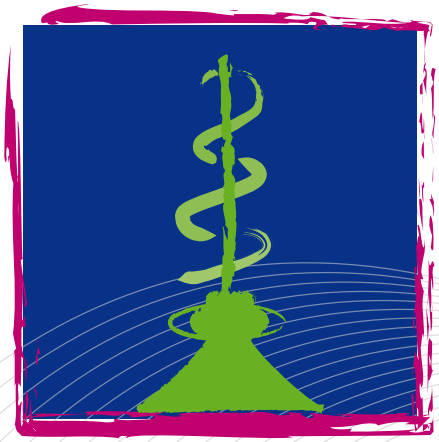
Queen Victoria Hospital
NHS Foundation Trust

Annual Report

Quality Accounts and Financial Accounts

2010/11



Queen Victoria Hospital NHS Foundation Trust

Annual Report, Quality Accounts and Financial Accounts 2010/11

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

Contents

This annual report, produced by Queen Victoria Hospital NHS Foundation Trust, provides a commentary on the financial and operational performance of the trust during 2010/11. Like all public sector organisations, QVH faces a challenging financial situation. Staff have worked hard to control costs over the last year and this will need to continue. In order to meet our annual reporting requirements in the most cost effective way, we have made this year's annual report shorter than in previous years, focusing on statutory reporting requirements.

1.0 Introductions

1.1 Chairman's introduction

I am pleased to present the 2010/11 annual report for Queen Victoria Hospital NHS Foundation Trust.

Over the past year, QVH has continued to provide specialist reconstructive surgery and care for patients across the south east of England and first-class community services for our local population, maintaining the excellent clinical standards for which we are renowned. At the same time the trust has strengthened its financial position in the face of significant national and local challenges, ensuring that we have a firm foundation from which to continue providing expert, high quality care. We end the year looking forward to building six new operating theatres and supporting infrastructure for our patients.

The decision to invest in the new theatres is the result of a concerted and detailed review of the trust's long term business strategy which the board of directors undertook this year. Our ageing estate is our greatest challenge and the cost of maintaining facilities – many of which were built before 1940 – is high. Previous plans to rebuild the entire hospital or a new surgical centre became unaffordable in the current financial climate so the board reviewed the options for raising funds to make the most essential improvements. These options included merger with other NHS organisations that could invest in improvements to the QVH site and the option to maintain independence. The board considered that QVH was sustainable as an autonomous organisation and, having considered feedback from discussions with governors, staff and stakeholders, all of whom supported that view, commenced to develop plans on that basis.

With the trust's financial position stronger than forecast this year – as a result of a board-led recovery plan including systematic improvements to our patient pathways and the hard work of staff – and with the development of robust plans for continuous improvement in the coming years, the board is confident that QVH, on its own, can afford to make the necessary investments.

Like all NHS organisations, QVH faces the threat of declining revenues and increasing costs. But with this sound long-term strategy in place, I strongly believe that QVH can look forward to a successful, independent future in which we can continue to provide the highest quality care that our patients trust us to deliver.

On behalf of the board, I extend my heartfelt thanks to the Chief Executive and all his staff for their tremendous efforts throughout the year and the strong financial and operational performance positions achieved at year-end.

Peter Griffiths
Chairman

1.2 Chief Executive's introduction

2010/11 has been a challenging but successful year for Queen Victoria Hospital NHS Foundation Trust.

We continue to aim to achieve the high standards of clinical quality and safety that our patients and regulators have come to expect of QVH. Indeed, we have made strong progress against the priorities for improvement that we set ourselves at the beginning of the year.

We have worked hard to further improve our patients' experience by improving our administrative processes, minimising lengths of stay and reducing repeat visits and cancellations. We have also focused on improving key aspects of our care that had been highlighted for us in patient surveys.

As a result, we have improved the quality of care we provide, improved our productivity and reduced our running costs by some £2 million. Patients are given their outpatient appointments more quickly following referral; most patients now have a pre-assessment for their operation on the day of their outpatient visit rather than returning later; the great majority of patients with trauma receive their operation within 12 hours of admission; patients receive texted reminders of outpatient appointments (reducing the rate of non attendance); and we have halved the already small number of operations cancelled at short notice. Surveys of our inpatients regularly show that 100% of our patients would recommend us to their friends and relatives.

In addition, as a specialist surgical hospital, we have taken a critical look at the productivity of our theatres. By improving organisation and team working we have been able to significantly increase the effective use of theatre time. This means better use of resources and staff time, less waiting for patients and fewer cancelled operations.

We have demonstrated our capability to identify, act upon and sustain efficiencies that will enable us to become a more cost-effective organisation that can also deliver the highest quality care.

Our staff continue to provide exceptional care in unexceptional buildings. Much of our infrastructure is out-dated and in need of modernisation. We have recently built a new paediatric assessment unit and are currently refurbishing our inpatient children's ward. In the coming year, we will embark on building six new theatres to replace our American Wing theatre suite that dates from the 1940s.

Our hospital is not alone in facing difficult financial pressures as the NHS seeks to save £20bn over the next four years. But, at QVH, all who work here can be rightly proud of the excellent care we will continue to provide to our patients.

Amanda Parker
Acting Chief Executive

Signed on behalf of Adrian Bull, Chief Executive, who was not available to sign the Annual Report on the day it was submitted to Monitor.

1.3 Vice-Chairman of the Board of Governors' introduction

As an NHS foundation trust, QVH is governed by two boards. The board of directors is responsible for managing the trust and setting its strategic plans. The board of governors – consisting of elected members and stakeholder representatives – represents the communities that QVH serves and holds the board of directors to account for the trust's performance.

The QVH board of governors is unashamedly focused on patients. We want to ensure that QVH best meets their needs for specialist reconstructive surgery and care and community services. But, as a result of national and local challenges to all NHS services, achieving this seemingly simple ambition has become more difficult and complex than ever. Good clinical outcomes and positive experiences for patients are not possible without strong organisation and talented and committed staff working with fit for purpose facilities and equipment. Only a financially sound hospital can deliver all of this and that is what QVH aspires to do.

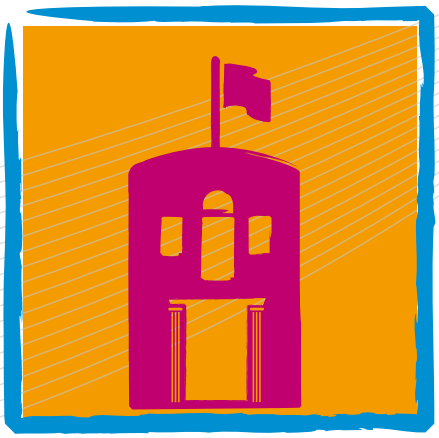
The trust concluded some time ago that it must redevelop its ageing estate, particularly its operating theatres, to really secure its finances. Governors have long supported the board of directors in 'grasping this nettle'. Nonetheless, taking a long term strategic view and facing the realities of how to achieve this has led this year to some uncomfortable options, including the potential for QVH to relinquish its independence.

The long term strategy can only be decided by the board of directors. However, throughout the strategic review, a series of joint board meetings and briefings enabled governors to contribute our perspective and experience as members of the community as well as the knowledge we have gathered since QVH's authorisation as a foundation trust almost seven years ago. Furthermore, the board of directors invited the governors to submit our own recommendations to help them reach their final conclusions; an invitation which we welcomed and took serious consideration of.

This collaboration between the boards is representative of the maturity of the QVH board of governors and illustrates what we believe to be good practice for the governance system of a foundation trust in difficult circumstances. With the decision taken for QVH to look forward to an independent future, the board of governors believes that the stage is now set for QVH to maintain its position as the leading regional provider of reconstructive surgery and care and local provider of community services.

Bernard Atkinson
Vice-Chairman of the Board of Governors

2.0 Director's report



2 Director's report

2.1 Who we are, what we do

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

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

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

In 2010/11, the principal activities of the trust were the provision of:

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

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

2.2 Business review

QVH made good progress in improving its underlying financial and operational position in 2010/11, while maintaining its strong record on patient safety and quality of care.

In 2009/10 the trust had identified that without action its financial position would deteriorate significantly in the next two years. A strategic action plan was drawn up by the board of directors and presented to Monitor. This was implemented, based on the principles of streamlining our processes of care, improving the efficiency of our services to patients, and reducing overall staffing numbers. The effects on improved cost controls and increased productivity have been closely tracked. A core component of the action plan was reducing pay costs by £1.4m through restructuring management and administration. A reduction of 40 WTE (whole time equivalent) posts was achieved, largely through natural turnover, only requiring three compulsory redundancies.

Other key elements of the plan included:

- improving theatre productivity by 15%
- delivering non-pay savings of £333k
- delivering annualised cost reductions of 4% (£2m)
- strengthening bank and agency cost controls
- a stronger focus on service line reporting, leading to improved financial contribution in specific clinical areas such as orthodontics.

QVH has continued to provide access to reconstructive services for patients across the South East through a number of partner hospitals. Managing and coordinating services for patients using other hospitals' PAS systems and clinic records services is inevitably more challenging than managing services on our own sites. Over the past year, we have improved mechanisms to monitor our remotely provided services and are working to achieve improvements in efficiency and productivity that match those achieved at East Grinstead. Developments include transferring patients at Maidstone to our own PAS systems, taking over through TUPE the administrative support to our clinicians at Medway, improving our access to Medway PAS systems and appointing a service coordinator to cover Medway and Dartford.

QVH has also continued to focus on its core reconstructive services. The provision of infrequent theatre sessions by visiting consultants for a range of general surgical specialities (such as vascular surgery for varicose veins once per month) were found to be inefficient and were compromising our ability to achieve waiting time targets. These have been discontinued and replaced by reconstructive surgery sessions. We have also continued to provide facilities for a

range of visiting consultants to conduct outpatient clinics for local patients covering the specialities of dermatology, rheumatology, cardiology, vascular surgery, gynaecology, paediatrics and urology.

This year we have provided the initial phases of a consultant-led plastic service to support and strengthen the regional trauma unit at Royal Sussex County Hospital in Brighton. This service will ensure patients with extensive injuries have access to specialist care as soon as possible, reducing length of stay and the need for transfers between hospitals. Additional burns clinics for both adults and children will also be provided at Brighton, extending the regional service we provide. In the next twelve months the service will continue to develop to provide a full five-days-per-week plastic surgery presence. The service complements the existing provision of plastic surgical services for skin cancer.

QVH provides non-acute inpatient medical care through its Jubilee ward. Although highly popular with the local community and local GP practices, demand for these beds has reduced in recent years. Of a maximum 28 beds, the unit is currently staffed to take a maximum of 15 patients. Occupancy is generally 12 patients or less. The small size of this unit makes it expensive to run and the service currently loses in excess of £500k each year. We have worked with NHS West Sussex, neighbouring district general hospitals and the local GP commissioning group to find a solution for the long term future of this service, so far without success. The hospital will not be able to subsidise the service into the future and we continue to work with our partners to find a solution.

2.3 Quality governance

Embedding quality as a trust-wide primary objective is paramount for the management team and board of directors. During 2010/11 the board has met directly with staff and patients on board walkabouts across the trust to assure themselves of this.

Embedding quality has been achieved using our risk strategy where we have identified a number of goals to be achieved during the year. Incorporated within this was the development of a patient safety vision that identified the roles that leadership, communication and learning play in ensuring that the care delivered is safe and of a high quality and that we prevent harm to patients. Directors have taken personal leadership in delivering on these goals.

The goals identified for 2010/11 within our strategy included national requirements for maintaining compliance with the Care Quality Commission essential standards of quality and safety. We reviewed the safety metrics regularly reported across the organisation to ensure they reflected safe care. These metrics monitor the development of pressure ulcers, the number of falls where patients came to harm and the number of cases of significant infection, namely MRSA and *Clostridium Difficile*. All these measures are considered nationally and therefore provide benchmarks for the standard of care provided to patients.

Delivery of safe care is discussed as a core item at the board and our quality and risk committee is chaired by a non executive director. Quality and risk management is discussed at divisional and departmental level as a standing agenda item and, where required to improve quality, action plans are developed and followed up with final sign-off occurring at our clinical policy committee, ensuring that learning from one department is communicated across the organisation.

At each board meeting, monthly information is provided on specific incidents rated red or amber, any noted incident trends, complaints, adult or child safeguarding concerns, ability to deliver same sex accommodation and progress against our safety metrics. In addition, an infection control report provides detail of Meticillin-Resistant Staphylococcus Aureus (MRSA), and *Clostridium Difficile* cases and compliance with our hand hygiene policy.

The risk register is also presented to the board each month and includes details of all significant risks, showing the controls in place to mitigate the risk and any actions required to further mitigate them. This information is used to support the population of our assurance framework which is reviewed regularly by the board.

QVH governors are engaged in the trust's quality governance arrangements and quality of care is the main item for discussion at the regular meetings with commissioners. We access patient views on the quality of services through our public engagement committee that has representation from Local Involvement Networks (LINks), Patient Advice and Liaison Service (PALS) and complaints.

2.4 Operational performance

Activity levels across QVH

Overall activity levels for the year were in line with trust expectations although in some areas were higher than commissioners had planned. During the year the trust reviewed service line performance and improved the overall efficiency in areas of previous underperformance.

Demand for trust services continued to be strong with overall referrals to QVH increasing by 7.4%

Overall non-elective admissions grew by over 10% and there were increases in day cases and outpatient procedures, reflecting the trust's strategy of treating as many patients as possible without the need for an overnight stay.

Income associated with patient activity also increased from 2009/10 as a result of the increases in national tariff prices in 2010/11 as well as a small increase in the market forces factor supplement payable to QVH.

Streamlining projects

Through the year the trust undertook a number of projects to improve the experience of patients by simplifying our administrative processes and revising clinical pathways to reduce the time taken for patients to move from one point to the next. This programme continues across the organisation, with a number of priorities identified in our quality report.

Work done through the year has included:

- Increasing the proportion of patients having pre-assessment for surgery on the same day as their outpatient appointment – a measure which has increased from less than 25% to over 60% in the year. Further improvements will see this proportion continue to rise. As a consequence, there is improved patient satisfaction, improved booking of theatres and reduced cancellations of surgery on the day of operation.
- Improving the speed of treatment of trauma cases – with the proportion of patients not having their trauma surgery within 24 hours continuing to decrease and the number of occasions on which trauma surgery was cancelled also reducing significantly.
- Improving the efficiency of outpatient appointment bookings – by revising the process, significantly reducing the administrative time and resources spent on this process and reducing the number of days taken to make such bookings to six days.
- Improving theatre efficiency - combined with the successful introduction of World Health Organisation (WHO) theatre check lists, leading to fewer theatre overruns, more effective use of theatre time, and 15% increase in weekly theatre throughput.
- Improving the management of patients in corneoplastic outpatients – which was a performance target agreed with NHS West Sussex under the Contracting for Quality Initiative (CQUIN), with reduced time taken for eye tests and to see the surgeon leading to improved patient satisfaction.

Performance against national targets

QVH met the key targets for treatment within 18 weeks and for the cancer pathways. However, QVH exceeded its maximum limits for *Clostridium Difficile* and MRSA. Full reviews have been undertaken and action plans have been implemented where required and QVH's record for infection remains strong. Against a Department of Health (DH) set limit of one case of MRSA bacteraemia, QVH had two such cases, which is less than the *de minimis* level of six set by Monitor for governance purposes. Each case was independent and there was no cross infection in the hospital. In each case the patient had extensive and complex injuries with high risk of such infection. Treatment was immediate and appropriate, with no clinical harm arising. Against a DH-set limit of four cases of *Clostridium Difficile*, QVH had six cases. Each case was independent and received immediate treatment with no complications, and with no cross infection.

There is significant pressure on achieving the target of 96% of patients with skin cancer being treated within 31 days of diagnosis. The numbers of such cases are small, such that any delay in single cases can materially affect this ratio. Delays in referral to QVH surgeons from dermatologists, cancellations due to heavy snow in November and December 2010, and congestion of histopathology testing has meant that this target was failed in Q3, although the total number of patients breaching the target was six out of 145. Further improvements to the processes of care have been introduced.

A detailed analysis of the trust's performance against national targets is provided at Annex B on page 86. It should be noted that the trust's Q4 amber-red governance rating, which relates primarily to performance against the *Clostridium Difficile* target, is not indicative of any weaknesses in the trust's internal controls.

2.5 Financial performance

QVH achieved a good financial performance for 2010/11 despite beginning the year with a challenging financial position. Overall the trust delivered a surplus of £2.8m before impairments and transformation costs.

The trust reduced the asset value of buildings which will be affected by the building of the new theatre block in 2011. This created an additional technical adjustment charge of £3.4m which is excluded from the financial risk rating calculation by Monitor.

QVH incurred a further £0.8m costs in 2010/11 relating to its staff restructuring. In accordance with the agreed treatment with Monitor these costs are also excluded from the financial risk rating calculation. QVH achieved an overall financial risk rating of 5 (5 being the lowest level of financial risk attainable under Monitor's compliance framework).

The business plan had identified a savings requirement of £2m as well as improved operational efficiency in order to deliver its targets. These targets were achieved in the year.

All figures in £m	Actual 2010/11	Actual 2009/10
Turnover	56.8	54.5
Pay	(36.2)	(36.2)
Non-pay costs excluding impairments	(17.0)	(16.4)
Interest and dividend	(0.8)	(0.9)
Surplus before impairments and transformation costs	2.8	1.0
Impairments	(3.4)	(2.0)
Transformation costs	(0.8)	0
Surplus / (deficit)	(1.4)	(1.0)
Cash balance	7.0	4.8
Financial risk rating at Q4	5	4

Overall, QVH saw more patients than commissioners had originally anticipated and income from patient activity increased over 2009/10 by £2.2m.

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

Pay costs fell slightly from 2009/10 and once pay inflation is taken into account a significant saving has been achieved through the restructuring.

Non-pay costs increased slightly from 2009/10 levels which is in line with the additional activity undertaken and the relatively high levels of inflation during the year. The trust took action to mitigate the impact where possible and increases in the costs of drugs and other clinical supplies were offset by benefits from improved procurement savings.

Interest income remained low given the low national interest rate levels.

QVH's cash position was adversely affected during the year by commissioners being slow to pay for activity undertaken. This in turn meant the trust was not able to pay its suppliers as quickly as planned. QVH aims to pay 95% of invoices within 30 days but achievement for non-NHS invoices 2010/11 was at only 48%. Improved cash flow in the last quarter of the year led to better performance and we aim to continue this improvement in 2011/12.

The trust will continue to set savings plans each year to achieve the national efficiency targets and manage service delivery within anticipated reductions in income. There are clear financial challenges in the coming year but good performance in 2010/11 has given QVH a reasonably sound platform to build upon.

2.6 Regulatory ratings

The trust reports to Monitor on a quarterly basis and its 2010/11 ratings are summarised below.

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

QVH exceeded its annual maximum allowable number of cases of *Clostridium Difficile* in Q2. Under the compliance framework for foundation trusts each subsequent quarter breach leads to an automatic deterioration in the governance rating, even when the breach cannot be prevented. The trust has kept Monitor informed of the outcome of each clinical case review and the actions taken. The trust believes the cases could not have been prevented given the clinical condition of the patients.

QVH also exceeded the maximum allowable cases of MRSA, having two cases against a target of one, but these are below the *de minimis* threshold applied by Monitor and therefore did not count against the governance rating.

QVH is registered with the Care Quality Commission (CQC) and is licensed to deliver specified services at two locations. CQC provide the trust with a quality and risk profile to support monitoring of compliance with essential standards of quality and safety, the most recent profile shows green for nine outcomes, amber for two outcomes and no outcomes rated red. This profile is used to inform the trust's quality and safety activity.

