held during protected time to discuss clinical cases of interest, review the results of audits and disseminate learning points from adverse events.
- **Clinical Policy Committee:** Multidisciplinary bi-monthly meetings held. Agenda includes developing policy in response to issues identified through clinical audit, and inviting the Clinical Outcomes Group to conduct audits of specific clinical policies to ensure implementation.

## EXISTING MEASURES OF QUALITY AND AREAS OF EXCELLENCE

Measures of safety, outcomes and experience are essential for assessing the quality of service provided. During 2008/09 the Trust developed a set of indicators for regular review by the Trust Board and Clinical Cabinet, which is the Executive decision making body within the organisation. Our performance against this range of metrics is detailed later within this account. This section reviews historical performance against a selection of indicators.

## INFECTION PREVENTION AND CONTROL

Maintaining our excellent record of hospital acquired infection rates is very important. Infections lengthen hospital stay, increase morbidity and, in some cases, result in death. Reducing the incidence of infection therefore has significant patient benefits. The Trust has reduced, from already very low numbers, its rates of infection in respect of Clostridium difficile and MRSA Bacteraemia. Performance for the past two years is detailed below.

| PERIOD | MRSA BACTERAEMIA | CLOSTRIDIUM DIFFICILE |
|---|---|---|
| Apr 2007 – Mar 2008 | 3 | 5 |
| Apr 2008 – Mar 2009 | 2 | 4 |

Although the Trust performs excellently on reportable hospital acquired infections we are committed to continuing to improve all elements of the service we provide to minimise the risk of hospital acquired infections. Much of this work is supported by training and awareness, regular audit and corrective action. The Infection Prevention and Control Team regularly present results from their audit programme to clinical directorates. Where there are issues that require changes to the environment, these are prioritised by the Hygiene Code and Environmental Risk Committee.

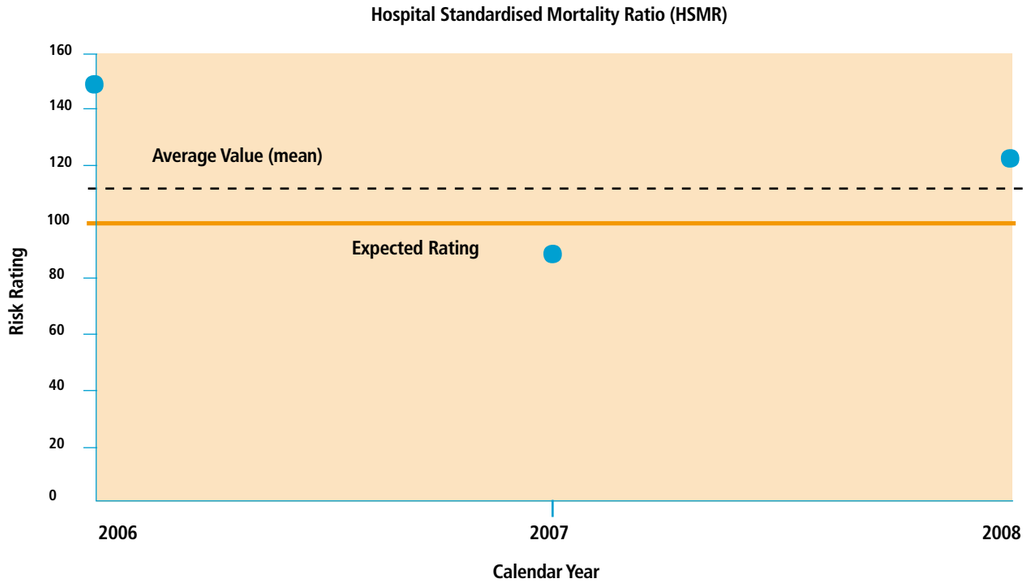
## HOSPITAL STANDARDISED MORTALITY RATIO (HSMR)

Hospital Standardised Mortality Ratio (HSMR) is a routinely collected measure for the Patient Safety First Campaign, which the Trust signed up to in 2008. HSMR is the ratio of the actual number of in-hospital deaths to the expected number of in-hospital deaths, for conditions accounting for 80% of inpatient mortality (56 diagnosis groups). The expected number of deaths is calculated by applying to our patient profile the national average mortality for particular age groups, gender, admission type, previous hospital history and co-morbidity.

HSMR is calculated by dividing the actual number of in-hospital deaths by the expected number of in-hospital deaths and multiplying by 100. 100 is therefore the benchmark, with a number lower than 100 indicating better than expected performance and a number above 100 indicating worse than expected performance. The Trust's HSMR is calculated thus:

$$\frac{\text{Actual Number of deaths}}{\text{Expected Number of deaths}} \times 100 = \text{HSMR}$$

## The Trust's three year HSMR is detailed below

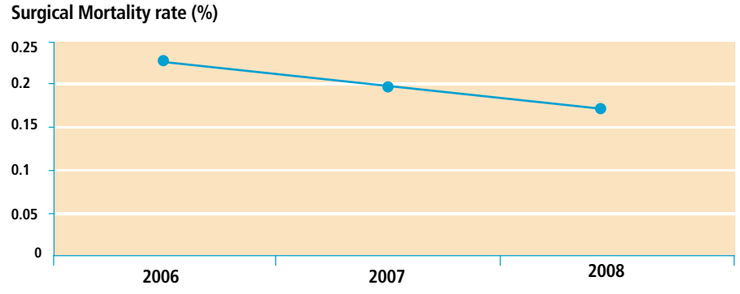



Mortality ratios were published for the first time by NHS Trust on the NHS Choices website www.nhs.uk in 2009. Specialist Trusts, such as the Queen Victoria Hospital, were excluded from the data presented in recognition of the unique patient case mix and generally lower volumes of patients, which would give a misleading picture. Lower volumes of activity mean the rating is subject to significant variance from year to year, resulting in a large differential between the lower and upper statistical control limits. The average HSMR over the three year period is 117. In 2008 the HSMR was 118.8. The small numbers mean that this is not statistically different from the average.

In spite of the acknowledged difficulties with the data for specialist hospitals, the Trust routinely reviews HSMR with a detailed review and assessment of every death. A key contributing factor is the provision of end of life care in our community ward, which provides medical beds for the local community under the joint care of our physician and local general practitioners. We will continue to track this as a key measure in 2009/10. We are satisfied that there are no concerns about the mortality rate at the hospital.

## Surgical Mortality

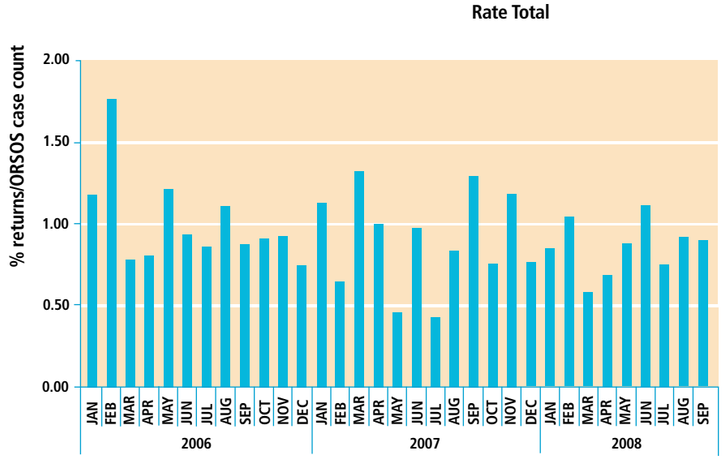
As a specialist surgical hospital we pay particular attention to our death rate following surgery. The surgical mortality rate is calculated by dividing the actual number of deaths for patients who have undergone a surgical procedure by the total number of patients admitted for a surgical procedure. These figures therefore exclude those admitted for rehabilitation or end of life care.




## Returns to Theatre

The Trust's Return to Theatre rate is an essential measure for a specialist surgical hospital. An unexpected return to theatre is an unplanned procedure taking place within seven days of the previous operation. The Trust's three year Return to Theatre rate is detailed below.

