ANNUAL REPORT AND ACCOUNTS

1st April 2010 – 30th November 2010

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1. Introduction

This report covers the financial period from 1st April to 30th November 2010, the final eight months as an NHS Trust prior to being licensed as a Foundation Trust.

Trust Profile

Ashford and St Peter's Hospitals NHS Trust was originally established in1998 from the merger of Ashford and St Peter's Hospitals. The Trust is now the largest provider of acute hospital services in Surrey and over the last two years has made a series of significant improvements during its journey towards becoming a Foundation Trust.

Ashford and St Peter's Hospitals NHS Trust serves a population of over 380,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow, Surrey Heath and beyond. We employ around 3500 staff and from April – November 2010 our turnover was £149.6m.

The Trust provides a whole range of services across its two hospital sites - Ashford Hospital, situated along the A30 close to the border with Hounslow, and St. Peter's Hospital in Chertsey. The majority of planned care, like day case and orthopaedic surgery and rehabilitation services is provided at Ashford hospital, with more complex medical and surgical care and emergency services at St. Peter's Hospital (more detail on the Trust's services is given on page 6).

Statement by the Chairman and Chief Executive

The first eight months of 2010/11 marked the final stages in our application to become a Foundation Trust. Staff have worked continuously hard to provide high quality, safe care for our patients which has culminated in Monitor giving us a licence to act as a Foundation Trust from 1st December 2010.

This has been a challenging process but our application to become a Foundation Trust was well received by Monitor and we were also the first Trust to pass through their newer and tougher standards for quality. This makes our achievement all the greater and something that we share and take pride in with every member of our staff.

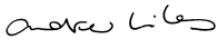
There is no doubt that Ashford and St Peter's is a safe place to receive care and treatment and patients can be assured of high quality care across our very wide range of disciplines and specialties. The Dr Foster Good Hospital Guide, published in November 2010, confirmed that we continue to have low mortality rates, and we were rated as joint fifth in the country for the lowest mortality rates for the most common causes of death in hospital – pneumonia, heart failure, heart attacks, stroke and falls.

During these past eight months we have continued to work with staff to embed our four values (*Patients first; Personal responsibility; Passion for excellence;* and *Pride in our team)* and associated behaviours and to focus strongly on improving patient experience across both our hospitals. We have also continued to develop our clinical services with increasing emphasis on good quality clinical leadership.

As we look to the final four months of this financial year we will be working to embed our new governance arrangements as a Foundation Trust and to develop our relationships with our new Governors and our members. Our driving force will continue to be making further improvements for our patients and the framework of being a Foundation Trust will help us to do that. We are ambitious for our patients and for our hospitals and will continue to work towards achieving our overall aim of becoming one of the best hospital trusts in the country.

Finally, we would like to underline our thanks to everyone who has made a contribution over the last year; to our staff in particular, but also to colleagues in primary care, at the primary care trusts and other NHS Trusts, our partners in local voluntary and community organisations, carers, both hospitals' Leagues of Friends, Hospital Radio Wey, patient representatives, not to mention all those who give up their time to raise funds for our hospitals. Thank you for all your support and co-operation.

Aileen McLeish
Chairman



Andrew Liles
Chief Executive

2. Directors' Report and Management Commentary

Management Commentary

Introduction

The Directors present their annual report for the last eight months as an NHS Trust (1st April – 30th November 2010) together with the audited financial statements for this period. The Directors' report incorporates a management commentary giving a general analysis of the development and performance of the Trust over the past eight months including a summary of our performance against our corporate objectives.

Overview

Overall 2010/11 was a successful year, the Trust having delivered well against its corporate objectives (see p. 9 for more details) and met its financial and statutory duties. During these first eight months the Trust reported a surplus of just under £3.2 million which represents the majority of our planned surplus for the full financial year (which closed at £3.3 million).

The Trust began the year with an unconditional registration by the Care Quality Commission and has continued to score well against quality and performance standards. The Trust continues to report a lower than average standardised mortality rate with the joint fifth lowest ratio nationally for a 'basket' of the most common causes of death in hospital – stroke, heart attack, congestive heart failure, pneumonia and falls (source: Dr Foster Good Hospital Guide 2010).

The Trust has also worked hard to deliver substantial improvements in other key areas; for example, by the end of the year we were operating on 96% of patients with a fractured hip within 36 hours of admission (compared to only 52% last year) and are now one of the best performing Trusts in the country in this area. We have made significant improvements in reducing the number of falls in hospital, another important indicator of quality and safety, and were also rated as the 7th best Trust in the country for the number of operations we carry out as day surgery, an indicator of good surgical practice.

The Trust has also put a lot of focus on improving patient experience over the last year and has seen good improvements in recent patient surveys, particularly in maternity services and paediatrics. The recently published inpatient survey results (for 2010) also show good overall improvements moving the Trust from the bottom 20% of acute trusts nationally to the middle 60% overall. In addition the Trust has achieved its best ever staff survey results with one of the highest response rates in the country.

This success is set against a background of some challenge. The 2010/11 Operating Framework set out two key financial challenges for hospitals – a 0% increase in the acute tariff, and a 30% marginal payment only for any emergency activity above 2008/09 levels. In addition, the Operating Framework called for an increased focus on quality, more integration of services across the different health sectors and further emphasis on providing more services closer to where people live.

NHS Surrey, the Trust's main commissioner, has also been under severe financial pressure during the year, and this is likely to continue into 2011/12. In November NHS Surrey introduced some urgent measures in order to reduce their forecast deficit including *Fast, Steady, Stop*, an initiative to make sure future referrals are clinically appropriate and that approved procedures are all considered clinically effective. This included a new approvals process for a range of common procedures, established clearer referral management but maintained fast access to urgent and life saving treatments.

In addition, the Trust – in line with the rest of the local health economy – has been experiencing severe pressure on capacity with the usual winter pressures beginning much earlier in the autumn. There have been continuing high numbers of elderly, frail patients needing hospital admission, often with complex conditions which need a longer hospital stay. However, despite these pressures, staff have risen to the challenge, maintaining their professionalism at all times and often working many additional hours to make sure patients continued to be treated safely and appropriately. The Trust has also received good support from external colleagues in social and community services, primary care and others, often resulting in improved working arrangements.

Many of these challenges are best met by working more proactively with other NHS and social care partners. As a result, and also in readiness for the changes anticipated from the Government's draft Health and Social Care Bill, the Trust's strategic work over the last year, and going forward, is focused on greater involvement with partners in North West Surrey, through a local Transformation Board. Part of this work is to develop a new model of care for local patients, to reduce emergency admissions, deliver more care into the community and integrate services in a better way across acute, community and primary care. More details are given on p. 21.

Principle activities

The Trust continues to provide the following hospital services to its catchment population:

- Admitted patient care for planned and emergency treatment
- Non-admitted patient care
- Accident and emergency
- Critical care

These are provided across the following range of specialties split across the two main hospital sites as follows:

Ashford Hospital

- day-case surgery
- stroke and rehabilitation care
- elective orthopaedic surgery
- ophthalmology
- outpatients (including paediatrics) and diagnostics; X ray, ultrasound, endoscopy (using cameras to look inside the body) and MRI scans

St. Peter's Hospital

- accident and emergency services
- intensive care
- emergency surgical and medical care
- elective and day-case surgery
- orthopaedics (Rowley Bristow unit)
- specialist brain injury unit
- maternity care
- paediatric services (children's services)
- neonatal intensive care unit which provides care for acutely ill babies
- outpatients and diagnostics; X ray, ultrasound, CT scans, endoscopy and MRI scans
- pathology services

Staff from Ashford and St. Peter's also run many specialist clinics in the community.

Activity review

Over the last three years the Trust has seen the overall number of patients treated increase year on year to a total figure of over half a million attendances in 2010/11 (compared to around 415,000 in 2008/09).

From 1st April – 30th November 2010 this equated to around 360,000 attendances across all activity types.

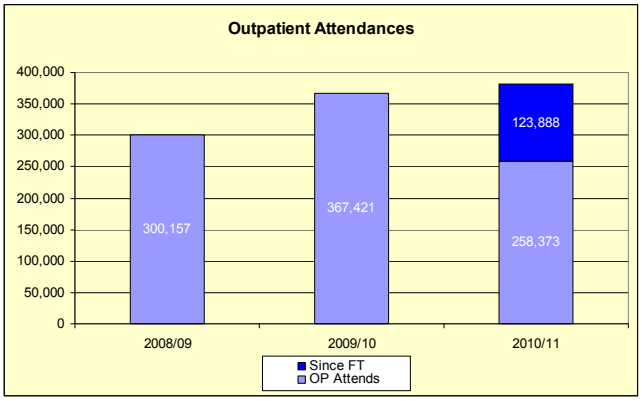
Over the year, the Trust has seen increases in the number of outpatient attendances, a small increase in the number of emergency admissions and in the number of births. An extremely busy winter period resulted in the Trust experiencing continuing high numbers of emergency admissions and, with a revenue cap on these numbers going forward, together with new caps on readmission rates, reducing these numbers will be a key focus going forward.

There has been a slight decline in the number of A&E attendances reported compared to last year, although this is partly explained by the transfer in July 2009 of the Walk-in Centre at Ashford Hospital to Greenbrooks Healthcare.

The Trust continues to perform well in terms of day case activity across specialties in line with good practice, and last year was rated 7th best in the country for day case rates. Overall, the number of planned procedures undertaken by the Trust was slightly down compared to 2009/10 and increasing elective activity will be a further focus for the Trust in the coming year. The improved reputation of our maternity services has encouraged more mothers to choose St Peter's and we are now seeing an increase in the number of births.

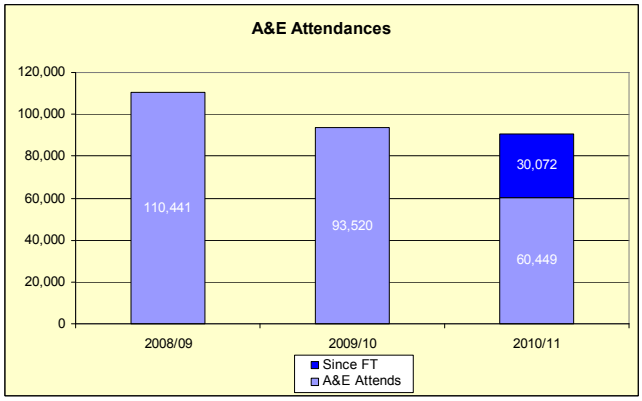
The following graphs demonstrate these overall trends, breaking down 2010/11 figures to show the Trust's activity for this reporting period (1st April – 30th November).

Fig. 1: Outpatient Attendances



Note: the increase in outpatient attendances from 2008/09 to 2009/10 is partly due to different recording processes. In 2008/09 most midwifery appointments were not included in outpatient figures (but were from 2009/10 onwards). In addition, physiotherapy services were brought into the Trust from NHS Surrey in 2009/10 which also adds to the figures shown.

Fig. 2: A&E Attendances



Note: A&E figures for 2008/09 included 24,807 attendances at the Ashford Walk-in Centre, and 6,585 in 2009/10 (before it transferred to Greenbrooks in July 2009).

Fig. 3: Emergency Admissions

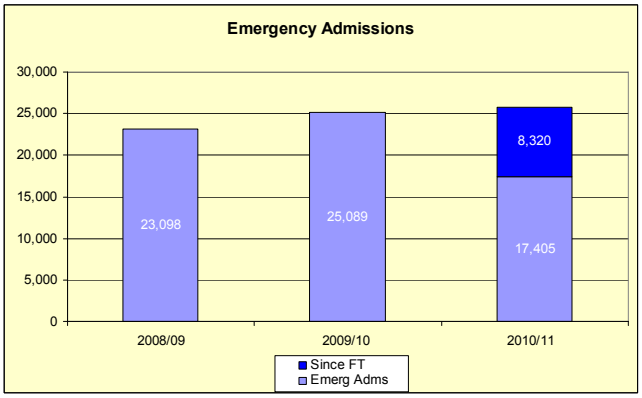


Fig. 4: Day Case Procedures

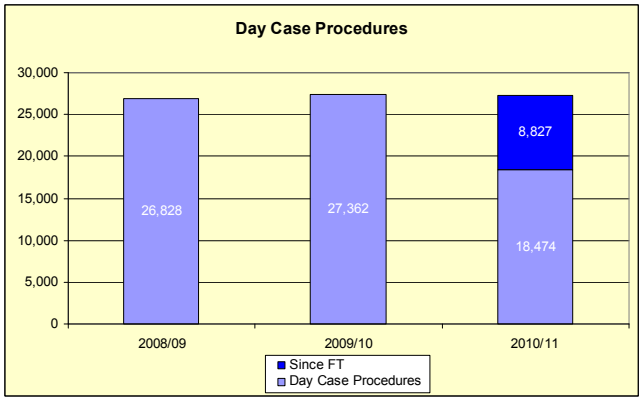


Fig. 5: Births

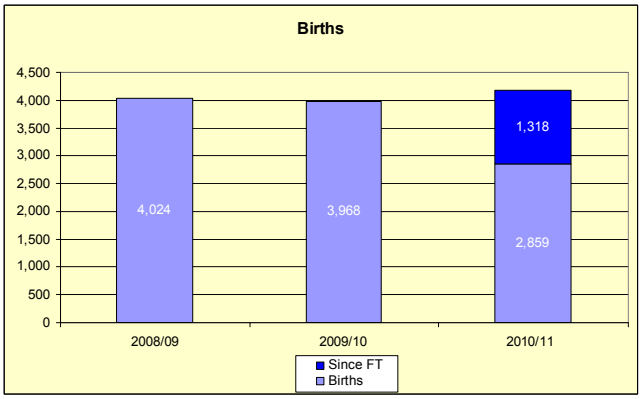
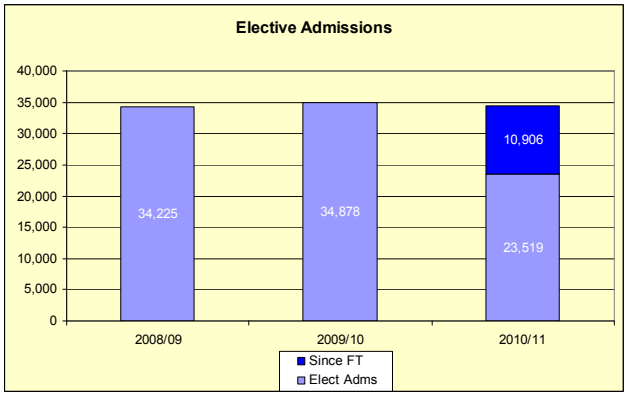