2.7 Principal risks and uncertainties

The principal risks facing the organisation remain the national economic climate, reforms to the commissioning side of the NHS and the ageing estate of the hospital.

The economic climate will drive an increased requirement to deliver financial and operational efficiencies so that the trust can continue to live within its resources. The national tariff is reduced for 2011/12 and commissioners are signalling their intention to reduce access for patients and thus future spend on elective surgery services provided by the trust.

Recent statements from PCTs in Kent, Surrey and Sussex have included proposals to withdraw funding from surgical treatment of non-oncological breast conditions, from common (disabling) conditions of the hand (such as Dupuytrens' contracture), and from other so-called low priority conditions including, for example, benign but symptomatic skin lesions. As the regional centre for specialist reconstructive surgery of these conditions and the provider of unique expertise for the more complex cases (such as traumatic amputation, surgical treatment of disseminated melanoma or microvascular breast reconstruction following cancer surgery), QVH is particularly vulnerable to changes of this sort. It is essential, if the population is to continue to have access to the more specialist services, that the hospital continues to treat the more routine cases to maintain operational and financial viability. We will continue to make representations to commissioning bodies demonstrating the efficacy of our services, the longer term consequences of avoiding or undertaking lower cost procedures in the short term and the level of morbidity associated with perceived low priority conditions.

PCTs and GP commissioning groups have also introduced a number of referral management systems (covering, for example, hand surgery, skin lesions, dento alveolar and orthodontic patients) which seek to divert patients to perceived lowest cost or pre-paid providers. QVH continues to work with commissioners to deliver and demonstrate best value for money. We believe that such referral management schemes cause inconvenience to patients, add unnecessary cost and result in additional and unnecessary interventions. We also believe that this approach contravenes the important development of patient choice – both of the type of treatment available and of the surgeon and hospital providing the treatment. We will continue to seek to establish our services on the basis of agreed treatment thresholds or criteria with commissioners.

In line with burns networks elsewhere in the country, the London and South East Burns Network has commissioned a full review of the current pattern of provision. QVH's burns unit is the sole provider of such services in Sussex, Surrey and Kent. Situated in the centre of the geographical area, it is not co-located with either a full accident and emergency centre or a full intensive care unit. It does provide three fully staffed critical care beds. QVH has close support for its burns service from Brighton and Sussex University Hospitals with which it has formed a strong strategic alliance and with whom it is working to develop trauma centre services at the Royal Sussex Hospital. The results of the network review are awaited. Clearly any determination by that review to downgrade the burns service at QVH would have significant repercussions both for the hospital and for burns services in the South East. QVH is fully engaged with this review, and has consistently responded to and resolved issues raised in previous such reviews.

The next two years will see a major restructure of local commissioning and contracting organisations with the creation of the new GP commissioning consortia and the dissolution of the PCTs. There will be increased risks during the transitional period with changing personnel and loss of corporate memory.

2.8 Estate

The QVH estate comprises many different buildings spread over 23 acres and a significant proportion is very old. The majority of the estate is unsuitable for longer term use. Of the 18,000m^2 estate buildings, just over 5% (925m^2) is considered suitable with a further 4% (600m^2) borderline. Many of the buildings are over 60 years old with heating plants, domestic water, sewage and electrical systems in many areas of a similar vintage. Electrical capacity on the site is reaching its maximum capacity and heating and drainage systems regularly fail.

During the last year there have been a number of infrastructure failures including loss of power, heating and hot water to clinical areas with the highest risk being the loss of power to theatres on several occasions. These incidents were managed appropriately and without threat to patient safety.

In order to ensure our ability to continue to deliver specialist reconstructive surgery to our catchment population of 4.5 million and mitigate our clinical risk caused by the age of the estate, the board requested in 2010/11 a review of the strategic options to support the future business of the trust and address the following key issues:

- Monitor's expectations regarding real-term decrease in public spending
- the national economic position and the reduction in NHS spend
- our weak financial position for the latter half of 2009/10
- estate issues and their impact on clinical risk.

Four options were reviewed by the board of directors:

- QVH to remain independent
- QVH to move with autonomy (i.e. move to an alternative site but retain independent status)
- QVH to identify a 'cash rich' partner to help develop the East Grinstead site
- QVH to identify a suitable alternative site – the 'move and merge' option.

The preferred option, following full option appraisal, was agreed by the QVH board in November 2010. This was to remain independent and to invest up to £12 million to build six new theatres with supporting infrastructure.

Detailed work has now commenced on the full business case for QVH to achieve Royal Institute of British Architects (RIBA) Stage C by April 2011 with the planned development completed for 2012.

All backlog maintenance work is linked to the site master plan. This ensures that the long term clinical and functional planning of the site is aligned with reducing the highest clinical risks due to infrastructure failure as quickly as is affordable. The capital programme for 2010/11 was £4.5m which included the major redevelopment of paediatrics. The proposed capital programme for 2011/12 is aligned to the site master plan.

2.9 Staff engagement

QVH works in partnership with local trade union representatives to consult with staff and communicate changes, service developments, events, news and achievements. There are two official consultation forums: the Joint Consultative and Negotiating Committee which is made up of trade union and management representatives, and the Local Negotiating Committee which is made up of management and medical staff representatives and a British Medical Association representative. There are a number of communication forums within the trust, including monthly team briefings, briefings and 'walkarounds' by the chief executive, the 'Connect' newsletter and an intranet site.

During 2010/11, a specific project on culture and values in the organisation has taken place, involving staff through focus groups, team meetings and one to one interviews. In 2011/12 the trust will be developing a staff engagement toolkit.

QVH regularly performs well in the annual national surveys of the people who work for the NHS. This year has been no exception, although there has been a small deterioration in some aspects of the trust's results when compared to previous years. In the 2010 survey, 52% of staff responded. In 2009, the response rate was 57%, however this was of a sample of staff (600) whereas in 2010 all staff (900+) were surveyed. Therefore, the 2010 response rate represents more people in the organisation.

Staff survey response rate		
Year	2009	2010
QVH response	57%	52%
National average	53%	Not provided
Improvement / deterioration	Please see above for commentary on change	

There are 38 'key findings' in the national survey. The table below shows how QVH compared on these 38 findings with other trusts.

	QVH better than average	QVH same as average	QVH worse than average
Compared with all other NHS acute trusts	24	8	6
Compared with other trusts in the region	25	11	2
Compared with 19 other specialist acute trusts	12	16	10

Teamwork is strong at QVH and the hospital scored well compared to all other trusts for the number of staff believing they work in a well-structured team environment. More staff at QVH felt able to contribute towards improvements at work and more staff at QVH reported good communication with senior managers than at other trusts. However, this last score fell in comparison to the previous year. The hospital also scored better than average for the number of staff having well-structured appraisals.

The findings show that there is a strong culture of patient safety at QVH. A slightly higher than average number of staff said they had reported errors or near misses and the survey showed that QVH is better than average for the fairness and effectiveness of our incident reporting procedures.

	2009		2010		
Top four scores	QVH	Acute specialist average	QVH	Acute specialist average	Improvement / deterioration
Perceptions of effective action from employer towards violence and harassment	3.83	3.62	3.80	3.67	0.03 deterioration
Impact of health and well-being on ability to perform work or daily duties	1.50	1.57	1.50	1.57	No change
Percentage of staff saying hand washing materials are always available	81%	71%	77%	68%	4% deterioration
Percentage of staff believing trust provides equal opportunities for career progression or promotion	93%	91%	94%	92%	1% improvement

QVH scored better than the average when compared with all types of trusts for how strongly staff would recommend their trust as a place to work or receive treatment.

	2009		2010		
Bottom four scores	QVH	Acute specialist average	QVH	Acute specialist average	Improvement / deterioration
Percentage of staff suffering a work-related injury in the last 12 months	20%	13%	17%	13%	3% improvement
Percentage of staff receiving job-relevant training, learning or development in the last 12 months	79%	77%	76%	79%	3% deterioration
Percentage of staff receiving health and safety training in the last 12 months	83%	80%	75%	84%	8% deterioration
Percentage of staff feeling there are good opportunities to develop their potential at work	47%	47%	42%	45%	5% deterioration

In addition, the key areas where scores have deteriorated from last year were:

- percentage of staff suffering work-related stress in the last 12 months
- percentage of staff reporting good communications between senior management and staff
- percentage of staff feeling pressure in the last three months to attend work when feeling unwell
- work pressure felt by staff.

The bottom four scores and the four areas of deterioration will be the focus of trust action plans to bring about improvements in the organisation. These plans will be developed at departmental level and monitored at the performance review meetings. A template action plan has been created and circulated to the heads of department. Since the staff survey was completed, the trust has implemented an employee assistance programme which provides a range of support to staff including telephone and face-to-face counselling and specific advice on debt, legal matters and cancer. It is anticipated that this will help with factors such as stress and work pressure.

Equality and diversity

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

- The development and publication of an Equality Scheme 2010-13 and action plan which encompasses all six equality strands to promote equality and diversity and meet our legal duties concerning race, disability and gender and to provide a framework for a co-ordinated approach on age, religion/belief and sexual orientation. This has now been amended to incorporate the changes brought in by the Equality Act 2010 and training within the trust has been provided.
- Quarterly equality, diversity and human rights steering group meetings which include representation on disability, race, gender and age. Topics for discussion include disabled parking provision, multi-faith room, translation service usage, human rights, policy review and progress on equality action plans.
- An executive lead in equality and diversity – Amanda Parker, Director of Nursing and Quality.
- Conducting and publishing the equality impact assessment of our services, functions and policies to ensure that equality and fairness is embedded into service delivery, planning, procurement and employment.
- Annual workforce statistics are prepared for the board and published on the internet which include analysis of statutory equality and diversity monitoring metrics including age, ethnicity, gender and disability.
- Providing equality, diversity and human rights training to all staff in the following ways:
  - during the induction of all new joiners
  - mandatory equality and diversity training for all staff
  - during recruitment and selection training
  - during equality impact assessment training.
- Liaison with internal and external stakeholders in the development, implementation and review of equality action plans to continually improve our healthcare services. Stakeholders include PALS, patient information group, public engagement group and the patient experience taskforce.
- Disciplinary, grievance, capability and whistle blowing policies are published on the intranet and signposted to staff during the induction process.
- Evaluation of employment and recruitment policies and practices is regularly conducted to ensure they are legally compliant and do not directly, indirectly, intentionally or unintentionally discriminate against applicants or employees.
- Personal development review and development processes are in place to ensure consistent development opportunities for all staff.

The trust is a 'two ticks' symbol employer which means that we meet the five standards set by Jobcentre Plus to be recognised as an employer committed to employing disabled people.

2.10 Stakeholder relations

Key external QVH stakeholders include the local community and council, governors, League of Friends, referring GPs, commissioners and partner hospitals.

QVH is fortunate in the support that it receives from the local community, the League of Friends, and from its members and governors. This is demonstrated by the financial support provided by the League of Friends, the work provided to the hospital by our volunteers, the support and assistance provided by the town council and the commitment to various governing bodies and committees by our governors.

Relations with our partner hospitals are critical to our ability to provide access to our specialist services across the South East. Partner providers include Medway, Dartford, Maidstone & Tunbridge Wells, Surrey & Sussex Hospital, Brighton and Sussex University Hospitals, East Sussex Hospitals, East Kent Hospitals, and Sussex Community Services.

NHS West Sussex has been our lead commissioner. The new Sussex Cluster PCT is now being established and we look forward to working constructively with this new organisation and with GP consortia once these are established and functional in the trust's catchment area. We have established a programme board which includes representatives of local PCTs and GP consortia. This group will review the strategic direction of healthcare for the local community and agree priorities for commissioning and service delivery. We have established regular working relations with all Sussex PCTs and providers in addressing the challenges to reduce overall spend through improvements in quality, innovation and productivity.

2.11 Patient care

QVH continues to work to improve access to its specialist services for the population of the region. We continue to deliver against the Department of Health's national targets. However, this year we failed to achieve the threshold for two targets: patients who acquire MRSA bacteraemia; and patients who acquire *Clostridium Difficile*.

For the MRSA target the trust had a limit of one, but two patients developed MRSA bacteraemia while for *Clostridium Difficile* six patients were affected against a reduction target of four. In all cases these were isolated incidents and there was no spread of infection to other patients.

The quality of healthcare is routinely monitored and is supported by the activity of the clinical audit department. This includes audit of compliance with National Institute for Health and Clinical Excellence (NICE) guidance and measures that support our specialist services (these are expanded on within the quality report).

Targets agreed with local commissioners were all linked to our Contracting for Quality Initiative (CQUIN) programme. These were to:

- improve responsiveness to the personal needs of patients
- reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE)
- improve patient safety by the development of a discharge plan within 24 hours of admission for elective care
- improve patient clinical outcomes by early detection of any nutritional issues
- improve the patient experience in ophthalmology
- Increase the use of templates based on NICE recommendations by consultants during assessment of patients when prescribing complex non-Payment by Results drugs
- Improve our patient safety culture.

For all these measures, QVH has regularly audited care and introduced actions to ensure that the service to patients and their experience is improved. Initial results suggest we have improved the quality of care we deliver.

The results of the 2010 national NHS inpatient survey show that QVH has maintained high levels of patient satisfaction. QVH ranks significantly better than most other trusts surveyed across the country. Areas in which the hospital has significantly improved since the last survey include our admission and discharge processes, delivery of single sex accommodation and ensuring patients' privacy and dignity when being examined or treated. This reflects work undertaken during 2009/10 on improving the elective admission process and the use of DH funding to improve the ability to deliver single sex accommodation.

During 2010/11 the trust reviewed the number of beds being used in the Jubilee Centre. Due to lack of appropriate patient demand, the current bed numbers have been reduced and the model of care for patients has been revised in order to continue to provide to local general practitioners and to the local community the medical and nursing services that they need.

2010/11 saw a continuation of the streamlining programme to improve the efficiency of our processes. This year work has focused on improving the waiting times in outpatient clinics, an aim to provide surgical pre-assessment on the day of outpatient appointments, a goal to avoid cancelling surgery and, where clinically indicated, to provide surgery for our trauma patients within 24 hours. Progress on these is expanded on within the quality report section of this report.

Complaints handling

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

All complaints received during the year have been fully investigated and any areas of concern acted upon. QVH will always attempt to resolve complaints locally wherever possible, using written responses, informal meetings and more formal conciliation meetings as appropriate. All complainants are offered the opportunity of a conciliation meeting and a total of three meetings were held. All were attended by either senior clinicians or senior management who were required to clarify and discuss the complaint in further detail. In all cases it appears that the meetings were helpful in resolving the complainant's issues at a local level.

The following statistics demonstrate the trust's complaints handling performance during 2010/11:

- 82 formal complaints received
- 10% decrease in the number of formal complaints received during this financial year compared with the previous year
- 70% of all complainants received a full response within the trust's 25 working day benchmark
- 98% of all complaints who made a formal complaint about the trust received a full response within the timescale agreed with them for their individual complaint
- Eight complaints were re-opened which is the same as the previous year
- Three new requests was made to the ombudsman for second stage review compared with one request during the previous year. Of the three new requests none were taken up by the ombudsman
- Five complaints for every 10,000 patient attendances.

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

- Formal complaints are fully investigated with comprehensive written responses provided from the chief executive or his deputy
- Conciliation meetings with the complainant are arranged where appropriate
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible
- Cooperation and openness when complainants request a review at a higher level (ombudsman).

The director of nursing and quality has responsibility at board level for all complaints.

The head of corporate affairs chairs the public engagement committee which meets quarterly; it includes a review of all complaints and PALS concerns and queries as well as the formal compliments received.

Monthly complaint review meetings are held between the chief executive, director of nursing and quality, head of corporate affairs and the PALS and complaints manager. The group review the management of complaints received, trends and the actions arising.

Monthly reports are provided to the clinical cabinet and the board of directors. These include information on any trends in aspects of complaints, complaints received that month as well as the key lessons learned and actions taken.

Complaints received during 2010/11 included the following themes and issues:

- Attitude of staff
- Cancellation of appointments
- Cancellation of surgery day before scheduled admission due to administration error
- Car parking prices
- Concerns about clinical diagnosis made
- Consent process and paperwork
- Discharge arrangements
- Failure to perform appropriate testing prior to surgery
- Outcome of clinical treatment
- Outcome of surgery
- Patient information leaflet
- PCT funding
- Request to be referred for private treatment
- Restaurant prices
- Standards of nursing care
- Transport criteria
- Trauma referral procedures
- Waiting times in clinic

Eighty-two formal complaints were received during 2010/11. The following are examples of actions taken by the trust as a result of the investigations:

- Junior clinicians have been advised by clinical leads of the procedures that will be funded by PCTs and to only accept referrals for which funding is available.
- Corneoplastics clinicians to indicate, prior to booking of patients' appointments, whether the patient will need more than a 15 minute appointment slot.
- Corneoplastics outpatient clinic waiting times are part of an ongoing service review.
- Orthodontic patient information leaflets have been improved to be clearer about when, and for how long, retainers need to be worn.
- Eligibility for patient transport will now include consideration of the patient's financial circumstances and age.
- Elderly patients undergoing eye surgery within the day surgery unit are to be placed, where possible, at the top of the theatre list to prevent excessive waiting.
- Improvements to communication regarding trauma referrals implemented. All trauma referrals made to the hospital should initially be put through to the trauma coordinator.

If a complainant remains unhappy with the outcome of the trust's investigation, they can ask the Parliamentary and Health Service Ombudsman to investigate. During 2010/11 three complainants submitted their case to the ombudsman. The ombudsman was satisfied that all three complaints had been appropriately and sufficiently dealt with by QVH and therefore did not investigate these cases further.

Amanda Parker
Acting Chief Executive

3.0 Governance report

3 Governance report

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

3.1 Board of Directors

Membership

At 31 March 2011, the QVH board of directors consists of the chairman, four non executive directors and four executive directors. There were no vacancies.

During the course of 2010/11 there was one non executive vacancy which became obsolete with the removal of an executive post from the board; after which time the board was again balanced according to the principles of best practice set out in the Monitor Code of Governance.

Full details of the membership of the board throughout the year is set out in Annex D on page 89.

Compliance

The trust is confident that the board of directors has complied with:

- the framework for the corporate governance of foundation trusts as set out in the Monitor Code of Governance (www.monitor-nhsft.gov.uk); and
- the terms of the QVH Constitution, Schedule 1 of the trust's Terms of Authorisation as an NHS foundation trust (http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/queen-victoria-hospital-nhs-foundati)

Interests

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

Meetings

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

Relationship with governors and members

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

Non executive directors

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

Sub-committees

There are three formal sub-committees of the board:

- Audit committee
- Quality and risk committee
- Nomination and remuneration committee.

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

A table setting out the members of the board throughout 2010/11 and their membership of, role in, and attendance of each of the three sub-committees is provided in Annex D on page 89.

Board evaluation

The board reviews its own performance and that of its committees on an annual self-assessment basis. Directors are subject to annual performance appraisal.

3.2 Nomination and remuneration committee

The purpose of the nomination and remuneration committee is to review and make recommendations to the board of directors on the composition, balance, skill mix and succession planning of the board. It recommends the appointment of executive directors. It is responsible for setting the overall policy for the remuneration of all trust staff, and it specifically authorises the remuneration packages for the chief executive, the executive directors and other very senior manager posts.

The nomination and remuneration committee was formed on 1 April 2007, replacing the former remuneration committee. This is the fourth annual report of the committee.

Membership of the committee

Hugh Ure, Deputy Chairman and Independent Senior Director, is Chairman of the Nomination and Remuneration Committee. The chairman, chief executive and all non executive directors are members of the nomination and remuneration committee. The head of human resources is secretary and advisor to the committee and the head of corporate affairs attends as advisor to the committee. The terms of reference are reviewed annually.