**Unexpected returns to theatre**

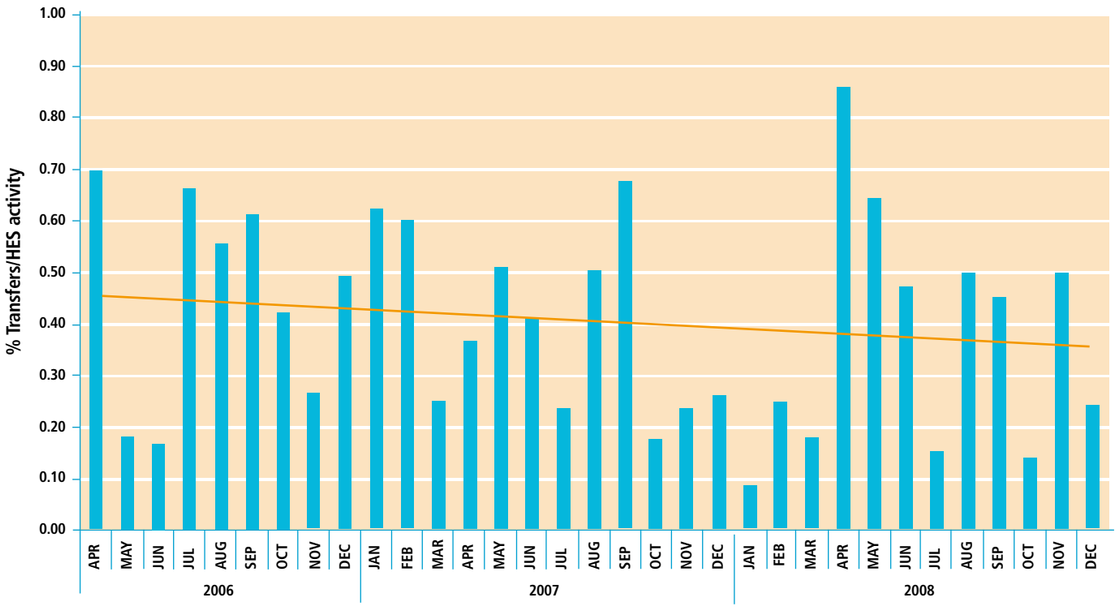



In 2008 less than 1% of patients unexpectedly returned to theatre for further surgery. It is often the case, particularly for patients with burns or requiring complex restorative surgery, that more than one visit to theatre is needed. These patients are excluded from the data. However some patients do need to return to theatre because of deterioration in their clinical condition or as a result of a recognised, but unexpected, complication. All such cases are reviewed within the clinical directorates and any applicable learning is shared across the hospital at the quarterly Joint Hospital Audit meetings

## Emergency Transfers Out

Unexpected transfers out are an important measure indicating our ability to provide safe, high quality care for all patients referred to us for treatment. As a tertiary referral centre the vast majority of our patients stay with us for a short period of time before being discharged home or back to the care of the referring hospital. An emergency transfer out is an unplanned transfer to another NHS hospital. It is expected that there will always be the need for some patients to be transferred out because the hospital does not provide the full range of clinical specialties and, on occasions, it is necessary and appropriate for further care and treatment to be provided elsewhere. The Trust's three year Emergency Transfers Out rate is detailed below.

**Emergency Transfers Out**



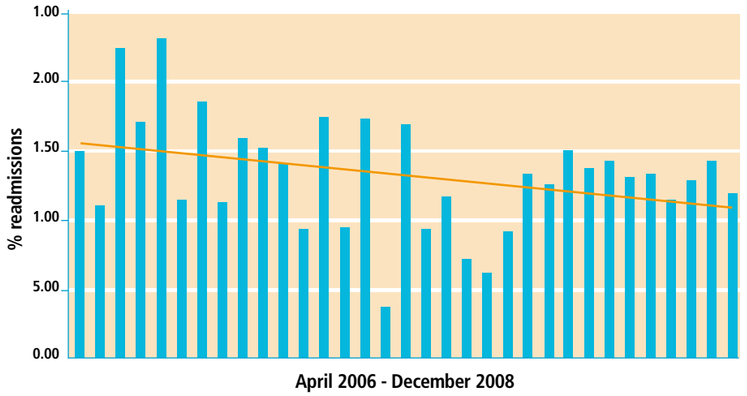

In 2008 less than 0.5% of patients had to be transferred to another hospital because of a change in their clinical condition. The largest patient group transferred to another hospital were from our community ward. This is often a complex mix of patients, ranging from those needed relatively straightforward rehabilitation, to those requiring long term interventions to enable them to return to activities of normal daily living. It is important that accepted admissions to the community ward are appropriate for the level of care we are able to provide and complexity of condition we are able to deal with, and this is an area under constant review. It is, however, recognised that patients admitted to the community ward often have multiple health problems and it is therefore entirely appropriate that they are transferred to a more suitable environment to meet their changing health needs. Maintaining the safety of all our patients is an absolute priority.

## Unplanned Readmissions

Unplanned readmissions are all patients admitted non-electively (unplanned) within twenty-eight days of discharge. The Trust's three year Unplanned Readmissions rate is detailed right.

The trend in unplanned readmissions shows an improvement. This data is routinely reviewed within clinical directorates and scrutinised in terms of the trend in readmissions, as well as identifying individual instances that require further investigation. A significant area of improvement has been the reduction of unplanned readmissions in plastic surgery, which has had a positive impact on the readmission rate. In 2008/09 less than 1.5% of patients required an unplanned readmission to Queen Victoria Hospital within twenty-eight days of their discharge.

**Unplanned readmissions**



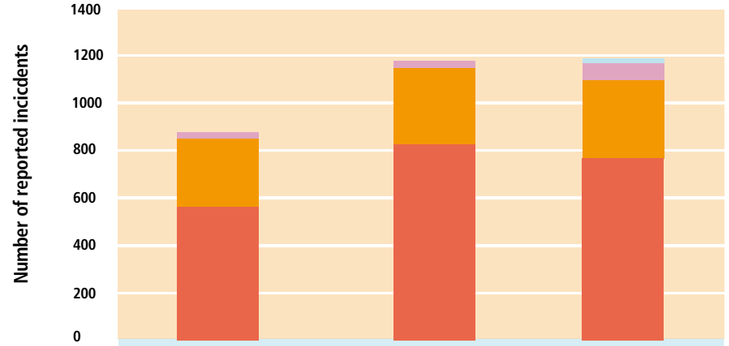

## Patient Safety Incidents

The Trust routinely reports all patient safety incidents to the National Reporting and Learning System (NRLS). This is a voluntary reporting system and includes a range of issues including patient falls, drug errors and record keeping. The Trust's reporting rate has been relatively consistent over the past three years, with approximately 100 incidents reported every month. Of these, around 70 are classified as being patient safety incidents. Over two thirds of patient safety incidents result in no harm to the patient, which is in line with national data.

A breakdown of reported patient safety incidents by severity over the past three years is detailed right.

There is much debate nationally about levels of incident reporting and whether higher or lower reporting rates indicate safer services. One argument is that since it is well recognised that reported incidents account for a fraction of the actual number of adverse events any increase should be welcomed and indicative of an open reporting culture. Nationally reporting rates have increased over the past three years.

**Reported incidents by Severity**




| | 2006 | 2007 | 2008 |
|---|---|---|---|
| Serious | 1 | 4 | 10 |
| Moderate | 8 | 23 | 68 |
| Minor | 294 | 322 | 343 |
| No Harm/ Near Miss | 571 | 833 | 771 |

In truth, the overall number of reported incidents is just one indicator of safety and quality. Our historical information tells us what we should expect to see and therefore we should be alerted to deviations from what is expected, along with the changes in the type and severity of incidents reported. Of greater concern than a significant increase or decrease in the overall number of incidents reported would be a change in the severity of incidents reported, indicating that more harm is being suffered. Reassuringly, the Trust reports very few incidents classified as resulting in major harm (less than 0.4% of reported events over the past three years) with the majority (72%) resulting in minor or no harm. This is in line with information collected by the National Patient Safety Agency as part of the National Reporting and Learning System, to which all NHS Trusts are required to report patient safety incidents.

All reported incidents are investigated and lessons are disseminated across staff and specialties.

## PRIORITIES FOR 2009/10 AND BEYOND

**Patient Safety**

- 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.
- Review the methods, tools and protocols for monitoring patients after surgery and ensure they are fit for purpose, used effectively and prevent patient deterioration.
- Understand and improve our 'rate of harm events' as defined by the Patient Safety First Campaign.
- Implement a pre-theatre list safety team meeting and enhance our checklist in line with National Patient Safety Agency (NPSA) / World Health Organisation (WHO) recommendations.
- Ensure all patients admitted as an emergency are reviewed by a consultant within 24 hours.
- Improve our compliance with hand decontamination (hand washing).

