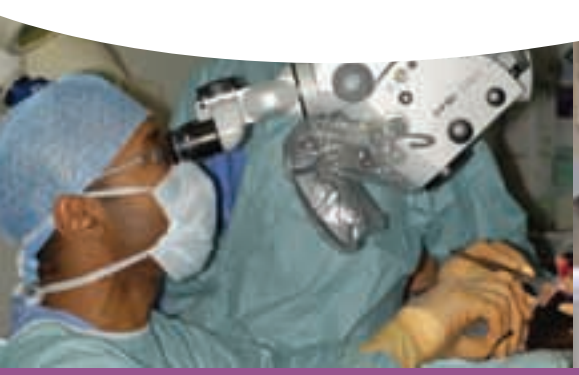
Queen Victoria Hospital NHS
NHS Foundation Trust

Building a better future:
Developing our hospital



ANNUAL REPORT AND FULL ACCOUNTS
2007/08

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Queen Victoria Hospital

NHS Foundation Trust

ANNUAL REPORT AND FULL ACCOUNTS 2007/08

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

An introduction from our Chairman

Peter Griffiths

It has been another successful year for the Queen Victoria Hospital NHS Foundation Trust.

During 2007/8 our hospital has met all the NHS standards and targets set by the Government, including those which really matter to patients, such as quality of care, safety and how responsive a trust is to patients.

We were delighted that the Healthcare Commission rated the Trust 'Excellent' for both the quality of our services and for the use of resources.

We have also demonstrated a strong, consistent financial performance and management of resources which Monitor (our independent regulator) endorsed by announcing that Queen Victoria Hospital was the first Foundation Trust to move to six monthly reporting because of its excellent track record.

Very importantly, we were judged by patients themselves to be the second best hospital in the country in terms of the patient experience. We were also shortlisted for Foundation Trust of the Year by the Healthcare Financial Management Association and Monitor.

Whilst I am very proud to be Chairman of such a successful hospital, this does not lead the trust to be complacent. Far from it. Every single member of staff, governor and each non executive director is determined to make the hospital even better. This was demonstrated during the latter half of 2007 by a strategic review culminating in the endorsement of proposals to develop services and the site over the next few years to make our hospital the best it can possibly be.

The review included the views and opinions of our governors, stakeholders and staff and we look forward to extending this consultation to the users of our services during the middle of 2008 to help us ensure we are delivering the services that our patients and community need and want.

I look forward to hearing your views about the hospital during the coming year.

And welcome from our Chief Executive

Sharon Colclough

Last year was my first as Chief Executive of Queen Victoria Hospital NHS Foundation Trust.

Much has happened during the year which is summarised in this report.

Whilst we can demonstrate considerable success in national surveys, both for inpatients and staff and we have hit or exceeded every single one of our targets, what matters most to us is the accountability to our patients, staff and community. As a foundation trust, this accountability is through our 10,500 public members who elect governors to represent them on the Board of Governors. This is vital to us because we want to improve our services and our buildings to bring very real benefits to each of our patients and to provide an excellent community facility. We cannot do this without you and we always welcome your views.

I would also like to praise our 910 staff. I continue to be impressed by the commitment of every single member of staff to make the hospital the very best it can be for our patients and visitors. Queen Victoria Hospital is a happy place to work and for the second year running, the hospital was recognised by the Nursing Times as the best employer for nurses working in hospital care.

If you would like to learn more about the hospital, visit our new website which we launched during the year at www.qvh.nhs.uk. It will give you a very good idea about our work, our staff and how you can access our services.

I hope you enjoy reading about the hospital's year in the following pages and that you will comment about our future plans and objectives.

Welcome to Queen Victoria Hospital.

Sharon Colclough

Who we are and what we do

The Queen Victoria Hospital became a foundation trust in 2004, under the Health and Social Care (Community Health and Standards) Act 2003. One of the first trusts in the country to achieve NHS foundation status, the hospital remains at the forefront of specialist care as a regional centre for maxillofacial, reconstructive plastic and corneo-plastic surgery as well as for the treatment of burns and also orthodontics. As a regional centre in the south east of England, the hospital serves over four million people.

The hospital also provides community services to the local population including a minor injuries unit.

As a foundation trust, we now have more than 10,000 public members across Sussex, Kent and Surrey but are always encouraging more hospital supporters to become members, to learn more about the hospital and its services and help us to develop both.

Each year we agree our proposals for the coming year which sets out what we want to do and how we plan to do it. The document is called the Annual Plan which we submit to Monitor, our regulator. The Board of Directors reviews the trust's performance against the Annual Plan at each of its meetings, and every six months the trust is required to submit a report to Monitor showing how it is performing against the Plan. We are pleased that we met all our own targets this year. This Annual Report therefore is closely linked to the Annual Plan for 2007/8, reporting on progress against each of our six objectives.

OUR CORE VALUES

Quality | Safety | Accountability | Openness | Inclusiveness

OUR VISION

To be a national and international leader in the development and delivery of specialist services and the first choice for patients requiring local community and specialist care

OUR OBJECTIVES FOR 2007/08

- Providing outstanding patient care
- Providing care closer to home
- Developing our site at East Grinstead
- Improving productivity, efficiency and effectiveness
- Valuing staff – developing organisational culture
- Maintaining and improving our finances
- Building relationships

Innovation | Integrity | Flexibility | Fairness | Respect

objective 1:
Providing outstanding patient care

PATIENT FEEDBACK

I am writing to express my sincere gratitude to all the staff of your hospital who provided me with the very highest standard of both care and kindness.

PATIENT FEEDBACK

The feeling of harmony that exists throughout the staff is very gratifying and comforting.

PATIENT SURVEY

The Healthcare Commission Inpatient Survey 2007 found that the Queen Victoria Hospital was amongst the best performing 20% of UK trusts in 56 out of 62 questions and in 14 of these 56 questions, QVH had the absolute highest score amongst all trusts, coming second overall in the country. The survey sought the views of 850 patients treated at QVH – of which 462 responded (55.2% response rate). It looked at many aspects of the care and services with a total of 81 questions. This survey is still regarded by the Trust as one of the most important indicators of patient satisfaction as it is conducted independently and anonymously.

In 66 of these questions QVH scored significantly better than the average of the 79 UK hospitals in this sample group managed by Picker Europe.

Below are some of the positive aspects highlighted by patients' experience:

- Overall – rating of care was good/excellent (96%)
- Overall – doctors and nurses work well together (96%)
- Doctors – always had the confidence and trust (92%)
- Hospital – room or wards very/fairly clean (98%)
- Care – always enough privacy when being examined or treated (92%)
- Care – less than five minutes to answer call button (90%)
- Surgery – risks and benefits clearly explained (86%)

The excellent care at the hospital was also recognised in the Healthcare Commission's review – Dignity in Care – where QVH was held up as an exemplar.

We seek views on the quality of our care continuously but the survey did highlight areas with less positive results, which we need to review. These are below:

- Information on how to complain
- Not asked to give views on quality of care
- Discharge delayed by one hour or more
- Who to contact when worried
- Not offered a choice of food

These areas are being addressed by an action plan which is being taken forward by the Quality and Risk Committee.

INFECTION PREVENTION AND CONTROL

QVH was set extremely tough targets for MRSA Bacteraemia by the Health Protection Agency (HPA) and also Clostridium Difficile targets by its local commissioning Primary Care Trusts. Despite some highly complex clinical cases during the year including major burns, QVH achieved its challenging target of only having 3 MRSA Bacteraemia and 5 Clostridium Difficile during the course of the financial year.

The Infection, Prevention & Control Team introduced many new initiatives during the year including wipeable computer keyboards, hydrogen peroxide deep cleaning machines and more signs (including on the floor) throughout the hospital, targeting hand washing and prevention of infection.

STANDARDS FOR BETTER HEALTH (ANNUAL HEALTHCHECK)

The trust introduced a more inclusive programme for achieving the Standards for Better Health during 2007, which forms part of the trust's Annual Healthcheck. There are currently seven domains within these standards and an executive director was identified as the lead for each domain. Alongside this executive overview, the reporting arrangements required that each domain reported through to a sub-committee of the Board, thus establishing a more inclusive assessment in determining our declaration of compliance.

The Board of Directors has been advised regularly on the progress of the assessment process throughout the year and Chantrey Vellacott, the trust's Internal Auditors, have commended the process and have also assessed our compliance to these Standards.

Other contributing agencies to our assessment process were the Patient & Public Involvement Forum, West Sussex Health Overview & Scrutiny Committee and the trust's Board of Governors who introduced a very comprehensive assessment in determining the standard of quality of care, which included16 governor tours to different wards and departments.

BEST OF HEALTH AWARDS

Two awards were presented to the hospital at the regional Best of Health and Social Care Awards.

The Leadership for Improvement award went to the hospital's consultant corneo-plastic and ophthalmic surgeon, **Sheraz Daya**. He has turned the corneo plastic unit and eye bank into an internationally renowned unit, providing some of the most modern eye care in the world. Mr Daya has developed a number of innovative new techniques in corneal transplant and his pioneering work in stem cell transplantation to restore ocular surface resulted in a breakthrough in 2005. The successes and accomplishments of the unit in providing patients with very complex conditions with exceptional treatment and care have been outstanding.

The second award, Innovative Information Communications and Technology, went to the team responsible for the hospital's telemedicine system, led by **Ted Balk**, the Head of Informatics. The system has enabled the sharing of the hospital's consultants' expertise across the South East of England.

objective 1:
Providing outstanding patient care

WHAT HAPPENS WHEN PATIENTS GO HOME?

Great care is taken to ensure that patients do not spend unnecessary time in the hospital when clinically it is safe for them to be discharged, so all discharges are well planned and co-ordinated with relatives, friends and other agencies. This ensures support is available at home and if for any reason it is not immediately available, our matron responsible for discharge co-ordination, supplies 'Lynn's Goodie Bag' which includes bread and milk for patients when they go home.

FIRST FOR BURNS PATIENTS

During 2007/8 the trust was successful in attracting national funding to establish a national pilot for a burns rehabilitation service. The trust has been providing this service for its own patients for a number of years, and has developed expertise in this area that could benefit other patients that require significant rehabilitation following burns injuries. This service will be fully established in 2008/9.

CANCER SERVICES

During the year the Trust made significant inroads into being recognised as a significant provider of cancer services. The Trust has been recognised within all three cancer networks across the South East Coast and is now included in the care pathways of patients with breast, skin and head and neck cancer. In addition, the Trust was recognised as the surgical centre for head and neck cancer for Kent. The Trust's consultants and other clinical staff regularly attend multi-disciplinary meetings to discuss the care and on-going management of cancer patients.

RESEARCH AND DEVELOPMENT OVERVIEW

The trust's traditional area of strength in research, wound healing and tissue reconstruction, has been complemented with an additional research programme this year. A new work stream looking at the psychosocial aspects of breast surgery has begun, and a full-time Research Psychologist appointed.

Academics from the University of the West of England – acknowledged leaders in this area - are collaborating with us on this new suite of projects. A large scale, prospective study is planned exploring the psychosocial well-being of all breast surgery patients. Exploratory research will also be carried out into the needs of patients with congenital asymmetry, together with a quantitative study into nipple reconstruction patients. The new programme will build on the experience gained in previous projects on returns to work following burns and telemedicine, and will ultimately draw in all of the Trust's surgical specialties.

Meanwhile, work has continued on our longstanding programme of 'wound healing and tissue reconstruction', with the following investigator-led projects ongoing or completing in 2007/8:

- A pilot study of looking at the long-term natural history of normal cutaneous scars at four plastic surgical units in the UK
- The extent of extra-capsular fibrosis following breast implant insertion
- A comparison between sheet grafts and 1:1 mesh grafts in burnt patients
- A review of split skin graft donor sites
- An investigation into the application of sprayed cultured skin cells to paediatric scalds (in conjunction with the Blond McIndoe Research Foundation)
- A comparison between sprayed cultured skin cells in combination with meshed split thickness skin grafts and meshed split thickness skin grafting alone in patients with full thickness burns (also in collaboration with the BMRF)
- Pharmacokinetics of antibiotics in burn patients:
- A trial to investigate the efficacy of Zesteem in accelerating the healing of graft donor sites
- A trial to investigate the efficacy of Juvista in the improvement of scar appearance following bilateral reduction mammaplasty
- A trial to investigate the efficacy of enzymatic debridement on burns patients (children and adults) – Phase III

Since its start in 2002/3, this programme has produced some 50 publications.

Outside our two main research programmes, we have also been conducting studies into:

- The relationship between malocclusion and bullying
- A comparison between oral paracetamol and intravenous paracetamol
- The effect of intra-operative passive movement on non-surgical site pain after breast reconstruction
- An investigation of the effect of wearing Bangerter occlusion foils
- A 20-year follow up of Goode T-Tubes in patients having undergone cleft palate repair
- Do genetic tests help specialists to detect cancer cells?
- A comparison of resorbable plates and metal plates for the management of fractured mandibles
- A comparative study of the construction and implementation of patient choice policies in the UK

The trust has been invited to take part in a research study to investigate how patient choice policy is being implemented and/or patient choices offered within the NHS.

HOW WE HAVE PERFORMED

HEALTHCARE TARGETS AND NATIONAL CORE STANDARDS

The trust has successfully met all its healthcare targets and national core standards for 2007/8, which contribute to the Healthcare Commission's Annual Healthcheck of trusts. The trust's rating for 2007/08 will be published by the Healthcare Commission in October 2008.