Activities of the committee

During 2010/11 the trust continued with an agreed rolling work programme. No new directors were appointed. The committee made decisions or recommendations on the following issues:

- Review of terms of reference
- National pay award
- Leadership programme
- Direct reports of the chief executive
- Potential redundancy payment for an executive director
- Remuneration for the acting director of nursing
- Work plan for 2010/11.

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

Pay and terms have been largely unaltered during 2010/11. The Hay report commissioned in the 2008/09 financial year was used to benchmark the head of corporate affairs salary, which was increased on the first anniversary of appointment. All other very senior manager salaries were frozen and not subject to an increase in 2010/11.

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

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

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

The salary details of the trust's chairman, executive and non executive directors are set out in the financial statements. There have been no compensatory agreements in the 2010/11 financial year.

Executive directors who served in the 2010/11 financial year

- Adrian Bull, Chief Executive
- Ken Lavery, Medical Director
- Richard Hathaway, Director of Finance and Commerce
- Amanda Parker, Director of Nursing and Quality (covered by an Acting Director of Nursing from 12 November 2010 to 20 February 2011)
- Mary Sherry, Director of Performance, Technology and Innovation (left 9 December 2010).

Other disclosures in the public interest

Communication and information giving actions are described under 'staff engagement'. In addition, formal consultation is described in the trust's change management policy which was reviewed in 2009/10 and re-launched in April 2010.

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

A formal consultation exercise began in March 2010 which related to a review of the orthodontic service. This was completed in October 2010. A redundancy consultation exercise was run between May and August 2010, resulting in 11 redundancies, three of which were compulsory. The last one, an executive director, secured suitable alternative employment and a redundancy payment was not required.

The trust reports sickness absence data quarterly via the health and safety committee and monthly at the people, quality and capital meeting and the trust board of directors meeting. The trust has had a steady average of 3.5% sickness absence over the last four years, which is below the NHS average. Seasonal variations are noted (i.e. higher in winter, lower in summer). A contracted out occupational health service is provided to staff through 'Team Prevent', with an occupational health nurse on site three days per week and an occupational health physician on site once per month. The trust also introduced an employee assistance programme in December 2010, provided by CiC. Both services were subject to appropriate selection processes.

The salary details of the trust's chairman, executive and non executive directors are set out in the remuneration report in Annex C on page 87. There have been no compensatory agreements in the 2010/11 financial year.

3.3 Audit committee

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

Membership and attendance

In line with the code, the trust's audit committee is comprised of up to three non executive directors. Shena Winning, one of the non executive directors and chair of the committee is a chartered accountant with over 20 years' experience within the retail sector. Attendance of the meetings held during 2010/11 is shown in Annex D on page 89.

How the committee discharges its responsibilities

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

During the year, the committee received reports from the trust's internal and external auditors that provided the committee with a review of the trust's internal controls and risk management systems. The internal auditors were able to report full or significant assurance for 92% of the areas reviewed, resulting in a head of internal audit opinion of 'significant' assurance.

The audit committee meets four times a year and is attended by the trust's director of finance and has representation from the trust in respect of risk management, the external and internal auditors and local counter fraud service.

At the beginning of every audit committee meeting, there is a closed session between the chair of the audit committee and committee members with the internal and external auditors.

In performing any work outside their statutory role, the external auditors took all necessary steps to ensure they maintained their independence from the trust. In 2010/11, the external auditors undertook a limited review of contractual arrangements in regard to private patient activity. The contract sum was not material and the work was undertaken by a separately managed team within PricewaterhouseCoopers.

Counter fraud

Through the year the trust employed South Coast Audit to provide its local counter fraud specialist (LCFS) service. An annual work plan was agreed with the LCFS and delivery was overseen by the audit committee. The trust's counter fraud policies and procedures are widely publicised and covered at induction for new staff.

3.4 Membership

Constituency	Eligibility criteria (I)	Eligibility criteria (II)	Membership at 31 March 2011
Public	Over 18 years of age	Resident in Kent, Surrey or Sussex	10,345
Staff		Held a contract of employment with QVH for over 12 months	810
			11,155

Summary

The trust has two membership constituencies – public and staff. Eligibility to join the public constituency is for individuals over the age of 18 who are resident in Kent, Surrey or Sussex, and who are not eligible to join the staff constituency. Eligibility to join the staff constituency is for individuals who are employed under a contract of employment by the trust; or who are not so employed but who nevertheless exercise functions for the purposes of the trust; and who satisfy the minimum duration requirements set out in paragraph 3(3) of Schedule 1 to the 2003 Act.

In 2010/11, the total public membership fell by 2%, no change from 2009/10. Staff membership fell by 4%, compared to a 0.2% increase last year, and this is mostly attributable to a restructure and a reduction in overall staff numbers. Targets for 2010/11 to increase our public

membership were set but not achieved. However, a reduction in the public membership was not unexpected due to a membership re-validation exercise undertaken in May 2010 and a regular data cleansing process undertaken by our membership database management contractor. Membership numbers remain within an acceptable level for the trust.

Strategy

The membership strategy for this year has continued to focus on more meaningful engagement with our existing membership. The re-validation exercise was undertaken to find out more about our members and their interests. Members were invited to give us more detailed information about them and the hospital services they are most interested in. We also asked them about how they would like to be involved and members were encouraged to provide an email address where possible, to ease communication.

The response to this was very successful, with around 1500 responses. This means that in future we can ensure more effective engagement by targeting particular members to ask their views about a service/department or invite them to a seminar or presentation that would be of interest to them.

As outlined in the Annual Plan 2010/11, our governors have been forging links with hospitals in our wider catchment areas with a view to reaching out to our patients who are seen in our spoke clinics, who use our services but do not visit our East Grinstead site. This will be developed further in 2011/12.

Disclosures and contact details

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

3.5 Board of governors

The board of governors represents, and is elected by, the public and staff members of the trust. In addition to public and staff governors, it includes a number of appointed governors representing key stakeholders of the trust.

The board of governors has specific statutory duties, as outlined in The NHS Foundation Trust Code of Governance, including, appointing or removing the chairman of the trust and other non executive directors, deciding how much they will be paid and other conditions of service and appointing or removing the trust's external auditor (this work is undertaken by the Appointments Committee who make recommendations to the full board of governors for approval). The board of governors also approves the appointment of the chief executive and receives the trust's annual report and accounts, including any report from the auditor. In preparation of the trust's annual plan, the board of directors must give due consideration to the views of the board of governors.

The QVH board of governors works through a governors steering group which supports and facilitates the work of the board of governors and actively engages governors in adding value to the trust. The governor steering group meeting is a high level monthly meeting, well supported by the board of directors. The group considers the core papers from the board of directors and identifies key priorities and discussion points for the board of governors. The chief executive attends these meetings on a regular basis in order to keep the governors informed and assured about the hospital's performance and answers any questions or concerns raised. The group also invites executive and non executive directors, clinical directors and senior managers as appropriate. Agenda items in 2010/11 have included performance at 'spoke' clinics, clinical audit and outcomes, and assuring clinical excellence and quality and risk.

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

Board of governors public meetings

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

Members of the board of directors, which is held to account by the board of governors, attend all public board of governors meetings and provide the board of governors with reports on the management of the trust, infection control figures and any other matters the governors should be kept aware of. Members and the public are invited to attend through the QVH newsletter and trust's website. A presentation is usually given to provide a greater insight into the work of the hospital and members of the public are encouraged to ask questions.

Where necessary the appointments committee reports to the board of governors in private in order to be able to consider appropriate actions regarding remuneration and appointment of the chairman and non executive directors.

Governor representative

The board of governors is represented by the governor representative, who attends all board of directors meetings in full (in a non-voting capacity) and provides a report to governors through formal meetings of the governors steering group and board of governors and through the governors monthly 'Update'. The governor representative also acts as a link between the board of directors and the board of governors and actively projects, protects and enhances the trust's reputation. In 2010/11 this position was held by Bernard Atkinson until May 2010 when Ian Stewart took on the role.

Vice chairman of the board of governors

The vice chairman role of the board of governors continues to be held by Bernard Atkinson whose term of office ends at the end of June 2011. The vice chairman provides advice to individual governors as required, supports governors in progressing governor business, represents the governors externally as necessary, works with the chairman of the trust on developing board of governors' governance arrangements as well as advising him on governor matters. He chairs the governors steering group and, when the chairman cannot attend or if it is appropriate, he also chairs the board of governors.

Membership of the board of governors

In May 2010 five candidates stood for the five available public governor positions available for election and one member of staff stood for the single staff governor vacancy. Due to there being exactly five public vacancies and one staff vacancy, their places were uncontested with candidates commencing their term of office from 1 July 2010. Therefore the full election process was not required in either constituency.

Four public meetings of the board of governors took place between 1 April 2010 and 31 March 2011. A full table listing the members of the board of governors, whether they are a public or staff member or representing a stakeholder, and the number of meetings they attended in 2010/11 is provided at Annex F on page 92.

4.0 Quality accounts

4.1 Statement on quality

QVH's core purpose is to provide specialist reconstructive surgery, expert rehabilitation, and first class community medical services. We strive to provide these services to the highest standards of safety and patient care. These accounts set out the progress made and standards achieved in 2010/11 in the areas of patient safety, clinical effectiveness, and patient experience.

This year we have focused on streamlining our pathways of care for patients, reducing administrative procedures, and improving the efficiency of our processes. This has resulted in reductions in the number of cancelled operations, improvements in the pre-assessment of patients for surgery and improvements in the speed with which patients with trauma are brought to theatre. The time that it takes to make appointments for patients to come to the hospital has been halved, the proportion of patients assessed for surgery on the day of their outpatient appointment has more than doubled, and the proportion of trauma patients unnecessarily waiting more than 24 hours for their operation has been reduced to a minimum.

We have continued to improve our internal processes to drive absolute patient safety, from an already very good position. Regular audits of hand washing compliance at all points of care, across all staff groups, have shown an improvement to well over 90%. We also have good compliance with assessments of venous thromboembolic (VTE) risk, nutritional status, and falls.

Our management of infection control remains exemplary. However, during the year two patients developed MRSA and six *Clostridium difficile*. This breached our limits for the year, but all cases were isolated incidents and there was no spread to other patients.

In our specialist areas we continue to lead the field in measuring and assessing clinical outcomes. For example, developing re-rupture measures following hand tendon repair, where the QVH rate is half that published elsewhere. We use nationally validated measures where possible, for example in assessment of our success in correcting severe cases of dental malalignment. This work on outcomes is supported by our research initiatives, such as our work on the psychological effects of breast reconstruction following cancer surgery.

In addition to the improvements in patient experience resulting from streamlining and greater efficiency, we have implemented a programme of initiatives to address areas highlighted in patient feedback and surveys. These have included reduced outpatient waiting times in our eye surgery clinics (part of the Contracting for Quality Initiative with the PCT), and revisions to our car parking arrangements which are to be implemented in the coming year.

We have made further improvements to our burns assessment and outpatient treatment area for children and we are currently refurbishing our paediatric ward. We have improved our arrangements for delivering same sex accommodation and are fully compliant with national requirements.

We are committed to providing care that is of the highest standards of safety, quality and excellence. These quality accounts set out our performance in detail and include our priorities for the coming year which are added to our programme of continuous improvement. I certify that to the best of my knowledge the information in this document is accurate.

A Parker
Acting Chief Executive

4.2 Priorities for improvement and statements of assurance

Performance against 2010/11 priorities

In our 2009/10 quality accounts we set out four priorities for quality improvement. We have made good progress in three of the four areas, but will continue to make improvements, measure and report progress. In the fourth priority (our out-patient appointment guarantee) we have made little progress. This will be maintained as a key focus for the coming year and is expanded on within Priority 4 for 2011/12.

Priority 1

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

This priority was selected because, in 2009/10, 99 patients had their operations cancelled on the day of surgery. 15 of these were through adverse weather, leaving 84 which were cancelled through a lack of theatre time, inadequate clinical preparation for surgery, equipment failure or staff unavailability. This impacts on the patient involved and leads to wasted theatre slots and unnecessary overnight stays.

Changes made during 2010/11 have included:

- Increased availability of pre-assessment clinics, particularly on the day of out-patient appointment
- Increased consultant anaesthetic input into pre-assessment
- Reviewed theatre scheduling
- Focus on theatre start times and pre-theatre list patient safety briefings
- Review and investigation of all cancellations through weekly meetings of service managers.

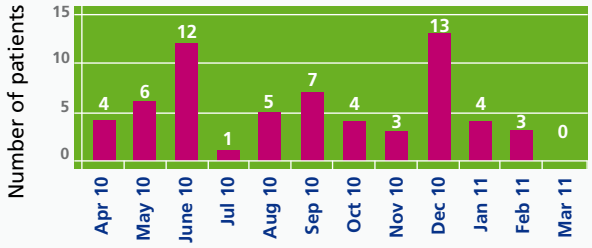
As a result:

- The number of avoidable cancellations on the day of surgery has fallen from 99 in 2009/10 to 62 in 2010/11. Of these in 2009/10 84 were avoidable and this has reduced to 49 that were avoidable during 2010/11
- There has been a 25% reduction in avoidable delays.

Peaks within June and December were related to failure of the power supply and adverse weather. All cancellations on the day of surgery, including those caused by adverse weather conditions, were re-scheduled within 28 days of the cancellation in line with Department of Health guidance.

Our cancellation rate continues to improve and will continue to be monitored.

Patients cancelled on day of surgery, April 2010-March 2011



Priority 2

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

This priority was chosen because patients sometimes had poor experiences, with postponements to their trauma surgery on a number of occasions and long waits before trauma or urgent surgery. In 2009/10 patients waited an average of 18 hours before unscheduled surgery, but some waited up to 59 hours.

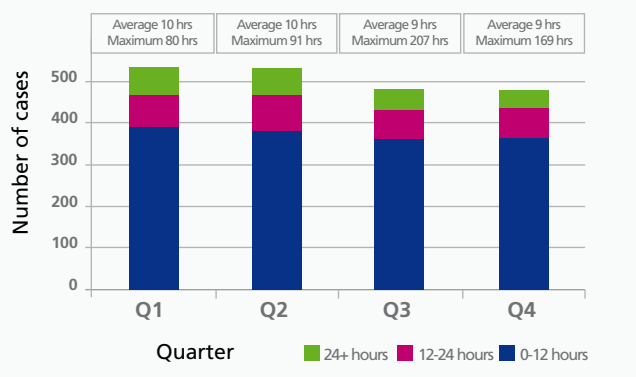
Changes made during 2010/11 have included:

- A focus on the patient pathway for the treatment of trauma
- Introduction of trauma co-ordinators to improve the service to referring hospitals and the scheduling and efficiency of trauma care.

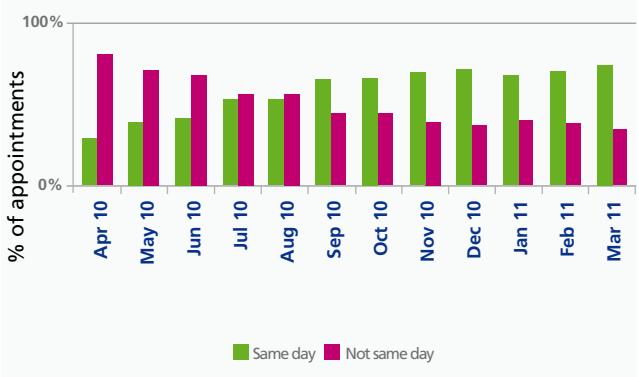
As a result:

- The average wait from admission to surgery for trauma has fallen from 18 hours in 2009/10 to 9 hours in 2010/11
- The percentage of patients receiving trauma surgery within 24 hours of admission in 2010/11 was 89%. (Of the remaining patients, some will have had a clinical reason for delay, for example swelling due to a facial injury in trauma.)

Trauma wait times, April 2010-March 2011



Pre-assessment on same day as outpatient appointment, April 2010-March 2011



The work to redesign the trauma pathway will continue and, in response to the recent National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report, we plan to make changes specifically for patients aged over 80 who suffer traumatic injuries. In addition, we will be introducing an electronic trauma board, accessible to medical, theatre and ward staff, to support and further refine the pathway.

Priority 3

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

This was selected as a priority because repeat visits to the hospital cause our patients unnecessary travel time and cost and improved and timely pre-assessment reduces cancellation of operations at short notice. In 2009/10, less than 50% of our surgical patients were able to undergo pre-assessment on the same day as their outpatient appointment.

Changes made during 2010/11 have included:

- A review of our elective admission process and two rapid improvement events with key people involved in pre-assessment
- Introduction of consultant anaesthetist led pre-assessment clinics.

As a result:

- The number of patients pre-assessed for surgery on the day of their outpatient appointment rose from 26% in April 2010 to 68% in March 2011.

Although we have not yet achieved our 80% target, we have more than doubled the proportion of patients who are able to attend pre-assessment on the same day as their outpatient appointment.

We will continue working to achieve our 80% target. During 2011/12 specific work will continue on improving the pre-assessment process for patients seen by QVH consultant teams at other hospitals before having their surgery at QVH. This includes looking at innovative technology and extending the use of telephone assessments.

Priority 4

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

This priority was chosen because complaints showed that too many patients have their outpatient appointment date changed, sometimes more than once. This does not provide the best experience and takes up unnecessary administrative time. Patient experience in corneoplastic outpatients was also sometimes poor, with long waits leading to crowded waiting areas.

Changes made during 2010/11 have included:

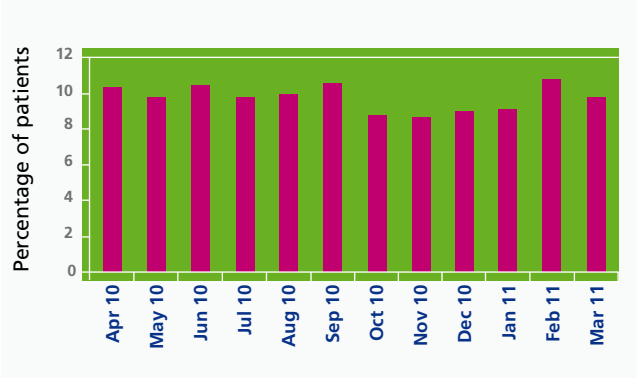
- Introduction of a formalised process to reduce the number of clinics that are cancelled at short notice and to avoid errors in clinic cancellations
- Where clinics are cancelled, we try our best to cover them or provide alternative arrangements, including bringing patients forward to an earlier date.

We have made some progress with this priority but it is unsatisfactory. Reasons for this include:

- Where patients make appointments through the national 'Choose and book' service they are often allocated to the wrong consultant at first patient booking, for example, a patient requiring hand surgery booking with a consultant who specialises in breast surgery
- Our 'hub and spoke' arrangement for providing outpatient clinics at multiple hospitals around the region mean that many of our outpatient clinic bookings are not within our control
- Periods of staff sickness in our outpatient departments.

We have had two complaints relating to outpatient appointments being cancelled and rebooked during 2010/11.

Hospital outpatient appointment cancellations, April 2010-March 2011



Therefore, during 2011/12 we will continue to focus on this area to minimise further the number of cancellations. This will include introducing nurse-led clinics in corneoplastics, the appointment of an orthoptist, and booking appointments only after histology results are available. We will also be working with neighbouring trusts regarding visiting consultant clinics to ensure that cancellations for these are also minimised.

Priorities for 2011/12

In developing priorities for 2011/12 the trust's governors, PCT quality team and staff from across the organisation were asked to identify areas they thought should be included. We also considered information from the national inpatient and outpatient surveys, national cancer patient experience survey, in-house patient experience reviews, clinical incident reporting, complaints, patient safety reviews and clinical audit.

A list of over 40 potential priorities was created and this was reviewed against a number of criteria which included the rationale for inclusion, status of any current activity and internal reporting and the benefit to patients.