**Clinical Quality & Effectiveness**

- 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.
- 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.
- Microvascular surgery (free tissue transfer or "free flap" surgery) is central to the our 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 against other units willing to share results.
- We will improve our contribution to the DAHNO National Audit to demonstrate the effectiveness of head and neck cancer care.
- We will give greater priority to Lower Limb Trauma patients, referred from surrounding hospitals, reducing time to admission, time to surgery with the aim of reducing length of stay and time to rehabilitative care.
- We will continue to review our links with Brighton and Sussex University Hospital 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 Alexander Children's Hospital in Brighton to work alongside QVH practitioners and help to oversee our paediatric care.
- We will develop new outcome measures in orthognathic surgery and burns care, enabling us to benchmark and improve performance.
- We will develop quality portfolios by individual clinical specialty as evidence of clinical performance.

**Patient Experience and Access**

- 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.
- We will continue to measure patient experience, focusing on issues of privacy and dignity and mixed 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.

## RESPONSE TO REGULATORS

The Queen Victoria NHS Foundation Trust declared full compliance with forty one of the forty four Department of Health Core Standards for the year 08/09. Details of the areas the Board declared non-compliance on, along with the reasons for the declarations and improvements are contained with the Trust's declaration to the Care Quality Commission, available via www.qvh.nhs.uk/assets/core standards_0809

## Performance against selected metrics

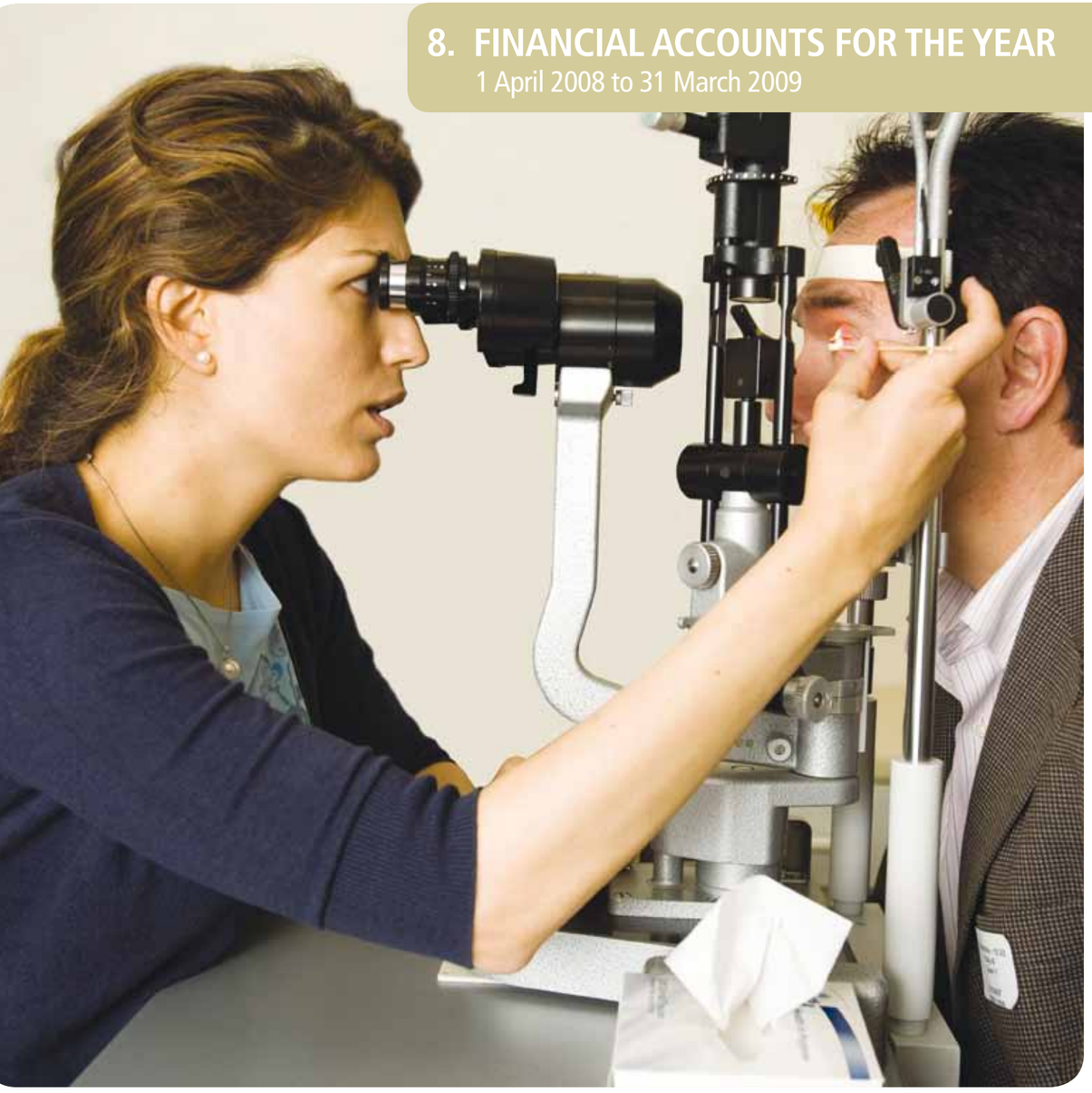
| PATIENT SAFETY | 2007/08 | 2008/09 |
|---|---|---|
| **Number of Serious Untoward Incidents or 'Never events'**<br>This is the number of serious untoward incidents (SUI) or 'never events' reported to the Strategic Health Authority. An SUI or 'never event' is one that resulted in, or had the potential to result in, significant harm to a patient, visitor, staff member, or the organisation in terms of reputation or finance. The two events during 2008/09 have both been subject to investigation from external agencies. One related to an unsubstantiated allegation against a staff member and the other is being reviewed by the NHS Counter Fraud team. | 0 | 2 |
| **Patient safety incidents per 1000 admissions**<br>A patient safety incident is defined as an unexpected event that occurred resulting or, or having the potential to result in, harm to the patient. The incidents are reported by Trust staff. Two thirds of the patient safety incidents reported resulted in no harm to the patient. | 38 | 46 |
| **Medication errors per 1000 admissions**<br>The administration of drugs is the most common transaction that takes place in any hospital and therefore it is recognised that errors will occur. The majority of errors are minor with no impact on the patient. | No comparable data | 7.2 |
| **Patient falls per 1000 admissions**<br>The majority of falls occur in our community ward, Jubilee. It should be noted that the reporting of falls includes those where staff have been present to support and aid patients and those resulting in no injury to patients. | 6.5 | 9.5 |
| **Grade 2 and above pressure sores per 1000 admissions (acquired at Queen Victoria Hospital)**<br>Pressure sores can develop when patients are unable to move for an extended period of time. Good nursing will ensure patients who are limited in their movement are regularly moved to prevent such sores developing. Pressure sores are graded from 1 (least serious) to 5 (most serious). | No comparable data | 0.8 |
| **Compliance with National Patient Safety Agency Wristband requirements**<br>The National Patient Safety Agency has issued all NHS Trusts with a standard dataset that should be captured on all patient wristbands. These include name, date of birth, unique hospital number and allergies. Audits show that all patients reviewed were wearing a wristband and that this included the patients name and hospital number, however not all of the data requirements were met, hence the figure of 74%. | No comparable data | **74%** |

| PATIENT EXPERIENCE & ACCESS | 2007/08 | 2008/09 |
|---|---|---|
| **Patient complaints per 1000 admissions**<br>The Trust received 67 complaints in 2008/09. All complaints are thoroughly investigated and responded to personally by the Chief Executive. Where necessary, changes are made to the way services are delivered. No complaints were taken to the further stages of the NHS Complaints Procedure (Healthcare Commission and Parliamentary and Health Service Ombudsman). | 3 | 4 |
| **Plaudits received per 1000 admissions**<br>The Trust received 173 letters of thanks / cards in 2008/09. These are very much appreciated by staff | 5 | 11 |

It should be noted that these areas of performance will be the focus of priorities for 2009/10, together with the new performance metrics that are being developed for quality.

# 8. FINANCIAL ACCOUNTS FOR THE YEAR

1 April 2008 to 31 March 2009



## STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officers, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed 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's Memorandum.

Adrian R Bull

Dr Adrian Bull
Chief Executive

8 June 2009

# STATEMENT ON INTERNAL CONTROL 2008/09

## 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 Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The 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 2008/09.

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.

During the year the Trust has reviewed its governance arrangements, with the newly formed Clinical Cabinet being established as the executive and clinical leadership body within the hospital. 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 on their agenda and is reviewed at their monthly meetings.

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 2008/09. 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 at 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 six monthly 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 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.

## 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 2009 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 into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

## 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 Head of Integrated Risk Management. The structure has been further enhanced in the year by the appointment of one of the Trust's consultant anaethetists to lead on clinical quality and outcomes.

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, updated in 2008, 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.