Fig. 6: Elective Admissions



Our vision and strategy

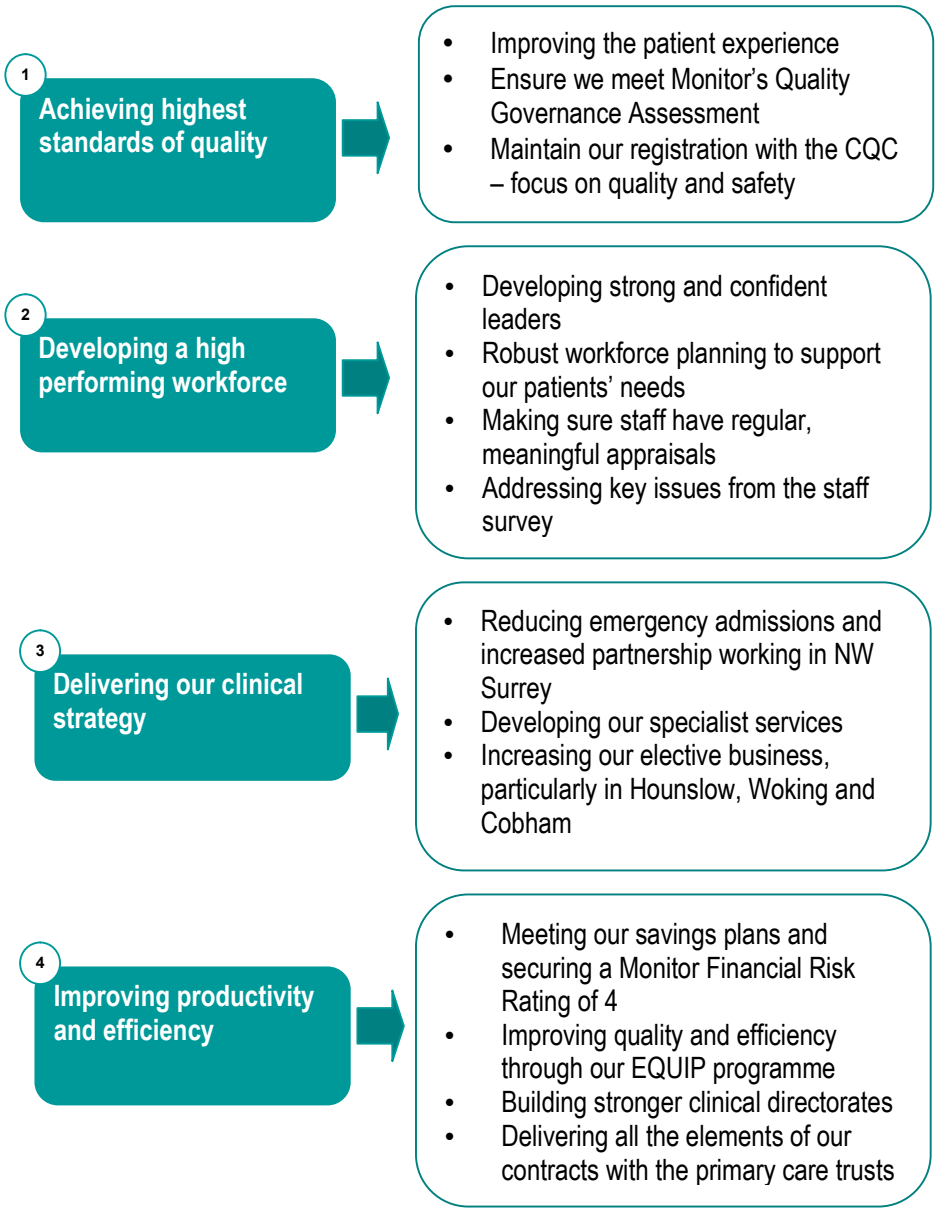
Our vision is to be one of the best healthcare Trusts in the country. In our 5 year Foundation Trust business plan we set out our four strategic objectives to deliver this vision - having the highest standards of quality, a high performing workforce, delivering our clinical strategy and improving productivity and efficiency. Since then, we have worked to develop a set of values with staff and patient representatives - the 4 Ps – which will guide us in *how* we realise our vision and objectives:

- Patients first
- Personal responsibility
- Passion for excellence
- Pride in our team

Progress against our corporate objectives

Our objectives for 2010/11 were developed within the context of our four strategic objectives (as set out below), the NHS Operating Plan for 2010/11 and our contract with NHS Surrey, our main commissioner. In summary, our plan for the year was as follows:

Fig. 7: Corporate objectives 2010/11



Corporate objective 1: Achieving the highest standards of quality

The following section gives an overview of the Trust's performance in terms of quality and safety, with particular emphasis on improving the patient experience.

Improving the patient experience

One of our key objectives during 2010/11 was to make real improvements to patient experience, and we did this in a number of ways:

Using patient feedback to drive improvements

We have improved the way we use patient feedback, bringing the various strands together to make sure the right learning takes place and that it is fed back to patients and the wider public.

Using patient stories – we invited individual patients to present their 'story' – good or bad - to the Trust Board so members were able to hear their individual experiences. This proved extremely valuable and we will expand this concept through a new programme called '*Living our Values'* over the next year to expose all members of staff to the emotions experienced by our patients.

Your Feedback - we introduced a new Feedback questionnaire giving all our discharged patients an opportunity to report their individual experiences. Ward teams were asked to discuss the feedback and develop actions in response. By 30 November 2010 we had received 1,758 forms and over the year there has been an increasing number of patients saying they would recommend us to family and friends.

National surveys – during the year the Trust participated in a number of national patient surveys although the results of the national inpatient survey for 2010 were not published during this reporting period. Our results from a national mothers' survey of maternity services showed marked improvements compared to a similar survey in 2007 when we were rated in the bottom 20% of Trusts (more detail on p. 13) and we also had good results in the national paediatric survey and in a peer review of our paediatric cancer services.

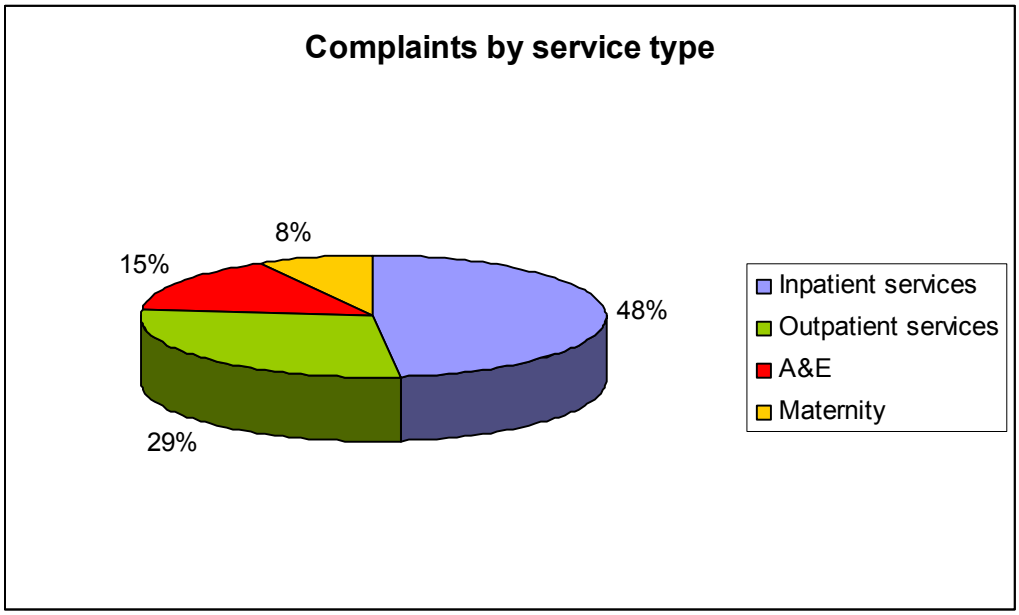
PALS (Patient Advice and Liaison Service) - between 1st April and 30th November our *Patient Advice and Liaison Service* had 951 contacts, 87% of which were resolved quickly.

As a direct result of issues raised through PALS we have taken a number of actions. For example we:

- have improved our discharge process to ensure that where patients live only with an elderly person, their discharge will be handled as though they live alone and they won't be discharged after 6pm.
- have improved our Ophthalmology appointment system to reduce cancellations and waiting times.

Learning from complaints - during the reporting period the Trust received 234 formal complaints, a 13% decrease in the number received during the same period in 2009/10 (267). The Trust achieved a 97.5% response rate within agreed timescales which reflects six missed deadlines. Fig. 8 illustrates the complaints received by service type:

Fig. 8: Complaints by service type



The main themes emerging from complaints were issues around communication with medical and nursing staff, clinical decisions and treatment. As a direct result of complaints we have taken a number of actions. For example we:

- introduced a series of discharge road-shows to help improve our discharge planning process
- introduced portable workstations for instant access to web-based interpreting services, to help ensure patients whose first language is British Sign Language receive full support and explanations ensuring safer, better care
- reviewed the consent process for certain surgical procedures along with a review of the provision of patient information for patients upon follow up care post-surgery.

Changes to the process for investigating and responding to complaints

In August 2010, changes were made to the Trust's process for investigating and responding to complaints with responsibility for this devolved to clinical divisions. This was to create and ensure more accountability for identifying and learning from the issues raised through complaints within individual divisions. Training and resources for senior managers have been put in place to help support the new process and the Trust Complaints Procedure was also fully reviewed.

Referrals for review by the Parliamentary and Health Service Ombudsman

During this period there were no new cases referred to the Ombudsman for review. The final report from a case previously upheld by the Ombudsman (which occurred in 2007) was received by the Trust and an action plan developed and agreed with the Trust Board.

Our wider patient and stakeholder engagement

Continuing engagement with our patients, patient representative groups and the wider community all contributes to a fuller understanding of how we can best meet patients' needs, and also keeps our stakeholders informed and up to date with what's going on within the Trust. We continue to develop a proactive engagement programme with our local stakeholders, patient groups and partner organisations.

Working with our Patient Panel – our Patient Panel comprises 15 patient representatives who are involved with around 35 groups and committees across the Trust including:

- Clinical governance
- Infection control
- Complaints monitoring group
- Patient and Environment Action Team (PEAT)

The work of the panel is invaluable in helping us to improve services and ensure that new developments are considered from the patients' perspective right from the start.

Working with our Governors and Members – during the run up to becoming a Foundation Trust we have started to develop a positive working relationship with our Governors. They have particularly expressed an interest in being actively engaged in improving patient experience which we welcome. We continue to communicate regularly with our Members through a quarterly newsletter and a programme of Members' Health Events.

Public accountability – we continue to maintain our links with Surrey County Council's Health Scrutiny Committee and with our Local Involvement Network (LINk) – an independent statutory body made up of volunteers from the local community, with a formal voice focusing on both health and social care. We also have strong links at borough level across our catchment area and are an active member of the Runnymede and Spelthorne Local Strategic Partnerships.

Strengthening our nursing leadership

High quality nursing is key to improving patient care and that means having the right numbers of highly skilled nurses and midwives in the right place at the right time. Following a comprehensive nursing and midwifery review towards the end of 2010, the Trust put in place plans to strengthen its nursing leadership to give a stronger focus on clinical issues and to ensure greater engagement with front-line clinical staff.

New Heads of Nursing posts have been introduced into the structure aligned to our seven new clinical divisions, accompanied by a strengthening of the ward sisters' role, giving them more control and accountability for their individual ward areas. Although the number of matrons is being reduced, the increased accountability from the Heads of Nursing will ensure stronger clinical leadership overall and support for nursing staff which is so critical to improving patient care at ward level.

Through this review the Trust also highlighted areas for further investment leading to an increase in the number of funded front-line nursing posts, to ensure we have the correct mix of skill and staffing numbers (nurse:patient ratio) on the wards and a senior nurse present at all times (24 hours/day).

Improving the patient environment

Continued improvements in patient areas - work continued to improve privacy and dignity and to ensure we completed our single sex accommodation programme to make sure patients are not having to share their accommodation or bathroom facilities with members of the opposite sex. The Trust met Department of Health's requirements by the end of the full financial year.

Improving car parking – work has continued on developing the plans for two new parking decks at St Peter's, with construction starting at the beginning of December 2010.

Maternity services – a continual improvement
We continue to see marked improvements in patient experience for our maternity services, with much improved results signalled in the latest national mothers' survey which was published by the Care Quality Commission in December 2010. In 2007, 88% of women rated their care as 'good, very good or excellent', which has increased to 93% this year. Women also reported improvements in their care during labour and birth, with 89% rating it as 'good, very good or excellent' compared to 82% in 2007. The biggest jump, however, is in the experience of new mothers after the birth – 89% now rate their postnatal care 'highly' compared to only 77% three years ago. This follows from the previous national results in 2007 where the Trust's results were disappointing.

Other improvements during the year include:

- All Party Parliamentary Award "Highly Commended" for Birth Reflections Service in July 2010
- Achievement of the highest patient safety standard from the NHS Litigation Authority – the Clinical Negligence Scheme for Trusts which measures the way maternity departments manage safety and risk. The Trust received the highest grading, a Level 3, the first Trust to achieve this under the NHS Litigation Authority's new stricter criteria.
- Opening of our new ensuite birthing rooms in May 2010
- Introducing recliners for all birthing rooms to enable birthing partners to be able to support the woman more comfortably
- Opening of a new birthing pool
- Launching of a new film for women on what to expect in the maternity unit.

Quality and safety

Quality and safety are of the upmost importance in the way we run our hospitals, from the Board to the front line.

Meeting Care Quality Commission quality and safety standards

On 1st April 2010 the Trust was officially registered under the Care Quality Commission's new monitoring standards for providing NHS healthcare. This is a legal requirement and the Trust was registered with no conditions. The new high standards cover issues such as cleanliness and safety, treating patients with dignity and respect and involving them in decisions about their care. Throughout the year the Trust has maintained its registered status and continued to meet quality and safety standards as set by the CQC.

Infection control

The Trust was set very tough infection control limits for 2010/11 – no more than five hospital acquired cases of MRSA bacteraemia to be reported, and a national target of no more than 103 cases of clostridium difficile with a local target set by the PCT of no more than 67. By the end of this reporting period the Trust had reported 5 cases of MRSA bacteraemia (our limit) and 27 cases of hospital acquired clostridium difficile. By the end of the full financial year we had still recorded a total of 5 cases of MRSA (demonstrating an impressive 246 days MRSA free) and just 36 cases of clostridium difficile.

Safeguarding

The Trust has appointed a full time Senior Named Nurse for safeguarding children.

Improving clinical outcomes

Low mortality rates - Dr Foster's Hospital Guide for 2010 reports the Trust's standardised mortality ratio as 89.4 (where 100 would be considered the expected number of deaths taking into account variables such as age, diagnosis and other characteristics). For the 'basket of 5' common

conditions which are some of the most common causes of death in hospitals (*heart attacks, stroke, pneumonia, congestive heart failure and falls)* the Trust was reported as having the fifth lowest mortality ratio of 83 in the country.

Stroke - the Dr Foster Guide named the Trust as performing particularly well in delivering quick diagnosis to patients who have suffered a stroke, the third biggest killer in the UK. The Trust also performed well in the annual Stroke Sentinel Audit, well above the national average for the % of patients spending over 90% of their time in the Trust on a dedicated stroke unit (91% against the national average of 70%), giving 95% of patients a brain scan within 24 hours of their stroke (against the national average of 93%), with excellent therapy input – 100% of patients having physiotherapy within 72 hours of admission and occupational therapy within 4 working days of admission.

Heart attack - the latest data from the Myocardial Infarction Audit Project (MINAP) for 2010 shows that Ashford and St Peter's is one of the highest performing trusts in the country (and the best in Surrey) for the quality of care given to patients suffering from a heart attack, exceeding national targets for administering clot busting drugs (thrombolysis) – 94% of patients are given these drugs within 30 minutes of arrival at hospital and 100% within 60 minutes of the ambulance call (the highest in Surrey). We also prescribe additional drugs (aspirin, beta blockers and statins) to prevent further heart attacks to 100% of eligible patients, against the national target of 80%.

Improving our treatment for fractured hips - at the beginning of the year, just 52% of our hip fracture patients were operated on within 36 hours; by the end of the year this had risen to 96% and we are now one of the best performing Trusts in the country. Furthermore we are now operating on 75% of our patients within just 24 hours against our locally set target of 40%.