This process resulted in four priorities covering patient experience, effectiveness and safety for 2011/12 which were presented to and agreed by the trust's board:

Priority 1

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

This was a priority for 2010/11 that we failed to make sufficient progress against. As described above, there are a number of reasons for limited progress and plans are already in place to address this. We have refined the priority for 2011/12 to focus on outpatient appointments at QVH rather than at other hospitals where we provide consultant clinics, reflecting our limited ability to make changes to processes at other trusts.

- During 2010/11 we introduced a formalised process to reduce the number of clinics that are cancelled at short notice and avoid errors in clinic cancellations. Additional action during 2011/12 will be a focus on performance management to ensure the process is followed.
- Where clinics are cancelled we try our best to cover them or provide alternative arrangements including bringing patients forward to an earlier date.
- We will introduce nurse led clinics in corneoplastics, appoint an orthoptist and only book appointments after histology results are available.
- We will also be working with our neighbouring trusts regarding the visiting consultant clinics to ensure that cancellations for these clinics are also minimised.
- Progress reports will be made monthly to our management team and quarterly to our quality and risk committee.

Priority 2

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

Both the cancer survey and national inpatient surveys for 2010 indicated that patients were not receiving sufficient written information to support them in their decision making.

To address this over the coming year we will audit patient consent forms for an indication that leaflets on surgical procedures were provided. We will also audit electronic discharge notifications to GPs regarding the provision of follow up care to ensure the patient is provided with a copy of this and we will reiterate our policy of copying letters to patients.

Progress reports will be made monthly to our management team and quarterly to our quality and risk committee. We would expect to see improved scores in the 2011 in-patient survey for the following questions:

- "Were you given written information about what you should do after leaving hospital?" In 2010 QVH scored 79% against a highest national score of 88%.
- "Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?" In 2010 QVH scored 50% against a highest national score of 91%.

Priority 3

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

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

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

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

- Aim for all elective surgery patients at the QVH to have their consent completed prior to the day of surgery
- We will audit our progress via our elective surgery admissions lounge and day surgery unit, sampling one week of every month and expand our current audit of consent looking at ten case notes per fortnight
- Baseline audit underway
- Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee.

Priority 4

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

Electronic discharge notification ensures that a patient's GP is aware of their hospital treatment, discharge arrangements and discharge medication within 24 hours. QVH has commenced electronic notification to GPs and will complete roll out across all wards during 2011/12.

We aim to have discharge notification emailed to GPs for 100% of QVH patients by March 2012. Currently we are rolling out the process and have sent 200 electronic discharge notifications to date.

Progress reports will be made monthly to our management team and quarterly to our Quality and Risk Committee.

Statements of assurance from the trust board

Review of services

During 2010/11, QVH provided burns care, general plastic surgery, head and neck surgery, orthodontic and corneoplastic surgery and community and rehabilitation services.

QVH has reviewed all the data available to it on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by QVH.

Review of quality of care

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

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

Participation in clinical audits

During 2010/11, five national clinical audits, as defined by the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and three national confidential enquiries covered NHS services that QVH provide.

During 2010/11, QVH participated in 60% of the NCAPOP national clinical audits and 100% of the national confidential enquiries which we were eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2010/11 are as follows:

NCAPOP national clinical audits	Participation
Elective surgery (national PROMs programme)	✓
Head and neck cancer (DAHNO)	✓
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓
Cardiac arrest (National Cardiac Arrest Audit)	✗
Adult critical care (Case Mix Programme)	✗

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

We do not participate in the Adult Critical Care Case Mix Programme because our intensive care unit serves a very select case mix, predominately burns patients and post-surgical head and neck cancer patients. This presents difficulties with comparison. No other stand alone burns units participate in this study.

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

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

National audits/ confidential enquiries	% cases submitted
Elective surgery (national PROMs programme)	100% and 96%
Head and neck cancer (DAHNO)	100% coded cases
Cardiac arrest procedures study (NCEPOD)	100%
Peri-operative care study (NCEPOD)	100%
Surgery in children study (NCEPOD)	100% (no relevant cases)

In the national Patient Reported Outcomes (PROMs) programme, we submitted data for 100% of hernia patients and 96% of varicose vein patients during the data collection period of April 2009 to May 2010. Two varicose vein patients declined to participate. In May 2010 we ceased to provide inguinal hernia or varicose vein surgery.

Other national audits (outwith NCAPOP) we have participated in during 2010/11 include:

- National audit of depression screening and management of staff on long term sickness absence by occupational health services in the NHS
- National audit of services for people with multiple sclerosis 2011
- National inpatient survey
- International burn injury database (IBID), incorporating the national burn injury database (NBID)
- Bisphosphonate-related osteonecrosis (BRONJ) national audit.

The reports of six national clinical audits were reviewed by the trust in 2010/11 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Review clinical coding methodology for head and neck cancer cases
- Implement single database for ongoing collection of DAHNO data to improve data completeness
- Ensure further development and ongoing use of QVH-designed database to monitor breast 'freeflap' outcomes
- Develop an action plan for provision of continence services.

The reports of 93 local clinical audits were reviewed by the trust in 2010/11 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Further develop a data collection system to monitor outcomes in the Recovery Unit
- Introduce new format clinical indicator reporting to encourage increased mortality and morbidity discussion within departments
- Review local antimicrobial prescribing policy
- Introduce new protocol for the ordering of blood products in head and neck cancer surgery
- Introduce new documentation to improve recording of central line care
- Introduce new documentation to encourage follow-up and safeguarding of paediatric patients who do not attend outpatient appointments
- Further development and use of a QVH-designed patient satisfaction tool for anaesthetics
- Further develop a patient reported outcome measures (PROM) for use in hand surgery
- Monitor patient reported outcomes in cataract surgery, following earlier trial of cataract PROM
- Review provision of waste disposal bins in clinical areas.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by QVH in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 365.

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

QVH was involved in conducting 26 clinical research studies in 2010/11, involving 52 clinical staff covering three medical specialities (plastics, anaesthetics and corneoplastics) as well as professions allied to medicine.

Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2010/11 and for the following 12 month period are available online at www.qvh.nhs.uk.

The monetary value attached to achieving CQUINs for 2010/11 was £796K. Activity to achieve CQUINs was undertaken and there is agreement of 100% achievement of the CQUIN initiatives.

Statements from the Care Quality Commission

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

CQC has not taken any enforcement action against QVH during 2010/11.

During the year we have participated in the CQC special review of support for families with disabled children and we are currently awaiting the final report.

Data quality

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

The data quality indicators reported below via the Secondary Uses Service show that we achieve higher than the national average for inclusion of valid NHS numbers and General Medical Practice codes with the exception of NHS numbers for outpatient care where the national average is 98.8%.

During 2010 we invested resource in removing duplicate records.

In the coming year we will be taking the following action to improve data quality:

- Continuing the work of the Data Quality Group which was set up in August 2010 with wide membership across the organisation to identify and resolve issues contributing to poor data quality
- Regularly producing and monitoring an internal dashboard of data quality metrics
- Developing actions plans to improve data quality where the metrics show performance is not of the required standard.

QVH submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99% for admitted patient care
- 98.6% for outpatient care
- 95.6% for accident and emergency care.

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

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

Information governance toolkit attainment levels

The QVH information governance assessment report overall score for 2010/11 was 65% and was graded 'not satisfactory'.

This was as a result of the trust not meeting the new required level of annual information governance training for staff. The trust met all other key indicators. QVH has developed an action plan to ensure achievement of all key requirements in 2011/12. For IG training this includes a roll out of e-learning programmes and introduction of accredited face to face training in line with the new toolkit requirements

Clinical coding error rate

QVH was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

4.3 Review of quality performance 2010/11

QVH has established processes for reporting on patient safety, clinical effectiveness and patients' experience across its acute and community services. Progress against key quality indicators is shown below. Feedback from our ability to deliver operational performance targets, feedback from patients, patient complaints and national surveys have all supported us identifying our additional priorities for 2011/12.

Where the clinical indicators are coloured green we are happy with our performance in that indicator, where amber we are close to target, but continuing to strive for improved performance. Where the clinical indicator is coloured red we are not satisfied with the results we are achieving and these will remain priorities for 2011/12. The letters G, A and R are included to denote green, amber and red to assist the visually impaired.

The arrows next to the results indicate whether the result has improved (green) or worsened (red) since 2009/10. However, the changes in performance may not be significant.

Patient safety

We are committed to preventing harm to patients by continuing to drive leadership, communication and learning to create an environment of trust between patients and staff that ensures safe, high quality, effective care is delivered to all our patients. This includes ensuring the organisation is prepared to continue delivering care through robust emergency and business continuity planning arrangements.

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

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Clinical incidents reported per 1000 patient spells G We absolutely encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. Of these incidents 67% caused no harm, or were near miss incidents, compared with 70% causing no harm in similar trusts. We aim for an open reporting system to aid learning from incidents.	Monthly analysis of Datix clinical incident reporting system	N/A	57 per 1000 SEC NRLS benchmark	50 per 1000 patient spells	51 per 1000 patient spells ⬆
Number of clinical incidents reported that have caused patient harm (actual number) G Although we would like to see a large number of clinical incidents reported to aid governance, we would like a low number of incidents that have caused patient harm. Serious harm accounts for approximately 1% of all incidents reported.	Monthly analysis of Datix clinical incident reporting system	0	30% of all incidents reported (NRLS of specialist trusts (April to Sept 2010)	217 incidents causing harm 25% of all reported incidents*	187 incidents causing harm 22% of all reported incidents ⬇
Documented consultant review of emergency admissions within 24 hours A NCEPOD recommends that all emergency admissions are reviewed by a consultant within 24 hours of admission, and that this is documented clearly.	Internal six monthly retrospective audit of 50 trauma patients	100%	92% (NCEPOD)	66%	82% ⬆

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Hand hygiene (washing or alcohol gel use) G Good hand hygiene is linked with a reduction in hospital acquired infections.	Internal monthly audit of the five moments of hand hygiene	100%	N/A	87%	93% ↑
VTE risk assessment (percent of admissions) G Patients assessed for the risk of venous thrombo-embolism can have the correct precautions, including compression stockings and low molecular weight heparin.	Monthly internal audit	100% (90% national target)	26–70% average rate in SEC SHA 2010	92%	97% ↑
Nutritional assessment within 24 hours of admission G Maintenance of nutrition is important for physical and psychological well-being. When illness or injury occur, nutrition is an essential factor in promoting healing and reinforcing resistance to infection.	Three monthly internal audit	100%	N/A	84%	99% ↑
Theatre lists starting with a surgical team safety briefing A A whole team safety briefing, including surgical, anaesthetic and nursing staff before theatre lists improves communication, teamwork and improves patient safety in the operating theatre.	Three monthly internal audit	100%	N/A	91%	83% ↓
Use of the WHO Safer Surgery checklist R The correct use of a checklist prior to anaesthesia and surgical incision reduces "never events" such as wrong site surgery.	Monthly internal audit	100%	Sign in Time out Sign out	81% 63% 48%	97% ↑ 67% ↑ 53% ↑
Development of pressure ulcer grade 2 or over (per 1000 spells) G Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat. In the majority of cases they can be prevented if simple measures are followed.	Internal audit	0	6.0 / 1000 spells (SEC SHA average March 10-Feb 11)	0.5 / 1000 spells (Total number = 10 cases)	0.5 / 1000 spells (Total number = 9 cases) ↔
Patient falls, including falls associated with harm (actual number) G New falls assessment procedures have been introduced, including alerting all staff to patients at risk. Actions of ward staff are reviewed following a fall. Rates of patient falls tend to be higher in elderly patients who are being rehabilitated.	Internal audit	0	7.4 / 1000 spells (SEC SHA average March 10-March 11)	121 falls 7.3/1000 spells 30 causing harm 1.7/1000 spells	82 falls 4.8/1000 spells ↓ 31 causing harm 1.8/1000spells ↑

Patient safety (continued)

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Number of reportable MRSA bacteraemia cases [A] MRSA in the blood may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis.	Internal audit	1	N/A	1	2 ↑
Number of reportable *Clostridium difficile* cases [A] *Clostridium difficile* may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis.	Internal audit	4	N/A	1	6 ↑
Patients receiving all correct physiological monitoring during admission. [A] Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to prevent physiological deterioration of patients.	Internal fortnightly audit of 10 patient records	100%	N/A	72%	80% ↑
Patients who have all the correct actions taken when physiological measures are starting to fall outside normal limits [R] When potential deterioration is recognised, care must be escalated, additional expertise requested, and observations be repeated. All actions must be documented.	Internal monthly audit	100%	N/A	20%	40% ↑
Percentage of staff who would feel safe being treated at this hospital [G] Staff are very aware of potential patient safety issues within their areas, and provide a good indication of how safe care in general is.	Annual on-line survey of safety culture of 100 clinical staff	100%	N/A	91%	92% ↑
Percentage of staff witnessing harmful errors, near misses or incidents in the last month [A] Ideally no harmful errors, near misses or incidents should occur. Where these are witnessed or known about staff will report them for investigation.	National staff survey	N/A	32% National NHS result (All trusts 2011)	34%	35% ↑
Percentage staff uptake of seasonal influenza vaccine [A] Frontline staff uptake of influenza vaccine is crucial in ensuring the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans.	Internal audit	>60%	National rate 2010: 34.2%	24.9%	49.7% ↑

Clinical effectiveness

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

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

ALL SPECIALTIES					
Clinical effectiveness indicator and why we measure it	**How the data is collected**	**Target**	**Benchmark**	**2009/10**	**2010/11**
In-hospital surgical mortality G Because of our specialist work it is not comparable to present a hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rates presented here represent only three deaths, so one death can make a large difference to the rate. All deaths at the QVH are reviewed within specialities and a multidisciplinary forum.	Continuous monitoring of PAS data	N/A	N/A	0.013%	0.021%
Unexpected return to theatre within 7 days G A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. We monitor rates in individual surgical specialties and overall to monitor quality of service.	Continuous monitoring of PAS data (Change of methodology April 2010)	<1%	N/A	0.97%	0.83%
Unexpected readmission to QVH following discharge G This may be due to a complication such as wound infection, dehiscence, or other complication from surgery.	Continuous monitoring of PAS data (Change of methodology April 2010)	<1.5%	N/A	1.08%	1.04%
Unplanned transfer out of QVH for additional care G We are supported by surrounding trusts in the provision of specialist services such as respiratory medicine and cardiology, which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services.	Continuous audit by ITU outreach nursing staff (Change of methodology in June 2010)	<0.5%	N/A	0.46%	0.35%

BURNS CARE

In 2010 the Burns Centre accepted 870 adult burns referrals, 194 of whom required inpatient care. Of these 194, 28 required intensive care (ICU). No patients requiring a ward bed were refused due to lack of capacity but a total of three ICU patients were refused due to ICU being full. These three patients were treated in alternative burns centres in the South East.

The accrued mortality rate for burns inpatients with a burn injury of more than 5% total body surface area was 2%. This excludes those patients who were either accepted for purely palliative care or those whose injuries were assessed as being such that they would not survive and so commenced on the Liverpool End of Life Care Pathway within 24 hours of admission.

This 2% equates to four out of 194 inpatients, all of whom were ITU patients with concurrent inhalation injuries and burns that were a serious threat to life, measured by the Abbreviated Burns Severity Index (ABSI). One died having been discharged to another burns centre, as they required specialist treatment for kidney failure.

We accepted 582 paediatric burns referrals during 2010, of who 109 required inpatient care on our paediatric ward. QVH aims to enable all burn injuries to heal within 21 days and for 2010 the average healing time for paediatric burns was 19 days. Ninety-five per cent of paediatric burns were healed within 21 days, with a minimal 'did not attend' rate.

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

PLASTIC SURGERY – BREAST SURGERY, HAND SURGERY, SKIN CANCER CARE AND TRAUMA

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

Breast surgery

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Breast reconstruction after mastectomy using free tissue transfer – flap survival G The gold standard for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but carries greater risks of failure than an implant or pedicled flap reconstruction, so it is important we monitor our success. We performed 124 free flap breast reconstructions in 2010.	Continuous prospective electronic database (124 cases)	100%	95–98% (published literature) 98% BAPRAS 2009	98.7%	98.4%

Hand surgery

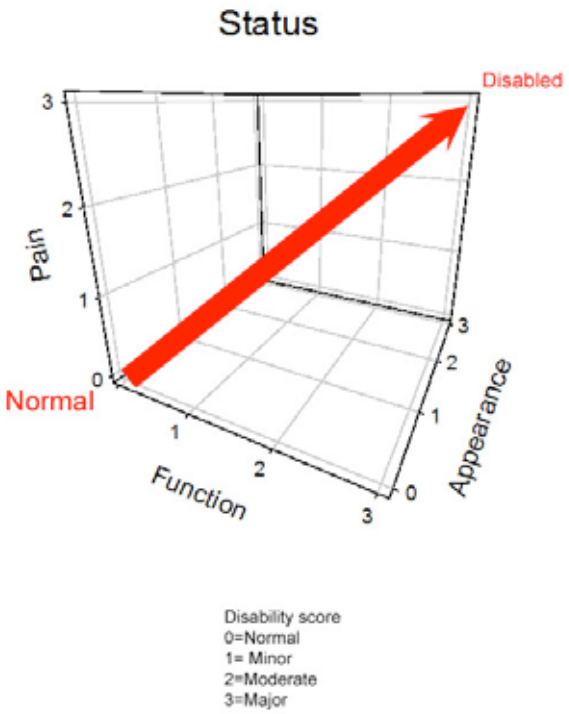
Our hand surgery team covers a range of elective conditions as well as trauma. It includes consultants with specific interests in congenital hand anomalies; rheumatoid and osteoarthritis; wrist surgery for arthritis and instability; compression neuropathies; and post-trauma reconstruction. We offer,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

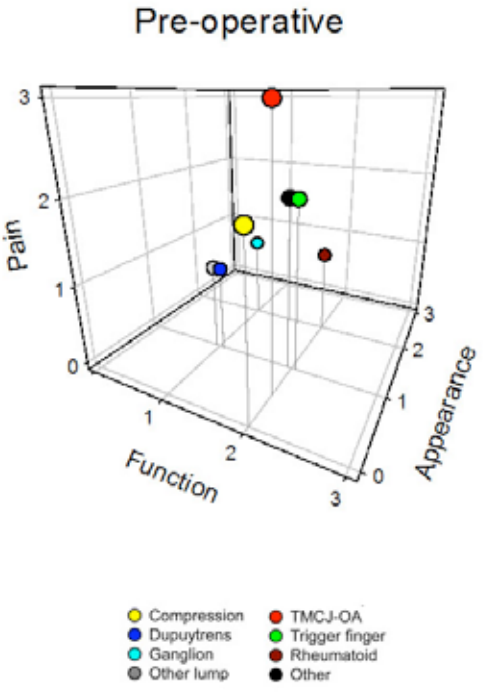
Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Rupture rate following repair of flexor tendon injuries G Hand surgery accounts for 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and post-operative therapy.	Ongoing monthly audit between hand surgeons and therapists, with complications collected via a trauma database. 2010/11 result based on 156 patients.	0%	9–13% (published literature)	6–7%	4%

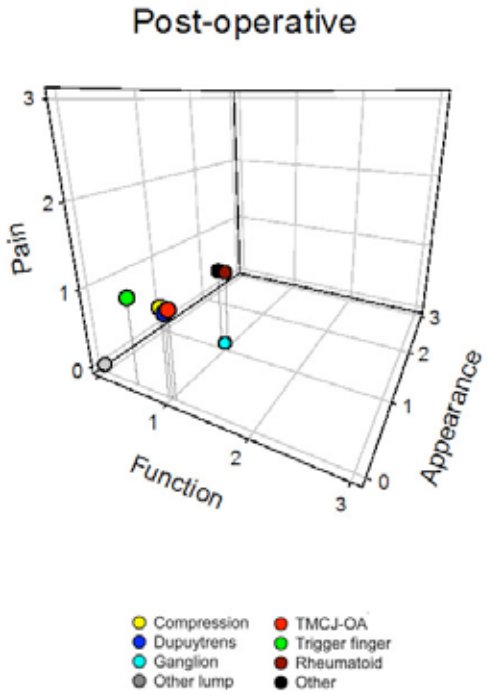
Patient reported outcome measure (PROM) after elective hand surgery

In 2010 252 patients scheduled for elective hand surgery for conditions such as Dupuytren's disease, rheumatoid disease, trigger finger and nerve compression were invited to complete a short pre-operative questionnaire grading the severity of the pain, dysfunction and deformity of their hand(s) on a four point scale (0 (normal) – 3 (severe)). This process was repeated approximately six months after their operation. The results can be charted on a 3-axis graph, where 0 is no pain, normal function and normal appearance. Patient reported scores moving towards 0 following their surgery indicates a successful outcome.