The Annual Healthcheck assesses whether healthcare organisations are getting the basics right and if they are making and sustaining progress. The trust's performance against the Annual Healthcheck indicators is set out in the table below. Note that only the indicators applicable to the trust are included in the table.

EXISTING TARGETS

INDICATOR	DESCRIPTION /RATIONALE	NATIONAL TARGET	QVH'S PERFORMANCE
All cancers - 31 day target	One month diagnosis (decision to treat) to treatment. No patient should wait longer than one month (31 days) from diagnosis of cancer to beginning of treatment.	98% of patients to meet criteria	100% Achieved
All cancers - 62 day target	Two month urgent GP referral to treatment. No patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to beginning of treatment.	95% of patients to meet criteria	100% Achieved
All cancers - two week waits	Two week maximum wait from GP referral to first outpatient appointment for all urgent suspected cancer referrals.	100% of patients to meet criteria	100% Achieved
Cancelled operations	All patients who have operations cancelled for non-clinical reasons, to be offered another binding date within 28 days.	Low Value indicates good performance	0.335% Achieved
Convenience & Choice - provider information in place to support choice	Availability of slots within 13 weeks as shown on Choose and Book utilisation reports. Does the Trust follow national guidance on clinic types when loading information into the Directory of Services.	Compliance with criteria	Fully compliant
Delayed Transfers of Care	To reduce the numbers of patients occupying an acute hospital bed whose transfer of care is delayed.	Low value indicates good performance	0% Achieved

objective 1:
Providing outstanding patient care

EXISTING TARGETS

INDICATOR	DESCRIPTION /RATIONALE	NATIONAL TARGET	QVH'S PERFORMANCE
Number of electives waiting longer than the standard	Number of patients waiting 26 weeks or more for inpatient treatment 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	Number of patients waiting 13 weeks or more for outpatient treatment 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	To maintain the four hour maximum wait in A&E from arrival to admission, transfer or discharge. This target is applicable to the Trust's Minor Injuries Unit (MIU).	98% of patients to meet criteria	99.75% achieved (minor injuries unit)
Use of resources	Assessment of the trust's historical and projected financial performance. The score for foundation trusts is based on the financial risk rating from Monitor, the FT regulator.	Monitor rating of 5	Rating of 5 Achieved

NEW TARGETS

INDICATOR	DESCRIPTION /RATIONALE	TARGET	ACHIEVED
Data quality on ethnic group	Completeness of trust coding for ethnicity in patient data sets.	80% compliance with criteria	92.73% Achieved
Emergency bed days	To improve health outcomes for people with long term conditions through improved care in primary and community settings.	Low value indicates good performance	10.82% Achieved
Experience of patients	To secure sustained improvements in NHS patient experience, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independent validated surveys. Patient experience is surveyed in five domains:- • access & waiting • safe, high quality, coordinated care • better information, more choice • building closer relationships • clean, friendly, comfortable place to be.		Excellent results in Patient Survey
Referral to Treatment Times Milestones	To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.	85% of admitted patients must be treated within 18 weeks of referral. 90% of non-admitted patients must be treated within 18 weeks of Referral.	Trust achieved Admitted patients: 99% of patients were treated under 18 weeks, Non-Admitted patients: 94% of patients were treated under 18 weeks.
Obesity - Compliance with National Institute of Clinical Excellence (NICE) Guideline 43	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010		Fully compliant
MRSA Bacteraemia	To achieve year on year reductions in Methicillin Resistant Staphylococcus Aureus (MRSA) levels.	National Target set for Trust – 3 cases Low Value indicates good performance	3 cases (2007/8) 1 case (2006/7) 5 cases (2005/6)
Clostridium Difficile Infection	To achieve year on year reductions.	Low value indicates good performance Locally agreed target with PCT – 5 cases	5 cases (2007/8)
Waiting times for diagnostic tests	This indicator assesses progress on the diagnostic element of the 18 week target, based on the expectation that by 31 March 2008 patients should receive any diagnostic test within a maximum of 6 weeks.	Below 6 weeks	Under 6 weeks achieved

objective 1:
Providing outstanding patient care

PATIENTS SEEN AND TREATED

ACTIVITY 2007/08

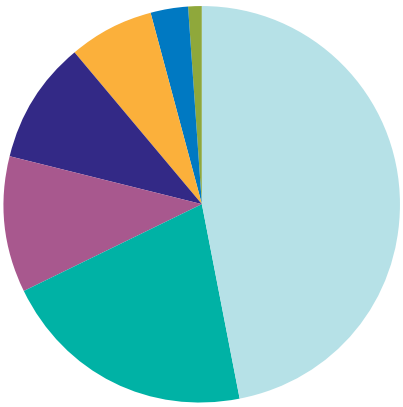
The trust saw a continued increase in inpatient activity in 2007/8, with an overall year on year increase of 11%. Of particular note was the increase in day case activity, which is in line with the trust's plan and future strategy.

Outpatient activity also increased during 2007/8 with all areas and specialties showing growth in line with the trust's marketing strategy.

Type of Activity	2007/08	2006/07	% increase
Elective FCEs	4,323	4,103	5.4%
Emergency FCEs	4,522	4,239	6.7%
Daycases FCEs	9,546	8,436	13.2%
New Outpatients	26,876	24,033	11.8%
Outpatient procedures / minor operations	9,816	8,010	22.5%
Follow-up outpatients	69,769	65,952	5.8%

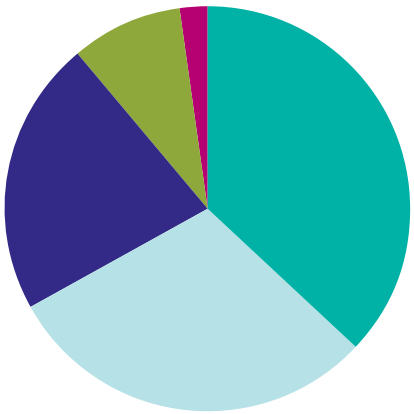
FCEs = finished consultant episodes, the measurement used for inpatient activity.

SPLIT BY SPECIALTY



INPATIENT ACTIVITY BY SPECIALTY

PLASTIC SURGERY	47%
MAXILLOFACIAL SURGERY	21%
OPHTHALMOLOGY	11%
CARE OF THE ELDERLY	10%
SLEEP STUDIES	7%
NON-CORE SPECIALTIES	3%
BURNS	1%



OUTPATIENTS ACTIVITY BY SPECIALTY

PLASTIC SURGERY	37%
MAXILLOFACIAL SURGERY	30%
NON-CORE SPECIALTIES	22%
OPHTHALMOLOGY	9%
SLEEP STUDIES	2%

INFORMATION GOVERNANCE

The Trust takes its responsibilites in respect of safeguarding the confidentiality of patient information extremely seriously. During the year the Trust has reviewed systems and processes for maintaining patient confidentiality and assessed the risks associated with all bulk transfers of data. Potential breaches of confidentiality are reported via the Trust's Incident Reporting System and subsequently investigated. There have been no Serious Untoward Incidents involving inappropriate disclosures or potential inappropriate disclosures of patient information during the financial year 2007/08.

objective 2:
Providing care closer to home

There is a national agenda to focus on the delivery of hospital services closer to patients' homes. For some years the trust has been providing its services on a hub (East Grinstead) and spoke model.
The table on the next page shows the wide range of services and sites at which the Queen Victoria Hospital operates.

This model of care allows the Trust to provide out-patient services and day case operations closer to patients' homes wherever possible. In-patient care for our specialist services is provided at the trust's main site in East Grinstead which also provides a community service for the residents of East Grinstead and it's local vicinity.

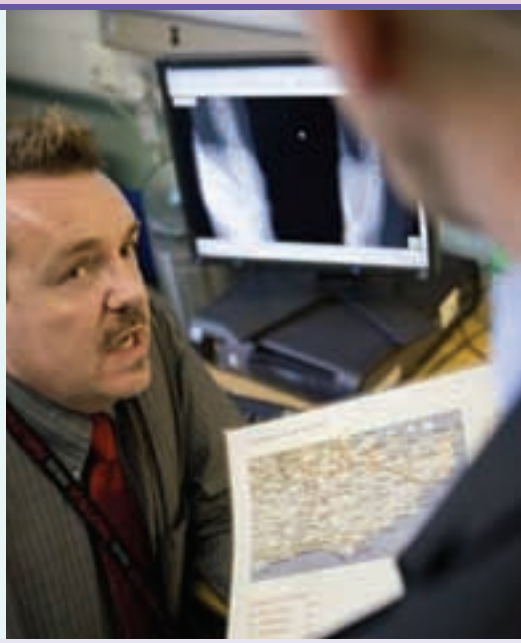
To put this into context, currently the levels of activity undertaken at the Trust spokes are as follows:

- 25% of all new out-patients
- 25% of out-patient procedures
- 13% of all day surgery
- 12% of out-patient follow-ups

This particular objective is important to us, and the strategic review supported the continued development of services outside of East Grinstead. We will be consulting our patients and public on this proposal during the coming year.

TELEMEDICINE

The trust has also increased the number of sites that host our telemedicine service. This helps to ensure that patients receive access to specialist advice regarding their wound as early as possible after an injury.



We are proud of this service, winning the South East Coast Strategic Health Authority (SEC SHA) Best of Health Award 2007/8 for Innovative ICT, recognising the development of innovative applications of information and communication technologies that support and improve the delivery of services for patients, service users or carers.

We are also introducing a community nurse practitioner service that assists with the care of patients in the right setting, particularly in relation to the care of the elderly. This service works closely with other acute trusts and community services ensuring that patients are cared for in the right setting and can return home as soon as it is appropriate.

CHOOSE AND BOOK

Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. By the end of March 2008 nationally more than 6 million appointments had been made via Choose and Book and 91% of all GP practices are using the service. The number of GP referrals made to QVH at East Grinstead by this method has risen from 25% in March 2007 to more than 60% by March 2008.

During 2007/8, the trust's plastic surgery and maxillofacial services at Dartford and Medway Hospitals were also made available via Choose and Book, as were the maxillofacial services at Uckfield, Horsham and the Kent & Sussex (Tunbridge Wells) Hospitals, and plastic surgery at East Kent Hospitals. A further five new services in plastic surgery and maxillofacial surgery have also been developed during this time for booking via Choose and Book and further new services will be made available for referral via this service. The trust now offers via Choose and Book all the specialist burns, plastic surgery, reconstructive and maxillofacial surgery, orthodontics and corneo-plastic surgery services available at East Grinstead and other sites, together with additional services in other specialties that the trust has developed for the local population.

From April 2008, the full roll out of choice policy means that the majority of patients being referred to hospital are able to choose where they wish to be treated. The Choose and Book application is changing to support this policy. Further changes to support referrals for diagnostic and other services such as xray and physiotherapy are also being introduced.

PATIENT FEEDBACK

I consider myself extremely lucky that my accident occurred within reach of such a professional team.

objective 2:
Providing care closer to home

OUR SERVICES

SERVICE / HOSPITAL	Queen Victoria	Brighton	Buckland Dover	Conquest Hastings	Darent Valley Dartford	Eastbourne	East Surrey Redhill	Horsham	Kent & Canterbury Canterbury	Kent and 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 Physician	OP																
Corneo-plastics	✓																
Dermatology	OPMO						OPMO	OPMO									
Dietetics	OP																
Direct Access	✓																
Ears, Nose and Throat	OPDC																
General Surgery	OPDC																
Gynaecology	OPDC																
Maxillo facial (jaws and face)	✓				OPDCMO		OPMO	OPMO		OP	OP	OPDCMO			OPDC		
• Head and Neck Oncology	✓				✓						✓	✓			✓		
• Lumps Clinic	✓										✓	✓					
• Dental Alveoli	✓				✓		✓	✓		✓	✓	✓			✓		
• Orthognathic	✓				✓					✓	✓	✓			✓		
Medical	OP																
Minor Injuries	✓																
Occupational Therapy	OP																
Orthodontics	✓									OP							
Paediatrics	OP																
Physiotherapy	OP																
Plastic Surgery																	
• Hand surgery	✓	OPDC		✓	OPDC			✓				OPDC					
• Breast reconstructive surgery	✓	✓	✓	✓	✓				✓		✓	OP		✓		✓	
• Skin cancer	✓	OPDC	✓	✓	✓	✓			✓		✓	✓		✓		✓	✓
• General plastic surgery	✓	OPDC	OPMO	OPMO	OPMO	OP			OPDCMO		OPMO	OPMO	OPDC	OPMO		OP	
Psychotherapy	OP																
Rheumatology (Arthritis)	OP																
Sleep Studies	✓																
Speech and Language therapy	OP																
Trauma and Orthopaedics (Bones, joints and muscles)	OPDC																
Urology (Urinary tract disease)	OP																
Vascular	OPDC																

KEY

- ✓ Full service
- OP Out patients
- DC Day cases
- MO Minor operations
- * The service in North Surrey commences in July 2008

objective 3:
Developing our site at East Grinstead

Developing our site is a vital objective for the hospital. Following the appointment of the Programme Director in 2007, the hospital is now making good progress towards the planning stages and it is anticipated that an Outline Business Case (OBC) will be completed by autumn 2008.

The trust has only been able to do this following a strategic services review, involving staff, stakeholders, governors, local GPs and others, over the latter half of the year. The outcome of the review is that there is a general consensus to expand our services both at our main site in East Grinstead and at our spokes, but to do this it is essential that we invest in our hospital buildings.

These proposed developments will be the basis of a consultation the trust will be conducting during the summer 2008, prior to the OBC going to the Board of Directors later in the year.