Reducing falls in hospital that result in harm - in 2009/10 the Trust reported a total of 32 falls that resulted in harm. For 2010/11 we set ourselves a target of no more than 29 falls that resulted in harm. At the end of the year we had reported to the Trust Board a total of 16 falls that had resulted in harm; thus reducing the total number of falls resulting in harm by 50%.

Enhancing Quality Programme - the Trust is now participating in a South East Coast wide programme called 'Enhancing Quality'. This is a clinical change programme covering four key clinical conditions: Heart attacks; heart failure; hip and knee replacements; and community acquired pneumonia. The programme aims to improve outcomes for patients by setting out and standardising the key clinical interventions or care each patient should have on their 'patient journey' and then monitoring Trusts against these. Our achievement against these standards will account for 0.5% of the Commissioning for Quality and Innovation (CQUIN) payments for 2010/11.

Accredited services

- The Pathology and Pharmacy department have met all standards in external inspections including from MHRA (Medicines and Healthcare Regulatory Agency), CPA (Clinical Pathology Accreditation), HTA (Human Tissue Authority) and Royal Pharmaceutical Society for Great Britain)
- Our Maternity Services have achieved the highest standard for patient safety, CNST Level 3 (Clinical Negligence Scheme for Trusts) by the NHS Litigation Authority.

Safer prescribing

The Trust now has an electronic medicines formulary available on our intranet which will help ensure safe, effective and economic prescribing for all patients. This will be further updated over the next year with the addition of appropriate clinical guidelines.

Corporate objective 2: developing a high performing workforce

Our second corporate objective reinforces the fact that a high performing workforce will deliver better quality care for patients. This year our emphasis has been on developing strong and confident leaders, a focus on our appraisal programme and addressing key issues raised by staff in the annual national survey.

Embedding our Values and Behaviours

Fig. 9: Our Pledge and Values

Throughout the year staff have signed-up to the principles of our Pledge and Values (4 Ps), saying 'I Will' to putting *Patients First*; taking *Personal Responsibility*; having a *Passion for Excellence*; and taking *Pride in our Team*.

Learning and Development

We continue to offer undergraduate and student placements for medical and nursing staff, and also run comprehensive postgraduate training centres at both hospitals. Both our undergraduate and postgraduate programmes are supported by two Health Science Libraries, one at each hospital site.

In terms of ongoing training we have recently reviewed our provision of statutory and mandatory training to ensure our staff receive the right training at the right intervals to meet health and safety and other formal requirements and that they are clear about what they need to do.

We also have a wide range of continuing professional development programmes for staff across the organisation. For example we offer a wide range of NVQs and apprenticeships to enable our support staff to develop their competencies and attain a nationally recognised qualification.

Leadership development

One of our key objectives is to support and develop good quality leadership across our organisation and across all staffing levels.

Open to all staff, the first year of our *Good to Great Leadership Programme* was based around the four strategic objectives and 100 of our employees attended a series of master-classes led by best in class speakers from the NHS, private industry and academia.

These master-classes were supported by action learning sets, an output of which was a wide scope of improvement projects. Good to Great participants and other members of staff were invited to present these projects and bid for support and funding for them in a 'Dragon's Den' event, hosted by the Trust Chairman and Director of Workforce & Organisational Development. The 'Dragons' were two business executives from the private sector alongside the Chief Executive and Director of Finance and Information.

We are also launching a bespoke development programme for our ward sisters, particularly looking at strengthening their accountability for their ward areas and a further development programme for our new specialty leads to ensure they are equipped with the right tools and ideas to take forward and develop their specialty areas.

Supporting Equality & Diversity

The Equality Act 2010 requires public bodies to have due regard to promoting equality for all. For Ashford and St Peter's this means ensuring that staff and patients, whatever their differences, feel valued, have the same opportunities and are not discriminated against in any way.

Last year, the Trust Board approved a Single Equality Scheme, which sets out plans to challenge discrimination and promote equality in terms of race, disability, age, gender, sexual orientation, religion and belief. Each of these six strands of diversity has a champion within the organisation who, through our Equality and Diversity steering group which is chaired by the Chief Executive, will help develop positive action plans for improving each area for both staff and patients.

Over this first year there has been good progress in delivery of the Single Equality Scheme action plan, and the Board has now approved a programme of work for year two of the scheme.

A particular area of focus has been the roll-out of an awareness training programme, 'Valuing People', under the mantra of 'people work best when they can be themselves'. This has seen a high level of engagement, with more than100 members of staff trained to deliver this programme in their areas of work. This has led to the Trust having its highest ever number of staff trained in equality and diversity awareness.

As part of its portfolio of leadership development for staff, the Trust commissioned a career development programme for black and ethnic minority staff in 2010 - *'Road to Success'* – and we look forward to seeing the participants develop further as this programme continues during 2011/12.

Improving Staff Experience

In the summer of 2010, the Trust carried out a local survey of its staff over a two-week period. Despite this short timescale, 57% of staff completed the survey, a response rate that exceeded the national average (50%).

A report to the Trust Board in August 2010 demonstrated positive improvement for the majority of areas where the Trust was performing below average in the 2009 national survey.

There remained three noted areas for improvement (below national average), namely:

- Availability of hand-washing materials;
- Perception of equal opportunities in regards to career progression; and
- Reporting of errors, near misses, incidents.

During the autumn of 2010 staff participated in the national staff attitude survey, with the Trust's best ever response rate of 72%, one of the highest in the country. Results were published in early 2011 and are reported in the Trust's Annual Report for December 2010 – March 2011. Early indications were that these results showed further improvements putting the Trust among the top 20% of acute Trusts nationally.

Relationship with unions and formal staff engagement

We enjoy healthy and constructive working relationships with our staff side union representatives. Our Employee Partnership Forum, with alternating chairmanship by the Chief Executive and Staff Chair, meets monthly. Views and opinions on a wide range of issues, ranging from internal change programmes affecting staff to national policy updates, are sought in the formal setting.

In addition, Staff Side representatives are involved in a range of other groups and committees to fully develop partnership working. The Trust also has an active Local Negotiating Committee which is supported by the British Medical Association.

Health, Safety and Wellbeing

Providing a safe environment for our staff to work in and helping them to have a healthy lifestyle is a crucial element in the Trust achieving its vision to be one of the best healthcare Trusts in the country. As well as fulfilling our duties of care as an employer, by prioritising staff health, safety and wellbeing we will reap the benefits of improved patient satisfaction, stronger quality scores and better patient outcomes.

The following are our key areas of focus:

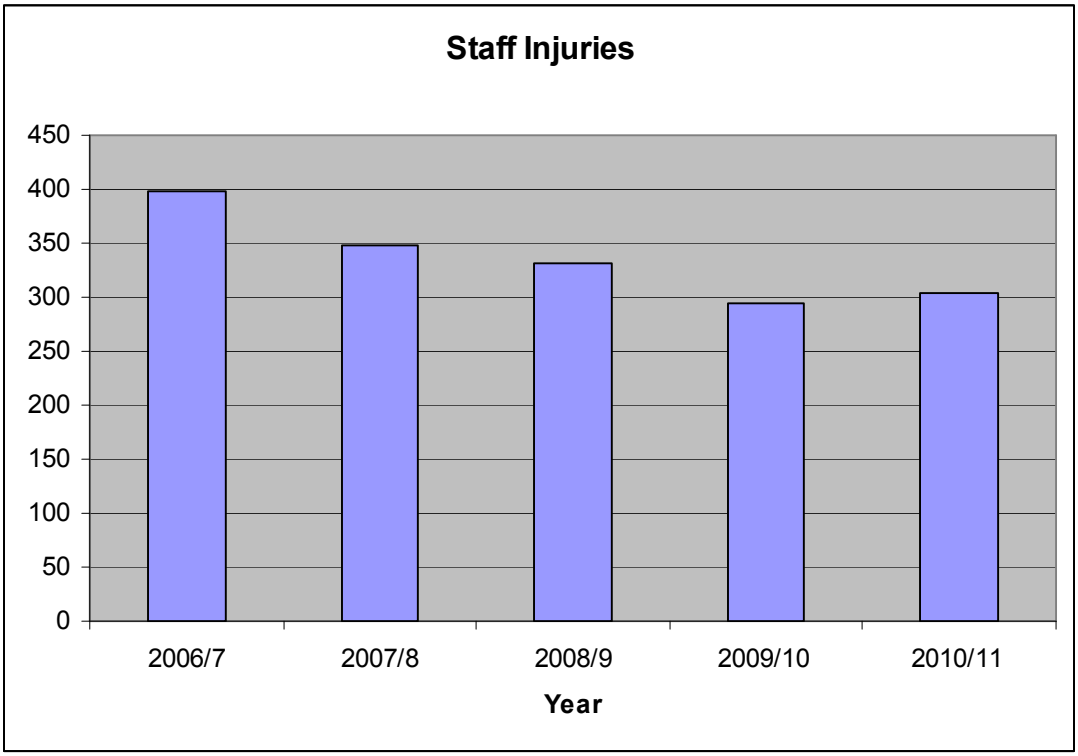
- Illness and injury prevention;
- Prompt rehabilitation;
- Providing a supportive working environment; and
- Staff engagement and involvement.

The Trust continues to work towards these ends through the provision of occupational health services, health and safety training, flexible working and employee assistance programmes.

Reducing staff injuries at work

The Trust reported a slight increase in staff injuries at work this year, although numbers remain relatively low at approximately half the national average. Injury rates are calculated per 100,000 employees; our staff injuries at work rate works out at 869 per 100,000 employees compared to the national rate of 1,730 per 100,000 employees. (Source: Labour Force Survey).

Fig. 10: Staff injuries at work



In order to continue to support and protect staff, a number of new developments have taken place this year:

- The Trust has purchased two Hoverjacks for raising injured patients from the floor safely
- A wellbeing programme has been introduced for staff to encourage fitness and to provide lifestyle guidance.
- Following a successful business case as part of the "Good to Great" programme the Trust now has a full time physiotherapist dealing with staff referrals.
- The introduction of safety canulas throughout the Trust is now complete. Further safety devices will be evaluated and introduced as necessary to comply with the European Directive on preventing injuries from sharp objects.

Sickness/absence

Our sickness absence rate for the full year (April 2010 – March 2011) was 3.3% - that is, the number of days of sickness as a percentage of the number of available working days of all staff, which is well below the national average of 4.5%. This equates to an average of 7.5 days taken per employee over the year.

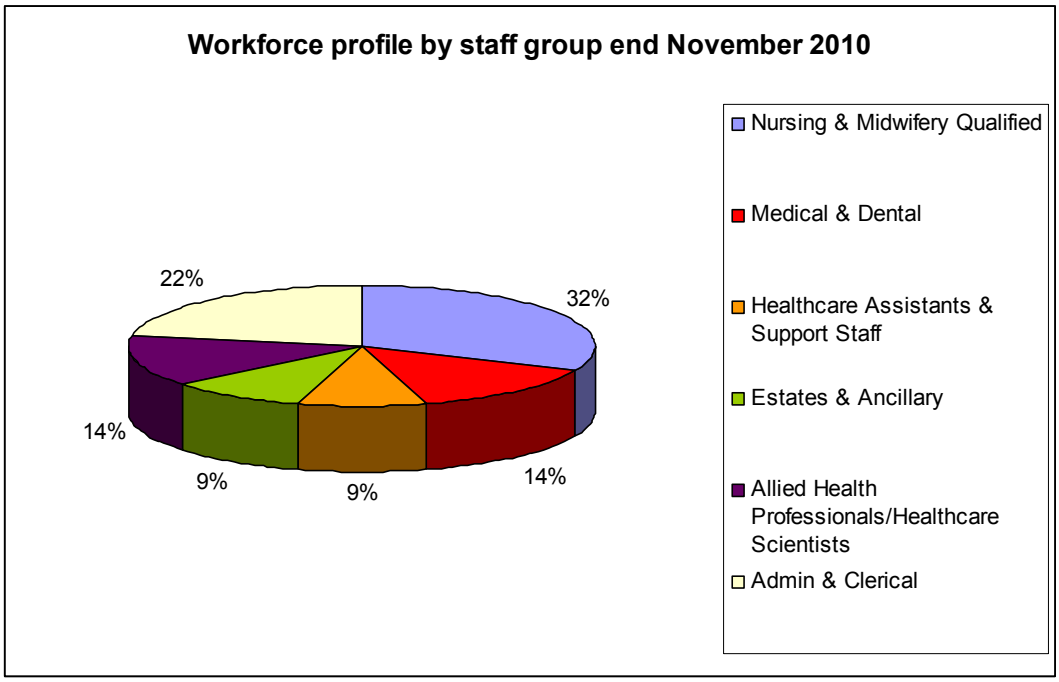
For the eight months commencing 1st April – 30th November 2010, sickness absence was 3.2%, which equates to an average of 4.9 days per employee during this period.

Workforce Planning

Our staff are the Trust's most valuable asset and our Workforce Redesign Group (involving a wide range of clinical and support staff) is responsible for leading the planning for our future workforce needs. This involves close working with Divisions across a range of issues – for example, temporary staffing, job planning and new ways of working – to ensure that our workforce has the right numbers and skills for the services we deliver currently, and for the future.

Workforce profile – at the end of November 2010 the Trust employed 3,518 individual members of staff, excluding bank and agency staff (headcount); this equates to 3,015 full-time equivalent staff in post. The following chart shows the workforce profile by staff group at the end of November 2010.

Fig. 11: Workforce profile by staff group



Voluntary Services

Staff, patients and visitors benefit greatly from the support of more than 350 volunteers across both hospitals, who together make a contribution of over 1300 man hours every week. Our volunteers, who come from variety of different backgrounds, provide a range of services from welcoming patients and visitors, working with the spiritual care team, helping on the wards, with Hospital Radio Wey, support for patients at mealtimes, portering and a range of administrative support.

Current projects/achievements

Highlights of the service over the year have included:

- A nomination for the Queen's Award for Voluntary Service
- Development of a Volunteer Strategy.
- Helping local company, Lilly UK, by providing an opportunity for their staff to take part in a one-day volunteering event as part of their corporate citizenship programme.
- Recent introduction of a 'meet and greet' service in main reception at St Peter's Hospital to help patients and visitors find their way around the hospital.

Our 'Friends' – in a league of their own

The teams of volunteers who work with both hospitals' Leagues of Friends – the Friends of Ashford Hospital and the Friends of St Peter's – make an invaluable contribution to both hospitals and over the last year have once again made significant donations of equipment and other items for the benefit of both patients and staff as well as providing other valuable services – the Friends' cafés at both hospitals, the shop at St Peter's and a trolley service to patients on both sites.

Corporate objective 3: delivering our clinical strategy

Our clinical strategy in 2010/11 focused on increasing our elective work – particularly in Hounslow, Woking and Cobham – reducing emergency admissions and continuing to develop our clinical services.

Reducing emergency admissions through partnership working in North West Surrey

With payment for any additional emergency admissions over those experienced in 2008/09 set at only 30% of tariff one of the key priorities for 2010/11 has been to reduce the number of emergency admissions. This has meant a concerted effort to work with our partners in North West Surrey – through a local Transformation Board, chaired and supported by NHS Surrey - to try and create effective alternatives to hospital admission, including:

*Nursing home project - o*ur Care of the Elderly Consultants have been working with a small sample of nursing homes to provide support and advice so that, when a resident's health deteriorates, where appropriate there is an alternative to sending the patient to A&E. The project team have linked with local GPs and nursing home managers and to date we have seen a 43% reduction in patients from these nursing homes being admitted to hospital. The project has recently been extended to 20 nursing homes and we hope to roll this out to all nursing homes in the area.