190 patients completed the study. A significant improvement toward normality was seen after surgery in each surgical group.







Skin cancer care and surgery

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Complete excision rates in basal cell carcinoma (BCC) G BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage or immuno-modulators or a combination. Surgical excision is highly effective with a recurrence rate at 2%. Complete surgical excision is important to reduce recurrence rates. Sometimes this is not possible because of the size or position of the tumour. Sometimes the incomplete excision will only become evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases.	Audit of two months activity (286 BCC cases)	100%	88.9–95.3% (published literature)	92.9%	92%
Complete excision rates in malignant melanoma G Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Sometimes total excision is not possible because of the health of the patient, or the size, position or spread of the tumour, and the MDT may recommend incomplete excision.	Audit of two months activity (42 melanoma cases)	100%	75% NICE guidance	83%	100%
Complications from axillary and inguinal lymph node block dissections for metastatic skin cancer G					
These difficult procedures for metastatic cancer are well recognised to be associated with a high morbidity or complication rate, particularly associated with wound infection, wound dehiscence, seroma formation and the requirement for re-operation. We keep a prospective database of all lymph node block dissections and their complications.	Seroma formation		40% (published literature)	41%	29%
	Wound infection		20% (published literature)	6%	11%
	Wound breakdown		24% (published literature)	6%	0%

HEAD AND NECK, INCLUDING HEAD AND NECK, ORTHOGNATHIC AND ORTHODONTIC SURGERY

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

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

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Nerve injury rates in third molar (wisdom tooth) extraction and mandibular (jaw) fracture surgery G	Prospective audit of 93 patients	0%	Temporary numb lip: 5–10%	2%	4.4%
Wisdom tooth extraction is a commonly performed procedure. A recognised complication is inferior dental or lingual nerve injury which may be temporary or permanent. We treat approximately 1000 patients for wisdom teeth extraction each year. We had no cases of permanent nerve injury.		0%	Temporary numb tongue: 2–8%	4%	4.4%
Facial nerve injury rates in condylar fracture (jaw fracture) repair G	TraumaCard (continuous trauma and complications database)	0%	17%	12.5%	9%
We monitor damage to the facial nerve during open fixation of mandibular fractures. We continue to have a zero permanent nerve injury rate.					
Patient reported outcome measures in orthognathic surgery (correction of bony jaw abnormalities) G	Prospective database of all orthognathic surgery patients		How do you rate the orthodontic service and care?	88% excellent 12% good	
This new PROM has been developed to look at patient satisfaction with the orthodontic and orthognathic surgery service and satisfaction with the appearance, dentition and face following treatment. Due to the long treatment period this had so far only captured the results from 17 patients. No benchmark is available.			How do you rate the surgical service and care?	82% excellent 18% good	
			How satisfied are you with facial appearance?	75% very satisfied 12% satisfied	
			How satisfied are you with dental appearance?	55% very satisfied 36% satisfied 8% dissatisfied	
Peer Assessment Rating (PAR) index for orthodontic treatment G	Continuous prospective data collection of all orthodontic patients		>70% very high standard <50% poor standard	95%	95%
The PAR index is a fast, simple and robust way of assessing the standard of orthodontic treatment that an individual provider is achieving. The index is designed to look at a large group of patients rather than an individual patient's outcome.					

CORNEOPLASTIC AND OCULOPLASTIC SURGERY

Our corneoplastic unit and eye bank is a high-profile and technologically advanced specialist and tertiary referral centre for complex corneal problems and oculoplastics.

Our specialist cornea services include high risk corneal transplantation; stem cell transplantation for ocular surface rehabilitation; innovative partial thickness transplants (lamellar grafts); and vision correction surgery.

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

Audit in 2010 also demonstrated full compliance with NICE guidelines for the treatment of patients with primary open angle glaucoma and ocular hypertension at QVH.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease G We performed 1199 phacoemulsification procedures for cataracts in 2010/11, 99% of these as day cases. There were no cases of post-operative eye infection. We monitor the number of these patients who achieve significant improvement to the vision in that eye.	Annual audit of 100 patients	100%	96% (UK EPR)	96%	96%
Percentage of patients achieving vision better than 6/12 after cataract surgery with other significant eye disease G We also perform cataract surgery on a large cohort of patients with complex anterior segment conditions as part of our specialist surgery service which is not comparable to other units.	Annual audit of 100 patients	100%	78% (UK EPR)	84%	84%

ANAESTHETICS

We have 19 consultant anaesthetists at QVH with supporting staff in the operating theatres, high dependency unit and in the burns centre.

The department has pioneered and developed special expertise in dealing with patients with abnormal airways due to facial deformity, techniques to lower blood pressure and reduce bleeding during delicate surgery, and the use of ultrasound for the placement of regional local anaesthetics for the upper limb.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Percentage of patients requiring no recovery room intervention following anaesthesia G The anaesthetic recovery room exists to ensure patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties.	Continuous prospective audit of all in-patient recovery room procedures	100%	N/A	83%	86%

Patient experience

We are rightly proud of the quality of experience that patients tell us they receive at QVH.

Of the 17 patients who rated our services on NHS Choices (www.nhs.uk) in 2010/11, all 17 stated that they would recommend us. A total of 45 patients out of 46 would recommend us since comments began. We score 5/5 for hospital staff working well together, patients feeling they were treated with dignity and respect and patients feeling they were involved with decisions about their care. Patients scored us 4/5 for the environment in which they were treated ("very clean").

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Failure to deliver single sex accommodation (occasions) G In all wards outside of theatre recovery areas and critical care we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting.	Continuous internal audit	0	N/A	144	1 ↓
Complaints per 1000 spells G It is important to monitor complaints about the quality of service we provide, in order to facilitate continuous improvement.	Continuous internal audit	0	N/A	5	5 ↔
Claims per 1000 spells A This reflects legal action against the trust by patients/carers and includes all cases whether founded or unfounded.	Continuous internal audit	0	N/A	0.7	0.8 ↑
Percentage of patients who would recommend QVH to a friend or relative G	Picker National Inpatient Survey	100%	91.8% Picker average 2010/11	99%	98% ↓
Percentage of patients who felt they were always treated with respect and dignity G	Picker National Inpatient Survey	100%	78.3% Picker average 2010/11	90.8%	92.6% ↑
PEAT scores A PEAT is an annual assessment of inpatient healthcare sites in England with more than 10 beds. PEAT is self-assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). The benchmark is the % achieving excellent.	National Reporting Learning Service	Excellent	All trusts 2010/11		
Environment Food Privacy and dignity		25% 57% 48%		Excellent Good Good	Good ↓ Excellent ↑ Good ↔
Percentage of patient who rated their quality of care as good or excellent G We invite all patients to complete a questionnaire about their quality of care on discharge.	In-house discharge questionnaire	100%	92% highest score achieved in CQC IPS	New measure	99%
Percentage of patients who reported sufficient privacy when discussing their condition or treatment G Those who rated their anaesthetic service as good or excellent.	In-house discharge questionnaire	100%	93% highest score achieved in CQC IPS	New measure	94%
Satisfaction with anaesthetic service G Those who rated their anaesthetic service as good or excellent.	Survey of all patients during one week who had general or regional anaesthesia	100%	N/A	New measure	98%

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Improving access to pre-assessment clinics A	Monthly data collection	N/A	>80%	<50% March 2010	68% March 2011 ↑
Improving access to all patients is key to developing services. At QVH we have concentrated this year on increasing access to pre-assessment on the day of a patients outpatient appointment to reduce the number of visits a patient needs to make to the hospital.					

Patient feedback

Patient comments on their care during 2010/11 include:

"I would like to say a Big Thank You for all the extra special meals that you have made for me. I have cerebral palsy and often find some foods difficult to eat but you have managed to cater for some of my favourites."

"The staff are always courteous, efficient and friendly and it is all spotlessly clean and tidy. This is how hospitals should be run and should be the norm, not the exception."

"It is unfortunately too common to need to complain about the current state of the NHS and services provided, therefore, I really felt I should write in praise of your staff and hospital."

"I would like to take the opportunity in expressing how thankful and grateful I am to have been treated so well at this hospital. I do hope that all staff are recognised for how wonderful they are."

Performance against key national targets for 2011/12

Performance against national targets is set out in Annex B on page 86.

4.4 Statements from third parties

During April 2011 third parties were asked to comment on the accuracy of the quality accounts and were sent a draft of the document. Amendments from the draft include updating figures to reflect full/ratified final year data.

Statement from Local Involvement Network (LINK)

I confirm that to the best of my knowledge the Queen Victoria Hospital NHS Foundation Trust Quality Accounts contain accurate information. Queen Victoria Hospital NHS Foundation Trust should be congratulated for the extensive work carried out to improve services in the current financial climate.

2010/11 priorities

I agree that good progress was made in three of the 2010/11 priories and welcome that they will continue to look for improvements in these areas. The fourth priority was always going to be difficult. I accept that it is difficult to control the other hospitals providing outpatient clinics. Despite the Trust not being satisfied they only received two complaints relating to outpatient appointments being cancelled.

Priorities for 2011/12

Priority 1

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

I agree that they should focus on outpatient appointments at QVH as it is difficult to manage services provided off site. The outpatient eye clinic is possibly a victim of its reputation. Hopefully the changes being proposed for this area will lead to the required improvements.

Priority 2

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

I welcome the aim of QVH to provide written communication to patients. This is in line with the actions of other hospitals. I am pleased that they have taken note of patients raising this in various surveys.

Priority 3

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

This priority is welcomed by the patients. I understand this is being now being carried out at pre-assessment. Patients are nervous on day of surgery and don't always grasp what is being said.

Priority 4

We aim to roll out electronic discharge notification for all patients by March 2011.

This is a practice I would like to see adopted by all hospitals. There is history of unacceptable gaps between patient discharge and the GP being informed of any home follow up required and details of medication provided. Hopefully this will overcome this problem.

Tables and statistics

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

Statement from Overview and Scrutiny Committee (HOSC)

It is difficult for HOSC to review the accuracy of information about services as set out in Quality Accounts. HOSC does not carry out the type of research that would be necessary to give an evidence-based opinion on this.

HOSC has established good liaison arrangements with QVH during the last year, with regular informal meetings between the trust and its two HOSC liaison members. It is hoped that this will continue into the future, and will be particularly important during this period of significant change for the NHS.

HOSC's scrutiny of QVH has focused on community services during 2010-11, with two formal meetings looking at the future of the services currently provided by the trust. HOSC is concerned to ensure that during this period of change, the quality of services and patient experience remains of a high standard – and that business continuity should be maintained. HOSC understands that there are a number of pressures on provider trusts, but hopes that QVH will continue to work with its partners – and particularly the local GP commissioners and other acute trusts providing services in the NE of West Sussex – to ensure that patient's needs are met.

HOSC welcomes the measures QVH has taken during the past year, as set out in its draft Quality Account, to streamline pathways of care and improve patient experience. Some specific areas where further information would be helpful are:

- There appears to be a spike in the number of operations cancelled in June and December but without a clear indication as to why: It would be useful if an explanation for this could be given.
- The number of out-patient appointments cancelled appears to be relatively high: It would be helpful if further information could be provided in terms of steps being undertaken to address this. HOSC liaison members will wish to monitor this issue.
- The priority to improve discharge information for patients and GPs is welcomed, but it is unclear why there had been a problem with the previous system.

As the Quality Account is a means for NHS trusts to be held to account by the public and local stakeholders for delivering quality improvements, the HOSC is disappointed that QVH continues to hold its Board meetings in private. HOSC believes that this goes against the principle of Foundation Trusts being accountable to local people, and hopes that QVH will reconsider its position on this in the future.

(QVH note: QVH board of governor meetings are open to the public with board of director meetings held in private.)

Statement from Primary Care Trust

Thank you for sending NHS West Sussex a draft copy of your Quality Account for 2010-2011. We have reviewed the content against the national criteria and further, specifically against the organisations performance and ambition.

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

NHS West Sussex considered that there were areas of significant strength within the accounts, namely that the accounts have a very clear link with the 2009/10 accounts and give robust indication of performance against the organisation's 2010/11 objectives.

Queen Victoria Hospital NHS Foundation Trust should also be commended on the breadth and balance of data presented in regards to the published quality indicators.

NHS West Sussex and Queen Victoria Hospital NHS Foundation Trust have worked collaboratively to move quality improvement forward. These improvements have been evidenced by the organisation's success in achieving 100% of its quality improvement and innovation goals agreed in its 2010/11 CQUIN's targets. These included the following Quality Improvement Goals:

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

NHS West Sussex has also undertaken two clinical site visits in 2010/11 which highlighted the commitment to quality improvement within Queen Victoria Hospital NHS Foundation Trust.

The PCT regularly monitors the performance and quality of services through both quality and contractual meetings with the trust and also through receipt of the trust's Quality and Risk committee papers and minutes.

In relation to the priorities for 2011/12 NHS West Sussex feels that there is a clear explanation of how the organisation has set the priorities with a clear plan of how the organisation will achieve its priorities. In future the organisation would also benefit from exploring and using more patient outcome based measures of quality improvement.

NHS West Sussex considers the four published priorities appropriate for this organisation. These strengthen and support the four quality improvement and innovation goals agreed in its 2011/12 CQUIN's targets. These include:

- To improve responsiveness to personal needs of patients.
- Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).
- The Sit and See project has been designed to take key indicators of good fundamental practice, and use them as vital signs to demonstrate Care Kindness and Compassion.
- Patient Experience Ophthalmology

This document highlights the progress the trust has made in moving forward its quality agenda and has identified how it will continue to monitor its progress in these areas. It has also set out its plans for further improvement during 2011/12. An increasing focus on patient experience and on improving outcomes during 2011/12 will continue to work to the benefit of patients and improve the quality of services provided by Victoria Hospital NHS Foundation Trust Quality.

Statement from the QVH Board of Governors

The Board of Governors takes a very close interest in all aspects of the quality of the services Queen Victoria Hospital provides. A Governor Representative attends all Board of Director meetings, highlighting to the Board any concerns or issues which the Governors may have and reporting back to governors on the Board activities. A governor attends the meetings of the Quality and Risk Committee which oversees all quality and risk activities on behalf of the Board. The Governors' Steering Group (GSG) takes monthly reports from the executive and the Chief Executive Officer and other Directors regularly attend GSG meetings to discuss various aspects of the Trust's operations. Governors attend meetings of the Patient Experience Taskforce which is reviewing all aspects of the patient experience and making recommendations for improvement. Governors attend the Patient Information Group which aims to ensure that the information given to patients is clear and easy to understand. There are many other areas of interaction with hospital activities and with the patients. Regular governor tours take place with reports presented to the GSG. There is governor involvement in the main PEAT inspection and governors regularly attend the "mini-PEAT" inspections which are undertaken continuously by the Trust. During 2010 governors commenced a monthly programme of outpatient surveys to ensure a thorough understanding of the patient experience in this area. There are also staff governors on the Governing Body which help provide a balanced view and understanding of the hospital.

This gives the Governing Body a clear and comprehensive view of the activities within Queen Victoria Hospital and of the quality of the patient experience in its most general terms and, more specifically, with regard to patient safety and clinical effectiveness. We have reviewed the Quality Accounts produced for 2010/11 and, from our knowledge of all that has been reported during the year and from our involvement in many of the activities, we are fully confident that the information in the quality accounts is accurate. We are further confident that Queen Victoria Hospital pays close high level attention to the general patient experience, patient safety and clinical effectiveness and has, as a priority, the improvement of these areas from the current excellent performance.

Statement of director responsibilities in respect of the quality report

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

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting manual 2010–11;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010–June 2011
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
  - Feedback from the commissioners dated 20/05/2011
  - Feedback form governors dated 06/05/2011
  - Feedback from LINks dated 09/05/2011
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011
  - The national patient survey 21/04/2011
  - The national staff survey 16/03/2011
  - The Head of Internal's Audit's annual opinion over the trust's control environment dated 26/05/11
  - CQC quality and risk profiles dated 09/03/2011
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreporting manual).

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

By order of the Board

Chairman
2 June 2011

Acting Chief Executive
2 June 2011

Independent Auditor's Report to the Board of Governors of Queen Victoria Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Queen Victoria Hospital NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of the Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes from April 2010 to April 2011 (the period);
- Papers relating to quality reported to the Board over the period;
- Feedback from the commissioners dated 20/05/2011;
- Feedback from governors dated 11/05/2011;
- Feedback from LINKS dated 09/05/2011;
- The trust's complaints report which was incorporated into the trust's Patient Experience report;
- 2010 Picker Patient Survey Report and a Patient Survey Report based on information generated from PALS;
- CQC 2010 National NHS Staff Survey;
- The Head of Internal Audit's annual opinion over the trust's controls environment dated 18/05/2011; and
- CQC Quality and Risk Profile dated March 2011.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of the Trust as a body, to assist the Board of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and the Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

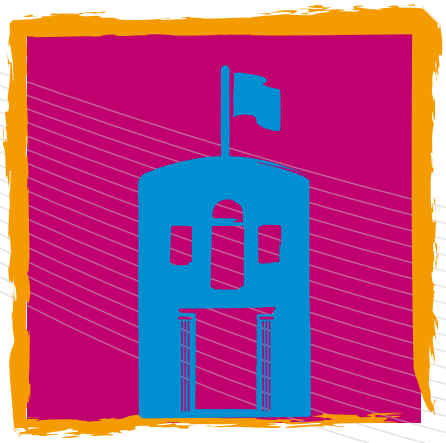
Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

PricewaterhouseCoopers LLP
Chartered Accountants, London

6 June 2011

5.0 Financial accounts



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

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

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him 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.

Amanda Parker
Acting Chief Executive
2 June 2011

Independent Auditors' Report to the Board Of Governors of Queen Victoria Hospital NHS Foundation Trust

We have audited the financial statements of Queen Victoria Hospital NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

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

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2011 and of its income and expenditure and cash flows for the year then ended 31 March 2011; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- in our opinion the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Accounting Officer's Statement on Internal Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.
- we have qualified our report on any aspects of the Quality Report.

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.

PricewaterhouseCoopers LLP

Anna Blackman (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
7 More London Riverside, London

6 June 2011

Foreword to the accounts

These accounts for the year ended 31 March 2011 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.