The trust is very conscious that whilst the clinical care is second to none, many of our buildings do not reflect the high standard of care that is delivered within them. Sensitive to the history and extremely grateful for the vociferous local support for the hospital, we wish to work with the community to improve our built environment to deliver the best care possible.

During the year the hospital's ageing estate caused a number of problems and investment was made to improve facilities for patients and to ensure that the estate continues to be well maintained ahead of the longer term redevelopment plans for the East Grinstead site.

For 2008/9 the Board of Directors has agreed a capital investment programme amounting to £3.9m to address some of the issues relating to the site and to ensure that there is sufficient capacity

to deliver patient activity and to make improvements to ensure service continuity and safety. Two particular schemes for 2008/9 that will improve facilities for patients will be the new modular maxillofacial unit and redevelopment of the Trust's paediatric facilities.

PATIENT FEEDBACK

I think the hospital should be extended because they have so many patients every day.

PATIENT FEEDBACK

As with all hospitals, I feel that the car park area could be improved.

objective 4:
Improving productivity, efficiency and effectiveness

PATIENT FEEDBACK

My daughter is 13 years old and was treated with the respect normally only given to adults. I was surprised at the way in which she was informed and consulted at every step.

PATIENT FEEDBACK

They have removed cancer from me and rebuilt my face and my life.

I have nothing but praise for the wonderful doctors that are there.

PATIENT SATISFACTION AND CUSTOMER CARE

The trust received 47 formal complaints during 2007/8, six fewer than the previous year, and 86% of these were responded to within 25 working days. No complainants requested a Healthcare Commission independent review.

The Patient Advice and Liaison Coordinator has been instrumental in "nipping problems in the bud" and making sure minor matters of dissatisfaction are handled quickly by the most appropriate person and are not allowed to escalate to become a more serious problems.

Work continues on a customer care training package which is very well attended and helps to give staff greater awareness of how to see matters through the eyes of a patient / relative, with examples used to demonstrate how we can improve our interactions when dealing with patients and learn from where we have got it wrong in the past.

During the year the trust continued to focus on improving productivity, efficiency and effectiveness. In line with the trust's overall strategy to maximise its income and expenditure margins, the trust was able to deliver a significant increase in its year on year margins.

The development of service line reporting and service line management across the care groups improved service delivery and financial performance, particularly in relation to the trust's service for care of the elderly. Work was undertaken to look at the skill mix and establishment of the nursing staff in the areas of care of the elderly and surgical wards to ensure that the workforce in these areas is in accordance with the acuity of care delivered and levels of activity. This work has realised significant savings, and has also resulted in an establishment that is more in line with the levels of care and activity in these areas.

The trust also continued to review and improve its models of care and care pathways. This work will continue into 2008/09, particularly in respect of the trust's site redevelopment. The work on the outline and full business cases will require a full review of all the models of care and patient pathways to ensure that they are in line with the latest thinking in terms of delivering high quality patient care safely and efficiently, and that the new development provides the best care for our patients.

objective 5:
Valuing our staff – developing organisational culture

PATIENT FEEDBACK

I was dealt with in a professional respectful and friendly manner at all times and great care was taken over confidentiality and dignity.

As the largest employer in East Grinstead we were pleased that the 2007 staff survey was very positive, with the trust highlighted as the top performing specialist trust in the UK in 13 out of the 26 key indicators. These included the extent of positive feeling in the organisation, quality of job design, availability of hand washing materials and perception of effective action towards harassment and violence. QVH has also just been awarded, for the second year running, the accolade of Top Employer for Hospital and Secondary Care by Nursing Times magazine.

We ran our fourth staff awards evening in October 2007 where many staff were honoured for their achievements in education, performance or loyalty to the organisation. Thank you to the Ashdown Park Hotel and to Lingfield Race Course for donating additional prizes for the awards ceremony. We also had a summer barbeque for staff and their families, a Christmas party accompanied by entertainment from the children of Imberhorne School, and a subsidised Christmas lunch in the Spitfire restaurant.

The trust works in partnership with trade union representatives to consult with staff and communicate changes, service developments, events, news and achievements. There are two official consultation forums: the Joint Consultative and Negotiating Committee which is made up of trade union and management representatives and the Local Negotiating Committee which is made up of management and medical staff representatives and a British Medical Association representative.

There are a number of staff communications channels within the trust, including monthly Chief Executive briefings, 'Can do' groups, team meetings, staff bulletins and newsletters and an intranet. Recently introduced is 'QVH Breaking News' which ensures that staff are always aware of urgent important news, such as issues announced in press releases, before the media. It is important to the trust that staff are aware of what is happening before all others.

During 2007/8, in partnership with the unions, the trust has continued to implement the Agenda for Change job evaluation scheme, with regular panels to evaluate new and re-designed roles. This could not be managed without the dedicated support of the union representatives.

Similarly, staff have the opportunity to elect three governors, who play a significant part within the Board of Governors.

We are also pleased that the trust was reaccredited for Investors in People and also for the 'two ticks' symbol, raising disability awareness.

objective 5:
Valuing our staff – developing organisational culture

LEARNING AND DEVELOPMENT

The learning and development strategy group meets quarterly, to take a corporate overview of learning and development in the hospital. The priority for the last year has been to embrace the changes brought about by Modernising Medical Careers, which includes setting up a new infrastructure of academic boards to enable local decisions to be made about the training of doctors in the QVH. In addition, the group has continued to monitor both the attendance at mandatory training and the relevance of the learning and development opportunities on offer. The trust is extremely grateful to the League of Friends for their continued financial support in funding the Rosemary Wootton bursary, which enables more staff to take up non mandatory learning and development activities.

During the year over 200 staff were also directly involved with the strategic service review and this consultation will widen and continue over the coming year to ensure that all proposals for service and site redesign are led and strongly influenced by staff as well as patients and users.

Through the four Care Groups (Family Health – Surgical Care – Critical Care – Corneo-Plastics) staff are directly involved in performance achievement, the management of activity and the management of risk and clinical governance. Each Care Group is led by a director (senior clinician) who is a member of the Trust Management Team (TMT). Reports from the TMT are given to all staff through the emailed weekly briefing as well as through team briefings.

The Trust has recently employed a consultant in equality and diversity to assess its achievements in this field and make recommendations about improvements we could make. Following a successful bid in the business planning process, we will be recruiting a permanent equality and diversity manager in the near future.

The trust continues to be an equal opportunities employer, having achieved re-accreditation for the two ticks standard and Investors in People. We have funded interpreters for deaf people to come to interviews for employment and have organised assessments for staff who may have specific needs, such as those with dyslexia.

The occupational health and counselling service is in the process of being re-tendered. We had a successful visit from the Health and Safety Executive in September 2007, which focussed on stress in the workplace. The staff survey results frequently show that we have the lowest level of stress across the acute specialist sector.

PATIENT FEEDBACK

Queen Victoria was outstanding in cleanliness, teamwork, continuity of care, communication and efficiency.

objective 6:
Maintaining and Improving our Finances

The Finance Director's Report

HEADLINE FIGURES

The trust's financial and investment strategy is to maximise income and expenditure margins and to generate cash reserves and borrowing potential in order to improve services for patients through the redevelopment of its East Grinstead site and development of its spokes.

Our financial results for 2007/08 support this strategy and continue the trust's excellent track record of financial performance.

The headline figures for 2007/08 are set out below, with comparatives for the previous year's financial performance:-

	2007/08	2006/07	% Change
Turnover	£48.5m	£44.8m	8.30%
Surplus	£2.07m	£1.2m	72.50%
Income & Expenditure Margin	4.27%	2.60%	64.20%
Cash balance	£5.5m	£3.2m	71.90%
***Financial risk rating**	5	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.

BULLETIN FROM MONITOR

Queen Victoria Hospital NHS Foundation Trust is the first to move to six-monthly monitoring. This reflects the trust's consistent track record of performance ahead of plan, and six consecutive quarters with a financial risk rating of 5 and green risk ratings for governance and mandatory services.

Monitor, FT Bulletin December 2007

TRACK RECORD

As a foundation trust, Queen Victoria Hospital has a number of financial freedoms that allow it to retain any surpluses that it generates and to borrow in order to support capital investment. It is also able to determine its own capital investment strategies to improve patient services and business focus. It is these financial freedoms that underpinned the trust's financial and capital investment strategy for 2007/08 in order to deliver improved services for patients.

Over the past four years since becoming a foundation trust in 2004/05, the trust has maximised the benefits of the foundation trust finance regime in order to increase its turnover year on year and to start to generate significant cash surpluses. During 2007/08, Monitor, the regulator for foundation trusts, acknowledged the trust's strong track record of financial performance and we were given a further freedom of six-monthly reporting. We were the first foundation trust to be given this additional freedom.

objective 6:
Maintaining and Improving our Finances

INCOME AND EXPENDITURE

Details of the Trust's income and expenditure for the year are set out in the Summary Financial Statements. However, the key messages for the year are as follows:-

INCOME

In line with the trust's strategy to increase its turnover year on year, growth in income for 2007/08 was 8.3% (8% for 2006/07).

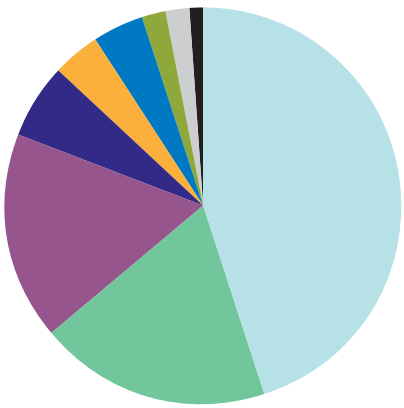
Clinical income from the delivery of services to patients grew by 8.3% during 2007/08. The trust continued to see the shift in the delivery of elective activity from in-patients to day cases. For 2007/08 the income arising from day case activity and in-patients activity, was 21% and 20% respectively, compared to 17% and 23% in 2006/07. In terms of income by specialty, the activity profile was in line with the previous year.

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

CLINICAL INCOME ANALYSED BY ACTIVITY TYPE

ELECTIVE ADMISSIONS	20%
DAY CASES	21%
NON-ELECTIVE ADMISSIONS	22%
OUTPATIENTS	29%
ATTENDANCES	8%

CLINICAL INCOME ANALYSED BY SPECIALITY



PLASTICS	45%
MAXILLOFACIAL	19%
BURNS	17%
OPTHALMOLOGY	6%
CARE OF ELDERLY	4%
NON-CORE SPECIALITIES	4%
SLEEP STUDIES	2%
MINOR INJURIES UNIT	2%
DIRECT ACCESS SERVICES	1%

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.

EXPENDITURE

Expenditure increased by 6.6% compared to the previous year, which was 2.2% below income growth, allowing the trust to increase its surplus generated from this differential. During the year the trust developed further its understanding of its cost base. This work was driven by focusing on service line management to improve the financial performance of some of the trust's service lines.

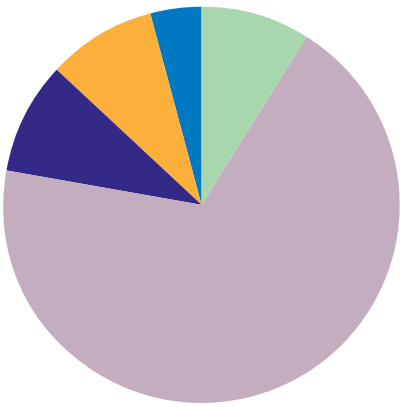
The trust saw some pressures on non pay expenditure in 2007/08. These were in specific areas rather than across the board. There were pressures on estates and facilities expenditure as a result of maintaining the ageing estate, and the trust also saw an increase in patient transport and drug expenditure. However, the trust did benefit from the savings made through procurement initiatives undertaken in 2006/07, and made significant savings particularly on its out-sourced services.

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

PATIENT FEEDBACK

If all hospitals could perform to this standard the NHS would be in fine form.

ANALYSIS OF EXPENDITURE



SERVICES PURCHASED FROM EXTERNAL BODIES	9%
STAFF COSTS	69%
DRUGS & CLINICAL SUPPLIES	9%
GENERAL RUNNING COSTS	9%
DEPRECIATION	4%

PATIENT FEEDBACK

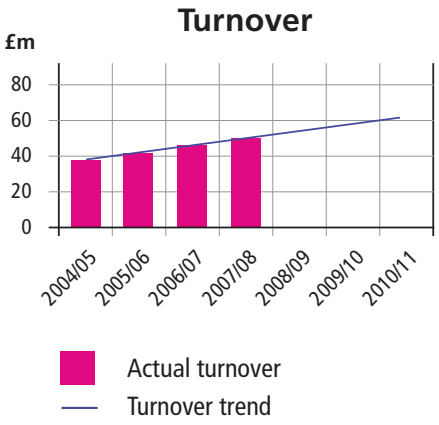
The staff on my ward were very caring although clearly very busy.

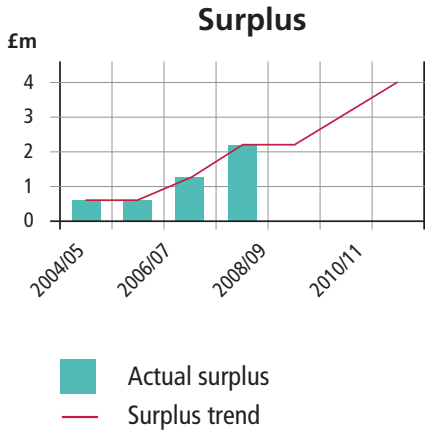
I left feeling I had really been 'cared for' in the best sense of the word.