Virtual ward – a joint project with colleagues across North West Surrey to reduce the number of medical patients readmitted to A&E (around 80% of our readmissions). This 'virtual ward' gives better support to discharge from hospital by giving patients the required input and support in a non-hospital environment. Patients will be carefully selected and will be visited several times each day at their home by the community matrons.

Developing a new Model of Care for North West Surrey

Clinicians from primary care, community care, acute care and mental health services have been working together since October 2010 to develop a better way of delivering care to patients in North West Surrey. This has provided front line clinical leaders with an opportunity to start with a blank sheet of paper and describe how they would like to see care delivered locally. The work focused on five areas: planned care, urgent and emergency care, chronic care, end of life care and women's and children's services.

The Trust has been instrumental in driving and supporting this work which has resulted in improved relationships between organisations and clinicians. Work is now underway to agree how to take these plans forward, looking specifically at planned care, the way patients access emergency care (and alternatives to hospital admission) and improving communication between organisations.

Developing our specialist services

One of our key objectives for 2010/11 was to win the bid with NHS Surrey to become the renal centre for Surrey. However, part-way through the year, following a change in leadership at NHS Surrey who have focused on addressing their continuing financial pressures, the tender process was withdrawn.

The Trust continues to explore opportunities for the future development of cardiology and vascular services and during the year linked with Epsom Hospital to provide a joint vascular service for emergency and elective care for local patients.

The Trust has also been working with other Surrey Trusts to develop a shared pathology service – the Surrey Pathology Service – which will build on existing partnership arrangements between Frimley Park Hospital NHS Foundation Trust and the Royal Surrey County Hospital NHS Foundation Trust. Earlier in the year Surrey and Sussex Healthcare NHS Trust withdrew from the partnership but work continues with the other two Trusts to develop this shared service which will allow for greater specialisation and enhanced quality as well as reducing overall costs.

Making best use of our hospital sites – day surgery

Nationally day surgery is being encouraged as good practice because of the benefits it brings patients. At Ashford and St Peter's we have a dedicated day surgery unit at both hospitals and last year 83% of all our planned operations were done as day surgery. As a result, we were rated as the 7th best Trust in the country for our day case rates. We also have the highest day case rates in the South East Coast for the 'basket' of day case procedures.

One of our objectives this year was to make best use of our two hospital sites and focus more day surgery at Ashford Hospital where there is a larger dedicated unit. This has focused specifically on surgical day case procedures and our target was set at 70%. Since September, this has been achieved in the main (with slight dips in December and March) with an overall figure for the year of 67.4%.

Overall market position

The Trust's overall outpatient share in Surrey was stable at 26% over the year, with a 1% rise in overall elective (planned activity) since the beginning of the year. In Hounslow there has been a slight reduction (1% in outpatient share and 2% in elective activity) and the Trust is now concentrating on recapturing activity from Feltham and West Hounslow. There has been significant improvement in market share in the latter part of the year in East Berkshire, with overall outpatient market share up by 4.5% with nearly every specialty showing an improved position. Our successful 'any willing provider' bid for bariatric surgery in South Central should offer further opportunities to increase elective market share in East Berkshire and North-East Berkshire.

Expanding in the community

As part of developing our business – in particular beyond our traditional catchment area – the Trust has looked to actively increase the number of clinics we offer in community settings, which is more convenient for patients. Of note is the particular success in the Cobham area with new clinics being offered in Cobham Community Hospital. These include cardiology, ENT (ear, nose and throat), dermatology and urology, all of which are helping the Trust to improve its presence in this area.

Working with GPs

We have continued to develop our relationship with local GPs/consortia, particularly as they begin to develop their commissioning role. Our business development team undertakes regular practice visits to practices within our wide catchment area. Our spotlight seminars for GPs – evening events focusing on a clinical specialty with talks from consultants – provide another way of engaging and informing GPs. We also hold regular clinical interface meetings – our clinicians talking with GPs about services – which are helping to improve communication as well as distributing our monthly newsletter, *GP News,* to around 700 practices. Our Service Directory continues to grow and become more intuitive as we work with practices to make sure we supply the information they need.

Further clinical developments

During the year we have seen a number of developments across our clinical services including:

- Introducing nurse-led rheumatology clinics at Ashford Hospital
- Opening our lithotripsy suite at St Peter's – the lithotripter breaks up kidney and other stones without surgery, using a high density acoustic pulse
- Introducing a sacral nerve stimulation service
- Developing our bariatric service, widening the procedures we offer and meeting the 'any willing provider' criteria for South Central

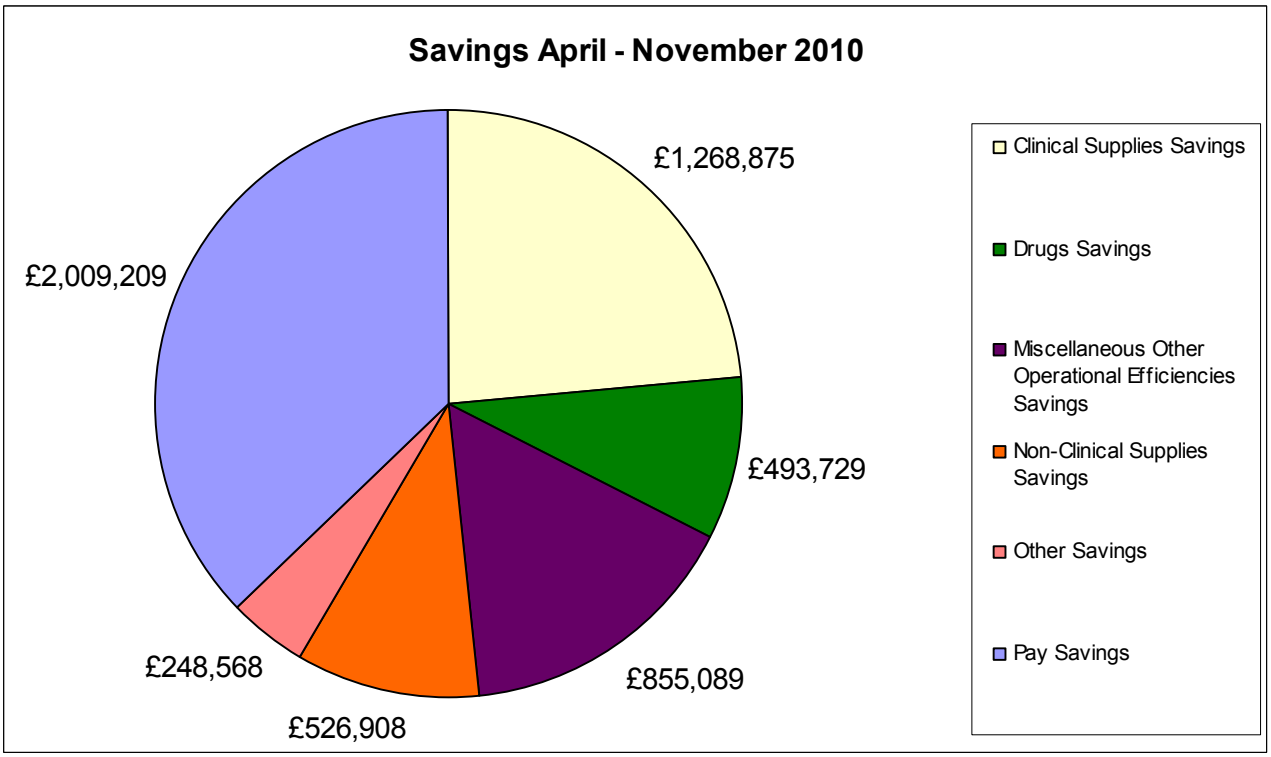
- A range of improvements in ophthalmology including daily consultant led casualty clinics (so urgent patients can be seen within 24 hours by a consultant), evening theatre sessions to give patients more flexibility and choice over surgery times and a review of appointment times to standardise the amount of time patients spend with a consultant and to reduce waiting times
- Partnership with St George's Healthcare NHS Trust to provide a monthly paediatric surgery list at St Peter's hospital, a convenient local service for children and their families
- Expanding our chronic pain service, particularly in the Hounslow area
- Improving waiting times for all our therapy services
- Installing new digital X-ray equipment in A&E and the Rowley Bristow Unit for a faster service with better quality images
- Additional equipment doubling our capacity for 'cooling babies' in our neonatal intensive care unit
- Development of a one-stop allergy clinic for children
- Introducing a new movement disorder clinic at Ashford Hospital (in addition to the service at St Peter's)
- Nurse-led Parkinson's Disease Clinic at Ashford Hospital that runs alongside consultants' clinics
- Extending our Specialist Stroke nursing service from 9am – 5pm Monday to Friday, to 8am – 8pm every day, 7 days a week thanks to additional funding from the Department of Health and the Surrey Heart and Stroke Network.

Improving productivity and efficiency

Achieving our cost improvement plans

At the end of November 2010 the Trust's cost and quality improvement programme was on track to fully meet the savings target of £9m by year end. By the end of November, £5.4m of savings had been achieved through changes in practice and particularly through the elimination of waste, demonstrated across areas as follows:

Fig. 12: Savings April – November 2010



Pay cost savings were primarily achieved through the reduction in temporary staffing - bank and agency spending - and through a skill mix review.

Of particular significance are the drug savings, achieved through national and local negotiation of prices, and through reducing usage and waste of some medicines.

Other substantial savings were achieved by improving theatre utilisation (see below), a £500,000 (at end November) saving by the Trust's procurement department in negotiating lower prices for a range of products and savings of over £233,000 (at end November) by Trauma and Orthopaedics through negotiating lower prices for various prostheses.

Theatre and Day Surgery Utilisation

The Division has worked well to bring about major changes in the way in which the operating theatre lists are managed and utilised, including an improved theatre management system (software), achieving a year end saving of around £780,000. As well as improving theatre productivity, the Trust has also repatriated theatre work back into the Trust from other providers.

The Trust has also seen an increase in day case rates, with better use of theatre space at Ashford Hospital and the introduction of 23 hour surgery (where patients benefit from one night in hospital) at St Peter's, making our theatres both more efficient and adhering to good practice. In 2010 the

Trust was rated as 7th best in the country for its day case rates – that is the number of procedures being undertaken as day case surgery.

Becoming more environmentally sustainable and energy efficient

The Trust now recycles 61% of all its domestic waste with the remainder going to a local waste plant to generate electricity, with no waste going to landfill sites. We now comply with the latest guidance in managing offensive (non-infectious) waste which will generate significant savings and are starting to introduce this new system in our Children's and Maternity Wards.

Other developments during the year include:

- Ventilation controls, particularly reducing use of fans when areas (e.g. theatres) are not in use
- Engineered replacement schemes for light fittings, using new high efficiency lighting, including daylight saving and motion sensors
- Developing a scheme for Buildings Management and energy monitoring of our existing buildings at St Peter's Hospital
- Upgraded departmental block heating controls.
- Replaced boilers at Ashford with more energy efficient boilers.
- Replacement windows and increased insulation to Kingfisher ward external fabric
- Use of gas powered air conditioning systems in Juniper and Aspen ward to comply with the requirements of the heat wave plan (i.e. keeping wards cool in the hot weather) and the use of a more efficient form of energy
- Continued eradication of bottled water coolers and replacement by mains water supply type; reducing use of plastic and travel to replace water bottles.
- Transport – developing a travel plan, improving facilities for cyclists, participating in local cycle and walk to work schemes, use of diesel fuel in all transport vehicles

Furthering our EQUIP programme

The Trust established its Lean improvement programme 'EQUIP' - Efficiency, Quality, Improvement and Productivity - in September 2009. Originating from the car industry, LEAN looks at work as a process and focuses on finding and getting rid of the wasteful parts. As a consequence, pathways can become more efficient and improve the experience for both patients and staff. One of its key principles is the involvement of the staff delivering the service, giving relevant members of the team at all levels the opportunity to lead and influence service change.

Recent EQUIP successes include:

- Doubling the proportion of patients with broken hips who have their operation within 36 hours and also doubling the proportion who are on their feet again within 24 hours of surgery. These two changes are known to greatly improve survival rates.
- We are now treating many of our Paediatric allergy patients in a 'one stop' outpatients clinic, meaning that families only have one trip to hospital instead of returning several times to see different staff or have tests. This has also increased efficiency of how we use our available capacity and will reduce wait times in the longer term.
- We have greatly improved the coordination of the Trust's HR and Finance systems, reducing confusion, inefficiency and the potential for increased costs.

Building stronger clinical divisions

During the year the Trust restructured its clinical departments and management arrangements to create stronger clinical leadership and improved accountability and business control. The Trust has now moved from 11 clinical directorates to 7 clinical divisions, each led by a Divisional Director (a consultant), a Divisional General Manager and Heads of Nursing, ensuring good clinical engagement and management. The new divisions and divisional directors are as follows:

- Emergency Services and Acute Medicine
  Dr Mike Wood
- Trauma and Orthopaedics
  Mr David Elliott
- Surgery
  Mr John Hadley
- Theatres/Anaesthetics and Critical Care
  Dr Mick Imrie
- Ambulatory Care
  Dr Gulam Patel
- Diagnostics and Therapeutics
  Dr Andrew Laurie
- Women and Children's services (from April 2011)
  Dr Paul Crawshaw

Divisional Directors join the Executive Directors at the Trust's Executive Committee which ensures Divisional Directors are involved in major operational decision-making, particularly around issues relating to quality and safety, new business developments, risk and finance.

To empower frontline clinical staff to have even more of a say in the development of services, these divisions will be supported by around 30 specialty leads. Each lead will be responsible for developing a clinical strategy for their specialty and for managing and working with the whole multi-disciplinary team (i.e. doctors, nurses, therapists and others). The new management structure has also been supported by improved reporting processes (service line management) ensuring directorates have the information they need at their fingertips to keep tight control of their business, to make the right strategic decisions about service development and to drive better performance.

Information Governance

In order to protect the information we hold, in particular personal information on behalf of our patients and staff, there is an established Information Governance Framework within the Trust with the Medical Director in the role of Caldicott Guardian – the senior person in the organisation who has overall responsibility for protecting patient information. The role of Senior Information Risk Owner (SIRO) is the Director of Finance and Information who takes ownership of the organisation's Information Risk Policy and Risk Management Strategy. The Trust has an active Information Governance Steering Group which meets regularly and ensures that the Information Governance Policy is implemented and that patient and staff information is safeguarded at all times.

We also have a number of information sharing protocols covering other NHS bodies and multi agencies that we work with. Following the ongoing concerns regarding public sector data protection and in particular the security of information being transferred between locations and organisations, any identified risk areas are immediately acted on.

The Trust has a duty to report any incident regarding personal data, however minor. During this time period the Trust recorded thirteen such incidents which were not classified as serious but which we reported internally as part of our incident reporting protocol. These are grouped together and summarised in the table overleaf.

These included issues such as sending the incorrect letter to a patient and recorded patient information dropped in a corridor. Each reported incident is reviewed by relevant members of staff, with actions taken to minimise the likelihood of any recurrence. The Trust continues to actively promote information governance training to all members of staff in line with national requirements.

Fig. 13: Summary of other personal data related incidents

SUMMARY OF OTHER PERSONAL DATA RELATED INCIDENTS - 1 APRIL 2010 to 30 NOVEMBER 2010		
Category	**Nature of Incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1
II	Loss of inadequately protected electronic equipment, devise or paper documents from outside secured NHS premises	2
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	8
V	Other	2

End of year performance April 2010 – end March 2011

The following table outlines our performance by the end of the full year (April 2010 – March 2011) against key national priorities contained within the Monitor Compliance Framework and other key Care Quality Commission indicators.