## 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 has 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 and is driven by a bottom up approach, 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 are also identified and referenced to specific risks on the Trust's Risk Register.

**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 Head of Integrated Risk Management and is reviewed regularly by the Clinical Directorates and Quality and Risk Committee. In addition the Trust has also developed a risk register for its site redevelopment project. This register is reviewed regularly by the Project Steering Group, which reports to the Board via the Clinical Cabinet.

During the year the Assurance Framework is reviewed and updated by the executive leads responsible, and is reviewed regularly by the 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. In addition, during 2008/09 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 Care Quality Commission (previously the Healthcare Commission) Core Standards declaration.

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. Care Quality 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 final declaration, by 30th April 2009, as to its compliance with the core standards self-assessment for the year ended 31 March 2009. 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 2008/09 reflects the breaches of Duty 2 c,d,e and 4 a,b,c,e of the Hygiene Code as identified by the Healthcare Commission visit in November 2008. Although immediate action was taken to address these issues the Trust's declaration acknowledges these breaches. The Trust is also declaring that Domain 1 Safety C4a, Domain 3 Governance C7 a,c, and Domain 6 Care Environment & Amenities have not been met in full. The issues regarding Domains 1 and 6 are also in relation to the Healthcare Commission visit. The non compliance for Domain 7 reflects the fact that there was a gap in management arrangements whilst the new Clinical Directorate structure was being implemented.

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 the 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 roll out of a programme of impact assessments and the associated training; equality and diversity reports, presentations and training for the Trust Board.

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.

## 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 2008/09 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 2008/09 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.

## 6. REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the 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 compliance with the standards set out by the NHS Litigation Authority. In 2008/09 the Trust was accredited with Level 1, under the new NHSLA scheme.

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.

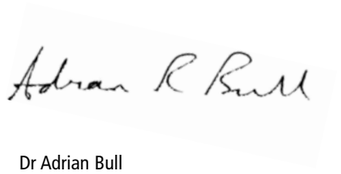
During the year the effectiveness of internal control has also been demonstrated by the following: -

- The Trust met all performance and waiting list targets
- Financial performance delivered a surplus of £1.2m (£0.8m after impairment 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. CONCLUSION

The Trust is not declaring full compliance for this year's Standards for Better Health Declaration although the issues raised by the Healthcare Commission visit to assess compliance with the Hygiene Code and the gap in management arrangements have now been addressed. At the end of the year there are no known significant internal control issues for the Trust.



Dr Adrian Bull
Chief Executive

8 June 2009

# INDEPENDENT AUDITOR'S 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 2009 which comprise the Income and Expenditure Account, the Balance Sheet, the Cash Flow Statement, the Statement of Total Recognised Gains and Losses, and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Financial 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 Chief Executive's Responsibilities [set out on page 65] the Chief Executive is 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.

## 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 Financial Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2009 and of its income and expenditure and cash flows for the year then ended 31 March 2009; and
- have been properly prepared in accordance with the NHS Foundation Trust Financial 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 Financial 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 Financial 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

8 June 2009

Notes:

(a) 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.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

## FOREWARD TO THE ACCOUNTS
## QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2009 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.

Adrian R Bull

Dr Adrian Bull
Chief Executive

8 June 2009

## INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2009

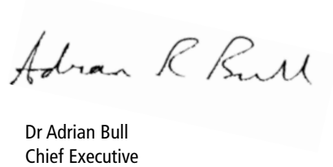
| | NOTE | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| **Income from activities** | 2 | **49,129** | 45,649 |
| **Other operating income** | 3 | **3,290** | 3,006 |
| **Operating expenses** | 4-5 | **(50,855)** | (45,936) |
| **OPERATING SURPLUS** | | **1,564** | 2,719 |
| **Loss on disposal of fixed assets** | 7 | **(65)** | (25) |
| **SURPLUS BEFORE INTEREST** | | **1,499** | 2,694 |
| Finance income | | **194** | 198 |
| Finance costs - unwinding of discount | 14 | **(12)** | (11) |
| **SURPLUS FOR THE FINANCIAL YEAR** | | **1,681** | 2,881 |
| Public Dividend Capital dividends payable | | **(824)** | (809) |
| **RETAINED SURPLUS FOR THE PERIOD** | | **857** | 2,072 |

The notes on pages 79 to 102 form part of these accounts.
All income and expenditure is derived from continuing operations.

## BALANCE SHEET AS AT 31 MARCH 2009

| | NOTE | 2009 £000 | 2008 £000 |
|---|---|---|---|
| **FIXED ASSETS** | | | |
| Intangible assets | 8 | **65** | 80 |
| Tangible assets | 9 | **33,684** | 31,022 |
| | | **33,749** | 31,102 |
| **CURRENT ASSETS** | | | |
| Stocks and work in progress | 10 | **346** | 271 |
| Debtors | 11 | **4,412** | 3,701 |
| Cash at bank and in hand | 17.3 | **3,110** | 5,510 |
| | | **7,868** | 9,482 |
| **CREDITORS:** Amounts falling due within one year | 12 | **(5,670)** | (4,822) |
| **NET CURRENT ASSETS** | | **2,198** | 4,660 |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | | **35,947** | 35,762 |
| **PROVISIONS FOR LIABILITIES AND CHARGES** | 14 | **(554)** | (563) |
| **TOTAL ASSETS EMPLOYED** | | **35,393** | 35,199 |
| **FINANCED BY:** | | | |
| **TAXPAYERS' EQUITY** | | | |
| Public dividend capital | | **12,212** | 12,212 |
| Revaluation reserve | 16 | **14,415** | 15,957 |
| Donated asset reserve | 16 | **2,692** | 2,185 |
| Income and expenditure reserve | 16 | **6,074** | 4,845 |
| **TOTAL TAXPAYERS' EQUITY** | 15 | **35,393** | 35,199 |

The financial statements on pages 76 to 102 were approved by the Board on 26 May 2009 and signed on its behalf by:



Dr Adrian Bull
Chief Executive

8 June 2009

## STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2009

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Surplus for the period before dividend payments | **1,681** | 2,881 |
| Unrealised surplus on fixed asset revaluations | **3,768** | 7,120 |
| Unrealised (deficit) on fixed asset revaluations | **(4,342)** | (334) |
| Increases in the donated asset reserve due to receipt of donated assets | **194** | 193 |
| Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets | **(283)** | (231) |
| **Total recognised gains and losses for the year.** | **1,018** | 9,629 |

## CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2009

| | NOTE | 2008/09 £000 | 2007/08 £000 |
|---|---|---|---|
| **OPERATING ACTIVITIES** | | | |
| **Net cash inflow from operating activities** | 17.1 | **3,599** | 4,408 |
| **RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:** | | | |
| Interest received | | **194** | 198 |
| **CAPITAL EXPENDITURE** | | | |
| Payments to acquire tangible fixed assets | | **(5,353)** | (1,582) |
| Receipts from sale of tangible assets | | **0** | 140 |
| Payments to acquire intangible fixed assets | | **(16)** | (12) |
| **DIVIDENDS PAID** | | **(824)** | (809) |
| **Net cash inflow before financing** | | **(2,400)** | 2,343 |
| **(Decrease) / Increase in cash** | 17.3 | **(2,400)** | 2,343 |



# NOTES TO THE ACCOUNTS

## 1. ACCOUNTING POLICIES AND OTHER INFORMATION

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2008/09 NHS Foundation Trust Financial Reporting Manual issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

### 1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. NHS foundation trusts, in compliance with HM Treasury's Financial Reporting Manual, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

### 1.2 Income recognition

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

### 1.3 Expenditure

Expenditure is accounted for applying the accruals convention.
The costs of operating leases are charged to the income and expenditure account on a straight-line basis over the term of the lease.

### 1.4 Tangible fixed assets

#### Capitalisation

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

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

#### Valuation

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

All land and buildings are revalued using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last valuations of land and buildings were undertaken in 2009 as at the valuation date of 31 March 2009.

The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property and existing use value for non-specialised operational property. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

In accordance with International Valuation Application 1 and RICS standards the current replacement cost of specialised buildings is based on the current cost of replacing the building with its modern equivalent.

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

Operational equipment is valued at net current replacement cost. Revaluation is carried out, using cost indices issued by the Department of Health, every five years with an interim revaluation in the third year. Equipment surplus to requirements is valued at net recoverable amount.

The directors are aware that the revaluation of land and buildings carried out during the year to 31 March 2009 has resulted in a material change in value.

**Depreciation, amortisation and impairments**

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

Assets in the course of construction are not depreciated until the asset is brought into use.