COST IMPROVEMENT PROGRAMME

The trust delivered cost improvements of £0.95m for the financial year. Working closely with the PCTs the trust was able to agree a locally negotiated price for its head and neck cancer activity. The trust also made efficiency savings by reviewing its skill mix in some clinical areas. The trust also continues to make general procurement savings.

objective 6:
Maintaining and Improving our Finances





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% of total patient income. Income from private patient activity for 2007/08 totalled £0.08m, which equates to 0.18% of total patient related income, which is within the cap. However, as the trust is reaching its private patient cap it needs to keep abreast of the national debate on this issue.

BALANCE SHEET AND CASHFLOW

Over the year, the trust's balance sheet increased by £8.6m (32.4%). The main areas contributing to the increase in balance sheet worth were the revaluation of the estate of £6.2m, and an increase in net current assets of over £2m. It should be noted that accounting standards require the trust to revalue its estate every three years.

The trust also continued to maintain its strong track record against the Better Payments Practice Code target that requires invoices to be paid within 30 days of receipt.

During the year the trust increased its cash position by £2.3m (71.9%), ending the year with a cash balance of £5.5m. The trust was also not required to use any of its £3m working capital facility or prudential borrowing limit during the year.

CAPITAL PROGRAMME

The trust made a capital investment of £1.5m during 2007/08. The main schemes undertaken were the completion of the extension to the critical care centre, which was opened in May, and the refurbishment and extension to the corneo-plastics out-patient area. The trust also continues to make investments in information technology and medical equipment.

During the year the trust received national funding for the redevelopment of its paediatric facility, as well as funding for the trust to establish itself as a national pilot site for burns rehabilitation. The trust also disposed of a residential property that was surplus to requirements, the sale realised £0.13m. The League of Friends also made a significant contribution of £0.16m to the years capital programme, in addition, and have committed a further £0.06m to the purchase of a cone beam CT scanner to support the work of the maxillofacial satellite navigation system that they purchased for the trust last year.

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

One of the trust's key objectives for 2007/08 was to increase its income and expenditure margins to improve its financial standing ahead of a major site redevelopment. The trust has made a significant increase in its income and expenditure margin year on year from 2.60% to 4.27%.

The plans going forward continue this trend. However, whilst in 2008/09, the trust continues to see a growth in turnover, the planned surplus remains at £2.1m for a second year succession, as the trust sees a stepped change in costs in order to deliver the increasing levels of activity. Beyond 2008/09 annual surpluses continue to increase in line with turnover.

Sally Flint
Director of Finance

objective 7:
Building Relationships

PARTNERSHIP INITIATIVES

Partnerships are important to the hospital and last year, the hospital worked closely with its commissioners and in particular with West Sussex Primary Care Trust. The Chief Executive and Professional Executive Committee Chairman were invited to discuss the PCT's plan for Fit for the Future not only with the Board of Directors, but also with senior clinicians, managers and the Governors. The discussion culminated in the hospital offering to support the PCT with a range of services. We await the outcome of the review.

One significant development is a Memorandum of Understanding with Brighton and Sussex University Hospitals NHS Trust (BSUH), both trust's realising the importance of closer working. This is particularly the case with BSUH as the critical care centre for West Sussex and QVH supporting that role with its world class specialist services. This will benefit patients and both trusts.

By the end of the year, the trust developed a closer working relationship with the Blond McIndoe Research Foundation, a registered charity based on the hospital site. To make the most of each organisation's expertise, both recognise the importance of working far more closely and a Memorandum of Understanding will cement what is expected to again be a fruitful partnership, supporting research and development in both organisations.

For the first time during 2007/8, the trust held an open day which was supported strongly by the governors. They showed visitors around special areas such as the burns centre, rehabilitation unit, medical photography and the kitchens! The tours were supplemented by displays showing the full range of services including orthodontics, sleep disorders, day surgery and corneo-plastic surgery. Some displays were more unusual than others, such as wound care with maggots and leeches.

GUINEA PIG CLUB

The trust is proud of all its partnerships, but one is special. The world famous Guinea Pig Club met for its last annual tea party hosted by the hospital (pictured left). The exclusive club was formed from RAF and allied aircrew who were badly burned during the war and who required reconstructive plastic surgery by Sir Archibald McIndoe and his team at the hospital. Because of the age of members there will be no more formal get togethers, but the Guinea Pigs still meet and they can often by seen lunching together in the hospital's Spitfire dining room.

HOSPITAL MUSEUM

Related to the story of the Guinea Pig Club is the hospital's museum. During 2007/8 it was agreed to relocate and re-display the museum, which is acknowledged to be a valuable resource, not just telling the story of QVH and the Guinea Pigs, but also the development of plastic surgery generally.

In February 2008, the museum was packed up under the supervision of the Honorary Curator, Bob Marchant, and put into a secure offsite store. This was in advance of its relocation from the American Wing (above the hospital's operating theatres) to a far more publically accessible building adjacent to the surgeon's mess. A project group (including a representative from East Grinstead's town museum) has been set up under the Chairmanship of Dr Renny Leach and a museum consultant, Mrs Stella Mason, has been contracted to co-ordinate the project. Fundraising is underway and if all goes to plan the museum will re-open in its new location in Spring 2009. Vacating the old museum has freed up the space for junior doctors to support their training and development in close proximity to the library.

objective 7:
Building Relationships

LEAGUE OF FRIENDS

Another significant partner is the hospital's League of Friends who continue to support the work of the hospital.

Although no longer managing the hospital's coffee shop nor running their own League of Friends shop, they continue to raise funds on behalf of the trust, as shown below:

MAIN GIFTS PAID FOR BY THE LEAGUE DURING THE YEAR

Cardiology	Treadmill	£18,453
Speech Therapy	Lightwriter	£2,470
Burns Unit	Icemaker	£1,174
Canadian Wing	Sterilizer	£11,250
American Theatres	HEPA filter drying cabinet	£14,006
X ray Department	Image Intensifier	£40,800
Canadian/Jubilee	LAL Room sterilizer	£2,730
Burns Unit	Arjo Hoist	£4,769
Jubilee	Patio	£13,852
Learning & Development	Projector	£1,911
Corneo Plastics	Refurbishment	£75,000
Bursaries	Rosemary Wootton Award	£8,833

With other donations, the League spent £198,646 supporting the work at the hospital last year – thank you.

OTHER DONORS

And the League of Friends is not the only organisation to help us. Below are just a few:

£20,000 From the **Myfanwy Townsend Melanoma Research Fund** to support the initial appointment of a specialist skin cancer nurse.

£5,887 From **Stoke Brunswick School** (pictured below) for Peanut Ward

£3,145 From **Dr R L Phillips** towards the burns fund

For all who gave to the hospital, or supported us with staff discounts or benefits (including Waitrose, the Ashdown Park Hotel, Lingfield Race Course) during the year, no matter how large or small, thank you.

Thanks to the generosity of Serco Group plc, burns patients at Queen Victoria Hospital are benefiting from an unusual form of therapy.

Serco donated two Nintendo Wii games consoles and LCD TVs to the hospital (pictured right). Using a Wii, with the guidance of specialist therapists, can help patients recover from treatment to burns or other injuries. With its motion sensing technology, the Wii involves the user acting out all the physical movements involved in sports, such as tennis or golf.

SUPPORT GROUPS

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

Peanut Ward – the children's ward offers the opportunity for current and former patients to attend camps and a Christmas party. Anyone interested in being included in these events should contact Debbie McCarthy on 01342 414469.

McIndoe Burns Support Group provides friendship and reassurance to those who have suffered burns, and to their families and also some financial support as appropriate. Contact the burns centre on 01342 414440.

Parkinson's Pals 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.

The Children's Fire and Burns Trust supports children and families affected by burns and scalds. It works closely with the Fire & Rescue Services. Contact Alison Tweddle on 020 7233 8333 or www.childrensfireandburntrust.org.uk

BLOND MCINDOE RESEARCH FOUNDATION

QVH's work with the Blond McIndoe Research Foundation, which is registered as a charitable company limited by guarantee, is very important to us (pictured above).

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 see their website at www.blondmcindoe.com

PATIENT AND PUBLIC INVOLVEMENT FORUM

The trust is sorry that the Patient and Public Involvement Forum (PPI Forum) came to an end on 31 March 2008, to be superseded in Autumn 2008 by the county's Local Involvement Network (LINk). Until then the trust has encouraged the PPI Forum to remain in situ, and proposals for the coming year include the inclusion of the PPI Forum members into the trust's PPI Committee, expanding its membership to include more external representatives including patients and users. We warmly thank all the members of the Forum, led by Sue Hull, for their work.

This will be particularly important during the coming year, as will be our relationship with the Health Overview and Scrutiny Committee, as we consult about the future of the hospital and its services.

THE MEDIA AND PUBLIC

During the latter part of 2007/8 we have raised the profile of the hospital, through a series of stories in the media demonstrating the amazing work of our surgeons and other staff.

Together with highlighting our successes with surveys and awards, this helps to cement the hospital's excellent reputation and share it with a wider audience for the long term sustainability of the hospital.

objective 7:
Building Relationships

SOCIAL RESPONSIBILITIES 2007/8

In 2007/8 we reported for the first time about our responsibilities to the wider community. Much has happened since.

Recycling and waste management

During the year we introduced a compactor onto the site and we are delighted that not only has this stopped three lorry collections a week, the trust only pays for the contents to be removed by its weight and not by any other measure.

Large cardboard, shredded paper, tins and toner cartridges are now being recycled. The hospital is also compliant with the Waste Electrical and Electronic Equipment Directive (WEEE) which manages the disposal of all electrical equipment, medical and non medical.

The Environment Agency visited the hospital during the year, commenting that they felt the hospital handled its waste in a responsible manner and that as a trust we were proactive, citing our inclusion of the management of waste within the staff induction programme .

Awareness that the hospital and its grounds are 'smoke free' has also been raised, although we recognise the difficulty for some patients and staff. Smoking cessation support is offered for staff and patients.

However, a significant problem faced by the trust has been car parking. Over the past year, and continuing into spring 2008,

many new spaces have been created, marking improved, and disabled spaces moved closer to entrances.

Discussions have been held with Metrobus about better ways the two organisations can work together and save unnecessary car journeys. The trust is also to consider a cycle to work scheme.

During the year the trust started to consider its strategy for sustainable procurement, and has embarked on a project to install an e-procurement system to reduce the volume of paper records processed by the trust. The trust has started this work by implementing e-procurement for stationery orders. The trust has also updated its policy on disposal of obsolete equipment, to ensure that this is either recycled or disposed of by the most environmentally friendly route.

Due to the layout of the site, which has developed quickly since the war, it was agreed to relocate the main entrance to the buildings to the Canadian Wing, and a new reception desk built. From spring 2008 this is staffed by volunteers who assist visitors and patients with information and directions. New signage and lighting is being introduced to help navigation around the site, pending redevelopment.

Patient Environment Action Team (PEAT) Assessment 2008

Since 2000 the National Patients Safety Agency (NPSA) requires all trusts to undertake an audit of the level of cleanliness and standard of patient food. This is a self assessment made against a nationally agreed set of standards which are matched to the Healthcare Commission's core standards. The focus is specifically from a patient's perception against the following six core standards.

- **Cleanliness**
- **Infection control**
- **Environment**
- **Access and external areas**
- **Food**
- **Privacy and dignity**

There were two areas in particular that we will be addressing: maintenance and disabled facilities in our children's ward (Peanut) and decor in outpatients. In addition we will improve the choice and presentation of patient food during the coming year.

Above all, the fabric of the buildings remains a major challenge and this was reflected in the scores.

INVESTING IN STAFF

- Outstanding staff survey results
- Top employer for nurses in hospitals twice running
- Investors in People
- New infrastructure of academic boards to enable local decisions for doctors in training
- Appraisals and personal development plans implemented
- Two ticks symbol for disability awareness

GREEN CREDENTIALS

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

SOCIAL RESPONSIBILITIES 2007/8

our patients and their care

QUALITY OF CARE

- Outstanding patient survey results
- Met all national and local targets
- Excellent Healthcare Commission rating for quality of care and use of resources
- Winner of Best of Health Awards
- First pilot in country for a burns rehabilitation service
- Shortlisted Foundation Trust of the Year

PUBLIC AND PARTNERS

- 10,000+ foundation trust members
- Membership and Engagement Strategy
- Governor and volunteer involvement throughout hospital
- First open day
- New partnership with Brighton and Sussex University Hospitals Trust
- Closer working with Blond McIndoe Research Foundation
- Working with partners to relocate museum

Our Board of Governors

BERNARD ATKINSON,
THE GOVERNORS' REPRESENTATIVE
ON THE BOARD OF DIRECTORS

GOVERNORS' AND MEMBERS' CORNER

The role of the foundation trust governor is to represent the interests of patients, members and the community at large, in order to ensure the hospital delivers excellent services. These responsibilities involve:

- monitoring performance, particularly patient care and finance
- ensuring that the range and quality of services to patients are first class
- promoting the well-being of the establishment for the benefit of patients, and
- contributing to both short and long term development plans.

Queen Victoria Hospital NHS Foundation Trust (QVH) demonstrates its excellence when measured against the multitude of demanding criteria used within the NHS to assess patient care and performance by:

- having a long established reputation for clinical excellence
- retaining and attracting dedicated professional staff
- maintaining first class cleanliness and infection control regimes
- having an exceptional degree of patient loyalty and support from the local community
- being financially sound with robust financial reporting systems in place

Against this background, QVH governors have asked themselves:

- Why is this so?
- What makes QVH so respected?