Performance against key national priorities 2010/11	Performance	Target	Actual	Target for 2011/12
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge		95.00%	97.65%	<=4hrs
A maximum two-week wait standard for Rapid Access Chest Pain Clinics.		98.00%	100.00%	N/A
Thrombolysis 'call to needle' of at least 68 per cent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack.		68.00%	92.90%	N/A
Elective admissions cancelled on the day offered a date within 28 days		5.00%	1.64%	N/A
Delayed transfer of care - % of patients whose transfer was delayed		3.50%	2.37%	
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals.		93.00%	98.25%	93.00%
A maximum wait of one month from diagnosis to treatment for all cancers		96.00%	99.15%	96.00%
A maximum wait of two months from urgent referral to treatment of all cancers.		85.00%	92.69%	85.00%
Breast symptoms referred to a specialist who are seen within two weeks of referral		93.00%	95.77%	93.00%
31 days for second or subsequent cancer treatment(drug)		98.00%	100.00%	98.00%
31 days for second or subsequent cancer treatment (surgery)		94.00%	100.00%	94.00%
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment		90.00%	98.92%	90.00%

Performance against key national priorities 2010/11	Performance	Target	Actual	Target for 2011/12
MRSA number of infections		5	5	4
Clostridium difficile		67	36	33
Number of diagnostic waits > 6 weeks		0.00%	0.00%	N/A
18 weeks Referral to Treatment (RTT) Completed Pathways - Admitted patients		90.00%	94.11%	95% of patients wait 23 weeks or less. The Trust will report on the average wait of 95% of our patients.
18 weeks RTT Completed Pathways Non-Admitted patients		95.00%	98.19%	95% of patients wait 18.3 weeks or less. The Trust will report on the average wait of 95% of our patients.
MRSA Screening - Elective admissions		100.00%	99.40%	Not applicable Not a national priority for 11/12
Cancelled Operations		0.80%	0.79%	Not applicable Not a national priority for 11/12
48 Hours GUM access		100.00%	100.00%	Not applicable Not a national priority for 11/12

Our priorities for future development

As we move forward as a Foundation Trust from December 1st 2010, we want to continue to build on the gains we have made for both patients and staff and mature into one of the best acute Trusts in the country.

Our key priorities – matched against our strategic objectives – for 2011/12 will be:

1 Achieving highest standards of quality	Making real improvements to the patient experience, particularly discharge, and ensuring we perform to the top of our game
2 Developing a high performing workforce	Developing confident leaders right through the organisation, and making sure we harness talent and support learning
3 Delivering our clinical strategy	Reducing emergency admissions to hospital, developing our specialist services and working with partners across NW Surrey
4 Improving productivity and efficiency	Meeting our savings plans and improving the quality and efficiency of our services, particularly through EQUIP

These priorities have been developed within the context of a continuing period of financial challenge, particularly relating to the position of NHS Surrey our biggest commissioner, the Operating Framework for this year and a period of unprecedented change in the NHS foreseen in the new Health and Social Care Bill. The national context includes a 1.5% reduction in tariff for 2011/12, with further financial challenges created by new payment systems for readmissions and a continued cap on the payments made to acute Trusts for non elective work.

Next year we will continue our work on developing a new model of care in North West Surrey, working with our local health and social care partners to drive this work forward with quality very much the organising principle. This work will include a focus on reducing emergency admissions, readmissions and multiple admissions by reviewing pathways in a structured and whole system manner that increases the focus on patient experience and also reduces cost in the system.

We expect these objectives will see the configuration of the Trust change in the following ways:

- A contraction in some of the acute care currently delivered by the organisation
- Potential growth in the scope of the organisation – with responsibility for some activities extending into community settings
- Expanding and strengthening clinical networks across Surrey and beyond.

3. Governance

The business of the Trust is governed by our Board of Directors who are responsible for making sure we are fulfilling our key objectives. The Board is also accountable for ensuring the organisation is well governed in terms of patient safety and quality, finance, our performance, staff and public engagement and the future direction of the Trust.

The Board of Directors

The Board is made up of the Chairman, 5 Non-executive Directors and 6 Executive Directors. The Head of Corporate Affairs attends all Boards meetings as company secretary. The Trust also appointed a non-Executive designate from 1 June 2010 in preparation for becoming a Foundation Trust in December 2010.

Introducing our Board of Directors …

Aileen McLeish, Chairman
Aileen McLeish has been Chairman of Ashford and St Peter's Hospitals since October 2008 having been a Non-executive of the Trust since November 2005. She was educated at The Mount School York and Girton College Cambridge where she obtained a degree in Mechanical Sciences. During her career Aileen has worked at Unilever PLC and H J Heinz Co Ltd in the UK where she became Group Financial Controller. She then transferred to the not for profit sector as Director of Finance at Historic Royal Palaces followed by a move to WWF-UK as Director of Resources. At Historic Royal Palaces she led on the transformation of the organisation from a Government Agency to a Non-Departmental Public Body and registered charity with no public funding (an early precursor of the process of becoming a Foundation Trust). Aileen is a Fellow of the Royal Society of Arts, a Fellow of the Institute of Directors, as well as a Fellow of the Chartered Institute of Management Accountants.

Nadeem Aziz, Non-executive Director
Nadeem Aziz was Director for Group Financial Planning at Actavis, a leading generic pharmaceutical drugs manufacturer and distributor and has worked as financial director in a range of industries. Nadeem has an MBA (Sheffield Business School), is a Chartered Management Accountant, and has a Diploma in Marketing (Chartered Institute of Marketing).

Nadeem was appointed as a NED in June 2010 and resigned from the Trust due to international business commitments from 31 December 2010.

Professor Philip Beesley, Non-executive Director
Professor Philip Beesley is Dean of Science and Professor of Molecular Neuroscience at Royal Holloway, University of London. By training, Philip is a biological scientist specialising in neuroscience and has been closely involved in the development of biomedical science at Royal Holloway and in the development of collaborative work with St. George's University of London (from where the Trust receives a number of medical students) and Kingston University. In his role as Dean of Science Philip is responsible for managing the seven Science Departments at Royal Holloway and is a member of the College's Senior Management Team.

Philip joined the Board in July 2008.

Norman Critchlow, Non-executive Director
Norman Critchlow enjoyed a long career at director level in the private sector with a number of senior finance and general management appointments prior to joining the Board in November 2005. Norman is a chartered accountant and an ex-Chief Executive of a £300 million turnover construction services business.

Norman resigned from the Trust with effect from 31 May 2010.

Sue Ells, Non-executive Director
Sue Ells has worked as a management consultant for more than 20 years. Her specialism is transformation, change management and organisation development. These skills have been in constant use, achieving successful organisational change in both the public and private sectors. Aligning with business strategy, Sue has designed, managed and personally delivered a cross-section of change programmes in UK, Europe, US and Asian cultures. She has a track record in developing high performing teams, coaching senior individuals and running audits of why major programmes and organisational changes fail, so that lessons can be learnt and future success assured. Sue has a degree in psychology, an MBA, and is a member of the British Psychological Society's Occupational and Coaching Divisions.

Sue joined the Board in February 2009.

John Kelly – Non-executive Designate (deceased)
John Kelly was an experienced business leader with a specialist interest in the realisation of strategy and organisational change. He was a senior partner of Bridge Consulting International LLP which he helped found in 2003. Prior to that he was Managing Partner at Ernst and Young Consulting UK.

John started his professional career with Unilever and has also worked for Coopers and Lybrand (now part of PriceWaterhouseCoopers). Throughout his consulting career John worked in a range of industries both in the UK and overseas.

It was with great sadness that the Board learned of his death in August 2010.

Terry Price, Non-executive Director
Terry Price has wide ranging experience in both the public and voluntary sectors. He relinquished full time employment in early 2006 and now holds a number of non executive roles with the Children's Commissioner for England, the Criminal Cases Review Commission, the National Fire Service College, the Office of the Independent Adjudicator for Higher Education Ltd, and Community Building Services Ltd (a subsidiary of Affinity Sutton Housing). Terry's career has included senior finance and corporate positions in the Metropolitan Police, Sport England and local authority finance. In the voluntary sector Terry is Chair of the Board of Governors at Esher Sixth Form College and Chair of the Governing Body at St. Lawrence C of E (Aided) Junior School in East Molesey. He is also Vice Chair of the Board at St. Mungo's Housing Association and Treasurer of East Holmes Housing Association. Terry is a fully qualified CIPFA accountant.

Terry joined the Board in September 2008.

Peter Taylor, Non-executive Director and Senior Independent Director
Peter Taylor worked until recently with the South East England Development Agency, responsible for supporting small and medium size enterprises and promoting manufacturing and innovation. As an advisor to many industries he has an extensive knowledge of marketing, new product development and lean enterprise techniques. Peter has also held general management and marketing director roles at companies such as Unipart, The Rank Organisation, Grand Metropolitan (now Diageo) and Cadbury Schweppes. He holds an MBA, is a Fellow of the Chartered Institute of Marketing and a Councillor of Runnymede Borough Council, sitting on their Housing and Corporate Management Committees.

Peter joined the Board in August 2008 and was appointed Senior Independent Director in November 2010.

Andrew Liles, Chief Executive
Andrew Liles joined the Trust in January 2009 from the Royal West Sussex NHS Trust, where he had been Chief Executive for three years. After University he was an NHS Management Trainee for 2 years, completing his training in 1992. Since then his career has progressed through general management and operational posts in acute NHS Trusts and Executive Director posts in Winchester, Southampton and Epsom and St Helier Hospitals trusts. Andrew is the Chief Executive lead for leadership and talent management for the NHS in the South East.

Valerie Bartlett, Deputy Chief Executive
Valerie has nearly 15 years of Board level experience within the NHS, including 4 years as a Chief Executive of a mental health trust and 3 years as Director of Service Delivery at the Royal Cornwall Hospitals NHS Trust. Graduating from Oxford, with an MBA from Henley Management College, Valerie also has experience of working outside the NHS, in both local government and the voluntary sector. She has also worked in consultancy and research, designing and delivering significant programmes of organisational change with government agencies, local authorities and with NHS Trusts across the UK.

Valerie's experience within the acute sector of the NHS includes leading on significant service redesign programmes and delivering programmes of substantial financial recovery and significant performance improvement. Valerie joined the Trust in April 2009.

Dr Mike Baxter, Medical Director
Dr Mike Baxter joined Ashford and St Peter's in 1992 as a consultant diabetologist and endocrinologist and has since developed this service. He then became Clinical Director for seven years before becoming Medical Director in 2002. Mike was heavily involved with the merger of Ashford and St. Peter's hospitals, the reconfiguration of clinical services across the two sites and the merger talks with Frimley. Mike played a large part in laying the groundwork for the Trust's Foundation Trust Application and is now leading a programme on organisational transformation.

Caroline Becher, Chief Nurse
Caroline Becher, RGN BSc (hons) joined the Trust in June 2009 and brought with her nearly 10 years of executive board level experience within the NHS. She was previously worked as Director of Nursing and Quality at Queen Victoria Hospital NHS Foundation Trust at East Grinstead. Caroline trained at Guys Hospital in London and has subsequently held several senior nursing posts in the NHS and private sector, all in acute services. Caroline put patients' needs at the top of her agenda.

Caroline retired in July 2010.

Paul Bentley, Director of Strategy
Paul Bentley was appointed by the Trust as Director of HR in 2006. He was Acting Chief Executive for an 11 month period during 2007-08. Paul has worked in the health service since 1987, initially in London teaching hospitals before working across a range of community and acute providers.

Paul was appointed Director of Strategy in 2009 and among his responsibilities he led on the Trust's Foundation Trust application up to the Monitor assessment phase. In June 2010 Paul left the Trust to join Maidstone and Tunbridge Wells Hospitals NHS Trust.

Raj Bhamber, Director of Workforce and Organisational Development
Raj Bhamber graduated from the University of British Columbia, Vancouver, Canada in 1986 and was awarded an MSc in Human Resources Leadership in 2005. She has enjoyed a wide variety of roles in pharmacy, cable television, banking, the Manpower Services Commission and the Hotel and Catering Training Board. Raj has held a number of Board level workforce and organisational development appointments in both the NHS (acute, health authority and primary care) and Further Education, as well as a secondment at the Department of Health. She is a Fellow of the Chartered Institute of Personnel and Development; the Law and Business Faculties at Kingston University and is an Ambassador of the Public Appointments Network for the Government's Equalities Office.

Raj joined the Trust in April 2009.

John Headley, Director of Finance and Information
John Headley has a degree in Philosophy, Politics and Economics from Oxford University and is a Fellow of the Chartered Institute of Management Accountants. Following several years in finance roles in the Life Insurance sector in the UK and in Spain, John worked for 13 years in Bupa, initially in its Spanish subsidiary Sanitas and subsequently as Finance Director of Bupa International. John was appointed Director of Finance and Information at the Trust in January 2009.

***Susan Osborne* was interim Chief Nurse** from July 2010 until the substantive appointment of *Suzanne Rankin* in December 2010.

We would like to extend our thanks and appreciation to Norman Critchlow, Caroline Becher, Paul Bentley and John Kelly (deceased), for their hard work and contribution during their time with the Trust.

Board meetings

The Board meets in public each month.

Details of Board members attendance at Board of Directors' meetings is shown in the table below:

Name	End of term of office	Meetings attended
Non Executive Directors		
Ms Aileen McLeish	30/09/2012	9/9
Mr Nadeem Aziz	Resigned 31/12/10	4/5
Prof Philip Beesley	15/07/2012	7/9
Mr Norman Critchlow	Resigned 31/05/10	0/2
Ms Sue Ells	08/02/2013	9/9
Mr Terry Price	13/09/2012	9/9
Mr Peter Taylor	15/08/2012	9/9

Executive Directors	Position held	Meetings attended
Mr Andrew Liles	Chief Executive	9/9
Mrs Valerie Bartlett	Deputy Chief Executive	8/9
Dr Mike Baxter	Medical Director	7/9
Mrs Caroline Becher	Chief Nurse	3/5
Ms Raj Bhamber	Director of Workforce and Organisational development	9/9
Mr John Headley	Director of Finance & Information	9/9
Ms Susan Osborne	Interim Chief Nurse	6/6

Board Committees

The Board of Directors has 4 formal sub committees:

- Audit Committee
- Remuneration Committee
- Integrated Governance and Assurance Committee
- Finance Committee

In addition, the Board established a Foundation Trust Project Board to oversee the application for Foundation Trust status. This Project Board was disbanded on the successful achievement of foundation trust status on 1 December 2010.

In fulfilling their roles, all Non–executive Directors are active participants in Board committees as stated here:

Aileen McLeish, Chairman
Aileen attended the Remuneration Committee and Chaired the Foundation Trust Project Board.

Nadeem Aziz
Nadeem was the Chair of the Finance Committee at Ashford and St Peter's and a member of the Remuneration Committee.

Norman Critchlow
Norman chaired the Finance Committee and was a member of the Audit Committee

Professor Philip Beesley
Philip chaired the Integrated Governance and Assurance Committee and the Clinical Excellence Awards Committee and was also a member of the Foundation Trust Project Board.

Sue Ells
Sue was a member of the Remuneration Committee.

Terry Price
Terry chaired the Audit Committee and was also a member of the Finance Committee and Integrated Governance and Assurance Committee.