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

Equipment is depreciated on current cost evenly over the estimated life. Medical and other forms of equipment are assigned lives between five and fifteen years depending on their nature. I.T. equipment is assigned a life of five years.

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

**1.5 Intangible fixed assets**

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

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

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred, and amortised over the shorter of the term of the licence and their useful economic lives.

**1.6 Donated fixed assets**

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

**1.7 Private Finance Initiative (PFI) transactions**

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides definitive guidance for the application of application note F to FRS 5.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI payments are recorded as an operating expense.

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

**1.8 Stocks and work-in-progress**

Stocks and work-in-progress are valued at the lower of cost and net realisable value.

**1.9 Cash, bank and overdrafts**

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

**1.10 Research and development**

Expenditure on research and development is not capitalised. Expenditure on development would only be capitalised if it met the following criteria:

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

At present these conditions do not apply.

### 1.11 Provisions

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

### 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 19 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in Note 19 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 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at Note 14.

### 1.14 Non-clinical risk pooling

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

### 1.15 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. 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. As a consequence it is not possible for the foundation trust to identify its share of the underlying scheme liabilities. Therefore, the Scheme is accounted for as a defined contribution scheme under FRS 17. The NHS Pension Scheme (England and Wales) Resource Account is published annually and can be found on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk.

The Scheme is subject to a full actuarial investigation every four years. The last such investigation, published in December 2007, covered the period from 1 April 1999 to 31 March 2004. The conclusion of this investigation was that the scheme had accumulated a notional deficit of £3.3bn against notional assets at 31 March 2004. The basis for this conclusion is set out in the report by the government actuary which can be found on:

http://www.nhspa.gov.uk/nhspa_site/foi/foi1/Scheme_Valuation_Report/NHSPS_Valuation_report.pdf.

Taking account of the changes to the benefit and contribution structure effective from 1 April 2008, the conclusion of the investigation was that employer contributions should continue at the existing rate of 14% of pensionable pay. From 1 April 2008, employees pay contributions according to a tiered scale from 5% to 8.5% of their pensionable pay.

Employer's 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 income and expenditure account at the time the trust commits itself to the retirement, regardless of the method of payment.

### 1.16 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.

### 1.17 Foreign exchange

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

### 1.18 Third party assets

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

### 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities i.e. the net assets of a public benefit corporation.

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

### 1.20 Financial instruments

#### 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.

**De-recognition**

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

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

**Classification and Measurement**

Financial assets are categorised as 'Loans and receivables'. Financial liabilities are classified as 'Other Financial Liabilities'.

**Loans and Receivables**

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

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

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

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

**Financial Liabilities**

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 balance sheet date, which are classified as long-term liabilities.

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

**Impairment of Financial Assets**

At the balance sheet 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 have an impact on the estimated future cashflows of the asset.

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



## 2. INCOME FROM ACTIVITIES

### 2.1 SOURCES OF INCOME FROM ACTIVITIES

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| NHS Foundation Trusts | **0** | 172 |
| NHS Trusts | **22** | 7 |
| Strategic Health Authorities | **0** | 57 |
| Primary Care Trusts | **44,005** | 40,426 |
| Department of Health | **4,547** | 4,556 |
| NHS Other | **73** | 126 |
| Non NHS: | | |
| - Private Patients | **89** | 83 |
| - NHS Injury Scheme (was Road Traffic Act) | **212** | 167 |
| - Other | **181** | 55 |
| | **49,129** | 45,649 |

NHS Injury Scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

### 2.2 INCOME FROM PROTECTED AND NON-PROTECTED SERVICES

'Protected services' refers to all clinical services that an NHS foundation trust is under an obligation to offer to NHS patients as defined in its terms of authorisation.

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Income from protected services | **48,828** | 45,399 |
| Income from non-protected services | **301** | 250 |
| | **49,129** | 45,649 |

### 2.3. PRIVATE PATIENT INCOME

Section 15 of the Health and Social Care (Community Health and Standards) Act 2003 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 its base year.

The Trust's private patient cap is 0.2% as set out in its terms of authorisation as a foundation trust.

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Private patient income | **89** | 83 |
| Total patient-related income | **49,129** | 45,649 |
| Proportion | **0.18%** | 0.18% |

## 3. OTHER OPERATING INCOME

| | 2008/09 | 2007/08 |
|---|---|---|
| | | |
| Education, training and research | **1,865** | 1,597 |
| Charitable and other contributions to expenditure | **187** | 145 |
| Transfers from donated asset reserve | **283** | 231 |
| Non-patient care services to other bodies | **366** | 556 |
| Other income | **589** | 477 |
| | **3,290** | 3,006 |

## 4. OPERATING EXPENSES

### 4.1 OPERATING EXPENSES COMPRISE:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Services from Foundation Trusts | **527** | 20 |
| Services from other NHS Trusts | **2,947** | 3,656 |
| Services from other NHS bodies | **174** | 83 |
| Purchase of healthcare from non-NHS bodies | **38** | 59 |
| Executive directors' costs | **417** | 464 |
| Non-executive directors' costs | **129** | 106 |
| Staff costs | **34,026** | 31,095 |
| Drugs | **1,023** | 828 |
| Supplies and services - clinical (excluding drugs) | **4,430** | 3,679 |
| Supplies and services - general | **638** | 543 |
| Establishment | **992** | 860 |
| Transport | **127** | 138 |
| Premises | **2,180** | 1,781 |
| Increase / (decrease) in bad debt provision | **(7)** | 43 |
| Depreciation and amortisation | **1,903** | 1,675 |
| Impairment of fixed assets | **324** | 260 |
| Audit fees | **88** | 73 |
| Other auditors remuneration | **24** | 0 |
| Clinical negligence | **128** | 175 |
| Other | **747** | 398 |
| | **50,855** | 45,936 |

### 4.2 OPERATING LEASES

#### 4.2/1 OPERATING EXPENSES INCLUDE:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Hire of plant and machinery | **261** | 280 |
| Other operating lease rentals | **321** | 235 |
| | **582** | 515 |

#### 4.2/2 ANNUAL COMMITMENTS UNDER NON-CANCELLABLE OPERATING LEASES ARE:

| | 2008/09 | 2008/09 | 2008/09 | 2007/08 |
|---|---|---|---|---|
| | **Land and buildings** | **Plant and machinery** | **Total** | |
| | **£000** | **£000** | **£000** | £000 |
| Operating leases which expire: | | | | |
| Between 1 and 5 years | 356 | 256 | **612** | 455 |
| After 5 years | 31 | 0 | **31** | 29 |
| | **387** | **256** | **643** | 484 |

## 5. STAFF COSTS AND NUMBERS

### 5.1 STAFF COSTS

| | 2008/09 | 2007/08 |
|---|---|---|
| | **Total** | Total |
| | **£000** | £000 |
| Salaries and wages | **28,590** | 26,169 |
| Social Security Costs | **2,385** | 2,235 |
| Employer contributions to NHSPA | **3,200** | 2,926 |
| Agency staff | **268** | 229 |
| | **34,443** | 31,559 |

## 5.2 AVERAGE NUMBER OF PERSONS EMPLOYED

| | 2008/09 | 2007/08 |
|---|---|---|
| | **Total** | |
| | **Number** | Number |
| Medical and dental | **119** | 115 |
| Administration and estates | **205** | 194 |
| Healthcare assistants and other support staff | **131** | 132 |
| Nursing, midwifery and health visiting staff | **199** | 196 |
| Scientific, therapeutic and technical staff | **132** | 131 |
| Bank and Agency | **55** | 47 |
| Total | **841** | 815 |

## 5.3 EARLY RETIREMENTS DUE TO ILL HEALTH

During the year there were no early retirements due to ill health (2007/08, none). (This information has been supplied by NHS Pensions.)

## 6. BETTER PAYMENT PRACTICE CODE

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

| Compliance | 2008/09 | 2008/09 | 2007/08 | 2007/08 |
|---|---|---|---|---|
| | **Number** | **£000** | Number | £000 |
| Total bills paid in the year | 16,177 | 23,322 | 15,272 | 15,590 |
| Total bills paid within target | 14,546 | 17,391 | 14,155 | 10,541 |
| Percentage of bills paid within target | 89.92 % | 74.57 % | 92.69 % | 67.61 % |

These figures include both NHS and non-NHS payments. Of non-NHS payments, 93.40 % (2007/08 - 93.54%) by number and 85.63 % (2007/08 - 89.17%) by value complied with the code.

No claims against the Trust were made under the Late Payment of Commercial Debts (Interest) Act 1998, (2007/08 nil).