In attempting to answer these questions they have taken both internal and external approaches by:

- auditing 'the hospital culture', and
- benchmarking QVH against their experiences of other hospitals.

The governors are convinced that it is the 'whole' hospital trust approach which allows QVH to sustain the highest standards year after year and to respond to new challenges, such as new infection control criteria or a new 'target', for example the 18 week period from referral to treatment. In other words, QVH has all the best advantages of a strong, extended family.

Perhaps these attributes go some way to explaining why the foundation trust governor system has been welcomed throughout the hospital and how innovative activities by governors have been easier to implement within QVH than at many other hospitals. Examples of the latter include:

- an extensive programme of hospital visits to measure and monitor the standards and quality of care given to patients;
- a governor representative on the Board of Directors to provide a link between the two Boards, and
- governor involvement in QVH development plans from the outset.

Thus the QVH governors have adopted an approach based upon:

- engagement
- involvement
- co-operation
- commitment, and not least
- robust discussion.

In short, the QVH governors are embedded in the 'whole' hospital approach. They do not view themselves as a pressure group, but are committed to the supportive, co-operative, constructive, creative tension that is a feature of many of the best, well-run, well-founded organisations.

Governors, of course, have a varied range of experience, interests and available time. Consequent upon these realities they have found that their most effective modus operandi is to use small working groups co-ordinated by an elected steering group. This has allowed individual governors to explore and utilise their experience and enthusiasms and at the same time, to control their time commitments. Such arrangements have shown themselves to be:

- effective
- efficient
- focused, and
- inclusive.

The latter is particularly important in that it has allowed each and every governor to contribute what they can, when they can.

Over the past year these arrangements have led to much successful activity, particularly with regard to:

- **QVH going forward**
  A review of the strategic plans for the future through presentations, seminars, 'away' days and joint meetings of the Board of Directors and the Board of Governors.

- **Proposals for the QVH site redevelopment at East Grinstead**
  Conceptual planning, identification of criteria, and establishing future needs, all driven by breakaway sessions

following presentations and interactions with staff from all areas of the hospital.

- **Focused hospital visits**
  A programme of 16 visits by groups of 2 or 3 governors and non-executive directors to all areas of the hospital from theatres to waste disposal facilities.

- **Healthcare Commission declaration of performance against standards**
  QVH has to provide self-certification against a demanding range of standards. Governors have the responsibility of monitoring the QVH approach and providing a written report on their findings for the hospital's Regulator.

- **Participation in QVH structures**
  The governors are involved with:
  - McIndoe Burns Support
  - Website development
  - Junior doctor training
  - Patient pathways
  - Equality and diversity
  - Improving working lives
  - Patient information
  - Patient public involvement
  - Clinical governance and quality

- **Governor working groups**
  These groups focus largely on short-term intensive activity by 3 or 4 governors to inform and advise the Board of Governors, examples include:
  - promotion of interaction with members
  - consideration of the Annual Plan
  - development of the Annual Report and Accounts, review of external audit process
  - governor performance; (the appointment, remuneration and assessment of the Chairman and Non- Executive Directors being carried out separately by the Appointments Committee)

- **Patient thesaurus**
  The staff and governors have worked together to produce a glossary of 132 terms used regularly in the hospital but whose meaning and use can sometimes be unclear to patients and their families.

- **Interaction and communication with members**
  The governors have worked with the staff to keep members informed of QVHFT activities, through
  - open days
  - DVD supported presentations
  - articles in local publications, eg church magazines
  - displays in public and commercial buildings
  - seminars by QVH clinicians
  - the members' newsletter

- **National Governors' Forum (NGF)**
  QVH governors are members of the NGF. This provides opportunities for the exchange of ideas and practices, and not least for assessing QVH governor performance against a countrywide background.

Clearly being a governor at QVH is no sinecure; it requires active participation to contribute to a focused and effective Board of Governors. The reward is one of satisfaction to be gained from assisting an excellent hospital to maintain its standards, not only in delivering first class patient care, but also in positioning itself to accommodate the inevitable future challenges.

MEMBERSHIP AND ENGAGEMENT STRATEGY

The Trust is eager to grow a representative membership and to improve interaction and engagement with members. As a consequence, the Membership Strategy 2005 was re-written during 2007/8 and approved by the Board of Directors in January 2008. It also includes a delivery plan which is the responsibility of a membership task force, led by the Membership and Engagement Manager.

The Strategy is ambitious and firmly links membership growth to the hospital's spoke sites and the patient base rather than a 'scatter gun' approach, which might recruit some members, but not necessarily very meaningful members. This was considered a sensible approach by both Boards, bearing in mind our extensive catchment area across South East England – East and West Sussex, Surrey and Kent which equates to 4.2M.

As our Governors have pointed out, the hospital has effectively two cohorts of public members: local people who are proud of the excellent reputation of the hospital and who historically have accessed both the community hospital and specialist services and secondly, those who come from further afield who only access the specialist services.

Over the past year, recruitment has concentrated on patients. This has been successful but any membership gains have been offset by the cleansing of the membership database by Computershare, a company that now manages the database for us. Early signs for 2008/9 show that we are now making significant gains in membership following concerted efforts by the trust in partnership with Governors. Below are the figures as at 31 March 2008. Note there are only two constituencies – public and staff.

Public constituency	2007/8
At year start (April 1)	11,706
New Members	293
Members leaving	1,538*
At year end (March 31)	10,461

Staff constituency	2007/8
At year start (April 1)	805
New Members	92
Members leaving	86
At year end (March 31)	811

*public database validated

Our Board of Governors

OUR BOARD OF GOVERNORS

As a foundation trust, the Board of Governors is important for us, and key to our accountability to the local community, because the governors are elected from the membership, in our case, by over 10,000 members across south east England.

It has important powers, for instance to appoint or remove the Chairman of the trust and other non executive directors and it also decides how much they will be paid and other conditions of service. The Board of Directors is therefore accountable to the Board of Governors. Both Boards work increasingly together, with a Governor Representative attending the Board of Directors and members of the Board of Directors attending meetings of the governors.

In essence, because the Board of Governors is elected from the membership and the directors are responsible to it, the views of the local community should always be heard and considered in the running of the hospital. Governors do not hold an operational role, but their views are vital.

How the Board of Governors is made up – 36 Governors in total

Stakeholders – 9 with 2 vacancies

- Renewed to 2010: Chris Rolley, EGTC
- Renewed to 2010: Ricky Banarsee, Imperial College
- Renewed to 2010: Tom Cochrane, Guinea Pig Club
- Renewed to 2010: Roy Daisley, University of Brighton
- July 2007-2010: Barbara Wilkins, West Sussex PCT
- July 2006-2009 – Peter Evans, Local Authority Representative
- May 2006-June 2009: Derek Pocock, League of Friends

Staff - 3

- July 2007-June 2010: Tony Josling
- July 2005-June 2008: Maureen Adams
- July 2005-June 2008: Amanda Wood

Public – 24 with 3 vacancies

- July 2007-June 2010: John Gooderham (resigned 21 Sep 07), Claud Isidore (resigned 28 Nov 07)
- July 2006-June 2009: Edward Belsey, Gillian Brack, Howard Matthews, Andrew Robertson, Manya Sheldon
- Re-elected July 2006-June 2009: Bernard Atkinson, Leonard Barlow, Stuart Barnett, Caroline Hitchcock
- July 2004-June 2007: Re-elected to June 2010: Ann Horscroft, Alison Tweddle, Sharon Watkinson, Alan Lord
- July 2004-June 2008: Bill Hatton, Michael Hannah, Shirley Mitchell
- July 2005-June 2008: Noshir Khambatta, Martin Plimmer, John Bowers, Linda Witten, Peter Dingemans

Governor elections

Public governors – the election was uncontested in 2007, due to various reasons. Two new governors and four current governors were therefore appointed unopposed in July 2007. Staff governors – a second ballot took place in 2007 to elect one new staff governor, with a turnout of 35%.

Board of Governor attendance at meetings

Five meetings of the Board of Governors took place between 1 April 2007 and 31 March 2008. Attendance at the meetings was good apart from one stakeholder governor who has, early in 2008/9, been removed.

Name	Attendance
Ms Maureen Adams	3
Mr Bernard Atkinson	4
Mr Ricky Banarsee	0
Mr Leonard Barlow	4
Mr Stuart Barnett	3
Mr Edward Belsey	3
Mr John Bowers	5
Mrs Gillian Brack	3
Mr Tom Cochrane	5
Dr Roy Daisley	4
Rr Adm Peter Dingemans	4
Mr Peter Evans	4
Mr Michael Hannah	2
Mr Bill Hatton	3
Ms Caroline Hitchcock	5
Mrs Ann Horscroft	4
Mr Tony Josling	3
Mr Noshir Khambatta	2
Mr Alan Lord	4
Mr Howard Matthews	4
Mrs Shirley Mitchell	2
Mr Martin Plimmer	5
Mr Derek Pocock	4
Dr Andrew Robertson	3
Mr Chris Rolley	3
Mrs Manya Sheldon	5
Mrs Alison Tweddle	4
Mrs Sharon Watkinson	3
Mrs Barbara Wilkins	3
Mrs Linda Witten	3
Ms Amanda Wood	3

It is with sadness that we report that Alan Lord, public governor, died during May 2008. He contributed much to the Board of Governors and the hospital as a whole and is sorely missed at the QVH and in East Grinstead.

Register of Governors' Interests

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

Contacting governors

Any member who wishes to contact a Governor, or wishes to discuss any issues about membership and the Board of Governors, please either email myra.scarbrough@qvh.nhs.uk or telephone Myra on 01342 414508,

Our 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 (Trust Secretary).

During 2007/8 the Board of Directors considered its own effectiveness and introduced a simple process to review each meeting and a more in-depth survey to review the working of the Board as a whole. As a consequence, changes have been made to the agenda and how each Board meeting is organised, with more opportunity for informal discussion and interaction with clinical and non clinical staff who are not Board members. The trust is also in the process of developing the Board Forum, which has no formal status but will allow the Board time to discuss and develop strategy in conjunction with senior staff and clinicians.

Importantly, a summary is also now produced after each meeting and included within the Weekly Briefing, so all staff are aware of the issues being discussed and the decisions taken. In addition, the Governor Representative reports on the Board of Directors meetings to Board of Governors, so the Governors are always aware of the issues at the hospital, over and above the report from the Chief Executive.

The major issue discussed by the Board throughout 2007/8 was the strategic service review and the subsequent plans for the site redevelopment. These plans will remain a significant part of future discussions at the Board for some considerable time.

EXECUTIVE DIRECTORS

CAROLINE BECHER

Director of Nursing and Quality was appointed in September 2003. She trained at Guy's and has considerable experience in acute health services having held senior posts both within the NHS and BUPA. Her style of management is to be highly visible and she is well known by staff across the organisation.

SHARON COLCLOUGH

(Sharon Kearns until December 2007) **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.

MAGGIE MIDDLETON

Director of Operations and Development joined QVH as general manager in April 2003 and became Director of Operations in December the same year before appointment as Director of Operations and Development in February 2006. Having trained as a nurse working in the NHS she has senior management experience as a hospital manager in the private sector. Maggie Middleton left the Trust in April 2008.

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

Interim Medical Director (1 November 2007 with substantive appointment from 1 April 2008) 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.

STEPHEN SQUIRES

Medical Director (1st April 2007 – 31 October 2007) Stephen graduated in 1979 from St Georges Hospital Medical School, and has been a Consultant Anaesthetist since 1989. He joined QVH in 1994 following 18 years in the Royal Navy and has since worked mainly in anaesthesia and critical care for burns and plastic surgery.

Our Board of Directors

NON-EXECUTIVE DIRECTORS

JEREMY BEECH CBE, QFSM

From Frittenden in Kent, Jeremy is a Consulting Engineer. He has spent over 30 years in the fire service occupying positions as Assistant Chief Fire Officer in the London Fire Brigade and then Chief Fire Officer of Kent. He was also one of five UK Members of the Channel Tunnel Safety Authority and UK Chairman of the Rescue and Public Safety Working Group. He is also a Non-Executive Director of the Port of London Authority and a Trustee of the Kent Foundation.

Appointment: 1 October 2005 to 30 September 2009

Committees: Nomination & Remuneration, Clinical Governance & Quality, Integrated Risk Management

PETER GRIFFITHS (CHAIRMAN)

Peter is from Wadhurst, in East Sussex. He was chief executive of the Health Quality Service, an independent organisation providing quality development support to health services nationally and internationally. He is a former deputy head of the NHS in England and a past chief executive of Guy's and Lewisham NHS Trust and President of the Institute of Health Services Management. On appointment to QVH he stepped down as a non executive director of the Sussex Downs and Weald Primary Care Trust. He is a member and the Vice Chairman of the Foundation Trust Network Board.

Appointment: 1 April 2005 to 31 March 2009

Committees: Nomination & Remuneration

RACHAEL HOEY

Rachael, from Groombridge, is an Australian university business graduate who also qualified as a chartered accountant. She graduated from CASS University of London with an MBA in International Banking and Marketing. Her career has included various international roles in general management, marketing and business development. Rachael 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.

Appointment: 1 October 2005 to 30 September 2008

Committees: Nomination & Remuneration, Audit

DR RENNY LEACH

Dr Leach lives in Forest Row. He is Chief Executive of a clinical research consultancy company 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 to 31 December 2010

Committees: Nomination & Remuneration, Research & Development,

HUGH URE

Hugh is from Haslemere in Surrey, and was appointed to the Board in December 2000. He is also currently a Non-Executive director in the Ministry of Defence. 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. He is a former council member of the Rotary Club of London, and currently a trustee of their charitable fund.