Amanda Parker
Acting Chief Executive
2 June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2011				
	Notes		2010/11 £000	2009/10 £000
Operating income	3, 4		**56,821**	54,536
Operating expenses excluding impairments	5		**(54,019)**	(52,622)
Impairments of property, plant and equipment	6		**(3,454)**	(1,999)
Operating (deficit)			**(652)**	(85)
Finance costs				
Finance income	13	71		14
Finance expense – unwinding of discount on provisions	23	(16)		(12)
Finance expense – other	24	(2)		–
PDC dividends payable	14	(828)		(961)
Net finance costs			**(775)**	(959)
SURPLUS/(DEFICIT) FOR THE YEAR	30		**(1427)**	(1044)
Other comprehensive income: (See Statement of Changes in Taxpayers' Equity on page 54)				
Revaluation gains/(losses) on property, plant and equipment			**11**	(1,388)
Increase in the donated asset reserve due to receipt of donated assets			**82**	13
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets			**(525)**	(257)
TOTAL COMPREHENSIVE (EXPENSE) FOR THE PERIOD			**(1,859)**	(2,676)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011				
	Notes		31 March 2011 £000	31 March 2010 £000
NON-CURRENT ASSETS:				
Intangible assets	15		**65**	87
Property, Plant and Equipment	16		**28,025**	32,128
Trade and other receivables	19		**15**	48
Total non-current assets			**28,105**	32,263
CURRENT ASSETS:				
Inventories	18		**225**	319
Trade and other receivables	19		**2,452**	3,339
Cash and cash equivalents	20		**6,967**	4,801
Total current assets			**9,644**	8,459
CURRENT LIABILITIES:				
Trade and other payables	21		**(2,653)**	(4,590)
Tax payable	21		**(781)**	(803)
Other liabilities	22		**(293)**	(2,185)
Provisions	23		**(433)**	(38)
Total current liabilities			**(4,160)**	(7,616)
NON-CURRENT LIABILITIES				
Provisions	23		**(460)**	(522)
Other liabilities	22		**(2,361)**	–
Obligations under finance leases	24		**(43)**	–
Total non-current liabilities			**(2,864)**	(522)
TOTAL ASSETS EMPLOYED			**30,725**	32,584
TAX PAYERS' EQUITY: (See Statement of Changes in Taxpayers' Equity on page 54)				
Public dividend capital			**12,212**	12,212
Revaluation reserve			**12,125**	14,075
Donated asset reserve			**1,883**	2,326
Income and expenditure reserve			**4,505**	3,971
TOTAL TAX PAYERS' EQUITY			**30,725**	32,584

The accounts on pages 52 to 55 were approved by the Board on 26 May 2011 and are signed on the Board's behalf by:

Amanda Parker
Acting Chief Executive
2 June 2011

The notes on pages 56 to 80 form part of these accounts.

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY					
	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Income and Expenditure Reserve £000	**Total £000**
2010/11					
Taxpayers' equity at 1 April 2010	12,212	14,075	2,326	3,971	**32,584**
Deficit for the year	-	-	-	(1,427)	**(1,427)**
Revaluation of property, plant and equipment	-	11	-	-	**11**
Receipt of donated assets	-	-	82	-	**82**
Depreciation of donated assets	-	-	(525)	-	**(525)**
Transfer in respect of impairment of property, plant and equipment	-	(1,531)	-	1,531	-
Transfer of the difference between current cost and historical cost depreciation	-	(430)	-	430	-
Taxpayers' equity at 31 March 2011	12,212	12,125	1,883	4,505	**30,725**
2009/10					
Taxpayers' equity at 1 April 2009	12,212	15,769	2,692	4,587	**35,260**
Deficit for the year	-	-	-	(1,044)	**(1,044)**
Revaluation of property, plant and equipment	-	(1,266)	(122)	-	**(1,388)**
Receipt of donated assets	-	-	13	-	**13**
Depreciation of donated assets	-	-	(257)	-	**(257)**
Transfer of the difference between current cost and historical cost depreciation	-	(428)	-	428	-
Taxpayers' equity at 31 March 2010	12,212	14,075	2,326	3,971	**32,584**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011				
	Notes		2010/11 £000	2009/10 £000
Operating Surplus/(Deficit)			**(652)**	(85)
Non-cash income and expense				
Depreciation and amortisation	5		**2,233**	1,833
Impairments	5,6		**3,454**	1,999
Transfer from the donated asset reserve	4		**(525)**	(212)
Decrease in inventories	18		**94**	27
Decrease in trade receivables	19		**1,024**	1,025
Increase / (decrease) in trade and other payables	21		**(1,186)**	1,775
Increase / (decrease) in provisions	23		**379**	6
Net cash inflow from operations			**4,821**	6,368
Cash flows from investing activities				
Interest received	13	**9**		14
Payments to acquire intangible assets	15	**(15)**		(47)
Payments to acquire property, plant and equipment	16	**(1,710)**		(3,607)
Net cash used in investing activities			**(1,716)**	(3,640)
Cash flows from financing activities				
Capital element of finance lease rental payments	24		**(4)**	–
Interest element of finance lease	24		**(2)**	–
PDC dividends paid	14		**(933)**	(1,037)
Increase in cash			**2,166**	1,691
Cash and cash equivalents at 1 April 2010	20		**4,801**	3,110
Cash and cash equivalents at 31 March 2011	20		**6,967**	4,801

Notes to the financial statements

1. Accounting policies

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

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Income

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

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

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

1.2 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

Additional pension liabilities arising from early retirements

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

1.3 Expenditure on other goods and services

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

1.4 Property, Plant and Equipment

Recognition

Property, plant and equipment are capitalised where:

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

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

Measurement

Valuation

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

To this end, valuations of land, buildings and fixtures are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date. Revaluations are never less than triennial. The latest valuations were undertaken in 2010 as at the prospective valuation date of 31 March 2010 and were accounted for in the 2009/10 accounts. In 2010/11 the Trust consulted with valuers and concluded that a valuation was not required.

Fair values are determined as follows:

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

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

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

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

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

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

Subsequent expenditure

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

Depreciation

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

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

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

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

Revaluation and impairment

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

Decreases in asset values and impairments resulting from loss of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

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

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

Donated assets

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

1.5 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

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

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

Amortisation

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

1.6 Inventories

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

1.7 Cash and cash equivalents

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

1.8 Trade receivables

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

1.9 Trade payables

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

1.10 Financial assets and financial liabilities

Recognition

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

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as 'Loans and Receivables'.

Financial liabilities are classified as 'Financial Liabilities'.

Loans and receivables

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

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

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

Financial Liabilities

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

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

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

1.11 Leases

Finance leases

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

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Where land is leased for a short term (eg 10 years) and there is no provision for the transfer of title, the lease is considered to be an operating lease.

The Trust as lessor

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

1.12 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 23. The Trust does not carry any amounts relating to these cases in its own accounts.

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

1.13 Contingencies

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

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

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

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that, as PDC is issued under legislation rather than contract, it is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by theTrust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.15 Value Added Tax

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

1.16 Corporation Tax

No Corporation Tax was charged to the Trust for the financial year ending 31 March 2011.

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

1.18 Third party assets

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

1.19 Accounting standards issued but not yet applied

a) IASB standard and IFRIC interpretations

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

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

i) IFRS 7 – Financial Instruments: Disclosures
This is an amendment to the standard to require additional disclosures where financial assets are transferred between categories (e.g. 'Fair Value through Profit and Loss', Loans and Receivable etc). It is applicable from 2011/12. It is unlikely to affect NHS bodies as they rarely transfer financial instruments.

ii) IFRS 9 – Financial Instruments
This is a new standard to replace - IAS 39 Financial Instruments: Recognition and Measurement. Two elements of the standard have been issued so far: Financial Assets and Financial Liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two: Amortised Cost and 'Fair Value through Profit and Loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

iii) IAS 24 (Revised) – Related Party Disclosures
This new standard seeks to reduce the extent of disclosures required by government entities whose transactions are principally with other government entities. It is due for adoption in 2011/12. This may potentially relieve NHS bodies from providing some of its related party disclosures with other entities within the Whole of Government Accounts boundary, unless HM Treasury chooses to adapt the standard to retain the existing closures.

iv) IASB Annual Improvements 2010
The document makes minor changes to 6 standards and one IFRIC Interpretation. Three of the standards IFRS 1 First time adoption of IFRS, IAS 34 Interim financial reporting and IFRIC 13 customer loyalty programmes are not relevant to NHS bodies.

The amendments to IAS 1 presentation of financial standards, IAS 27 consolidated and separate financial statements, IFRS 3 business combinations and IFRS 7 financial instrument are minor changes in disclosures and should have little or no impact for NHS bodies.

v) IFRIC 14 – IAS 19 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction
This is an amendment to the IFRIC that applies from 2011/12. There will be no impact on most NHS bodies as they are not members of a defined benefit scheme. It will have no immediate impact on those bodies which are members of a defined benefit scheme as most local government schemes are in deficit rather than in surplus.

vi) IFRIC 19 – Extinguishing financial liabilities with equity instruments
This new IFRIC applies from 2011/12 but will have no impact because NHS bodies have no equity instruments and therefore cannot issue them to settle financial liabilities.

b) Government Financial Reporting Manual (FReM) changes

The following changes to the HM Treasury FReM are potentially applicable to NHS bodies from 2011/12.

i) Treatment of grants received
Under the new approach, grants received towards the cost of an asset are recognised in income unless the funder imposes a condition on the grant e.g. that it must be used to fund the construction or acquisition of an asset. If there are no conditions, or once all conditions have been met, the grant is recognised in full in within income. If adopted, the impact is likely to be an increase in volatility in annual results where capital grants are received or released once conditions have been met. When the change is applied, the existing government grants deferred account is likely to be realised to Retained Earnings.

ii) Donated assets
The new approach for donated assets is effectively identical to that for grants above. Where donations are received without conditions, or if they have conditions, once these have been met, they should be recognised in income. If brought into effect it would result in most, or all, donations being reflected in income in the year of receipt which could lead to greater volatility in the annual result. The existing donated asset reserve would be transferred to the Retained Earnings and, where it includes an element of asset revaluations, to the revaluation reserve.

c) Other changes

The HM Treasury dispensation from applying IAS 27 to NHS charitable funds only applies to 2010/11. If this dispensation is not extended then, in 2011/12, it is likely that the NHS bodies will be required to consolidate NHS charitable funds that are controlled by NHS bodies.

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

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

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

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

The Trust has early adopted the amendment to IFRS 8, included within the IASB 2009 improvement project above, which exempts entities from disclosing assets by segment if they are not regularly reported to the Chief Operating Decision Maker.

1.20 Profit-sharing agreement

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

1.21 Critical accounting estimates and assumptions

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

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

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

Provisions for early retirements – The Trust makes additional pension contributions in respect of a number of staff who have retired early from the service. Provisions have been made for these contributions, based on actuarial assessments of the expected remaining lives of those concerned.

Property valuation – Property forms a large proportion of the Trust's asset value and its valuation can therefore have a critical effect on the Trust's accounts. As noted above, regular valuations are carried out by professional valuers, on whose opinion the Trust places reliance. In 2010/11, acting on advice received from valuers, the Trust concluded that no revaluation was necessary.

Impairment of property – During 2010/11 the Trust board approved the replacement of most of the hospital's operating theatres. This project will entail the decommissioning and/or demolition of a number of existing buildings, and the consequential impairment in value of these buildings has been recognised in these accounts.

The withdrawal from service of those buildings that are due for demolition will take place in the second half of 2011/12. Their book value has therefore been reduced to the level of the depreciation that will be charged on them during the first two quarters of the year.

The existing main theatre complex occupies approximately seventy percent of the block in which it is accommodated and it will be taken out of service on completion of the new theatres towards the end of 2012/13. Seventy percent of the book value of the block has therefore been reduced to the level of the depreciation that will be charged on it over the next two years.

1.22 Operating segments

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

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

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

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

2. Operating segments

The Chief Operating Decision Maker is considered to be the Trust board because it is the board that makes all major strategic decisions and oversees the day-to-day running of the Trust. At monthly Board meetings key operational decisions are reached following scrutiny of performance and resource allocation across the Trust's operating segments.

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

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

The financial results for each segment were as follows:

Financial results for each segment	2010/11		2009/10	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Reconstructive surgery	44,779	31,784	42,110	27,142
All other segments	11,399	4,448	12,307	6,205
Total of reportable segments	**56,178**	**36,232**	**54,417**	**33,347**
Corporate services (see note below)		14,215		17,323
Depreciation		2,192		1,833
Impairment of Property, Plant and Equipment		3,454		1,999
Restructuring costs		739		–
Finance income		(71)		(14)
Finance expense – unwinding of discount on provisions		16		12
PDC dividends payable		828		961
Surplus/(Deficit) for the year		**(1,427)**		**(1,044)**

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

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

	2010/11 £000	2009/10 £000
West Sussex PCT (acting on behalf of all Sussex PCTs)	**20,773**	19,973
West Kent PCT	**11,564**	10,228

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

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

	2010/11 £000	2009/10 £000
Wales	**36**	33
Scotland	**6**	5
	42	38

3. Income from patient care activities

	2010/11 £000	2009/10 £000 *(restated, see * below)*
NHS trusts	286	72
Primary care trusts	52,945	50,779
Department of Health	5	20
NHS other	39	76
Non-NHS:		
Private patients	249	231
Injury costs recovery	209	235
Other	112	49
	53,845	51,462

"Injury costs recovery" is income received from insurance companies for the treatment of patients who have been involved in road traffic accidents. It is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection.

Mandatory and Non-mandatory services

Mandatory services are those which provide for the healthcare of NHS patients. All other services are non-mandatory. Of the total income reported above, £53,596,000, (2009/10 £51,133,000) was derived from the provision of mandatory services.

** Private patient income*

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient-related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year. The definition of private patient income was broadened for 2010/11 and the income cap increased correspondingly. The Trust's revised cap is 0.8% of total patient-related income.

Performance	2010/11 £000	2009/10 £000 *(Restated*
Private patient income	249	231
Total patient-related income	53,845	51,462
Proportion	0.46%	**0.45%**

4. Other Operating Income

Performance	2010/11 £000	2009/10 £000
Education, training and research	1,644	1,960
Charitable and other contributions to expenditure	90	119
Transfers from Donated Asset Reserve	525	212
Non-patient care services to other bodies	82	122
Rental income	–	12
Other income	635	649
	2,976	3,074

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

5. Operating Expenses

	2010/11 £000	2009/10 £000
Services from NHS foundation trusts	**678**	733
Services from other NHS trusts	**2,399**	2,848
Services from other NHS bodies	**222**	69
Purchase of healthcare from non NHS bodies	**230**	196
Executive directors' costs	**419**	598
Non-executive directors' costs	**118**	119
Staff costs	**35,658**	35,498
Consultancy	**167**	84
Drugs	**958**	890
Supplies and services – clinical (excluding drugs)	**4,686**	4,716
Supplies and services – general	**655**	705
Establishment	**1,011**	1,066
Transport	**203**	248
Premises	**1,557**	1,657
Provision for impairment of receivables	**727**	113
Depreciation	**2,155**	1,808
Amortisation	**37**	25
Audit fees – statutory audit	**149**	88
Other auditor's remuneration – other services	**33**	74
Clinical negligence	**363**	354
Restructuring costs	**739**	–
Other	**855**	733
	54,019	52,622
Impairments of property, plant and equipment	**3,454**	1,999
	57,473	**54,621**

Notes:

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

Restructuring – In 2010/11 the Trust embarked upon a restructuring project with the objective of reducing costs whilst maintaining the quality of patient care whilst improving efficiencies. Redundancies and other payments associated with the elimination of posts entailed costs of £739,000 in 2010/11, (£nil in 2009/10).

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

6. Impairment

The Trust is in the process of reproviding most of its operating theatre and outpatients facilities in new buildings. This project will entail the demolition of some existing buildings and the downgrading of others. The carrying value of these buildings has therefore been reduced to the level of their forecast depreciation up to the point at which they are to be taken out of service.

Reductions in value relating to purchased assets have been treated as impairments and charged to the Statement of Comprehensive Income. Those relating to donated assets have been regarded as accelerated depreciation.

The effect of this on the Statement of Comprehensive Income is:

	2010/11 £000
Impairment	3,454
Accelerated depreciation	324
	3,778

Balances in the revaluation reserve relating to impaired assets amounted to £1,531,000. This amount was transferred from the revaluation reserve to retained earnings in accordance with Treasury directions.

7. Operating leases

7.1 As lessee

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

The agreement relating to the heating systems ended in March 2011. The purchase of the associated assets was under negotiation at the end of the financial year.

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

Payments recognised as an expense	2010/11 £000	2009/10 £000
Minimum lease payments	747	696

Total future minimum lease payments	2010/11 £000	2009/10 £000
Payable:		
Not later than one year	464	672
Between one and five years	739	175
After 5 years	30	60
Total	**1,233**	907

7.2 As lessor

Premises were leased to a private healthcare body for a period which ended in 2010/11.

Rental Revenue	2010/11 £000	2009/10 £000
Minimum payments	–	12

8. Employee benefits and staff numbers

8.1 Employee benefits	Permanently Employed £000	Other £000	2010/11 Total £000	2009/10 £000
Salaries and wages	**28,271**	–	**28,271**	28,460
Social Security Costs	**2,510**	–	**2,510**	2,536
Employer contributions to NHS Pension scheme	**3,423**	–	**3,423**	3,433
Agency/contract staff	–	**1,873**	**1,873**	1,667
Employee benefits expense	**34,204**	**1,873**	**36,077**	36,096
Non-executive directors benefits not included above	118	–	118	119
	34,322	1,873	36,195	36,215

8.2 Average number of people employed	Permanently Employed Number	Other Number	2010/11 Total Number	2009/10 Total Restated
Medical and dental	**123**	–	**123**	120
Administration and estates	**187**	–	**187**	208
Healthcare assistants and other support staff	**130**	–	**130**	137
Nursing, midwifery and health visiting staff	**191**	–	**191**	198
Scientific, therapeutic and technical staff	**136**	–	**136**	142
Bank and agency staff	–	**55**	**55**	54
Total	**767**	**55**	**822**	**859**

The 2009/10 figures have been restated to show all agency staff on the "Bank and agency" line.

8.3 Directors' remuneration and highest paid director	2010/11 £000	2009/10 £000
In aggregate, directors' pay costs were:		
Executive directors	**419**	598
Non-executive directors	**118**	119
Total	**537**	717

The pay cost of the highest paid director in 2010-11 and 2009-10 was £140,000.

8.4 Staff exit packages for staff leaving in 2010-11

Staff exit packages are payable when the Trust terminates the employment of an employee before the normal retirement date or whenever an employee accepts voluntary redundancy in return for these benefits. During the year there were ten such cases which were consequential upon the restructuring referred to in Note 5, above. The cost of these packages fell within the following bands:

Exit package cost band £000	Number of compulsory redundancies	Total exit packages by cost band
10–25	**1**	**5**
25–50	**0**	**4**
50–100	**1**	**1**
Total	**2**	**10**

No exit packages were paid in 2009-10.

9. Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 December 2010 with summary global member and accounting data.

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

c) Scheme provisions

In 2010-11 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

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

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

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

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

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

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

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

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

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

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

10. Retirements due to ill-health

During the year there was one early retirement due to ill health (2009/10, none).
(This information has been supplied by NHS Pensions.)

11. Better Payment Practice Code

	2010/11 Number	2010/11 £000	2009/10 Number	2009/10 £000
Total Non-NHS trade invoices paid in the year	14,520	12,675	13,597	12,711
Total Non-NHS trade invoices paid within target	6,364	6,147	7,823	7,903
Percentage of Non-NHS trade invoices paid within target	**44%**	**48%**	58%	62%
Total NHS trade invoices paid in the year	1,154	6,635	1,131	7,379
Total NHS trade invoices paid within target	397	2,591	117	585
Percentage of NHS trade invoices paid within target	**34%**	**39%**	10%	8%

In the early part of the period the Trust experienced cashflow difficulties which resulted in delayed creditor payments. In later months the position improved markedly, but the effect of the early cash-shortage is still evident in the figures reported here. In period 12 for example, the percentage of Non-NHS and NHS invoices paid within the target was 90% and 56% respectively.