## 7. LOSS ON DISPOSAL OF FIXED ASSETS.

During the year the trust disposed of protected assets with an aggregate net book value of £65,000. Since there were no proceeds, the resulting loss on disposal has been carried to the Income and Expenditure account.

## 8. INTANGIBLE FIXED ASSETS

| | 2008/09 | 2007/08 |
|---|---|---|
| | **Software Licences £000** | Software Licences £000 |
| Gross cost at 1 April 2008 | **151** | 140 |
| Additions | **16** | 11 |
| **Gross cost at 31 March 2009** | **167** | 151 |
| Amortisation at 1 April 2008 | **71** | 41 |
| Provided during the year | **31** | 30 |
| **Amortisation at 31 March 2009** | **102** | 71 |
| **Net book value** | | |
| - Purchased assets at 1 April 2008 | **80** | 99 |
| - Purchased assets at 31 March 2009 | **65** | 80 |

## 9. TANGIBLE FIXED ASSETS

### 9.1 TANGIBLE FIXED ASSETS AT THE BALANCE SHEET DATE COMPRISE THE FOLLOWING ELEMENTS:

| | 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 | 0 | (318) | 0 | 0 | 0 | 0 | (6) | **(324)** |
| Reclassifications | 0 | 2,379 | (2,569) | 136 | 0 | 54 | 0 | **0** |
| Other revaluations | (2,304) | 319 | 0 | 0 | 0 | 0 | 417 | **(1,568)** |
| Disposals | 0 | (70) | 0 | (146) | 0 | 0 | 0 | **(216)** |
| **At 31 March 2009** | **9,229** | **18,865** | **592** | **9,248** | **7** | **2,219** | **698** | **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** |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Revaluations | 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 | 16,644 | 592 | 3,039 | 3 | 824 | 661 | **30,992** |
| - Donated assets as at 31 March 2009 | 0 | 2,201 | 0 | 443 | 0 | 11 | 37 | **2,692** |
| **Total at 31 March 2009** | **9,229** | **18,845** | **592** | **3,482** | **3** | **835** | **698** | **33,684** |

As stated in Note 1.4, a revaluation of land and buildings was carried out with an effective date of 31 March 2009. The revaluation was made by an independent, qualified valuer using a Modern Equivalent Asset basis for specialised buildings. The revised land value takes account of the fall in residential land values since the previous revaluation, which was as at 1 April 2008 and which was included in the 2007/08 accounts.

### 9.2 THE NET BOOK VALUE OF LAND, BUILDINGS AND DWELLINGS AT 31 MARCH 2009 COMPRISES:

| | 2009 | 2008 |
|---|---|---|
| | **£000** | £000 |
| Freehold | **28,074** | 27,046 |

### 9.3 PROTECTED AND NON-PROTECTED FIXED ASSETS

Land, buildings and dwellings required for the provision of mandatory goods and services are protected and cannot be sold without the permission of Monitor.

| Net book value: | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| Protected land, buildings and dwellings | **26,321** | 24,855 |
| Non-protected land, buildings and dwellings | **1,753** | 2,191 |
| | **28,074** | 27,046 |

## 10. STOCKS AND WORK IN PROGRESS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| Raw materials and consumables | **346** | 271 |
| | **346** | 271 |

## 11. DEBTORS

### 11.1 DEBTORS BY CATEGORY

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| **Amounts falling due within one year:** | | |
| NHS debtors | **2,399** | 2,665 |
| Provision for irrecoverable debts | **(75)** | (82) |
| Prepayments and accrued income | **1,599** | 674 |
| Other debtors | **427** | 368 |
| **Sub Total** | **4,350** | 3,625 |
| | | |
| **Amounts falling due after more than one year:** | | |
| NHS debtors | **62** | 76 |
| **TOTAL** | **4,412** | 3,701 |

## 11.2 PROVISION FOR IMPAIRMENT OF NHS DEBTORS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| At 1 April | **41** | 41 |
| Arising during the period | **28** | 0 |
| Reversed unused | **(41)** | 0 |
| **At 31 March** | **28** | 41 |

## 11.3 PROVISION FOR IMPAIRMENT OF NON-NHS DEBTORS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| At 1 April | **41** | 17 |
| Arising during the period | **6** | 24 |
| **At 31 March** | **47** | 41 |

## 11.4 AGEING OF IMPAIRED DEBTORS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| Over six months | **75** | 82 |

## 11.5 AGEING OF NON-IMPAIRED DEBTORS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| Up to three months | **2,979** | 1,245 |
| Three to six months | **169** | 157 |
| Over six months | **123** | 50 |
| Total | **3,271** | 1,452 |

## 12. CREDITORS

| | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **£000** | £000 |
| **Amounts falling due within one year:** | | |
| NHS creditors | **2,543** | 1,578 |
| Tax and social security costs | **782** | 713 |
| Capital creditors | **112** | 121 |
| Other creditors | **838** | 862 |
| Accruals and deferred income | **1,395** | 1,548 |
| **Total** | **5,670** | 4,822 |

NHS creditors include £426,000 outstanding pensions contributions at 31 March 2009 (31 March 2008 - £363,000).

## 13. PRUDENTIAL BORROWING LIMIT

NHS foundation trusts are required to comply with the Prudential Borrowing Limit set for them by Monitor. In 2008/09 the foundation trust had a long-term borrowing limit of £11,200,000 (2007/08 - £10,400,000) and a working capital facility agreed by Monitor of £3,000,000 (2007/08 - £3,000,000). During the period the foundation trust was not required to use any of its borrowing limit.

## 14. PROVISIONS FOR LIABILITIES AND CHARGES

| | Pensions relating to staff | Legal claims | Other | **Total** |
|---|---|---|---|---|
| | £000 | £000 | £000 | **£000** |
| At 1 April 2008 | 524 | 15 | 24 | **563** |
| Arising during the period | 25 | 7 | 0 | **32** |
| Utilised during the period | (23) | (10) | 0 | **(33)** |
| Reversed unused | 0 | 0 | (20) | **(20)** |
| Unwinding of discount | 12 | 0 | 0 | **12** |
| At 31 March 2009 | **538** | **12** | **4** | **554** |
| **Expected timing of cashflows:** | | | | |
| Within one year | 25 | 12 | 0 | **37** |
| Between one and five years | 105 | 0 | 4 | **109** |
| After five years | 408 | 0 | 0 | **408** |

The provision for pensions relating to staff comprises £463,000 in respect of injury benefit (31/3/2008 - £449,000) and £75,000 in respect of early retirements (31/3/2008 - £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. The probability of loss has been assessed by the NHSLA as being between 50% and 75%. Partial reimbursement of payments made is expected from a number of NHS Primary Care Trusts. These claims also give rise to contingent liabilities which are disclosed in Note 19.

The provision for legal claims is shown net of the reimbursement due from the NHS Litigation Authority.

£812,000 is included in the provisions of the NHS Litigation Authority at 31/3/2009 in respect of clinical negligence liabilities of the foundation trust (31/03/2008 - £376,000).

## 15. MOVEMENT IN TAXPAYERS' EQUITY

| | **2008/09** | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Taxpayers' equity at start of period | **35,199** | 26,379 |
| Surplus for the financial year (before Public Dividend Capital dividend) | **1,681** | 2,881 |
| Public Dividend Capital dividends | **(824)** | (809) |
| (Deficit)/Surplus from revaluations of fixed assets | **(1,170)** | 6,473 |
| Movements in donated asset reserve | **507** | 275 |
| **Taxpayers' equity at 31 March 2009** | **35,393** | 35,199 |

## 16. MOVEMENTS ON RESERVES

Movements on reserves in the period comprised the following:

| | Revaluation Reserve | Donated Asset Reserve | Income and Expenditure Reserve | **Total** |
|---|---|---|---|---|
| | £000 | £000 | £000 | **£000** |
| At 1 April 2008 | 15,957 | 2,185 | 4,845 | **22,987** |
| Transfer from the income and expenditure account | 0 | 0 | 857 | **857** |
| (Deficit)/Surplus on revaluation of fixed assets | (1,170) | 596 | 0 | **(574)** |
| Receipt of donated assets | 0 | 194 | 0 | **194** |
| Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets | 0 | (283) | 0 | **(283)** |
| Other transfers between reserves | (372) | 0 | 372 | **0** |
| At 31 March 2009 | 14,415 | 2,692 | 6,074 | **23,181** |