Peter Taylor
Peter chaired the Remuneration Committee and is a member of both the Finance and Audit Committees. Peter was acting Chair of the Finance Committee from January 2011 to April 2011.

Formal business of the Board
Formal business is conducted through the Board and its sub-committees. Executive Directors undertake day to day management of the organisation and meet weekly to discuss operational issues and report to the Board.

Access to register of Directors' Interests

Members of the public can gain access to the register of Directors' interests by making a request to the Trust secretary , at St Peter's Hospital Guildford Rd, Chertsey, KT16 0PZ, or via email jane.gear@asph.nhs.uk or by telephone on 01932 723110.

Audit Information

Ashford and St Peter's Hospitals NHS Trust directors confirm that there is no relevant information that the Trust's auditors are unaware of and that all steps have been taken to ensure the auditors are aware of that information.

Establishing the Council of Governors

In preparation for becoming a Foundation Trust the Trust ran a formal election process to a Council of Governors during the autumn of 2010 (to elect a total of 16 public and 5 staff Governors). In addition, 7 major stakeholder organisations were invited to appoint a Governor.

The Council of Governors represents the interests of the local community and shares information about key decisions with Foundation Trust members. The Council of Governors will not be responsible for the day-to-day management of the organisation which remains the responsibility of the Board of Directors.

Both staff and the local community showed high levels of interest in the election process, with 85 members of the public and 19 members of staff, including 4 volunteers, standing for election. Only one position was uncontested. 34% of our membership voted in the elections, which is above the national average for similar elections (around 30%). Elected members joined 7 appointed Governors from local stakeholder organisations.

Membership of the full Council of Governors is available on the Trust web site www.ashfordstpeters.nhs.uk or from the Trust Secretary at St Peter's Hospital, Guildford Rd, Chertsey,KT16 0PZ , or via email jane.gear@asph.nhs.uk or by telephone on 01932 723110.

A first introductory meeting was held for the Board and Council in November 2010 to start establishing their relationship and to give an overview of the Trust and its activities prior to authorisation on 1st December 2010.

Foundation Trust membership

We have continued to engage with our membership through regular health events and our quarterly publication, *Members Matters*. We also continue to recruit and develop our membership with a mail drop undertaken during the year in targeted areas with a very successful outcome. Other initiatives to encourage membership have included inviting all new outpatients to become members.

4. Financial Report and Accounts

Financial review

As a result of the Trust becoming a Foundation Trust on 1st December 2010 the accounts in this Annual Report cover the eight month period to 30th November 2010. These eight month accounts have been prepared using the Department of Health's Manual for Accounts 2010/11.

Over the whole of the financial year the Trust met its planned surplus of £3.3m. For the eight month period to 30th November 2010 the Trust achieved a surplus of £3.2m against a plan of £2.8m as set out below: -

	Plan £m	Actual £m	Var £m
Income			
Clinical Income	135.0	138.4	3.4
Non-Clinical Income	11.3	11.2	-0.1
Total Income	146.3	149.6	3.3
Expenses			
Pay Costs	-90.3	-93.7	-3.4
Non-Pay Costs	-43.0	-44.4	-1.4
Total Expenses	-133.3	-138.1	-4.8
EBITDA	13.0	11.5	-1.5
Depreciation & Amortisation	-6.6	-4.9	1.7
Non-operating expenses	-	-	-
Interest (net)	-0.2	-0.2	-
Dividend on PDC	-3.4	-3.2	0.2
Net surplus	2.8	3.2	0.4

Key variances from plan are set out below: -

- NHS clinical income was £3.4m above plan due to activity over-performance across most specialties.
- Non-clinical income was £0.1m below plan mainly due to a reduction in other income.
- Pay costs were £3.4m higher than plan, primarily due to an increase in clinical activity which was in excess of plan, resulting in short-term staffing solutions and increased spend on temporary staffing.
- Non-pay costs were £1.4m higher than plan because of increased use of drugs, pacemakers and prosthesis related to increased activity.
- Depreciation and dividend costs were underspent by £1.7m and £0.2m respectively due to a revaluation in land and property and delayed capital expenditure.
- Net interest received was in line with plan.
- 100% of the planned cost improvement programme was delivered during the period.

The Trust spent £3.3m on purchased capital during the period and ended the reporting period with a cash balance of £13.7m. The results for the final four months of 2010/11 and the plan for 2011/12 are set out in the Annual Report of the Foundation Trust.

Accounting policies for pensions and other retirement benefits are set out in note 10 to the accounts and the details of senior employee remuneration can be found on page 39 in the remuneration report.

Our performance with the Better Payments Practice Code is set out in note 11 to the accounts.

Remuneration Report

Remuneration Committee and Policy on Remuneration of Senior Managers

The Remuneration Committee consists of the Non-Executive Directors of the Trust Board chaired by Non-Executive Director, Peter Taylor and meets as a minimum once a year. It met four times during this period with Peter Taylor, Aileen McLeish and Sue Ells attending all four meetings.

The Remuneration Committee sets the policy, and the level, for remuneration of the Executive Directors of the Trust. The Committee receives at least annual reports on the performance of Executive Directors. Mindful of its duties in managing public funds its policy is set to balance the need to appoint and retain Executive Directors within the Trust, in doing so it obtains independent information from external providers where required. All Directors' contracts were open-ended with notice periods of three to six months. There were no contracts containing a provision for compensation for early termination.

Salary and pension entitlements of senior managers for the 8 month period to 30 November 2010

The Trust has included within the definition of senior managers the members of the Executive Team, as well as the Chairman and Non-Executive Directors.

A) Remuneration

	8 month period to 30 November 2010			2009-10		
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (Rounded to the nearest £100)**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind (Rounded to the nearest £100)**
Executive Team	£000	£000	£00	£000	£000	£00
Andrew Liles Chief Executive	110-115	0-5	19	165-170	-	46
Paul Bentley Director of Strategy (from 22 January 2009 to 15 June 2010)	20-25	-	10	120-125	-	50
Keith Mansfield Director of Finance (to 6 April 2009)	-	-	-	0-5	-	-
John Headley Director of Finance (from 9 July 2009) Acting Director of Finance (from 19 March 2009 to 8 July 2009)	75-80	0-5	28	85-90 35-40	- -	21 -
Dr Mike Baxter Medical Director	30-35	100-105	32	50-55	150-155	48
Valerie Bartlett Deputy Chief Executive	85-90	0-5	-	110-115	-	-

A) Remuneration (continued)

	8 month period to 30 November 2010			2009-10		
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind Rounded to the nearest £100**	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind Rounded to the nearest £100**
Executive Team (continued)	£000	£000	£00	£000	£000	£00
Petra Cunningham Acting Director of Human Resources (to 30 April 2009)	-	-	-	5-10	-	-
Raj Bhamber Director of Workforce and Organisational Development (from 20 April 2009)	70-75	0-5	-	105-110	-	-
Ruth Lallmahomed Acting Director of Nursing & Governance (to 31 July 2009)	-	-	-	25-30	-	-
Caroline Becher Chief Nurse (from 1 June 2009 to 19 August 2010)	40-45	-	-	90-95	-	-
Susan Osborne Interim Chief Nurse (from 9 August 2010)	70-75	-	-	-	-	-
Chairman and Non-Executives						
Aileen McLeish Chairman (from 1 October 2008)	10-15	-	-	20-25	-	-
Norman Critchlow Non-Executive Director (to 31 May 2010)	0-5	-	-	5-10	-	-
Peter Taylor Non-Executive Director	0-5	-	-	5-10	-	-
Philip Beesley Non-Executive Director	0-5	-	-	5-10	-	-
Terry Price Non-Executive Director	0-5	-	-	5-10	-	-
Sue Ells Non-Executive Director	0-5	-	-	5-10	-	-
Nadeem Aziz Non-Executive Director (from 1 June 2010 to 31 December 2010)	0-5	-	-	-	-	-

Notes:

a) Amounts shown under Other Remuneration relate to Dr Mike Baxter for his medical work as Consultant at the Trust.
b) Benefits in kind relate to benefits for lease cars (please note that these costs are shown in £ hundreds and not £ thousands).
c) No remuneration was waived by directors, no allowances were paid in lieu and there were no payments in respect of golden hello's.

B) Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 30 November 2010 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 30 November 2010 (bands of £5,000)	Cash Equivalent Transfer Value at 30 November 2010	Cash Equivalent Transfer Value at 31 March 2010	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension (to nearest £100)
Executive Team	£000	£000	£000	£000	£000	£000	£000	£00
Andrew Liles Chief Executive	0.0-2.5	2.5-5.0	25-30	80-85	359	393	(24)	-
Paul Bentley Director of Strategy	0.0-(2.5)	0.0-(2.5)	30-35	95-100	464	565	(22)	-
John Headley Director of Finance & Information	0.0-2.5	-	0-5	-	37	31	4	-
Dr Mike Baxter Medical Director	0.0-2.5	2.5-5.0	60-65	190-195	1,306	1,417	(78)	-
Valerie Bartlett Deputy Chief Executive	2.5-5.0	7.5-10.0	35-40	105-110	550	564	(10)	-
Raj Bhamber Director of Workforce and Organisational Development	0.0-2.5	2.5-5.0	15-20	45-50	232	244	(8)	-
Caroline Becher Chief Nurse (to 19 August 2010)	0.0-2.5	0.0-2.5	45-50	135-140	n/a	1,016	n/a	-

Note:

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

John Headley
Acting Accountable Officer
2 June 2011

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory Accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

John Headley
Acting Accountable Officer
Ashford and St. Peter's Hospitals NHS Trust
2 June 2011

DIRECTORS' STATEMENT

Statement of Directors' responsibilities in respect of the Accounts

The Directors are required under the National Health Service Act 2006 to prepare Accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these Accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those Accounts, the Directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the Accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the Accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Accounts.

By order of the Board

J Headley
Director of Finance & Information and Acting Accountable Officer

Ashford and St. Peter's Hospitals NHS Trust
2 June 2011

DIRECTORS' STATEMENT ON INTERNAL CONTROL 2010/11

Statement on Internal Control 2010/11

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the 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 Ashford and St. Peter's Hospitals NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the period ended 30 November 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 the Trust Board has ultimate responsibility for ensuring that effective processes are in place. The Board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to protect patients, staff and the public from harm and to protect the Trust from losses or damage to its reputation.

The Trust's approach to risk is set out in the Integrated Governance and Risk Strategy, which identifies the roles and responsibilities of Directors, managers and staff in relation to risk identification, analysis and control.

Through the Integrated Governance Assurance Committee (IGAC), which is chaired by a Non-Executive Director and which I attend together with the Head of Internal Audit, Executive Directors and senior managers, the Trust seeks to learn and share good practice through rigorous assessment of the Trust's risk registers (corporate and local) and the Board Assurance Framework, and to cascade this information to relevant Divisional teams through constructive challenge, training and support.

The Audit Committee provides the Board with the assurance that the following are in place:

- Key controls to assist in securing and delivering Trust business objectives;
- Effective and reliable control systems; and
- Agreed and timely corrective action plans for any gaps in controls, systems or assurances.

Internal and external audit reports are reviewed by the Audit Committee and references to best practice are identified and adopted wherever possible. The Audit Committee agrees the annual Internal Audit plan, commissioning this independent review of many aspects of the Trust's operations.

The Trust is committed to supporting its staff in exercising their roles and responsibilities with regard to health and safety risks and all other forms of risk.

Training is provided on an ongoing basis in order to equip staff to carry out their designated responsibilities according to their roles. In addition, risk management awareness is featured in the induction process for all

new staff and all staff have access to information on risk, safety and relevant Trust policies. All such policies are available on the Trust's intranet.

The risk and control framework

The Integrated Governance and Risk Management Strategy sets out the roles of the Board, Directors and key officers, managers and all staff. It describes the governance and risk management structures in place. The strategy sets out the variety of ways in which risks are identified, and puts in place a risk grading matrix based on likelihood and severity.

Management must decide, taking into account the grading of each risk, whether it is appropriate to tolerate, transfer, terminate or treat the risk.

Local and corporate risk registers form the basis for a regular review of all risks, enabling IGAC to play a comprehensive oversight role in the progress in managing risk.

There is an established Information Governance framework within the Trust with the SIRO role (Senior Information Risk Officer) held by the Director of Finance and Information and the role of Caldicott Guardian being held by the Medical Director. A number of Information Asset Owners support the SIRO.

The Trust has an active Information Governance Steering Group which meets on a quarterly basis. The Group is responsible for reviewing any breaches of patient confidentiality and information security incidents recommending appropriate action where necessary. Information Governance policy is overseen ensuring relevant legislation is adhered to, safeguarding person identifiable information at all times.

The Trust also has in place defined and documented information sharing protocols covering other NHS bodies and multi-agencies.

The Trust submitted the IG Toolkit on 30 March 2011, with a self-assessed score of 71% and the Trust achieving Level 2 compliance in all 22 of the Key Requirements. The Trust has availed itself of the extension to 30 June 2011 to achieve the requirement for IG training, and has put in place additional classroom style training to supplement the online training package.

As at 27 May 2011, 78% of staff have been trained. Achieving the target of 95% of staff trained by 30 June 2011 remains a significant challenge for the Trust.

The Trust's Board Assurance Framework has been in place for the whole year, having been considered by the Trust Board five times. As in previous years, the process by which the Board Assurance Framework is constructed and maintained has been reviewed by IGAC.

The Board Assurance Framework links the main elements and aims of the Trust's internal control and governance policies. It is structured around the high level risks which were deemed to be the most significant risks to prevent delivery of the corporate objectives in 2010/11. The Framework consists of the following key elements:

- Key risks: the main risks as identified under the Integrated Governance and Risk Management Strategy which might impede the Trust in achieving its objectives;
- Key Controls / Treatments: mechanisms for controlling the risks that have been identified;
- Board Assurance: the Board gained assurance that the Trust's objectives were being achieved and the risks controlled through a variety of assurance processes, including performance reports with KPIs, audit (internal and external), assessments by regulatory and monitoring agencies and reports from its assurance sub committees.

During 2010/11 the Board Assurance Framework highlighted the following areas, which were graded as posing the highest risk to the Trust's key objectives and where some degree of gap in a control and or assurance had been detected. Associated action plans and accountabilities for resolution were also fully detailed and updated in each iteration.

- The growing volume of emergency work posed a number of risks: to targets, patient experience and financially. Action plans were in place both within the Trust and also in terms of collaborative working with community hospitals and local GPs.

- In a large hospital organisation there is a risk that pockets of poor practice and poor patient experience can pass undetected. A variety of controls are in place, but further actions were underway to reinforce the need for staff to report incidents.
- One of the Trust's key objectives is to improve the experience of patients. A real time patient feedback system ("Your feedback") has been put in place and action plans are in place for a major programme of staff engagement around the patient experience.

The Trust's risk management system supports staff in assessing the risks inherent in their work and workplace, in identifying and implementing appropriate mitigating actions, and in monitoring their outcome.

All Executive Directors, Divisional Directors and General Managers have a responsibility to lead with a strong risk management approach in all aspects of the Trust's activities. Business priorities and decisions made by the Trust Executive Committee and Trust Board reflect risk management assessments and consideration of high risk factors.

Managers at all levels of the organisation are responsible for managing risks at a local level and developing an environment where staff are encouraged to report risk issues proactively.