Appointment: 1 October 2005 to 30 September 2008

Committees: Nomination & Remuneration, Audit

SHENA WINNING

Shena, from Elham, near Canterbury, is a Chartered Accountant. Formerly Finance Director of Carpet Right 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

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

There were 11 meetings during 2007/8 with the following attendance:

Executive Directors

Caroline Becher	9
Sharon Colclough	10
Sally Flint	11
Ken Lavery	5 (part year)
Maggie Middleton	9
Stephen Squires	4 (part year)

Non Executive Directors

Jeremy Beech	11
Peter Griffiths (Chairman)	11
Rachael Hoey	8
Renny Leach	10
Hugh Ure (Deputy Chairman)	9
Shena Winning	10

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

The Board of Directors reflects 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 the Queen Victoria Hospital NHS Foundation Trust, its Terms of Authorisation and Constitution.

None of the Non-Executive Directors have yet completed their initial three year appointment period and 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) on 1 April 2007, 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).

Board effectiveness

During the year, the Nomination and Remuneration Committee reviewed the effectiveness of the Board and has introduced a simple process to consider the effectiveness of each meeting and a more in depth survey to review the working of the Board as a whole.

As a consequence, changes have been made to the agenda and how each Board is organised, with more opportunity for informal discussion and interaction with clinical and non clinical staff who are not Board members. The trust is also in the process of developing the Board Forum, which has no formal status but will allow the Board time to discuss and develop strategy in conjunction with senior staff and clinicians.

Compliance with Monitor's 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 per year.

Early in 2007, we undertook a thorough review of our governance arrangements which resulted in A New Governance Framework which identified key areas for improvement. The action plan that resulted from the review also incorporated the governance requirements within Monitor's Code of Governance. As a result of the ongoing work during 2007/8, particularly following the appointments of Head of Corporate Affairs and Head of Integrated Risk Management, the Trust considers that it complies with the main and supporting principles of the code.

Whilst the relationship between the Board of Directors and Board of Governors is excellent, it has not been seen as a priority to agree a statement concerning resolution of disputes between the two boards (A.1.1.) nor Governor action if dispute resolution fails (B.1.8). However, the trust recognises that this work must be undertaken during the coming year.

Work has also begun on a document that sets out the clear division of responsibilities between the Chairman and Chief Executive (A.2.1), with approval from the Board of Directors, although the trust considers it would be a more useful document if it included the roles of the Executive Director and Non-Executive Director, all of which need to be seen within the context of the Board of Governors.

Two reports from the Board of Directors

NOMINATION AND REMUNERATION COMMITTEE ANNUAL REPORT 2007/2008

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 to the Committee and the Head of Corporate Affairs attends as advisor to the Committee. The terms of reference are reviewed annually.

During 2007/8 the Trust took a formal approach to the role of the Nomination and Remuneration Committee, with an agreed rolling work programme and more frequent meetings. The Committee met four times during the year. The Committee made decisions or recommendations on the following issues:

- Reviewing the effectiveness of the Board
- Governance
- The Constitution
- The 2007 national pay award
- Terms of Reference
- A local pay framework for the Executive Directors and other Very Senior Managers
- Reward issues for the workforce and national trends
- An aligned appointments process for Executive and Non-Executive Directors
- Medical management payments
- Work plan for 07/08

Attendance record of members
(out of a possible 4 meetings)

MEMBERS	MEETINGS
Hugh Ure (Chairman) Non-Executive Director	3
Jeremy Beech Non-Executive Director	4
Sharon Colclough Chief Executive	4
Peter Griffiths Non-Executive Director	4
Rachel Hoey Non-Executive Director	3
Renny Leach Non-Executive Director	4
Shena Winning Non-Executive Director	4

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 recommendations by the Head of HR who has benchmarked both salary and terms and conditions against other NHS organisations using information networks, the Very Senior Managers pay framework and the IDS report on NHS Boardroom pay.

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 Chairman and the Non-Executive Directors. Ann Horscroft, a publicly elected governor, is Chairman of the Appointments Committee. Other members are drawn from public governors, stakeholder and staff governors. The salary details of the trust Chairman, Executive and Non-Executive Directors are set out in the summary financial statements.

On behalf of the Board

Sharon Colclough
Chief Executive

REPORT FROM THE AUDIT COMMITTEE

In line with the NHS Foundation Trust Code of Governance, the Board is required to establish an Audit Committee composed of Non-Executive Directors. The trust's Audit Committee is chaired by Shena Winning, Non-Executive director, with two other Non-Executive Directors as members.

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 2007/08 the Committee fulfilled its objectives, as set out 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
- provided the Board with assurance that the trust has the appropriate risk management and assurance processes in place
- reviewed and monitored the effectiveness of the trust's internal audit function
- reviewed and monitored the external auditors' independence and objectivity
- agreed to extend the appointment of the trust's external auditor by a further two years
- reviewed the adequacy of management responses to issues identified by audit activity
- reviewed and agreed changes to the trust's Standing Financial Instructions
- reviewed the trust's procurement policies and procedures and were instrumental in assisting management in establishing key performance indicators in this area
- receiving regular reports from the trust's Local Counter Fraud Manager
- undertaking an annual review of the effectiveness of the Audit Committee itself.

The Committee meets four times a year, and is attended by the trust's Director of Finance, the external and internal auditors, and local counter fraud service and has representation from the Trust in respect of risk management. The Chief Executive is also able to attend the Audit Committee.

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 2007/08 IS SET OUT BELOW:-

MEMBERS	POSITION	MEETINGS
Shena Winning	(Non-executive director)	4 meetings
Rachael Hoey	(Non-executive director)	3 meetings
Hugh Ure	(Non-executive director)	4 meetings
Jeremy Beech	(Non-executive director)	1 meeting
IN ATTENDANCE		
Sally Flint	(Director of Finance)	4 meetings
Amanda Parker	(Acting Head of Integrated Risk Management)	3 meetings
Keith Soper	(Head of Integrated Risk Manaement)	2 meetings
PWC	(External Auditors)	4 meetings
Chantrey Vellacott	(Internal Auditors)	4 meetings
South Coast Audit	(Local Counter Fraud)	4 meetings

It should be noted that during the year Rachael Hoey replaced Jeremy Beech on the Audit Committee, as Jeremy took on the responsibility of chairing the Clinical Governance and Quality Committee and Integrated Risk Management Committee. It should also be noted that during the year the trust appointed a Keith Soper as its new Integrated Risk Manager.

Accounts for the Year

1 April 2007 to 31 March 2008

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE 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").

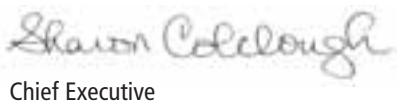
Under the National Health Service Act 2006, Monitor has directed Queen Victoria Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true 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 Memorandum.*



Chief Executive
12 June 2008

STATEMENT ON INTERNAL CONTROL 2007/08

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I also have responsibility 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 foundation trust's Standing Orders and Scheme of Delegated Authority outlines the accountability arrangements and scope of responsibility of the Board and the foundation 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 foundation trust, with the most critical priorities being those set out in the foundation trust's Business Plan 2007/08.

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

All Directors report to me through the regular Executive Team meetings in addition to one-to-one meetings.

The foundation 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 foundation trust's Business Plan 2007/08. It is reviewed by the senior management team on a regular basis. The Assurance Framework has been reviewed by the Board, the Integrated Risk Management Committee and the Audit Committee throughout the year and it has been cross-referenced to the Healthcare Commission Core Standards. Much work has been undertaken during the year to improve any gaps in control and assurances for each item.

As Accounting Officer I am a member of the foundation trust's Integrated Risk Management Committee, which is a sub-committee of the Board. The Integrated Risk Management Committee is responsible for implementing the foundation trust's risk management system, as set out in the foundation trust's Risk Management Strategy, and for prioritising and co-ordinating the management of risk within the foundation trust.

Risk management is now more formally addressed throughout the structure of the organisation. Risk is a standing agenda item on monthly Care Group meetings and high level risks are reviewed monthly at the foundation trust's Management Team meeting and by the Board. Risk management is also a standing item at the Audit Committee, whose remit is to review the systems of control surrounding risk. During the year the Board has taken a proactive role in the development of the foundation trust's risk management arrangements. The Board has also been regularly appraised on the Assurance Framework.

Risk is also reported externally to Monitor, the Independent Regulator for Foundation Trusts. The foundation trust is required to report to Monitor on financial, governance and mandatory service risk.

As Accounting Officer, I also have responsibility for reviewing the effectiveness of the system of internal control. This review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the Audit Committee who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. I have also taken into account comments made by external auditors and other review bodies in their reports.

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 2008 and up to the date of approval of the annual report and accounts.

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

3. Capacity to handle risk

Risk Management is a corporate responsibility and, accordingly, the foundation 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 foundation trust from losses or damage to its reputation.

The foundation trust's Integrated Risk Management 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 are maintained through the committee structures mentioned above.

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The foundation 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 foundation trust.

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

4. The risk and control framework

The foundation trust has an Assurance Framework in place that demonstrates that the Board has identified the key strategic risks for the foundation trust and has controls in place to mitigate against these risks. The framework also details the sources of assurance available to the Board that these control measures are in place.

The Assurance Framework comprises the following elements:

Principal risks – currently the framework incorporates the foundation trust's seven key strategic objectives in individual sections and the specific risks identified in the Annual Plan. The objectives of the individual Directors and the identified risks are also either included or mapped, where they align to the corporate objectives.

Key controls – which identifies the controls that are currently in place to mitigate against the risks identified.

Sources of Assurance – these are sources of assurance currently available for each area of risk.

The foundation 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 them. The risk register is managed by the Head of Integrated Risk Management and is reviewed regularly by the Care Groups and Integrated Risk Management Committee.

During the year the Assurance Framework has been developed through the Audit Committee and the Board in order that the framework properly fulfil its role within the foundation trust's governance arrangements. The foundation trust's new Governance Framework proposes that there are closer and clearer links between the detailed risk register and strategic Assurance Framework, where there are flows between the two evidencing the dynamic nature of both documents.

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

Public stakeholders are also involved in managing risks through the risks identified by external assessors, complaints and other external bodies.

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

The Integrated Risk Management agenda reflects the organisation's core business. The foundation trust seeks to learn from issues raised and implement good practice at all levels. The Board receives regular reports from the Integrated Risk Management Committee and its constituent Care Groups, including trend analysis and benchmarking (e.g. Healthcare Commission Standards). Serious Untoward Incidents are reviewed, investigated, analysed and reported back throughout the organisation.

The foundation 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 foundation trust's risk management strategy and for future business and strategic planning. This Risk Register is a foundation trust-wide database recording corporate/organisational, clinical and financial 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 foundation trust was required to submit a final declaration, by 30th April 2008, as to its compliance with the core standards self-assessment for the year ended 31 March 2008. The foundation trust involved all foundation trust Directors and a cross section of senior managers to undertake the final assessment. Based on this assessment the Board was able to submit a declaration identifying compliance with all standards.

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 managed by a dedicated Risk Manager has been in place for the whole of the year and has involved Board members and staff in its development to ensure it represents an accurate assessment of the risks facing the organisation.

Specifically the foundation trust has enhanced key risk management systems and processes during the year through:

- appointment of a Head of Integrated Risk Management;
- establishment of an Integrated Risk Management Committee chaired by a Non-Executive Director;
- review of Care Group risk registers at quarterly performance review meetings;
- giving a governor the opportunity to sit on the Clinical Governance & Quality Committee.

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 Integrated Risk Management Committee and the Board.

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

- development of the Assurance Framework within the year by regular review at the Integrated Risk Management Committee has lead to more comprehensive documentation of sources of assurance and links to the risk register;
- the Assurance Framework linked the main elements and aims of the foundation 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 foundation trust in achieving its objectives and to keep these under review by the foundation trust Board.
  Key Controls / Treatments: these were the mechanisms for controlling the risks that have been identified.

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

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

The foundation trust has robust processes in place to ensure the economic, efficient and effective use of resources, as follows:-

- robust business planning process;
- strong financial management, with a comprehensive Finance and Performance Report to the Board on a monthly basis;
- development of service line reporting, which is reported on a quarterly basis;
- key corporate objectives for Care Groups based on out-comes of service line reporting;
- weekly activity reporting;
- key performance indicators for productivity and efficiency gains included in the monthly Finance and Performance Report to the Board;
- quarterly performance review meetings with Care Groups;
- external benchmarking being used to identify efficiency of clinical services;
- value added reviews undertaken by internal audit and reported to the Audit Committee;
- bi-annual procurement report to the Board and procurement key performance indicators developed and reported to the Audit Committee.

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. 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 Integrated Risk Management 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 foundation trust's internal and external auditors, the self assessment declaration on the core standards for Standards for Better Health and compliance with the risk management requirements of the Risk Pooling Scheme for Trusts (RPST) and Clinical Negligence Scheme for Trusts (CNST).