## 17. NOTES TO THE CASHFLOW STATEMENT

### 17. 1 RECONCILIATION OF OPERATING SURPLUS TO NET CASHFLOW FROM OPERATING ACTIVITIES:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Total operating surplus | **1,564** | 2,719 |
| Depreciation and amortisation charge | **1,903** | 1,675 |
| Fixed asset impairments | **324** | 260 |
| Transfer from donated asset reserve | **(283)** | (231) |
| (Increase) in stocks | **(75)** | (28) |
| (Increase) / Decrease in debtors | **(711)** | 547 |
| Increase / (Decrease) in creditors | **886** | (539) |
| Increase / (Decrease) in provisions | **(9)** | 5 |
| Net cash inflow from operating activities | **3,599** | 4,408 |

### 17.2 RECONCILIATION OF NET CASH FLOW TO MOVEMENT IN NET FUNDS:

| | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| (Decrease)/Increase in cash in the period | **(2,400)** | 2,343 |
| Net funds at 1 April 2008 | **5,510** | 3,167 |
| Net funds at 31 March 2009 | **3,110** | 5,510 |

### 17.3 ANALYSIS OF CHANGES IN NET FUNDS:

| | At 1 April 2008 | Cash changes in year | Non-cash changes in year | **At 31 March 2009** |
|---|---|---|---|---|
| | £000 | £000 | £000 | **£000** |
| Commercial cash at bank and in hand | 30 | (4) | 0 | **26** |
| OPG cash at bank | 5,480 | (2,396) | 0 | **3,084** |
| | 5,510 | (2,400) | 0 | **3,110** |

## 18. CAPITAL COMMITMENTS

Commitments under capital expenditure contracts at 31 March 2009 were £346,000 (31 March 2008: £273,000).

## 19. CONTINGENCIES

| | At 31 March 2009 | At 31 March 2008 |
|---|---|---|
| Contingent liability: | **£000** | £000 |
| Gross value | **(7)** | (5) |

Contingencies relate to the provision for Legal Claims detailed in Note 14. They represent the difference between the provision, calculated on the basis of probability, and the maximum potential liability.

## 20. PUBLIC DIVIDEND CAPITAL (PDC) DIVIDEND PAYMENTS

The dividend paid on PDC is determined before the beginning of the accounting period and is calculated as 3.5% of forecast average relevant net assets for the period. Relevant net assets are total assets less the donated asset reserve and cash held in Office of the Paymaster General accounts.

Actual relevant net assets for the year were £28,555,000 (2007/08: £24,299,000) and the dividend payments of £824,000 (2007/08: £809,000) in the year therefore represented an annual dividend rate of 2.9% (2007/08: 3.3%). This was below the target of 3.5% because at the time the dividend was calculated capital expenditure during the year was expected to be only £2,000,000, whereas for operational reasons £5,303,000 was actually spent.

## 21. RELATED PARTY TRANSACTIONS

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Queen Victoria Hospital NHS FoundationTrust.

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

Goods and services were bought from and sold to:

a) McIndoe Surgical Centre Ltd, a private healthcare company many of whose shareholders are consultants employed by the foundation trust and with which the foundation trust has a profit-sharing agreement.

b) Centre For Sight and LAD Health, private healthcare companies owned by a consultant employed by the foundation trust.

Other public sector bodies included within the Whole of Government Accounts are also deemed to be related parties. The foundation 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 on the following page.

| Related party transactions | 2008/09 | | 31 March 2009 | | 2007/08 | | 31 March 2008 | |
|---|---|---|---|---|---|---|---|---|
| | Income | Expenditure | Debtor | Creditor | Income | Expenditure | Debtor | Creditor |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Private sector and charitable organisations** | | | | | | | | |
| The Queen Victoria Hospital NHS Trust Charitable Fund | **339** | **0** | **31** | **0** | 128 | 0 | 0 | 0 |
| McIndoe Surgical Centre | **132** | **16** | **12** | **0** | 102 | 3 | 11 | 3 |
| Centre for Sight and LAD Health | **44** | **46** | **13** | **0** | 57 | 71 | 12 | 4 |
| **Whole of Government Accounts bodies** | | | | | | | | |
| **a) Bodies with whom either income or expenditure exceeded £150,000 during the year:** | | | | | | | | |
| West Sussex PCT | **11,632** | **3** | **844** | **362** | 10,500 | 2 | 197 | 22 |
| West Kent PCT | **8,516** | **21** | **253** | **0** | 8,212 | 11 | 403 | 0 |
| Department of Health | **4,650** | **0** | **0** | **118** | 4,709 | 0 | 63 | 0 |
| East Sussex Downs and Weald PCT | **4,944** | **44** | **24** | **70** | 3,796 | 26 | 40 | 26 |
| Tower Hamlets PCT | **3,529** | **0** | **15** | **0** | 3,959 | 0 | -18 | 87 |
| Eastern And Coastal Kent PCT | **3,468** | **3** | **52** | **6** | 3,267 | 0 | 127 | 0 |
| Medway PCT | **3,398** | **52** | **61** | **79** | 3,118 | 50 | 84 | 53 |
| Surrey PCT | **3,285** | **0** | **144** | **0** | 2,894 | 0 | 315 | 0 |
| Hastings and Rother PCT | **1,088** | **0** | **0** | **0** | 1,056 | 0 | 3 | 0 |
| Brighton and Hove PCT | **897** | **0** | **0** | **0** | 964 | 0 | 13 | 0 |
| Bromley PCT | **600** | **0** | **0** | **5** | 559 | 0 | 11 | 0 |
| Bexley Care PCT | **579** | **0** | **0** | **1** | 595 | 0 | 18 | 0 |
| Croydon PCT | **359** | **0** | **14** | **0** | 292 | 0 | 15 | 0 |
| Hampshire PCT | **341** | **0** | **260** | **0** | 334 | 0 | 92 | 0 |
| Leicestershire County And Rutland PCT | **231** | **0** | **5** | **0** | 7 | 0 | 0 | 0 |
| Greenwich Teaching PCT | **160** | **0** | **4** | **0** | 127 | 0 | 5 | 7 |
| Maidstone And Tunbridge Wells NHS Trust | **2** | **1,173** | **1** | **622** | 3 | 1,104 | 1 | 430 |
| NHS Business Services Authority | **0** | **989** | **0** | **204** | 0 | 859 | 0 | 17 |
| East Sussex Hospitals NHS Trust | **1** | **736** | **26** | **186** | 0 | 731 | 8 | 157 |
| Medway NHS Foundation Trust | **0** | **488** | **0** | **167** | 0 | 517 | 0 | 129 |
| Dartford And Gravesham NHS Trust | **2** | **454** | **0** | **51** | 0 | 441 | 0 | 77 |
| South East Coast Ambulance Service NHS Trust | **0** | **421** | **0** | **44** | 0 | 491 | 0 | 130 |
| NHS Litigation Authority | **3** | **160** | **0** | **35** | 5 | 175 | 0 | 8 |
| **Others** | **2,989** | **11,293** | **849** | **1,818** | 2,967 | 9,973 | 1,418 | 1,524 |

## 22. PRIVATE FINANCE TRANSACTIONS

### 22.1 PFI SCHEMES DEEMED TO BE OFF-BALANCE SHEET

| Financial assets | 2008/09 | 2007/08 |
|---|---|---|
| | **£000** | £000 |
| Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet | **210** | 230 |
| The Trust is committed to make the following payments during the next year: | | |
| **PFI scheme which expires;** | | |
| 2nd to 5th years (inclusive) | **204** | 203 |
| Estimated capital value of the PFI scheme | **1,000** | 1,000 |
| Contract Start date: | | **2 March 1999** |
| Contract End date: | | **1 March 2011** |

The scheme is for the provision and operation of energy services, including the supply, installation and maintenance of equipment, with the object of achieving operational and energy savings. The achievement of the savings is guaranteed by the service provider. In the event of the scheme being terminated before the agreed date the Trust has a commitment to pay the service provider amounts based on the payments that would have been made had the agreement not been terminated early.

## 23. FINANCIAL INSTRUMENTS

Accounting standards FRS 25, 26 and 29, Derivatives and Other Financial Instruments 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 1.20.

**Liquidity risk**
The Trust's net operating costs are incurred under annual service agreements with Primary Care Trusts, which are financed from resources voted annually by Parliament. Queen Victoria Hospital NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

**Interest-Rate Risk**
100% of the foundation trust's financial liabilities carry nil or fixed rates of interest. 48% of its financial assets are held as cash at variable interest rates but interest receivable represents only 0.37% of total incoming resources (0.40% in 2007/08). The Queen Victoria Hospital NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

**Foreign Currency Risk**
The foundation trust has negligible foreign currency income or expenditure.

## 23.1 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY

| Financial assets | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **Carrying Value** | Carrying Value |
| | **£000** | £000 |
| Denominated in sterling | **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 I&E", "assets held to maturity" nor "assets held for resale".

| Financial Liabilities | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **Carrying Value** | Carrying Value |
| | **£000** | £000 |
| Denominated in sterling | **3,885** | 2,783 |

All financial liablities are classified as "other financial liabilities", with no financial liabilities being classified as "liabilities at fair value through the I&E".