All managers are expected to ensure that all staff report any near miss incidents, adverse incidents and serious incidents immediately using the Trust Incident Reporting Procedure. Managers are also responsible for ensuring that their staff receive appropriate feedback regarding specific incidents reported, and for ensuring that any recommendations following investigation of an incident are implemented and audited at a later date to ensure they have been effective in reducing the likelihood of the incident happening again.

Members of staff also have an important role to play in identifying and minimising risks as part of their every day work within the Trust. Each individual has a responsibility for their own personal safety and for the safety of their colleagues, patients and all visitors to the Trust. All staff are expected to have an understanding of the Incident Reporting Procedure and knowledge of the corporate categories of incident which must be reported.

The Trust is fully compliant with the requirements of registration with the Care Quality Commission.

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

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

To ensure that the Trust's obligation under the Climate Change Act and Adaptation Reporting requirements are met, risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, and based on the UK Climate Projections 2009 weather projects.

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

There are a number of processes in place to deliver economy, efficiency and effectiveness of the use of resources, including:

- Use of Standing Financial Instructions and a comprehensive Scheme of Delegation
- Use of modern procurement systems, and a robust tendering process for major spend items
- A "bottom-up" budget and cost improvement process with local ownership
- Controls on staffing establishment and recruitment
- Use of business cases and financial evaluation of new investments
- Selective use of benchmarking, e.g. back office functions and nursing establishments
- Involvement of clinicians in the business and devolved financial management of clinical services, supported by service line reporting and patient level costing

The Trust Board obtains assurance from the Finance Committee in respect of financial and budgetary management across the Trust.

Internal Audit includes value for money considerations in their audit scope and action points.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the Executive managers within the Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and IGAC and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board is highly aware of its responsibility for risk management. The role of the Trust Board and its sub-Committees has been thoroughly reviewed and tested as part of the successful Foundation Trust assessment process during the year.

The Audit Committee refreshed its terms of reference during the year, extending its formal responsibilities to cover counter fraud activity and putting in place a coordinated oversight process for the production and sign off of the Annual Report and accounts and the Quality Account. Significant progress was made in following up internal audit actions. The number of outstanding actions graded as "high" or "medium" fell from 67 to 21 by the end of the year.

The Integrated Governance Assurance Committee (IGAC) raised its profile within the Trust, reviewing the structure of clinical and non clinical risk sub committees. IGAC promoted local ownership of risks by reviewing and challenging local risk registers, and their link to the corporate risk register. IGAC sought detailed reviews in areas where a pattern of risk appeared to be manifested, contributing to a better understanding of the issues and improved action plans from local managers. IGAC has played a key role in shaping the Board Assurance Framework and Corporate Risk Register, ensuring that the risks of Foundation Trust status were promptly reflected upon authorisation.

The Head of Internal Audit has provided me with his opinion that "significant assurance" can be given is respect of the Trust's systems of internal control. 95% of the controls tested by internal audit were at "full" or "significant" levels – an increase of 5% compared to the previous year.

Conclusion

No significant internal control issues have been identified in the Trust for the period ended 30 November 2010 and up to the date of approval of the Annual Report and accounts.

John Headley
Acting Accountable Officer
For and behalf of the Board of Ashford and St. Peter's Hospitals NHS Trust
2 June 2011

INDEPENDENT AUDITORS' REPORT TO DIRECTORS OF THE BOARD

We have audited the financial statements of Ashford and St. Peter's Hospitals NHS Trust for the eight month period ended 30 November 2010 on pages 51 to 86. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of Directors of Ashford and St. Peter's Hospitals NHS Trust, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 44, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Ashford and St. Peter's Hospital NHS Trust as at 30 November 2010 and of its expenditure and income for the eight month period then ended; and

- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

- the information given in the director's 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 Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Statement on Internal Control does not reflect compliance with the Department of Health's requirements;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Certificate

We certify that we have completed the audit of the accounts of Ashford and St. Peter's Hospitals NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Ross Tudor for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square
London
E14 5GL

8 June 2011

ANNUAL ACCOUNTS

EIGHT MONTH PERIOD ENDING 30 NOVEMBER 2010

FOREWORD TO THE ACCOUNTS

These Accounts for the 8 month period ended 30 November 2010 have been prepared by Ashford and St. Peter's Hospitals NHS Trust under section 98(2) of the National Health Service Act 1977 (as amended by section 24(2), Schedule 2 of the National Health Service and Community Care Act 1990), in the form which the Secretary of State has, with the approval of the Treasury, directed.

STATEMENT OF COMPREHENSIVE INCOME FOR THE 8 MONTH PERIOD ENDED 30 NOVEMBER 2010

	Note	8 Month Period 2010/11 £'000	12 Month Period 2009/10 £'000
REVENUE			
Revenue from patient care activities	4	138,417	206,670
Other operating revenue	5	11,213	17,400
Operating expenses	7	(143,051)	(215,986)
OPERATING SURPLUS		6,579	8,084
FINANCE COSTS:			
Investment Revenue	12	27	86
Other gains and (losses)	13	(1)	(44)
Finance Costs	14	(252)	(491)
SURPLUS FOR THE FINANCIAL YEAR		6,353	7,635
Public dividend capital dividends payable		(3,165)	(5,508)
RETAINED SURPLUS FOR THE YEAR		3,188	2,127
OTHER COMPREHENSIVE INCOME			
Impairments and reversals		-	(36,920)
Gains on revaluations		-	473
Receipt of donated assets		224	1,220
Reclassification adjustments: - Transfers from donated reserve		(167)	(233)
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		3,245	(33,333)

The notes on pages 56 to 86 form part of these accounts.

Reported NHS financial performance position

The Trust's reported NHS financial performance position for the period to 30 November 2010 is the above surplus of £3,188k. Allowable adjusting items for this position in 2010/11 are Impairments and adjustments in respect of PFI assets (IFRIC 12). The Trust didn't have any of these adjustments in the reporting period.

STATEMENT OF FINANCIAL POSITION AS AT 30 NOVEMBER 2010

	Note	30/11/10 £'000	31/03/10 £'000
NON-CURRENT ASSETS			
Property, plant and equipment	15	145,118	146,090
Intangible assets	16	1,405	1,787
Trade and other receivables	20	799	885
TOTAL NON-CURRENT ASSETS		147,322	148,762
CURRENT ASSETS			
Inventories	19	3,133	3,042
Trade and other receivables	20	18,335	16,835
Cash and cash equivalents	21	13,681	11,659
TOTAL CURRENT ASSETS		35,149	31,536
TOTAL ASSETS:		182,471	180,298
CURRENT LIABILITIES			
Trade and other payables	22	(21,844)	(21,519)
Other Liabilities	24	(1,499)	(1,447)
DH Working Capital Loan	23	(2,450)	(2,450)
Borrowings	23	-	(4)
Provisions	27	(555)	(739)
NET CURRENT ASSETS		8,801	5,377
TOTAL ASSETS LESS CURRENT LIABILITIES		156,123	154,139
NON-CURRENT LIABILITIES			
Borrowings	23	-	-
DH Working Capital Loan	23	(3,675)	(4,900)
Provisions	27	(666)	(702)
TOTAL ASSETS EMPLOYED		151,782	148,537
FINANCED BY TAXPAYERS' EQUITY:			
Public dividend capital		85,706	85,706
Retained earnings		4,745	1,798
Revaluation reserve		59,508	59,267
Donated asset reserve		1,823	1,766
TOTAL TAXPAYERS' EQUITY		151,782	148,537

The financial statements on pages 52 to 86 were approved by the Board on 2 June 2011 and signed on its behalf by:

John Headley
Acting Accounting Officer
Ashford and St. Peter's Hospitals NHS Trust
2 June 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE 8 MONTH PERIOD ENDED 30 NOVEMBER 2010

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Donated Asset Reserve	Total
	£'000	£'000	£'000	£'000	£'000
BALANCE AT 1 APRIL 2010	85,706	1,798	59,267	1,766	148,537
CHANGES IN TAXPAYERS EQUITY FOR THE 8 MONTH PERIOD ENDED 30 NOVMBER 2010					
Retained surplus/(deficit) for the year	-	3,188	-	-	3,188
Transfers between reserves	-	(241)	241	-	-
Impairments and reversals	-	-	-	-	-
Net gain on revaluation of property, plant and equipment	-	-	-	-	-
Receipt of donated assets	-		-	224	224
Reclassification adjustments: - transfers from donated asset reserve	-	-	-	(167)	(167)
BALANCE AT 30 NOVEMBER 2010	85,706	4,745	59,508	1,823	151,782

STATEMENT OF CASH FLOWS FOR THE 8 MONTH PERIOD ENDED 30 NOVEMBER 2010

	Note	8 Month Period 2010/11 £'000	12 Month Period 2009/10 £'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit)		6,579	8,084
Depreciation and amortisation		4,893	9,361
Impairments and reversals		-	4,148
Transfer from donated asset reserve		(167)	(233)
Interest paid		(200)	(497)
Dividends paid		(1,813)	(6,209)
(Increase)/decrease in inventories		(91)	(86)
(Increase)/decrease in trade and other receivables		(2,115)	4,442
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade and other payables		(237)	3,318
Increase/(decrease) in other current liabilities		52	62
Increase/(decrease) in provisions		(220)	236
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		6,681	22,626
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		27	84
(Payments) for property, plant and equipment		(3,461)	(8,958)
Proceeds of disposal of assets held for sale (PPE)		-	1
(Payments) for intangible assets		-	(140)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(3,434)	(9,013)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		3,247	13,613
CASH FLOWS FROM FINANCING ACTIVITIES			
Loans repaid to the DH		(1,225)	(2,450)
Capital element of finance leases and PFI		-	(26)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(1,225)	(2,476)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		2,022	11,137
CASH (AND) CASH EQUIVALENTS AT THE BEGINNING OF THE PERIOD		11,659	522
CASH (AND) CASH EQUIVALENTS AT THE END OF THE PERIOD	21	13,681	11,659

NOTES TO THE ACCOUNTS 30 NOVEMBER 2010

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

There were no areas of critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have a significant effect on the amounts recognised in the financial statements.

Key sources of estimation uncertainty

There are no key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

1.4 Revenue

Revenue 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 revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

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

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 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 leave 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.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. 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.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
    - the item has cost of at least £5,000; or
    - collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
    - items 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, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

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

Land and buildings used for the Trust's services, or for administrative purposes, are stated in the Statement of Financial Position at their revalued amounts, 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 end of the reporting period. Fair values are determined as follows:

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes 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.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has

ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is change in accounting policy from previous years where all impairments were taken to the Revaluation Reserve to the extent that a balance was held for that asset and thereafter to expenditure. Gains and losses recognised in the Revaluation Reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis) indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the Revaluation Reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the Revaluation Reserve to the extent that a balance was held for that asset and thereafter to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the Revaluation Reserve.

1.10 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the Donated Asset Reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are 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 offset the expenditure. On sale of donated assets, the net book value is transferred from the Donated Asset Reserve to Retained Earnings.

1.11 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the Revaluation Reserve is transferred to Retained Earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the Donated Asset is then transferred to Retained Earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

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.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical

negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 27.

1.17 Non-clinical risk pooling

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

1.18 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.19 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised 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 cash flows 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 expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.20 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

oans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and
- The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.21 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.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the relevant spot exchange rate. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.23 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. Details of third party assets are given in Note 33 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trusts not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.26 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2009/10 and 2010/11, in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.27 Joint ventures

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. The Trust currently does not have any Joint ventures.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.28 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.29 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

2. Operating Segments

The Trust Board receives financial information for the Trust as a whole, making decisions based on this. On this basis that Trust has one operating segment being the provision of healthcare. The key data for this operating segment is: -

	Healthcare	
	8 months 2010/11	**12 months 2009/10**
	£'000	£'000
Income	149,630	224,070
Surplus	3,188	2,127
Net assets	151,782	148,537

Of the total income £137,371,000 (2009/10 - £204,376,000) relates to income from Primary Care Trusts.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. There were no income generation activities that are considered material in the context of the accounts.

4. Revenue from patient care activities

		8 months 2010/11 £'000	12 months 2009/10 £'000
Primary Care Trusts		137,371	204,550
Local Authorities		81	95
Department of Health		-	(33)
Non- NHS	Private patients	376	706
	Overseas patients (non reciprocal)	45	107
	Injury cost recovery	496	992
	Other	48	253
		138,417	206,670

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

5. Other operating revenue

	8 months 2010/11 £'000	12 months 2009/10 £'000
Education, training and research	5,298	8,159
Transfer from Donated Asset Reserve	167	233
Non-patient care services to other bodies	1,667	2,680
Income generation	3,088	4,809
Other income	993	1,519
	11,213	17,400

6. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating expenses

	8 months 2010/11 £'000	12 months 2009/10 £'000
Services from other NHS Trusts	256	593
Services from Primary Care Trusts	494	926
Services from other NHS bodies	17	104
Services from Foundation Trusts	290	121
Purchase of healthcare from non NHS bodies	2,902	5,014
Trust Chair and Non Executive Directors' costs	36	54
Employee Benefits	93,743	135,518
Supplies and services – clinical	26,782	38,182
Supplies and services – general	2,723	4,251
Consultancy services	1,190	1,653
Establishment	1,302	2,109
Transport	237	358
Premises	4,509	7,775
Provision for impairment of receivables	3	316
Depreciation	4,476	8,767
Amortisation	417	594
Impairments and reversals of property, plant and equipment	-	4,148
Audit fees	117	107
Other auditor's remuneration	63	62
NHS clinical negligence scheme	2,827	4,110
Education and Training	398	507
Other	269	717
	143,051	215,986

8. Operating leases

As lessee:

	8 months 2010/11 £'000	12 months 2009/10 £'000
Payments recognised as an expense:		
Minimum lease payments	367	343
Contingent rents	-	-
Sub-lease payments	-	-
	367	343

	8 months 2010/11 £'000	12 months 2009/10 £'000
Total future minimum lease payments:		
Not later than one year	319	290
Between one and five years	728	443
After five years	3	-
Total	1,050	733

9. Employee costs and numbers

9.1 Employee costs

	8 months 2010/11			12 months 2009/10		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	80,239	69,342	10,897	115,043	100,889	14,154
Social security costs	5,748	5,641	107	8,387	8,241	146
Employer contributions to NHS Pension scheme	7,749	7,605	144	11,163	10,969	194
Other pension costs	-	-	-	625	625	-
Termination benefits	7	7	-	300	300	-
	93,743	82,595	11,148	135,518	121,024	14,494

Prior year figures have been restated to a basis consistent with the current period.

9.2 Average number of people employed

	8 months 2010/11			12 months 2009/10		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	446	429	17	465	446	19
Administration and estates	899	837	62	1,006	933	73
Healthcare assistants and other support staff	499	413	86	27	27	-
Nursing, midwifery and health visiting staff	1,095	910	185	1,424	1,171	253
Nursing, midwifery and health visiting learners	13	13	-	13	13	-
Scientific, therapeutic and technical staff	410	404	6	427	400	27
Other	6	6	-	-	-	-
	3,368	3,012	356	3,362	2,990	372

9.3 Staff sickness absence

	8 months 2010/11	12 months 2009/10
Total days lost	14,981	22,645
Total staff years worked	2,007	2,939
Average working days lost (annualised)	7.5	7.7

The note above is based on data for the calendar year 2010 in line with national guidance. This data has been pro-rated for the four month period of these accounts.

9.4 Management costs

	8 months 2010/11 £'000	12 months 2009/10 £'000
Management costs	7,710	10,170
Income	149,630	222,830
Management costs as a percentage of relevant income	5.15%	4.56%

10. 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, GP 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 Trust 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 March 2011 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

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:

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".