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 Clinical Governance and Quality Committee, and Integrated Risk Management 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 foundation trust made a compliant submission for Standards for Better Health;
- the foundation trust met all performance and waiting list targets;
- financial performance in line with our annual plan target was achieved, with the foundation trust reporting a surplus of £2.07m;
- there was no significant adverse publicity for the foundation trust;
- during the year the foundation trust has reviewed systems and processes for maintaining patient confidentiality and assessed the risks associated with all bulk transfers of data. Potential breaches of confidentiality are reported via the foundation trust's Incident Reporting System and subsequently investigated. There have been no Serious Untoward Incidents involving inappropriate disclosures or potential inappropriate disclosures of patient information during the financial year 2007/08.
- the number of claims and complaints received by the foundation 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 Audit's opinion on the effectiveness of the systems of internal control;
- the Healthcare Commission Core Standards declaration and the ongoing monitoring throughout the year of progress against those areas with insufficient assurance;
- minutes of committee meetings;
- ongoing update and approval of the Assurance Framework;
- regular review and reports on the position of the Corporate Risk Register;
- regular reviews and bimonthly progress reports on progress against the foundation trust's objectives;
- review of the foundation trust's governance arrangements and monitoring implementation of the recommendations.

The Assurance Framework will be continually reviewed and updated by the Board throughout the year to ensure that it reflects the key risks currently relevant to the foundation trust.

7. Significant Control Issues

There are no known significant internal control issues in 2007/08 to be disclosed.

Chief Executive (on behalf of the Board)

12 June 2008

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 2008 which comprise the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses, the Cashflow Statement and the related notes*. These financial statements have been prepared in accordance with the accounting policies set out therein. We have also audited the information in the Directors' Remuneration Report that is described as having been audited.

Respective Responsibilities of Directors and Auditors

The Foundation Trust is responsible for preparing the Annual Report, the Directors' Remuneration Report and the financial statements in accordance with directions issued by the Independent Regulator of Foundation Trusts ("Monitor") under the National Health Service Act 2006. Our responsibility is to audit the financial statements and the part of the Directors' Remuneration Report to be audited in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland).

This report, including the opinion, is made solely to 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 (the Act) and for no other purpose. We do not, in giving this opinion, 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.

We report to you our opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Director's Remuneration Report to be audited have been properly prepared in accordance with the directions issued by Monitor under the National Health Service Act 2006. We also report to you whether in our opinion the information given in the Directors Report which comprises the sections of the Annual Report called "Our Board of Directors" and "Who we are and what we do" are consistent with the financial statements. We review whether the Accounting Officer's statement on internal control is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the Accounting Officer's statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the NHS foundation trust's corporate governance procedures or its risk and control procedures.

We read the information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only "Our Board of Directors" and "Who we are and what we do" "Chairman's introduction", "Chief Executive's welcome", "Our Board of Governors and Members", "Our Board of Directors" and "Two reports from the Board of Directors". We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

In addition we report to you if, in our opinion, the NHS foundation trust has not kept proper accounting records, if we have not received all the information and explanations we require for our audit, or if information specified by law regarding Directors' remuneration and other transactions is not disclosed.

Basis of audit opinion

We conducted our audit in accordance with section 62 and Schedule 10 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with relevant auditing standards issued by the Auditing Practices Board.

Opinion

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 affairs of Queen Victoria Hospital NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year then ended;
- the financial statements and the part of the Directors' Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and the directions made thereunder by Monitor; and
- the information given in the Directors Report is consistent with the financial statements.

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.

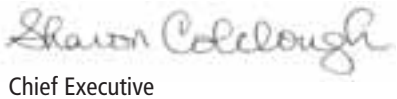
Signature PricewaterhouseCoopers LLP **Date** 16th June 2008

PricewaterhouseCoopers LLP
80 Strand
London
WC2R 0AF

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

Forward to the Accounts

These accounts for the year ended 31 March 2008 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.



Chief Executive
12 June 2008

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2008

		2007/08	2006/07
	NOTE	£000	£000
Income from activities	2	**45,649**	42,074
Other operating income	3	**3,006**	2,816
Operating expenses	4-5	**(45,936)**	(43,046)
OPERATING SURPLUS		**2,719**	1,844
Loss on disposal of fixed assets	7	**(25)**	0
SURPLUS BEFORE INTEREST		**2,694**	1,844
Finance income		**198**	134
Finance costs - unwinding of discount	14	**(11)**	(11)
SURPLUS FOR THE FINANCIAL YEAR		**2,881**	1,967
Public Dividend Capital dividends payable		**(809)**	(804)
RETAINED SURPLUS FOR THE PERIOD		**2,072**	1,163

The notes on pages 46 to 67 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 MARCH 2008

	NOTE	2008 £000	2007 £000
FIXED ASSETS			
Intangible assets	8	**80**	99
Tangible assets	9	**31,022**	24,806
		31,102	24,905
CURRENT ASSETS			
Stocks and work in progress	10	**271**	243
Debtors	11	**3,701**	4,248
Cash at bank and in hand	17.3	**5,510**	3,167
		9,482	7,658
CREDITORS: Amounts falling due within one year	12	**(4,822)**	(5,626)
NET CURRENT ASSETS		**4,660**	2,032
TOTAL ASSETS LESS CURRENT LIABILITIES		**35,762**	26,937
PROVISIONS FOR LIABILITIES AND CHARGES	14	**(563)**	(558)
TOTAL ASSETS EMPLOYED		**35,199**	26,379
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		**12,212**	12,212
Revaluation reserve	16	**15,957**	7,243
Donated asset reserve	16	**2,185**	1,910
Income and expenditure reserve	16	**4,845**	5,014
TOTAL TAXPAYERS' EQUITY	15	**35,199**	26,379

The financial statements on pages 46 to 67 were approved by the Board on 29 May 2008 and signed on its behalf by:

(Chief Executive)

Date: 12 June 2008

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2008

	2007/08	2006/07
	£000	£000
Surplus for the period before dividend payments	**2,881**	1,967
Unrealised surplus on fixed asset revaluations	**7,120**	9
Unrealised (deficit) on fixed asset revaluations	**(334)**	0
Increases in the donated asset reserve due to receipt of donated assets	**193**	177
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	**(231)**	(227)
Total recognised gains and losses for the year.	**9,629**	1,926

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2008

		2007/08	2006/07
	NOTE	**£000**	£000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	17.1	**4,408**	3,283
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**198**	134
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(1,582)**	(2,234)
Receipts from sale of tangible assets		**140**	125
Payments to acquire intangible fixed assets		**(12)**	(23)
DIVIDENDS PAID		**(809)**	(804)
Net cash inflow before financing		**2,343**	481
FINANCING			
New public dividend capital received		**0**	495
Increase in cash	17.3	**2,343**	976

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 2007/08 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 asset valuations were undertaken in 2008 as at the prospective valuation date of 1 April 2008. The revaluation undertaken at that date has been accounted for on 31 March 2008.

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.

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 fixed assets carried out during the year to 31 March 2008 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 Government grants
Government grants are grants for the provision of services from Government bodies other than income from primary care trusts or NHS trusts. Grants from the Department of Health are accounted for as Government grants. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to the income and expenditure account over the life of the asset on a basis consistent with the depreciation charge for that asset.

1.8 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.

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

1.10 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.

1.11 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.

1.12 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.

1.13 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed 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.

1.14 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.

1.15 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.

1.16 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 will 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.

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

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

1.19 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.

1.20 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.

1.21 Financial instruments

Change in accounting policy
The trust has adopted FRS 26 Financial Instruments: Recognition and Measurement and FRS 29 Financial Instruments: Disclosure for the first time in this financial year. This adoption represents a change in accounting policy. There is no prior period adjustment to reserves resulting from adoption of these standards as their provisions relate to disclosure.

Recognition
In accordance with FRS 26, 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 foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

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

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

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

Classification and Measurement
Financial assets are categorised as 'Fair Value through Income and Expenditure' or 'Loans and receivables'. Financial liabilities are classified as 'Fair value through Income and Expenditure' or "Other Financial Liabilities".

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'
Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

All other financial instruments are held for the sole purpose of managing the cash flow of the foundation trust on a day to day basis or arise from the operating activities of the foundation trust. The management of risks around these financial instruments therefore relates primarily to the foundation trust's overall arrangements for managing risks to their financial position.

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.

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

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

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

Determination of fair value
Financial assets and financial liabilities are carried at book value, which is the same as fair value. In the case of provisions, book value is determined from discounted cashflow analysis.

2. Income from Activities

2.1 Sources of income from activities

	2007/08	2006/07
	£000	£000
NHS Foundation Trusts	**172**	239
NHS Trusts	**7**	0
Strategic Health Authorities	**57**	0
Primary Care Trusts	**40,426**	36,908
Department of Health	**4,556**	4,761
NHS Other	**126**	0
Non NHS:		
- Private Patients	**83**	72
NHS Injury Scheme (was Road Traffic Act)	**167**	80
- Other	**55**	14
	45,649	42,074

In 2004/05 the foundation trust changed the form of its contracts with NHS commissioners to follow the Department of Health's Payment by Results methodology. To manage the financial impact of this change on the NHS foundation trust and its commissioners, transitional relief funding is provided through the Department of Health for a period of four years. The funding received in 2007/08 was £165,000.

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.

	2007/08	2006/07
	£000	£000
Income from protected services	**45,399**	41,922
Income from non-protected services	**250**	152
	45,649	42,074

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.

	2007/08	2006/07
	£000	£000
Private patient income	**83**	72
Total patient-related income	**45,649**	42,074
Proportion	**0.18%**	0.17%

3. Other Operating Income

	2007/08	2006/07
	£000	£000
Education, training and research	**1,597**	1,313
Charitable and other contributions to expenditure	**145**	247
Transfers from donated asset reserve	**231**	227
Non-patient care services to other bodies	**556**	0
Other income	**477**	1,029
	3,006	2,816

4. Operating Expenses

4.1 Operating expenses comprise:

	2007/08	2006/07
	£000	£000
Services from Foundation Trusts	**20**	39
Services from other NHS Trusts	**3,656**	3,865
Services from other NHS bodies	**83**	61
Purchase of healthcare from non-NHS bodies	**59**	97
Executive directors' costs	**464**	442
Non-executive directors' costs	**106**	102
Staff costs	**31,095**	29,520
Drugs	**828**	771
Supplies and services - clinical (excluding drugs)	**3,679**	2,864
Supplies and services - general	**543**	517
Establishment	**860**	850
Transport	**138**	125
Premises	**1,781**	1,618
Bad debts	**43**	17
Depreciation and amortisation	**1,675**	1,465
Impairment of fixed assets	**260**	0
Audit fees	**73**	71
Clinical negligence	**175**	167
Other	**398**	455
	45,936	43,046

4.2 Operating leases

4.2/1 Operating expenses include:

	2007/08	2006/07
	£000	£000 (restated*)
Hire of plant and machinery	**280**	217
Other operating lease rentals	**235**	139
	515	356

* One lease with expenditure of £138,000 in 2006/07, originally described as "Hire of plant and machinery", has been reclassified as an "Other operating lease".

4.2/2 Annual commitments under non-cancellable operating leases are:

	2007/08 Land and buildings £000	2007/08 Plant and machinery £000	2007/08 Total £000	2006/07 £000
Operating leases which expire:				
Between 1 and 5 years	**201**	**254**	**455**	2
After 5 years	**29**	**0**	**29**	455
	230	**254**	**484**	457

5. Staff costs and numbers

5.1 Staff costs

	Permanently Employed £000	Other £000	2007/08 Total £000	2006/07 Total £000
Salaries and wages	25,838	331	**26,169**	24,685
Social Security Costs	2,235	0	**2,235**	2,070
Employer contributions to NHSPA	2,926	0	**2,926**	2,809
Agency staff	0	229	**229**	398
	30,999	560	**31,559**	29,962

5.3 Early retirements due to ill health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were no such retirements during the year; (in 2006/07, one retirement at an additional cost of £36,908.97). (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:	2007/08 Number	2007/08 £000	2006/07 Number	2006/07 £000
Total bills paid in the year	**15,272**	**15,590**	14,704	14,180
Total bills paid within target	**14,155**	**10,541**	13,514	11,460
Percentage of bills paid within target	**92.69%**	**67.61%**	91.91%	80.82%

These figures include both NHS and non-NHS payments. Of non-NHS payments, 93.54% (2006/07 - 93.72%) by number and 89.17% (2006-07 - 90.14%) by value complied with the code.

No claims against the Trust were made under the Late Payment of Commercial Debts (Interest) Act 1998, (2006/07 - nil).

7. Loss on disposal of fixed assets.

During the year protected assets with an aggregate net book value of £25,000 were disposed of. Since there were no proceeds, the resulting loss on disposal has been carried to the Income and Expenditure account.