Other tax and social security cost amounts of £782,000 (2007/08 £713,000) and deferred income of £877,000 (2007/08 £915,000) are not considered to be financial instruments under UK GAAP and therefore have been excluded from the above analysis.

## 23.2 FINANCIAL ASSETS AND LIABILITIES BY CATEGORY

| Financial assets | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **Loans and receivables** | Loans and receivables |
| | **£000** | £000 |
| NHS Debtors (net of provision for irrecoverable debts) | **2,433** | 2,324 |
| Accrued income | **70** | 208 |
| Other debtors | **262** | 260 |
| Cash at bank and in hand | **3,110** | 5,510 |
| **Total** | **5,875** | 8,302 |

| Financial liabilities | 31 March 2009 | 31 March 2008 |
|---|---|---|
| | **Other financial liabilities** | Other financial liabilities |
| | **£000** | £000 |
| NHS Creditors | **2,543** | 1,578 |
| Other creditors | **465** | 572 |
| Accruals | **877** | 633 |
| Total | **3,885** | 2,783 |

## 23.3 FAIR VALUES

| | Book Value | Fair Value |
|---|---|---|
| | **£000** | **£000** |
| Financial assets | **5,875** | **5,869** |
| Financial liabilities | **3,885** | **3,885** |

### 23.4 MATURITY OF FINANCIAL ASSETS

All of the foundation trust's financial assets mature within one year with the exception of £62,000 NHS debtors which are expected to mature in annual amounts of approximately £4,000 subject to inflation until the balance is exhausted.

### 23.5 MATURITY OF FINANCIAL LIABILITIES

All of the foundation trust's financial liabilities mature in less than one year.

### 23.6 DERIVATIVE FINANCIAL INSTRUMENTS

In accordance with FRS 26, 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 (2007/08 £nil).

## 24 INTRA-GOVERNMENT AND OTHER BALANCES

| | Debtors: amounts falling due within one year | Debtors: amounts falling due after more than one year | Creditors: amounts falling due within one year |
|---|---|---|---|
| | £000 | £000 | £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 | 1,902 |
| **At 31 March 2009** | 4,350 | 62 | 5,670 |
| Balances with other Central government bodies | 2136 | 76 | 1,348 |
| Balances with NHS Trusts and Foundation Trusts | 583 | 0 | 1,319 |
| Balances with bodies external to government | 906 | 0 | 2,155 |
| **At 31 March 2008** | 3,625 | 76 | 4,822 |

## 25 THIRD PARTY ASSETS

The foundation trust held no cash at bank or in hand at 31 March 2009 (31 March 2008 £nil) which related to monies held by the foundation trust on behalf patients.

## 26 LOSSES AND SPECIAL PAYMENTS

There were 29 cases of losses and special payments (2007/08 - 16 cases) totalling £ 6,000 (2007/08 - £2,000) approved during 2008-2009.

There were no clinical negligence cases where the net payment exceeded £100,000 totalling £nil (2007/08 - £nil).

There were no fraud cases where the net payment exceeded £100,000 totalling £nil (2007/08 - £nil).

There were no personal injury cases where the net payment exceeded £100,000 totalling £nil (2007/08 - £nil). There were no compensation under legal obligation cases where the net payment exceeded £100,000 totalling £nil (2007/08 - £nil). There were no fruitless payment cases where the net payment exceeded £100,000 totalling £nil (2007/08 - £nil). The total costs in this note are on a cash basis.

## 27 EVENTS AFTER THE BALANCE SHEET DATE

At the date of signing the directors were aware of no events occurring after the balance sheet date that would materially alter the content of these accounts.

# IF YOU NEED TO GET IN TOUCH


Queen Victoria Hospital
NHS Foundation Trust

Holtye Road East Grinstead
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Tel: 01342 414000


### CHIEF EXECUTIVE

If you have a comment for the Chief Executive, please write to Dr Adrian Bull at the address above, or email him at adrian.bull@qvh.nhs.uk

### BECOME A MEMBER

If you are interested in becoming a member, please call the Membership and Engagement Manager on 01342 414508 or email myra.scarbrough@qvh.nhs.uk

### PATIENT ADVICE AND LIAISON SERVICE (PALS)

If you require information, support or advice about any of our services, please contact our PALS and Information Co-ordinator on 01342 414200 or email claire.charman@qvh.nhs.uk

### RECRUITMENT

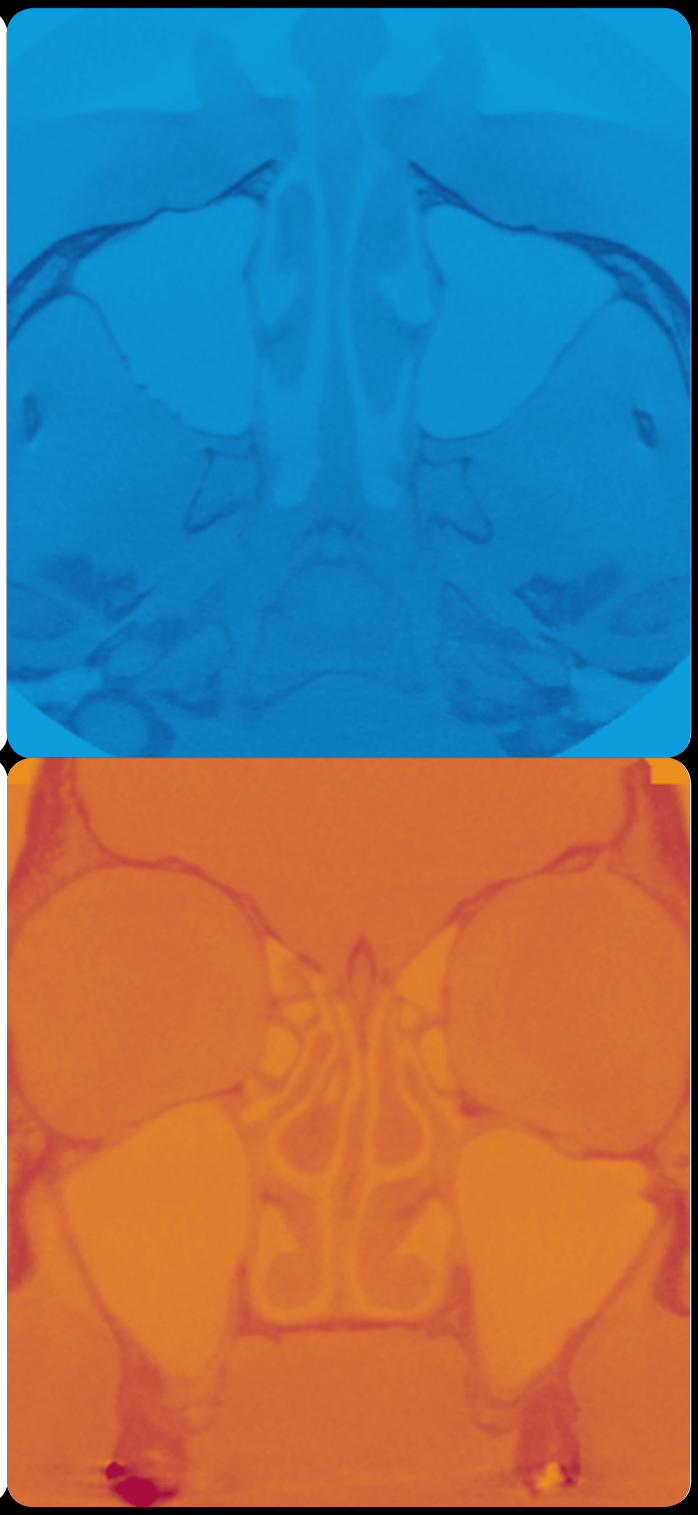
If you are interested in working at the hospital, please contact the Recruitment Co-ordinator on 01342 414495 or email job.applications@qvh.nhs.uk

### A DONATION?

If you wish to make a donation to the hospital's charitable fund, please call the Charitable Fund Manager on 01342 414280 or email sheila.kane@qvh.nhs.uk

### ANYTHING ELSE?

If you have any other query, or would like more copies of this report, please contact the Corporate Affairs department: 01342 414362 or email info@qvh.nhs.uk.



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