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.

Early payment of a pension, with enhancement is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the Scheme. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement, regardless of the method of payment.

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

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	8 months 2010/11		12 months 2009/10	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the period	39,131	51,288	56,160	71,138
Total Non-NHS trade invoices paid within target	37,103	48,045	52,502	63,949
Percentage of Non-NHS trade invoices paid within target	94.8%	93.7%	93.5%	89.9%
Total NHS trade invoices paid in the period	1,284	9,068	2,418	21,349
Total NHS trade invoices paid within target	982	6,660	1,350	13,329
Percentage of NHS trade invoices paid within target	76.5%	73.4%	55.8%	62.4%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

An amount of £nil (2009/10 – £nil) is included within Finance Costs (Note 14) arising from claims made under this legislation. No compensation was paid to cover debt recovery costs under this legislation.

12. Investment revenue

	8 months 2010/11	12 months 2009/10
	£'000	£'000
Interest revenue		
Bank accounts	27	86

13. Other gains and losses

	8 months 2010/11	12 months 2009/10
	£'000	£'000
Gain/(loss) on disposal of property, plant and equipment	(1)	(44)

14. Finance costs

	8 months 2010/11	12 months 2009/10
	£'000	£'000
Finance costs		
Interest on loans	252	491
Interest on obligations under finance leases	-	-
Interest on late payment of commercial debt	-	-
Total	252	491

15. Property, plant and equipment

2010/11:	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport & equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 April 2010	32,700	102,048	1,643	26,197	73	6,616	3,457	172,734
Additions purchased	-	-	2,998	318	-	-	-	3,316
Additions donated	-	-	-	189	-	-	-	189
Reclassifications	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	(481)	-	-	-	(481)
Revaluation/indexation gains	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-
At 30 November 2010	32,700	102,048	4,641	26,223	73	6,616	3,457	175,758
Depreciation at 1 April 2010	-	-	-	19,453	66	4,675	2,450	26,644
Reclassifications	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	(480)	-	-	-	(480)
Impairments	-	-	-	-	-	-	-	-
Charged during the period	-	2,750	-	1,162	1	423	140	4,476
Depreciation at 30 November 2010	-	2,750	-	20,135	67	5,098	2,590	30,640
Net book value at 30 November 2010	32,700	99,298	4,641	6,088	6	1,518	867	145,118
Net book value								
Purchased	32,700	98,521	4,641	5,156	6	1,473	836	143,333
Donated	-	777	-	932	-	45	31	1,785
Total at 30 November 2010	32,700	99,298	4,641	6,088	6	1,518	867	145,118
Asset financing								
Owned	32,700	99,298	4,641	6,088	6	1,518	867	145,118
Finance leased	-		-	-	-	-	-	-
Total at 30 November 2010	32,700	99,298	4,641	6,088	6	1,518	867	145,118

Of the totals at 30 November 2010 £2,000,000 (31/03/10 £2,000,000) related to land valued at open market value and £nil related to buildings and dwellings valued at open market value.

The Trust had its land and building revalued in March 2010 by the Valuation Office Agency.

The remaining economic lives of property, plant and equipment are:

	Minimum life (years)	Maximum life (years)
Land	-	100
Buildings excluding dwellings	-	89
Assets under Construction & POA	-	-
Plant & Machinery	-	12
Transport Equipment	-	2
Information Technology	-	8
Furniture & Fittings	-	8

16. Intangible fixed assets

2010/11:	**Software Licences**	**Total**
	£'000	£'000
Gross cost at 1 April 2010	4,036	4,036
Reclassifications	-	-
Additions purchased	-	-
Additions donated	35	35
Gross cost at 30 November 2010	4,071	4,071
Amortisation at 1 April 2010	2,249	2,249
Charged during the period	417	417
Amortisation at 30 November 2010	2,666	2,683
Net book value		
- Purchased	1,365	1,365
- Donated	40	40
Total at 30 November 2010	1,405	1,405

The Revaluation Reserve balance for intangible assets is £nil (2009/10 £nil).

The remaining economic lives of intangible assets are:

	Minimum life (years)	Maximum life (years)
Software	-	5

17. Impairments

There were no impairments of land and buildings during the period (2009/10 £41,068,000).

18. Capital commitments

Contracted capital commitments as at 30 November 2010 were as follows:

	30/11/10 £'000	31/03/10 £'000
Property, plant and equipment	626	608
Intangible assets	-	-
Total	626	608

19. Inventories

	30/11/10 £'000	31/03/10 £'000
Drugs	775	725
Consumables	2,295	2,254
Energy	63	63
Total	3,133	3,042
Of which held at net realisable value	-	-

20. Trade and other receivables

20.1 Trade and other receivables

	Current		Non-current	
	30/11/10 £'000	31/03/10 £'000	30/11/10 £'000	31/03/10 £'000
NHS receivables – revenue	11,625	10,833	-	-
NHS receivables – capital	-	-	-	-
Non NHS receivables – revenue	1,182	1,267	-	-
Non NHS receivables - capital	-	-	-	-
Provision for the impairment of receivables	(330)	(446)	-	-
Prepayments and accrued income	4,069	2,960	-	-
VAT	-	398	-	-
Other receivables	1,789	1,823	799	885
Total	18,335	16,835	799	885

20.2 Receivables past their due date but not impaired

	30/11/10 £'000	31/03/10 £'000
By up to three months	1,859	1,190
By three to six months	186	332
By more than six months	763	1,565
Total	2,808	3,087

20.3 Provision for impairment of receivables

	30/11/10 £'000	31/03/10 £'000
Balance at 1 April 2010	(446)	(271)
Amount written off during the period	119	141
Amount recovered during the period	-	-
(Increase)/decrease in receivables impaired	(3)	(316)
Balance at 30 November 2010	(330)	(446)

21. Cash and cash equivalents

	30/11/10 £'000	31/03/10 £'000
Balance at 1 April 2010	11,659	522
Net change in period	2,022	11,137
Balance at 30 November 2010	13,681	11,659

	30/11/10 £'000	31/03/10 £'000
Made up of		
Cash with OPG/GBS	13,644	11,634
Commercial banks and cash in hand	37	25
Cash and cash equivalents as in statement of financial position	13,681	11,659
Bank overdraft	-	-
Cash and cash equivalents as in statement of cash flows	13,681	11,659

22. Trade and other payables

	Current		Non-current	
	30/11/10	31/03/10	30/11/10	31/03/10
	£'000	£'000	£'000	£'000
Interest payable	69	17	-	-
NHS payables – revenue	1,762	2,140	-	-
Non NHS trade payables – revenue	4,130	4,203	-	-
Non NHS trade payables - capital	418	563	-	-
Accruals and deferred income	11,606	11,470	-	-
Social security costs	1,275	1,242	-	-
VAT	81	-		
Tax	1,604	1,517	-	-
Other	899	367	-	-
Total	21,844	21,519	-	-

23. Borrowings

	Current		Non-current	
	30/11/10	31/03/10	30/11/10	31/03/10
	£'000	£'000	£'000	£'000
Department of Health loan	2,450	2,450	3,675	4,900
Finance lease liabilities	-	4	-	
Total	2,450	2,454	3,675	4,900

The loan was taken out in March 2007 for a period of six years. Repayments of principal and interest are made in September and March each year and the last repayment is due in March 2013.

24. Other liabilities

	Current		Non-current	
	30/11/10	31/03/10	30/11/10	31/03/10
	£'000	£'000	£'000	£'000
Other	1,499	1,447	-	-

Other liabilities include £1,499,000 for outstanding pensions contributions at 30 November 2010 (31 March 2010 - £1,447,000).

25. Finance lease obligations

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease payments	
	30/11/10 £'000	31/03/10 £'000	30/11/10 £'000	31/03/10 £'000
Within one year	-	4	-	4
Between one and five years	-	-	-	-
After five year	-	-	-	-
Less future finance charges	-	-	-	-
Present value of minimum lease payments	-	4	-	4

26. Finance lease commitments

The Trust has not entered into any finance lease whereby the asset will be made available for use and rental payments commence in the year from 1 December 2010.

27. Provisions for liabilities and charges

	Pensions relating to other staff £'000	Legal claims £'000	Other £'000	Total £'000
At 1 April 2010	541	63	837	1,441
Arising during the year	-	-	5	5
Used during the year	(27)	(18)	(180)	(225)
Reversed unused	-	-	-	-
Unwinding of discount	-	-	-	-
At 30 November 2010	514	45	662	1,221
Expected timing of cashflows:				
Not later than one year	57	45	453	555
Later than one year but not later than five years	210	-	70	280
Later than five years	247	-	139	386
As at 30 November 2010				
Current	57	45	453	555
Non-Current	457	-	209	666
As at 31 March 2010				
Current	57	63	619	739
Non-Current	484	-	218	702

Of the provisions a total of £168,000 (31 March 2010 - £168,000) is recoverable from PCTs under back to back arrangements.

Clinical negligence provisions

Included in the provisions of the NHS Litigation Authority at 30 November 2010 is £20,749,000 in respect of clinical negligence liabilities of the Trust (31 March 2010 - £23,336,000).

Legal claim provisions

The majority of these provisions relate to claims under the Liabilities to Third Parties Scheme and Property Expenses Scheme, and are calculated based on information provided by the NHS Litigation Authority. The amounts involved and the timing of the payments represents their best estimate of the outcome of each claim against the Trust.

In addition to these provisions, contingent liabilities in respect of the claims are given in note 29.

Other provisions

Other provisions at 30 November 2010 include: -

- two injury benefit cases of £226,000 as notified to the Trust by the NHS Business Services Authority - Pensions Division;
- redundancy/restructuring costs of £334,000; and
- unpaid salary arrears for medical staff transferring to a new contract of £100,000.

28. Contingent assets/(liabilities)

Other

Other Contingent Liabilities for non-clinical negligence incidents total £(46,000) (2009/10- £(22,000)).

29. Financial instruments

29.1 Financial assets

	Loans & Receivables	Total
	£'000	£'000
Trade Receivables	12,807	12,807
Cash at bank and in hand	13,681	13,681
Total at 30 November 2010	26,488	26,488
Trade Receivables	12,100	12,100
Cash at bank and in hand	11,659	11,659
Total at 31 March 2010	23,759	23,759

29.2 Financial liabilities

	Other £'000	Total £'000
Trade Payables	6,311	6,311
Other borrowings	6,125	6,125
Total at 30 November 2010	12,436	12,436
Trade Payables	6,906	6,906
Other borrowings	7,350	7,350
Total at 31 March 2010	14,256	14,256

29.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with local 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 to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the 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.

Interest Rate Risk

The Trust borrows from Government for capital expenditure, subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1-25 years, in line with the life of the
associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit Risk

Because of 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 30 November 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contract with Primary Care Trusts, which are financed from resources voted annually by Parliament. The trust funds it capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

30. Events after the reporting period

On 1 December 2010 the assets and liabilities of Ashford and St. Peter's Hospitals NHS Trust transferred to the Trust's successor organisation, Ashford and St. Peter's Hospitals NHS Foundation Trust. There are no other events after the reporting period having a material effect on the accounts.

31. Financial Performance Targets

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

31.1 Breakeven Performance

The Trust's breakeven performance for 2010/11 is as follows:

	2006/07	2007/08	2008/09	2009/10	2010/11
	£'000	£'000	£'000	£'000	£'000
Turnover	179,522	191,650	213,266	224,070	149,630
Retained surplus/(deficit) for the year	1,068	2,450	5,513	2,127	3,188
Adjustments for impairments	-	-	261	4,148	-
Other agreed adjustment – reversal of RAB deduction	-	-	-	-	
Breakeven in year position	1,068	2,450	5,774	6,275	3,188
Breakeven cumulative position	(10,647)	(8,197)	(2,423)	3,852	7,040
Materiality test:					
Breakeven in-year position	0.59%	1.28%	2.71%	2.80%	2.13%
Breakeven cumulative position	(5.93%)	(4.28%)	(1.14%)	1.72%	4.70%

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

31.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of actual average relevant net assets. As at the Balance Sheet date the Trust has only made a payment of 50% of the estimated value. The Trust's successor organisation, Ashford and St. Peter's Hospitals NHS Foundation Trust, will be responsible for making the second payment in March 2011, although a partial accrual is reflected in the accounts of the Trust. The charge to expenditure in the period to 30 November 2010 was £3,165,000.

31.3 External financing

	8 months 2010/11		12 months 2009/10
	£'000	£'000	£'000
External financing limit		(3,247)	(6,199)
Cash flow financing	(3,247)		(13,613)
External financing requirement		(3,247)	(13,613)
Undershoot		-	7,414

The External Financing Limit (EFL) is a limit on the amount of external finance that the Trust may access in any one year and it is permitted to undershoot this. With a negative EFL the Trust is targeted with reducing its borrowing position or increasing cash balances. In 2009/10 the Trust recorded an undershoot of £7.4m against an EFL of (£6.2m) by repaying instalments on a loan (£2.5m) and increasing cash balances (£11.1m).

31.4 Capital resource limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to overspend.

	8 months 2010/11	12 months 2009/10
	£'000	£'000
Gross capital expenditure	3,540	10,303
Less: book value of assets disposed of	(1)	(45)
Plus: loss on disposal of donated assets	1	-
Less: donations towards the acquisition of fixed assets	(224)	(1,220)
Charge against the CRL	3,316	9,038
Capital resource limit	3,316	9,433
Underspend against the CRL	-	395

32. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Ashford and St Peter's Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the year Ashford and St Peter's Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

South East Coast Strategic Health Authority
London Strategic Health Authority
NHS Surrey
Hounslow PCT
Ealing PCT
Berkshire East PCT
Richmond & Twickenham PCT
Hampshire PCT
West Kent PCT
Lambeth PCT
Surrey and Borders Partnership NHS Foundation Trust
Royal Surrey County NHS Foundation Trust
NHS Business Services Authority
NHS Blood and Transplant
NHS Professionals Limited
NHS Litigation Authority
NHS Purchasing and Supply Agency
NHS Pensions Scheme

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with H M Revenue and Customs, Surrey County Council, Runnymede Borough Council and Spelthorne Borough Council.

The Trust has also received revenue and capital payments from the Ashford and St. Peter's Hospitals Charitable Fund. The Board members of the Trust are also Trustees of this charity. The audited annual report and accounts of the Charity are available to the public on request.

33. Third Party Assets

The Trust held £9,000 cash at bank and in hand at 30 November 2010 (31 March 2010 - £9,000) which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

34. Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other Central Government Bodies	12,482	799	7,013	-
Balance with Local Authorities	179	-	90	-
Balances with NHS Trusts and Foundation Trusts	1,237	-	579	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Balance with bodies external to Government	4,437	-	14,162	-
At 30 November 2010	18,335	799	21,844	-
Balances with other Central Government Bodies	9,933	-	1,100	-
Balance with Local Authorities	25	-	2	-
Balances with NHS Trusts and Foundation Trusts	900	-	1,040	-
Balances with Public Corporations and Trading Funds	-	-	-	-
Balance with bodies external to Government	5,977	885	19,377	-
At 31 March 2010	16,835	885	21,519	-

35. Losses and special payments

Losses and special payments are transactions that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. Payments are made in accordance with the HM Treasury publication *Managing Public Money*.

There were 108 cases of losses and special payments (2009/10: 156 cases) totalling £120,770 (2009/10: £270,000) paid between April and November 2010. There were no cases where the net payment exceeded £250,000 (2009/10 – nil). Total costs included in this note are on an accruals basis excluding provisions for future losses.