8. Intangible Fixed Assets	**2007/08 Software Licences £000**	2006/07 Software Licences £000
Gross cost at 1 April 2007	140	117
Additions and disposals	11	23
Gross cost at 31 March 2008	**151**	140
Amortisation at 1 April 2007	41	17
Provided during the year	30	24
Amortisation at 31 March 2008	**71**	41
Net book value		
- Purchased assets at 1 April 2007	**99**	100
- Purchased assets at 31 March 2008	**80**	99

9. Tangible Fixed Assets

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

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2007	6,099	19,570	102	913	6,051	6	2,007	408	35,156
Additions - purchased	0	91	0	599	534	0	83	0	1,307
Additions - donated	0	75	0	0	118	0	0	0	193
Impairments	0	(260)	0	0	0	0	0	0	(260)
Reclassifications	0	692	0	(1,183)	827	0	(336)	0	0
Other revaluations	5,465	(4,642)	25	0	623	1	0	(121)	1,351
Disposals	(31)	0	(127)	0	(120)	0	0	0	(278)
At 31 March 2008	**11,533**	**15,526**	**0**	**329**	**8,033**	**7**	**1,754**	**287**	**37,469**
Depreciation at 1 April 2007	0	4,695	18	0	4,418	2	1,063	154	10,350
Provided during the year	0	941	0	0	524	1	154	25	1,645
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	(4)	0	0	4	0	0	0	0
Revaluations	0	(5,619)	0	0	363	0	0	(179)	(5,435)
Disposals	0	0	(18)	0	(95)	0	0	0	(113)
Depreciation at 31 March 2008	**0**	**13**	**0**	**0**	**5,214**	**3**	**1,217**	**0**	**6,447**
Net book value									
- Purchased assets as at 1 April 2007	6,099	13,293	84	913	1,318	4	942	244	22,897
- Donated assets as at 1 April 2007	0	1,582	0	0	315	0	2	10	1,909
Total at 1 April 2007	**6,099**	**14,875**	**84**	**913**	**1,633**	**4**	**944**	**254**	**24,806**
- Purchased assets as at 31 March 2008	11,533	13,712	0	329	2,453	4	537	279	28,847
- Donated assets as at 31 March 2008	0	1,801	0	0	366	0	0	8	2,175
Total at 31 March 2008	**11,533**	**15,513**	**0**	**329**	**2,819**	**4**	**537**	**287**	**31,022**

As stated in Note 1.4, an interim revaluation of the land, buildings and equipment was carried out with an effective date of 1 April 2008 and has been included in these accounts. The previous valuation was carried out during 2004/05. An independent, qualified valuer has valued land and non-specialised buildings on an Existing Use basis, and specialised buildings using the principle of Depreciated Replacement Cost. The land value takes account of the increase in residential land values in the intervening years.

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

	31 March 2008	31 March 2007
	£000	£000
Freehold	**27,046**	20,974
Long leasehold	**0**	84
TOTAL	**27,046**	21,058

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 2008	31 March 2007
	£000	£000
Protected land, buildings and dwellings	**24,855**	19,905
Non-protected land, buildings and dwellings	**2,191**	1,153
	27,046	21,058

10. Stocks and Work in Progress	31 March 2008	31 March 2007
	£000	£000
Raw materials and consumables	**271**	243
	271	243

11. Debtors

11.1 Debtors by category	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
NHS debtors	**2,665**	3,079
Provision for irrecoverable debts	**(82)**	(58)
Other prepayments and accrued income	**674**	832
Other debtors	**368**	314
Sub Total	**3,625**	4,167
Amounts falling due after more than one year:		
NHS debtors	**76**	81
TOTAL	**3,701**	4,248

11.2 Provision for impairment of NHS debtors	31 March 2008	31 March 2007
	£000	£000
At 1 April	**41**	0
Provision for debtors impairment	**0**	41
At 31 March	**41**	41

11.3 Provision for impairment of non-NHS debtors

	31 March 2008	31 March 2007
	£000	£000
At 1 April	0	0
Provision for debtors impairment	17	0
At 31 March	17	0

11.4 Ageing of impaired debtors	31 March 2008	31 March 2007
	£000	£000
Over six months	58	41

11.5 Ageing of non-impaired debtors	31 March 2008	31 March 2007
	£000	£000
Up to three months	1,245	844
Three to six months	157	802
Over six months	50	424
Total	1,452	2,070

12. Creditors	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
NHS creditors	1,578	2,288
Tax and social security costs	713	665
Capital creditors	121	386
Other creditors	862	170
Accruals and deferred income	1,548	2,117
Total	4,822	5,626

NHS creditors include £363,000 outstanding pensions contributions at 31 March 2008 (31 March 2007 £306,000).

13. Prudential borrowing limit

NHS foundation trusts are required to comply with the Prudential Borrowing Limit set for them by Monitor. In 2007/08 the foundation trust had a long-term borrowing limit of £10,400,000 (2006/07 - £10,000,000) and a working capital facility agreed by Monitor of £3,000,000 (2006/07 - £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 2007	510	15	33	**558**
Arising during the period	23	13	0	**36**
Utilised during the period	(20)	(10)	0	**(30)**
Reversed unused	0	(3)	(9)	**(12)**
Unwinding of discount	11	0	0	**11**
At 31 March 2008	**524**	**15**	**24**	**563**
Expected timing of cashflows:				
Within one year	25	15	0	**40**
Between one and five years	105	0	24	**129**
After five years	394	0	0	**394**

The provision for pensions relating to staff comprises £449,000 in respect of injury benefit (31/3/2007 - £435,000) and £75,000 in respect of early retirements (31/3/2007 - £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.

£376,000 is included in the provisions of the NHS Litigation Authority at 31/3/2008 in respect of clinical negligence liabilities of the foundation trust (31/03/2007 - £194,000).

15. Movement in Taxpayers' equity

	2007/08	2006/07
	£000	£000
Taxpayers' equity at start of period	26,379	24,762
Surplus for the financial year (before Public Dividend Capital dividend)	2,881	1,967
Public Dividend Capital Dividends	(809)	(804)
Surplus from revaluations of fixed assets	6,473	9
New Public Dividend Capital received	0	495
Movements in Donated Asset Reserve	275	(50)
Taxpayers' equity at 31 March 2008	**35,199**	26,379

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 2007	7,243	1,910	5,014	**14,167**
Transfer from the income and expenditure account	0	0	2,072	**2,072**
Surplus on revaluation of fixed assets	6,473	313	0	**6,786**
Receipt of donated assets	0	193	0	**193**
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	0	(231)	0	**(231)**
Other transfers between reserves	2,241	0	(2,241)	**0**
At 31 March 2008	**15,957**	**2,185**	**4,845**	**22,987**

17. Notes to the cash flow Statement

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

	2007/08	2006/07
	£000	£000
Total operating surplus	**2,719**	1,844
Depreciation and amortisation charge	**1,675**	1,465
Fixed asset impairments	**260**	0
Transfer from donated asset reserve	**(231)**	(227)
(Increase) in stocks	**(28)**	(16)
(Increase) / Decrease in debtors	**547**	(959)
Increase / (Decrease) in creditors	**(539)**	1,254
Increase / (Decrease) in provisions	**5**	(78)
Net cash inflow from operating activities	**4,408**	3,283

17.2 Reconciliation of net cash flow to movement in net funds:

	2007/08	2006/07
	£000	£000
Increase in cash in the period	**2,343**	976
Net funds at 1 April 2007	**3,167**	2,191
Net funds at 31 March 2008	**5,510**	3,167

17.3 Analysis of changes in net funds:

	At 1 April 2007	Cash changes in period	Non-cash changes in period	**At 31 March 2008**
	£000	£000	£000	**£000**
Commercial cash at bank and in hand	31	(1)	0	**30**
OPG cash at bank	3,136	2,344	0	**5,480**
	3,167	**2,343**	**0**	**5,510**

18. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2008 were £273,000 (31 March 2007: £370,000).

19. Contingencies

	At 31 March 2008	At 31 March 2007
Contingent liability:	**£000**	£000
Gross value	**(5)**	(10)

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 £24,299,000 (2006/07: £22,067,000) and the dividend payments of £809,000 (2006/07: £804,000) in the year therefore represented an annual dividend rate of 3.3% (2006/07: 3.6%). This was below the target of 3.5% because of the effect on relevant net assets of the revaluation of fixed assets that took place at the end of the year. The outcome of this could not be predicted when the dividend payment was calculated. Had the revaluation not occured, average relevant net assets would have been £21,322,000 and the average dividend rate 3.8%.

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	2007/08		31 March 2008		2006/07		31 March 2007	
	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	**128**	**0**	**0**	**0**	207	0	0	0
McIndoe Surgical Centre	**102**	**3**	**11**	**3**	144	160	39	8
Centre for Sight and LAD Health	**57**	**71**	**12**	**4**	70	40	12	3
Whole of Government Accounts bodies								
a) Bodies with whom either income or expenditure exceeded £150,000 during the year:								
West Sussex PCT	**10,500**	**2**	**197**	**22**	16,100	66	1,235	29
West Kent PCT	**8,212**	**11**	**403**	**0**	7,610	0	149	0
HM Revenue & Customs	**0**	**4,953**	**0**	**410**	0	4,763	0	389
Department of Health	**4,709**	**0**	**63**	**0**	4,939	0	42	0
Tower Hamlets PCT	**3,959**	**0**	**-18**	**87**	5	0	1	0
East Sussex Downs and Weald PCT	**3,796**	**26**	**40**	**26**	14	0	25	0
Eastern and Coastal Kent PCT	**3,267**	**0**	**127**	**0**	3,733	0	19	0
Medway PCT	**3,118**	**50**	**84**	**53**	3,536	52	67	102
NHS Pension Scheme	**0**	**2,926**	**0**	**363**	0	2,740	0	306
Surrey PCT	**2,894**	**0**	**315**	**0**	2,698	0	390	0
National Insurance Fund	**0**	**2,235**	**0**	**303**	0	2,165	0	275
South East Coast Strategic Health Authority	**1,449**	**26**	**103**	**18**	1,198	7	111	7
Maidstone and Tunbridge Wells NHS Trust	**3**	**1,104**	**1**	**430**	6	394	8	378
Hastings and Rother PCT	**1,056**	**0**	**3**	**0**	7	0	0	0
Brighton and Hove City PCT	**964**	**0**	**13**	**0**	0	0	0	0
East Sussex Hospitals NHS Trust	**0**	**731**	**8**	**157**	8	1,267	41	260
Bexley Care Trust	**595**	**0**	**18**	**0**	727	0	9	0
Bromley PCT	**559**	**0**	**11**	**0**	708	0	75	0
Medway NHS Trust	**0**	**517**	**0**	**129**	2	470	2	210
South East Coast Ambulance Service NHS Trust	**0**	**491**	**0**	**130**	0	392	0	17
Dartford and Gravesham NHS Trust	**0**	**441**	**0**	**77**	0	357	0	45
Hampshire PCT	**334**	**0**	**92**	**0**	184	0	29	0
Croydon PCT	**292**	**0**	**15**	**0**	328	0	0	11
Surrey and Sussex Healthcare NHS Trust	**20**	**170**	**113**	**253**	7	900	76	606
Guy's and St. Thomas' NHS Foundation Trust	**174**	**14**	**448**	**10**	242	23	465	9
NHS Litigation Authority	**5**	**175**	**0**	**8**	1	167	0	0
b) Others:	**1,458**	**508**	**759**	**191**	1,543	1,246	422	309

22. Private Finance Transactions

22.1 PFI schemes deemed to be off-balance sheet

	2007/08	2006/07
	£000	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet	**230**	193

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

PFI scheme which expires;		
2nd to 5th years (inclusive)	**203**	187
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 1.21.

Debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures.

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. 64% of its financial assets are held as cash at variable interest rates but interest receivable represents only 0.40% of total incoming resources (0.30% in 2006/07). 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 2008 Carrying Value £000	31 March 2007 Carrying Value £000
Denominated in sterling	**8,302**	6,647

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".

The NHS Injury Cost Recovery Scheme amounts of £313,000 (2006/07 £237,000) and prepayments of £365,000 (2006/07 £365,000), are not considered to be financial instruments under UK GAAP and therefore have been excluded from the above analysis.

Financial liabilities	31 March 2008 Carrying Value £000	31 March 2007 Carrying Value £000
Denominated in sterling	**(2,783)**	(3,347)

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 £713,000 (2006/07 £655,000) and deferred income £915,000 (2006/07 £1,264,000) 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 2008 Loans and receivables £000	31 March 2007 Loans and receivables £000
NHS Debtors (net of provision for irrecoverable debts)	**2,324**	2,861
Accrued income	**208**	344
Other debtors	**260**	275
Cash at bank and in hand	**5,510**	3,167
Total	**8,302**	6,647

Financial liabilities	31 March 2008 Other financial liabilities £000	31 March 2007 Other financial liabilities £000
NHS Creditors	**(1,578)**	(2,288)
Other creditors	**(572)**	(206)
Accruals	**(633)**	(853)
Total	**(2,783)**	(3,347)

23.3 Fair Values

	Book Value £000	Fair Value £000
Financial assets	**8,302**	**8,288**
Financial liabilities	**(2,783)**	**(2,783)**

23.4 Maturity of financial assets

All of the foundation trust's financal assets mature within one year with the exception of £76,000 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 (2006/07 £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	**2,136**	**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**
Balances with other Central Government Bodies	2,419	81	886
Balances with NHS Trusts and Foundation Trusts	666	0	1,659
Balances with bodies external to government	1,082	0	3,081
At 31 March 2007	**4,167**	**81**	**5,626**

25 Third party assets

The foundation trust held no cash at bank or in hand at 31 March 2008 (31 March 2007 £nil) which related to monies held by the foundation trust on behalf patients.

26 Losses and Special Payments

There were 16 cases of losses and special payments (2006/07 - 44 cases) totalling £2,000 (2006/07 - £5,000) approved during 2007-2008.
There were no clinical negligence cases where the net payment exceeded £100,000 totalling £nil (2006/07 - £nil).
There were no fraud cases where the net payment exceeded £100,000 totalling £nil (2006/07 - £nil).
There were no personal injury cases where the net payment exceeded £100,000 totalling £nil (2006/07 - £nil).
There were no compensation under legal obligation cases where the net payment exceeded £100,000 totalling £nil (2006/07 - £nil).
There were no fruitless payment cases where the net payment exceeded £100,000 totalling £nil (2006/07 - £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
West Sussex RH19 3DZ
Tel: 01342 414000
www.qvh.nhs.uk

CHIEF EXECUTIVE
If you have a comment for the Chief Executive, please write to Sharon Colclough at the address above, or email her at sharon.colclough@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 Co-ordinator on 01342 414200 or email pals@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. The Head of Corporate Affairs can be contacted on 01342 414203 or email mary.goode@qvh.nhs.uk

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