12. The Late Payment of Commercial Debts (Interest) Act 1998

No claims against the Trust were made under the Late Payment of Commercial Debts (Interest) Act 1998, (2009/10 none).

13. Finance revenue

	2010/11 £000	2009/10 £000
Interest revenue from bank accounts	**9**	14
Increase in discount rate regarding early retirement and injury benefit provision	**62**	–
Total	**71**	14

During the year the discount rate applied to provisions relating to pensions was increased from 2.2% to 2.9%, in accordance with Treasury guidance.

14. Dividends

A dividend based on the Government's investment in the Trust is payable annually. It is calculated as 3.5% of the Trust's average net relevant assets during the year. Relevant net assets are total assets less the donation reserve and cash in the Trust's Government Banking Service account.

The dividend for any given year is paid in two installments during that year. The amounts paid are based on forcasts, because the true amount due cannot be known until the accounts for the year have been completed. There is therefore likely to be a difference between the amount shown in the accounts as dividend payable and the cash actually paid. This over- or under-payment is adjusted for in the first installment paid in the following year.

14.1 Dividends payable	**2010/11 £000**	2009/10 £000
Dividend payable – planned	**1,009**	1,037
Receivable – adjustment for amount actually due	**(181)**	(76)
Dividend payable – final	**828**	961

14.2 Dividend cashflow	**2010/11 £000**	2009/10 £000
Dividend payable – planned	**1,009**	1,037
Refund of overpayment in 2009/10 (see Note 14.1)	**(76)**	–
Cash paid in-year	**933**	1,037

15. Intangible Assets

15.1 Software Licences	**2010/11 £000**	2009/10 £000
Gross cost at 1 April 2010	**214**	167
Additions	**15**	47
Gross cost at 31 March 2011	**229**	214
Amortisation at 1 April 2010	**127**	102
Provided during the year	**37**	25
Amortisation at 31 March 2011	**164**	127
Net book value		
– Purchased assets at 1 April 2010	**87**	65
– Purchased assets at 31 March 2011	**65**	87

15.2 Fully amortised intangible assets

Fully amortised intangible assets with an aggregate gross carrying value of £98,000 are still in use.

16. Property, plant and equipment

16.1 Property, plant and equipment at 31 March 2011

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

2009-10 comparators	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and Machinery £000	Information Technology £000	Furniture and Fittings £000	Total £000
Cost or valuation at 1 April 2009	9,229	18,901	592	9,255	2,219	662	**40,858**
Additions – purchased	-	1,745	1,255	606	64	-	**3,670**
Additions – donated	-	7	-	6	-	-	**13**
Impairments recognised in operating expenses	-	(902)	(1,092)	-	-	(5)	**(1,999)**
Reclassifications	-	411	(427)	-	16	-	**0**
Revaluation gain/(loss)	284	(2,373)	-	-	-	(70)	**(2,159)**
Disposals	-	-	-	(44)	-	-	**(44)**
At 31 March 2010	**9,513**	**17,789**	**328**	**9,823**	**2,299**	**587**	**40,339**
Depreciation at 1 April 2009	-	20	-	5,770	1,384	-	**7,174**
Provided during the year	-	757	-	819	207	25	**1,808**
Revaluation gain/(loss)	-	(746)	-	-	-	(25)	**(771)**
Disposals	-	-	-	-	-	-	**0**
Depreciation at 31 March 2010	**-**	**31**	**-**	**6,589**	**1,591**	**-**	**8,211**
Net book value							
– Purchased assets as at 1 April 2009	9,229	16,680	592	3,042	824	625	**30,992**
– Donated assets as at 1 April 2009	-	2,201	-	443	11	37	**2,692**
Total at 1 April 2009	**9,229**	**18,881**	**592**	**3,485**	**835**	**662**	**33,684**
– Purchased assets as at 31 March 2010	9,513	15,774	328	2,935	699	553	**29,802**
– Donated assets as at 31 March 2010	-	1,984	-	299	9	34	**2,326**
Total at 31 March 2010	**9,513**	**17,758**	**328**	**3,234**	**708**	**587**	**32,128**

16.2 Protected and non-protected property, plant and equipment

The net book values disclosed above relate entirely to protected assets with the exception of non-protected land valued at £1,807,000 at 31 March 2011 (£1,807,000 at 31 March 2010), which is included within the totals.

16.3 Revaluation of assets

Land and buildings (including furniture and fittings) were revalued as at 31 March 2010 and the effect of that revaluation has been included in these accounts.

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

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

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

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

For 2010-11 independent valuers were consulted, and on the basis of their advice it was decided that the carrying values for land and buildings were not significantly different from current values. A revaluation was not therefore required.

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

16.4 Asset lives

The lives of the various elements of buildings have been determined by the same independent valuer who carried out the revaluation referred to in Note 16.3. They vary between two and eighty five years.

16.5 Fully depreciated assets

Fully depreciated assets with an aggregate gross carrying value of £4,804,000 are still in use.

16.6 Property, plant and equipment donated during the year

During the year, medical equipment with a value of £82,000 was donated to the Trust by the Queen Victoria Hospital NHS Trust Charitable Fund.

17. Capital commitments

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

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	**602**	114

18. Inventories

18.1 Inventories at 31 March	31 March 2011 £000	31 March 2010 £000
Drugs	**98**	101
Clinical consumables	**124**	211
Other	**3**	7
Total	**225**	319

18.2 Inventories recognised as expenditure	31 March 2011 £000	31 March 2010 £000
Drugs	**958**	890
Clinical consumables	**240**	390
Other	**196**	267
Total	**1,394**	1,547

During 2010-11 a number of minor stocks that were held as stock at 31 March 2010 were written off. The value of these items at 31 March 2010 was £24,000.

19. Trade and other receivables

19.1 Trade and other receivables comprise:	31 March 2011		31 March 2010	
	Current £000	Non-current £000	Current £000	Non-current £000
NHS and other related party receivables	**2,516**	**15**	2,095	48
Other trade receivables	**149**	**-**	305	-
Accrued income	**2**	**-**	494	-
Provision for the impairment of receivables	**(912)**	**-**	(185)	-
Prepayments	**697**	**-**	630	-
Total	**2,452**	**15**	3,339	48

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

19.2 Receivables past their due date but not impaired	31 March 2011 £000	31 March 2010 £000
By up to three months	**417**	355
By between three and six months	**10**	63
By more than six months	**130**	133
Total	**557**	551

19.3 Provision for impairment of NHS receivables	31 March 2011 £000	31 March 2010 £000
Balance at 1 April 2010	**(138)**	(28)
Amount recovered or written off during the year	**117**	-
Increase in receivables impaired	**(840)**	(110)
Balance at 31 March 2011	**(861)**	(138)

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

19.4 Provision for impairment of non-NHS receivables	31 March 2011 £000	31 March 2010 £000
Balance at 1 April 2010	**(47)**	(47)
Amount recovered or written off during the year	**47**	3
Increase in receivables impaired	**(51)**	(3)
Balance at 31 March 2011	**(51)**	(47)

£47,000 of the closing balance represents the probable non-recovery of costs of treating the victims of road traffic and other accidents. The recovery of costs is handled through the NHS Injury Scheme which recommends a provision for non-recovery of 9.2%. The trust has followed this advice.

20. Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance at 1 April 2010	**4,801**	3,110
Net change in year	**2,166**	1,691
Balance at 31 March 2011	**6,967**	4,801
Comprising:		
Cash with the Government Banking Service (GBS)	**7,326**	4,772
Commercial banks and cash in hand	**(359)**	29
Cash and cash equivalents as in statement of cash flows	**6,967**	4,801

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

21. Trade and other payables

	31 March 2011 £000	31 March 2010 £000
NHS payables	**1,194**	2,276
Trade payables – capital	**25**	181
Other payables – revenue	**290**	546
Accruals	**1,144**	1,587
Cash and cash equivalents as in statement of cash flows	**2,653**	4,590
Tax and social security costs	**781**	803
Total	**3,434**	5,393

NHS payables include £442,000 outstanding pensions contributions at 31 March 2011 (31 March 2010 £404,000).

22. Deferred Income

	31 March 2011 £000	31 March 2010 £000
Current	**293**	2,185
Non-current	**2,361**	-
	2,654	2,185

At 31 March 2010 deferred income included £1,944,000 relating to funding received in respect of a capital project which had not then commenced. At that stage there was a possibility that the project would not be proceeded with because the funding was insufficient. In that event the funding that had been received would have been returned to its source, and it was therefore accounted for as a current liability.

During 2010/11 further funding was secured and the project was confirmed, work starting towards the end of the year. Since it is now certain that the deferred income will be released over the life of the asset to which it relates, it is shown as a non-current liability at 31 March 2011. The project is expected to be completed by the last quarter of 2011/12, at which point the capital grant will start to be released.

23. Provisions

Current	31 March 2011 £000	31 March 2010 £000
Pensions relating to staff	**26**	26
Legal claims	**13**	10
Other	**394**	2
Total	**433**	38

Non-current	31 March 2011 £000	31 March 2010 £000
Pensions relating to staff	**460**	522

Movements in-year	Pensions relating to staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2010	548	10	2	**560**
Change in discount rate	(47)	-	-	**(47)**
Arising during the year	-	13	394	**407**
Used during the year	(26)	(8)	-	**(34)**
Reversed unused	(5)	(2)	(2)	**(9)**
Unwinding of discount	16	-	-	**16**
At 31 March 2011	**486**	**13**	**394**	**893**
Expected timing of cash flows:				
Within one year	26	13	394	**433**
Between one and five years	111	-	-	**111**
After five years	349	-	-	**349**
	486	**13**	**394**	**893**

The provision for pensions relating to staff comprises £419,000 in respect of injury benefit (31/3/2010 – £474,000) and £64,000 in respect of early retirements (31/3/2010 - £75,000). The amounts represent the discounted future value of annual payments made to the NHS Pensions Agency calculated on an actuarial basis. On the instruction of HM Treasury the discount rate has been increased from 2.2% to 2.9%

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

"Other" provisions include £394,000 in respect of estimated restructuring costs expected in 2011-12.

£317,000 was included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the Trust.

24. Finance lease obligations

	31 March 2011 £000	31 March 2010 £000
Gross liability at commencement	**58**	-
Capital repayment during year	**(4)**	-
Finance charges during year	**(2)**	-
	52	-

Gross Lease Liabilities at 31 March 2011	31 March 2011 £000	31 March 2010 £000
Due within one year	**8**	-
Between 2 and 5 years	**42**	-
After 5 years	**2**	-
	52	-
Future finance charges	**(9)**	-
Net Lease Liabilities	**43**	-

25. Financial instruments

Accounting standards IAS 32, 39 and IFRS 7 require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities.

Financial Instruments are recognised and measured in accordance with the accounting policy described under Note 1.10.

25.1 Financial assets and liabilities by category

All financial assets and liabilities are denominated in sterling.

Financial Assets	31 March 2011 Loans and receivables £000	31 March 2010 Loans and receivables £000
NHS and other related party receivables	**1,860**	2,067
Accrued income	**2**	11
Other receivables	**149**	305
Cash at bank and in hand	**6,967**	4,801
Total	**8,978**	7,184

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

Financial Liabilities	31 March 2011 Carrying Value £000	31 March 2010 Carrying Value £000
Trade and other payables	**1,501**	3,003
Accrued expenditure	**1,144**	1,587
Total	**2,645**	4,590

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

Other tax and social security cost amounts of £781,000 (2009/10 £803,000) and deferred income of £2,654,000 (2009/10 £2,105,000) are not classed as financial instruments and have therefore been excluded from the above analysis.

25.2 Maturity of financial assets

All of the Trust's financial assets mature within one year with the exception of one NHS debtor of £15,000 which is expected to mature in annual amounts of approximately £3,000, subject to inflation, until the balance is exhausted.

25.3 Maturity of financial liabilities

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

25.4 Derivative financial instruments

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

25.5 Financial risk management

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

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

Currency risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in note 19.

Liquidity risk

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

26. Prudential Borrowing Limit

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

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code. These are:

  Minimum Dividend Cover
  Minimum Interest Cover
  Minimum Debt Service Cover
  Maximum Debt Service to Revenue

  Because the Trust had not made any borrowings at 31 March 2011, the only one of these that was calculable for 2010/11 was Minimum Dividend Cover, which was 3.4, (2009/10 2.0).

- the amount of any working capital facility approved by Monitor.

Further information on the Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust has a maximum long-term borrowing limit of £10,100,000 (2009/10 £11,500,000). During the year the Trust made no borrowings (2009/10, none).

The Trust has an approved working capital facility of £4,000,000 (2009/10, £3,000,000). During the year the Trust drew down none of its working capital facility (2009/10, none).

27. Related Party Transactions

During 2009/10 the Trust undertook transactions with Bolt Partners LLP, a firm associated with one of its Directors. There were no such transactions in 2010/11. No other board members or members of the key management staff or parties related to them have undertaken any material transactions with Queen Victoria Hospital NHS Foundation Trust.

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

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

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

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

	2010/11		2009/10	
PRIVATE SECTOR AND CHARITABLE ORGANISATIONS	Income £000	Expenditure £000	Income £000	Expenditure £000
Bolt Partners	-	-	-	162
The Queen Victoria Hospital NHS Trust Charitable Fund	201	-	24	-
McIndoe Surgical Centre	142	30	142	29
	343	**30**	166	191

	31 March 2011		31 March 2010	
	Receivables £000	Payables £000	Receivables £000	Payables £000
Bolt Partners	-	-	-	40
The Queen Victoria Hospital NHS Trust Charitable Fund	-	-	-	-
McIndoe Surgical Centre	1	-	7	-
	1	**-**	7	40

	2010/11		2009/10	
WHOLE OF GOVERNMENT ACCOUNTS BODIES	Income £000	Expenditure £000	Income £000	Expenditure £000
Bodies with whom either income or expenditure exceeded £150,000 during the year:				
Income and expenditure				
West Sussex PCT	**20,856**	-	19,973	10
West Kent PCT	**11,565**	**40**	10,228	17
Medway PCT	**4,614**	**53**	4,235	53
Surrey PCT	**4,541**	**21**	4,526	21
Eastern & Coastal Kent PCT	**3,754**	**16**	5,168	-
Croydon PCT	**1,973**	-	402	-
London Specialised Commission Group	**1,858**	-	3,071	-
South East Coast Strategic Health Authority	**1,530**	**2**	1,641	-
Bromley PCT	**959**	-	721	-
Bexley Care Trust	**717**	-	687	-
Isle Of Wight NHS PCT	**329**	-	28	3
Guy's And St. Thomas's NHS Foundation Trust	**279**	**7**	-	14
Hampshire PCT	**171**	-	210	-
National Health Service Logistics Authority	-	**1,219**	-	1,176
Maidstone And Tunbridge Wells NHS Trust	**158**	**778**	29	974
Dartford And Gravesham NHS Trust	-	**711**	1	545
Medway NHS Foundation Trust	-	**571**	-	637
East Sussex Hospitals NHS Trust	-	**565**	-	739
NHS Litigation Authority	-	**410**	-	389
South East Coast Ambulance Service NHS FoundationTrust	-	**406**	1	396
Brighton And Sussex University Hospitals NHS Trust	**48**	**206**	35	208
Other	**1,779**	**600**	1,903	446
	55,131	**5,605**	52,859	5,628

	31 March 2011		31 March 2010	
WHOLE OF GOVERNMENT ACCOUNTS BODIES	Receivables £000	Payables £000	Receivables £000	Payables £000
Bodies with whom either income or expenditure exceeded £150,000 during the year:				
Receivables and payables				
West Sussex PCT	**78**	**-**	324	-
West Kent PCT	**275**	**50**	-	458
Medway PCT	**166**	**13**	3	89
Surrey PCT	**41**	**-**	311	5
Eastern & Coastal Kent PCT	**-**	**142**	584	-
Croydon PCT	**133**	**-**	-	-
London Specialised Commission Group	**74**	**-**	-	-
South East Coast Strategic Health Authority	**42**	**-**	2	-
Bromley PCT	**29**	**-**	1	-
Bexley Care Trust	**-**	**35**	-	20
Isle Of Wight NHS PCT	**5**	**-**	-	2
Guy's And St. Thomas's NHS Foundation Trust	**263**	**15**	102	19
Hampshire PCT	**191**	**-**	107	-
National Health Service Logistics Authority	**-**	**26**	-	86
Maidstone And Tunbridge Wells NHS Trust	**78**	**254**	10	325
Dartford And Gravesham NHS Trust	**2**	**62**	2	31
Medway NHS Foundation Trust	**-**	**25**	-	85
East Sussex Hospitals NHS Trust	**34**	**105**	1	176
NHS Litigation Authority	**-**	**-**	-	-
South East Coast Ambulance Service NHS FoundationTrust	**1**	**26**	-	43
Brighton And Sussex University Hospitals NHS Trust	**25**	**22**	160	101
Other	**869**	**419**	631	1,637
	2,306	**1,194**	2,238	3,077

28. Intra-Government and Other Balances

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

At 31 March 2010	Receivables: amounts falling due within one year £000	Receivables: amounts falling due after more than one year £000	Payables: amounts falling due within one year £000
Balances with NHS bodies	**2,092**	48	2,271
Balances with other government bodies	**98**	-	806
Balances with bodies external to government	**1,149**	-	2,316
	3,339	**48**	**5,393**

29. Losses and Special Payments

Losses and special payments are calculated on an accruals basis.

There were 40 cases of losses and special payments totalling £134,000 approved during 2010/11, (38 cases totalling £13,000 in 2009/10). The increase in losses compared to the previous year was due mainly to the writing off of irrecoverable debts owed by Welsh Health Service bodies.

There were no fraud cases.

30. Financial Risk Rating

Monitor, the independent regulator of Foundation Trusts, assigns a risk rating on a scale of 1 to 5 to each Foundation Trust. 1 reflects the highest level of risk and 5 the lowest. The rating is based on a basket of financial ratios, each of which has its own weighting. Ratios based on Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) are calculated after excluding impairments and restructuring costs. In 2010/11 the Trust achieved an overall rating of 5 (subject to confirmation by Monitor), (2009/10, 4), having over-performed by 35% against planned EBITDA, (2009/10, underperformed by 12%).

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

	2010/11 £000	2009/10 £000
Surplus from Statement of Comprehensive Income	**(1,427)**	(1,044)
Add back:		
Impairments of property, plant and equipment	**3,454**	1,999
Restructuring costs	**739**	-
Surplus for risk rating	**2,766**	955

6.0 Annexes

Annex A: Statement on Internal Control

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of QVH, 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 QVH for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. The trust is committed to supporting its staff in exercising their roles and responsibilities with regard to health and safety and all other forms of risk. This implementation requires varying levels of training across the trust.

The trust's risk and incident management policy is available to all staff and training is in place to ensure staff are fully briefed on the policy. During 2010 the trust has worked with an external company to further review our approach to risk management. This has involved staff at all levels and the outcomes further informed our risk strategy and supported the development of a vision for patient safety which has been communicated to all staff.

The management structure of divisional managers and matrons have responsibility for service areas as well as patient pathways. This matrix structure allows for transfer of good practice between the clinical directorates.

The risk and control framework

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

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

The trust's risk management strategy is executed via the trust's risk identification and management policy, which:

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

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

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

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

The assurance framework comprises the following elements:

- Principal risks – currently the framework incorporates the trust's six key strategic objectives in individual sections, with the specific risks set out under each key strategic objective. Risks are scored using the 5 x 5 matrix, with all risks rated 12 or above being reported to the board on a monthly basis.
- Key controls – the internal and external key controls that are currently in place to mitigate against the risks identified. Any gaps in control are also identified and referenced to specific risks on the Trust's risk register. The updated document during 2010/11 has included actions required where any gaps in controls are identified.
- Sources of assurance – these are the sources of assurance currently available for each area of risk. Any gaps in assurance are also identified.

The assurance framework also identifies the key performance indicators for each principle risk and the residual risk for each risk.

The trust also has a comprehensive risk register in place that supports the assurance framework. The register includes both clinical and non-clinical risks, with action plans and timescales in place for addressing the risks. The risk register is managed by the trust's risk and security manager and is reviewed regularly by the clinical directorates and quality and risk committee.

During the year the assurance framework is reviewed and updated by the executive leads responsible, and is reviewed by the quality and risk committee, audit committee and the board.

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

The risk management policy and associated procedures set out the framework and systems for implementation of risk and governance in the trust. These processes are evidenced within the Care Quality Commission regulations.

The integrated risk management agenda reflects the organisation's core business. The trust seeks to learn from issues raised and implement good practice at all levels. The board receives regular reports on quality and risk, including trends analysis and benchmarking (e.g. National Reporting & Learning Service reports and Care Quality Commission standards). Adverse events are reviewed, investigated, analysed and reported back throughout the organisation. Learning from complaints and claims is also shared across the organisation.

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

In respect of maintaining registration with the Care Quality Commission, a robust assessment of compliance against their outcomes has been undertaken and systems and processes are in place to provide management and board assurance.

The trust is fully compliant with the Care Quality Commission essential standards of quality and safety.

Since the adoption of the assurance framework, the executive team has fully embedded risk management in the activities of the organisation. Directors and managers have been required to identify risks within their areas of responsibility and to establish, in conjunction with the relevant managers, effective control measures and/or systems. The risk register is managed by the risk team and has involved board members and staff in its development to ensure it represents an accurate assessment of the risks facing the organisation.

The following actions have been taken to address gaps in control identified in the assurance framework:

- Corporate objectives are assigned to an executive director, and performance against these is assessed on a regular basis
- The assurance framework is reviewed regularly through the quality and risk committee, audit committee and the board.

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

- The assurance framework linked the main elements and aims of the trust's internal control and governance policies. The framework consists of the following key elements:
  - o Principal risks: the risk management policies sought to identify the main risks which might impede the trust in achieving its objectives and to keep these under review by the trust board.
  - o Key controls / treatments: these were the mechanisms for controlling the risks that have been identified.

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

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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. These include an equality, diversity and human rights steering group that meets regularly; regular monitoring of data; the roll-out of a programme of impact assessments and associated training; and equality and diversity reports, presentations and training for the trust board.

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

The trust's information governance strategy sets out a number of high level information governance principles with particular regard to confidentiality, integrity and availability of information. During the year the trust has established a new senior information risk owner (SIRO) role and has introduced enhanced requirements for encryption. Information governance is delivered through the trust's information security policy.

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

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

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

We have a robust business planning process that involves comprehensive meetings with the clinical directorates to determine the business plans for the coming year. For 2010/11 the emphasis continued to focus on the planning of clinical activity and the establishment of the activity plans for the next three years and the process had far more involvement from clinicians than in previous years.

QVH has strong financial management arrangements in place with a comprehensive finance and performance report presented to the board on a monthly basis which include key performance indicators for productivity and efficiency gains. Following the review of the trust's management structure, monthly business review meetings and quarterly performance review meetings with the clinical directorates have been introduced.

During the year, QVH continued to develop its service line reporting by reviewing the profitability of the sub-specialties within each of the clinical directorates. A number of the key corporate objectives for clinical directorates have been based on the outcome of service line reporting.

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

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

During the year, QVH has developed a number of key performance indicators and a score card to assist the clinical directorates in monitoring their performance. The trust also continues to undertake weekly activity reporting.

QVH is reviewing its use of natural resources and is developing a strategy to reduce its carbon footprint. This strategy will introduce four key actions to address a sustainable development management plan, ensure sign up to best practice models, ensure close monitoring of carbon usage and promote awareness within the organisation.

Annual quality report

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

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

- Quarterly updates to the quality and risk committee on progress against priorities identified in the 2009/10 quality accounts
- Monthly updates to clinical cabinet and the board of directors on metrics (including MRSA, cancer 62 days and 18 weeks refer to treatment targets)
- The clinical outcomes group receiving speciality information/ audit and national audit outcome data.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive mangers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and risk committee. In addition, I have drawn on work carried out by those three bodies in respect of their duties with regard to scrutiny of the systems of internal control in place at the trust. I am confident that no significant issues or gaps exist in internal controls and the board and its committees concur with that conclusion. Where weaknesses have been identified through management or internal audit work, plans are put in place to address these and ensure continuous improvement.

The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the work of the trust's internal and external auditors, and the systems and processes for assurance against CQC standards for registration purposes. The assurance framework is continually reviewed and updated by the trust throughout the year to ensure that it reflects the key risks currently relevant to the trust.

This evidence also gives assurance on the effectiveness of internal controls in relation to the production of the quality accounts. In line with Monitor's recent guidance, the trust will be undertaking a specific review on the quality accounts processes in 2011/12 and will ensure any resulting actions are addressed.

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

- The trust met all performance and waiting list targets except those described in the performance section* for which the trust has undertaken full reviews and implemented action plans where necessary.
- Financial performance delivered a surplus of £2.8m before impairments and transformation costs (£1.4m loss after technical adjustment for impairment of fixed assets)
- The number of claims and complaints received by the trust remains low and consistent with previous years.
- Monthly board performance and financial performance reports
- A rating of 'significant' assurance given in the head of internal audit's opinion on the effectiveness of the systems of internal control
- Minutes of quality and risk committee and audit committee reported to the board
- Ongoing update and approval of the assurance framework
- Regular review and reports on the position of the corporate risk register
- Review of the trust's governance and management arrangements.

*It should be noted that the failure to meet the targets related to healthcare associated infections should be viewed in the context of the very low trajectories set (MRSA – two instances against a trajectory of one; *Clostridium Difficile* – six instances against a trajectory of four, with all instances being isolated cases) and the trust's excellent record for infection control. Similarly, the trust's Q4 amber-red governance rating, which relates primarily to performance against the *Clostridium Difficile* target, is not indicative of any weaknesses in the trust's internal controls.

The trust's annual information governance toolkit submission revealed some weaknesses relating to the requirement that information governance awareness and mandatory training procedures are in place and all staff are appropriately trained. A national extension has been agreed to 30 June 2011 to allow trusts to meet this requirement. In addition, there were a number of other requirements where gaps in evidence were present but the trust was able to address these in time for the toolkit submission date of 31 March 2011. The board was apprised of this situation in March.

Conclusion

At the end of the year there are no known significant internal control issues for the trust.

Amanda Parker
Acting Chief Executive (on behalf of the Board)
2 June 2011

Annex B: Performance against national targets

National priority indicators	Measure	Target	2010/2011
Clostridium difficile infection	Count	<=4 per year	6 R
MRSA bacterium	Count	<=1 per year	2 R
18 week referral to treatment times – admitted	% treated in 18 weeks	>90%	92.4% G
18 week referral to treatment times – admitted	Median	<=11.1	10.0 G
18 week referral to treatment times – admitted	95 percentile	<=27.7	20.8 G
18 week referral to treatment times – non admitted	% treated in 18 weeks	>95%	97.5% G
18 week referral to treatment times – non admitted	Median	<=6.6	7.6 R
18 week referral to treatment times – non admitted	95 percentile	<=18.3	16.7 G
18 week incomplete pathway	Median	<=7.2	7.4 R
18 week incomplete pathway	95 percentile	<=36	17.1 G
Cancer – 2 week wait	%	>93%	97.9% G
Cancer – 31 day diagnosis to treatment – 1st treatment	%	>96%	97.9% G
Cancer – 31 day diagnosis to treatment – sub treatment	%	>94%	96.3% G
Cancer – 62 day diagnosis to treatment	%	>85%	94.3% G
Cancer – 2 week wait	Count	N/A	9
Cancer breaches – 31 day target – 1st treatment	Count	N/A	10
Cancer breaches – 31 day target – sub treatment	Count	N/A	16
Cancer breaches – 62 day target	Count	N/A	6
Cancelled operations for non-clinical reasons	Count	N/A	78
Theatre cancellations on day of operation	Count	N/A	559
Theatre cancellations not admitted within 28 days	Count	Zero	0 G
Data quality – ethnic origin	%	N/A	86.88% G
>26 week waiters	Count	Zero *	0 G
>13 week waiters	Count	Zero *	0 G
A&E >4 hours wait %	%	98%	99.22% G
A&E >4 hours wait number	Count	N/A	106
Delayed transfers of care – acute only	Count	N/A	23

* No longer an NHS target

Annex C:
Remuneration report (audited section)

Salary and pension entitlements of senior managers								
A. Remuneration	**1 April 2010 to 31 March 2011**				**1 April 2009 to 31 March 2010**			
Name and title	Salary (Bands of £5,000) £000	Performance-related bonus (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Benefits in kind Rounded to the nearest £100	Salary (Bands of £5,000) £000	Performance-related bonus (Bands of £5,000) £000	Other remuneration (Bands of £5,000) £000	Benefits in kind Rounded to the nearest £100
P Griffiths Chairman	40-45	0	0	0	40-45	0	0	0
J Beech Non Executive Director	10-15	0	0	0	10-15	0	0	0
R Leach Non Executive Director	10-15	0	0	0	10-15	0	0	0
H Ure Senior Independent Director and Deputy Chairman	15-20	0	0	0	15-20	0	0	0
S Winning Non Executive Director	10-15	0	0	0	10-15	0	0	0
A Bull Chief Executive	140-145	0	0	0	140-145	0	0	0
T Bolot Interim Director of Finance	0	0	0	0	115-120	0	0	0
R Hathaway Director of Finance and Commerce	100-105	0	0	0	0	0	0	0
K Lavery Medical Director	10-15	45-50	135-140	0	10-15	45-50	135-140	0
A Parker Director of Nursing and Quality	90-95	0	0	0	60-65	0	20-25	0
M Sherry Director of Performance, Technology and Innovation	70-75	0	0	0	65-70	0	0	0

Mr Ken Lavery, Medical Director, receives a clinical excellence award based on clinical performance. This is assessed and awarded nationally. Other executive directors' remuneration does not comprise a performance-related element.

Salary and pension entitlements of senior managers							
B. Pension benefits							
Name and title	Real increase in pension at age 60	Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2011	Lump sum at age 60 related to accrued pension at 31 March 2011	Cash equivalent transfer value at 31 March 2011	Cash equivalent transfer value at 31 March 2010	Real increase in cash equivalent transfer value
	(Bands of £2,500) £000	(Bands of £2,500) £000	(Bands of £5,000) £000	(Bands of £5,000) £000	£000	£000	£000
A Bull Chief Executive	0-2.5	5-7.5	15-20	55-60	359	423	(64)
R Hathaway Director of Finance and Commerce	0-2.5	5-7.5	25-30	75-80	355	380	(25)
K Lavery Medical Director	0-2.5	2.5-5	70-75	210-215	See note below	1,805	0
A Parker Director of Nursing and Quality	2.5-5	10-12.5	25-30	75-80	423	407	16
M Sherry Director of Performance, Technology and Innovation	0-2.5	2.5-5	25-30	80-85	525	523	2

Notes

1. As non executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non executive directors. This applies also to T Bolot.
2. A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.
3. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
4. Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
5. K Lavery reached normal retirement age during the year. His pension, therefore, now has no CETV.
6. The following directors joined the board during the year: R Hathaway (April 2010).
7. M Sherry left the board in December 2010.
8. This report is audited as part of the audit of the annual accounts 10/11.

Amanda Parker
Acting Chief Executive (on behalf of the Board)
2 June 2011

Annex D:
Board of directors register

Name, title and appointment	Meeting attendance and role 2010/11			
	Board of directors	Audit committee	Nomination and remuneration committee	Quality and risk committee
Peter Griffiths: Chairman 1 April 2005 to 31 March 2012	11 of 11 Chairman	–	3 of 3 Member	–
Hugh Ure: Senior Independent Director 1 October 2005 to 30 September 2011	9 of 11 Deputy Chairman	6 of 6 Member	3 of 3 Chairman	–
Jeremy Beech: Non Executive Director 1 October 2005 to 30 September 2012	11 of 11	–	3 of 3 Member	4 of 4 Chairman
Renny Leach: Non Executive Director 1 January 2007 to 31 December 2012	11 of 11	–	3 of 3 Member	3 of 4 Member
Shena Winning: Non Executive Director 1 October 2005 to 30 September 2012	11 of 11	6 of 6 Chair	3 of 3 Member	–
Adrian Bull: Chief Executive December 2008 to present	11 of 11	2 of 6 In attendance as required	3 of 3 Member	4 of 4 Member
Ken Lavery: Medical Director November 2007 to present	8 of 11	–	–	3 of 4 Member
Richard Hathaway: Director of Finance and Commerce April 2010 to present	10 of 11	6 of 6 In attendance	–	3 of 4 Member
Amanda Parker: Director of Nursing and Quality August 2009 to present	7 of 11	–	–	3 of 4 Member
Mary Sherry: Director of Performance, Innovation and Technology August 2009 to December 2010	8 of 8	–	–	–

Annex E: Board of directors biographies

Peter Griffiths, Chairman

Peter Griffiths has spent his entire career in healthcare.

His last executive appointments within the NHS were as Deputy Chief Executive for the Management Executive at the Department of Health and Chief Executive of Guys & Lewisham First-Wave NHS Trust.

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

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

Peter is also Chairman of the Foundation Trust Network Board.

Dr Adrian Bull, Chief Executive

Adrian became Chief Executive of Queen Victoria Hospital NHS Foundation Trust on 15 December 2008.

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

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

Richard Hathaway, Director of Finance and Commerce

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

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

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

Mr Ken Lavery, Medical Director

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

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

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

Amanda Parker, Director of Nursing and Quality

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

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

Amanda brings strong academic and operational experience to the role. She is a Registered Nurse Teacher with an MA in nursing and education, has an MSc in surgical and perioperative care and completed her MBA in 2010.

Hugh Ure, Non Executive Director

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

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

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

Jeremy Beech, Non Executive Director

Jeremy Beech from Frittenden in Kent is a consulting engineer.

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

Jeremy is also Non Executive Chairman of MKC Training Services Ltd and Vice Chairman of the Kent Foundation.

At QVH, Jeremy is Chairman of the Quality and Risk Committee.

Dr Renny Leach, Non Executive Director

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

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

Shena Winning, Non Executive Director

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

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

At QVH, Shena is Chairman of the Audit Committee.

Annex F: Board of governors register

Governor	Constituency	Term	Meetings attended (4)
Bernard Atkinson	Public	Re-elected 2008 to 2011	3
Len Barlow	Public	Re-elected 2008 to 2011	4
Stuart Barnett	Public	Re-elected 2008 to 2011	1
Gillian Baxter	Public	Elected 2008 to 2011	0
Edward Belsey	Public	Elected 2009 to 2012	4
John Bowers	Public	Re-elected 2008 to 2011	3
Gillian Brack	Public	Elected 2009; resigned October 2010	3
Patricia Brigden	Public	Elected 2010 to 2013	2
Sarah Creamer	Stakeholder: NHS West Sussex	Appointed 2008; resigned June 2010*	0
Arthur Crow	Public	Elected 2010; resigned August 2010	1
Mabel Cunningham	Staff	Elected 2008 to 2011	3
Roy Daisley	Stakeholder: University of Brighton	Re-appointed 2007 to 2010**	0
Peter Dingemans	Public	Re-elected 2008; resigned October 2010*	2
Peter Evans	Stakeholder: Local Authority	Re-appointed 2009 to 2012	1
Adrian Fuchs	Public	Elected 2008 to 2011	4
Brian Goode	Public	Elected 2010 to 2013	3
Princess Goodwin	Public	Elected 2010; resigned August 2010	0
Peter Harper	Public	Elected 2008 to 2011	0
Bill Hatton	Public	Re-elected 2008 to 2011	1
Caroline Hitchcock	Public	Re-elected 2008 to 2011	4
Ann Horscroft	Public	Re-elected 2007 to 2010	1
Sue Hull	Public	Elected 2008 to 2011	3
Valerie King	Public	Re-elected 2008 to 2011	3
Carol Lehan	Staff	Elected 2008 to 2011	3
Shirley Mitchell	Public	Re-elected 2008 to 2011	3
Moira McMillan	Public	Elected 2010 to 2013	3
Christian Petersen	Staff	Elected 2010 to 2013	2
Martin Plimmer	Public	Re-elected 2008; resigned June 2010	1
Derek Pocock	Stakeholder: League of Friends	Re-appointed 2009 to 2012; resigned 2010	2
Andrew Robertson	Public	Elected 2009; resigned June 2010 to take on stakeholder governor position	1
Andrew Robertson	Stakeholder: League of Friends	Appointed 2010 to 2013	3
Chris Rolley	Stakeholder: East Grinstead Town Council	Re-appointed 2010 to 2013	4
Manya Sheldon	Public	Elected 2009 to 2012	4
Ian Stewart	Public	Elected 2008 to 2011	4
Alan Thomas	Public	Elected 2009 to 2012	4
Alison Tweddle	Public	Re-elected 2007 to 2010	1
Jill Walker	Public	Elected 2008 to 2011; resigned 2010	1
Sharon Watkinson	Public	Re-elected 2007 to 2010	1

Annex G: Disclosures

Directors' disclosures

Statement of disclosure to auditors

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

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

- made such enquiries of his fellow directors and of the NHS foundation trust's auditors for that purpose; and
- taken such other steps (if any) for that purpose as are required;

by his duty as a director of the NHS foundation trust to exercise reasonable care, skills and diligence.

Going Concern

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

The accounts have been prepared under a direction from Monitor.

Accounting policies for pensions and other retirement benefits are set out in note 1.2 to the accounts and details of senior employees' remuneration can be found on page 87 of the Annual Report.

Information governance

QVH takes seriously its role in the protection of confidential data and the security of its systems. Regular checks and audits are undertaken to ensure compliance with relevant legislation and all members of staff are required to undertake information governance training. QVH had no significant breaches of data security during 2010/11.

As a key part of the information governance agenda, the Department of Health and the NHS Connecting for Health jointly produce an information governance toolkit. The toolkit is made available to assist organisations to achieve the aims of information governance, and currently encompasses:

- Information governance management
- The Confidentiality NHS Code of Practice
- Data Protection Act 1998
- Information security
- Information quality
- Records management
- Freedom of Information Act 2000.

QVH achieved a score of 65% for its 2010/11 submission and was graded satisfactory in all but one key requirement. Through dedicated resourcing and a proactive campaign to improve awareness in key areas the trust expects to improve significantly on this in 2011/12.

Information governance incidents 2010/11	
Type	Number
Misfiled documentation	4
Misplaced documentation	12
Breach of confidentiality (minor)	2
Misdirected confidential information	3

Other disclosures in the public interest

Communication and information giving actions are described in section 2.9. In addition, formal consultation is described in the trust's change management policy which was reviewed in 2009/10 and re-launched in April 2010.

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

A formal consultation exercise began in March 2010 which related to a review of the orthodontic service. A redundancy consultation exercise was run between May and August 2010, resulting in 11 redundancies, three of which were compulsory. The last one, an executive director, secured suitable alternative employment and a redundancy payment was not required.

The trust reports sickness absence data quarterly via the health and safety committee and monthly at the people, quality and capital meeting and the trust board of directors meeting. QVH has had a steady average of 3.5% sickness absence over the last four years which is below the NHS average. Seasonal variations are noted (i.e. higher in winter, lower in summer). Figures given for sickness absence are calendar year figures.

Statement of compliance with the NHS Foundation Trust Code of Governance

The Board of Directors of QVH confirms that the trust complies with the provisions of the NHS Foundation Trust Code of Governance.

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