Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS

1st APRIL 2011 to 31st MARCH 2012

Patients First Personal responsibility Passion for excellence Pride in our team

ANNUAL REPORT AND ACCOUNTS

April 2011 – March 2012

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1. Introduction

This report covers the financial period from 1st April 2011 to 31st March 2012.

Trust profile

Originally established in1998 from the merger of Ashford and St Peter's Hospitals, the Trust has been on a long journey of development and improvement to its current position as the largest provider of acute hospital services to Surrey residents, and having become a Foundation Trust in December 2010.

Ashford and St Peter's Hospitals NHS Foundation 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 3,300 staff and in 2011/12 our turnover for the year was £227 million.

The Trust provides a whole range of services across its two hospital sites in Surrey - 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 9).

Statement by the Chairman and Chief Executive

As we come to the end of our first full financial year as a Foundation Trust, we have seen many positive developments for our patients despite a challenging year both financially and in terms of capacity and change. Our staff have continued to work hard to ensure high quality and safe care for our patients and we remain proud of their commitment and dedication. In particular, we have seen our values – the 4 Ps (patients first; personal responsibility; passion for excellence; pride in our team) – really take hold within our organisation, guiding us in our work to improve patient care.

This has been one of our most successful years in terms of managing infection control, as we celebrated over a full year (crossing two financial years) without a hospital acquired MRSA bacteraemia infection, one of only a handful of Trusts in the country to do so. We continue to be a high performer for patients with broken hips and for providing the best care for patients coming to hospital after a heart attack (evidenced in the *Enhancing* Quality programme, see p. 21). We have also introduced a range of new services to improve patient care, such as our acute oncology service, a new telemedicine service for stroke thrombolysis and we continue to develop specialist services such as bariatric and vascular surgery.

But there have been some challenges; the unannounced visit by the Care Quality Commission in December – despite highlighting much good work – raised a number of concerns, particularly around how we manage capacity at times of peak demand (see p. 20 for more details). Along with the rest of Surrey, we experienced a particularly difficult winter in terms of capacity and have struggled to maintain the four hour waiting target; as a result we have been very focused on work to improve our emergency care pathway and on the flow of patients through our two hospitals.

Challenging times have also had an impact on how our staff feel and results from the latest national staff survey have shown us that we need to do more to engage and involve our staff (see p. 25) and this will be a key focus for us next year. Despite this, staff have continued to work in inspiring ways, going above and beyond on behalf of our patients and the many individual compliments and improving feedback bear testimony to a committed and skilled workforce.

We continue to develop a positive working relationship with our Council of Governors and our wider membership. Our Governors have been quick and willing to get involved with the working of the Trust and have offered fair challenge to the Board over a range of issues. We look forward to their increasingly important role under the new Health and Social Care Act and will be supporting them to exercise their new duties as representatives of our wider community and local stakeholder bodies.

As we come to the end of this financial year we have had to say goodbye to our Medical Director, Dr Mike Baxter, who has retired from the NHS. Dr Baxter first joined Ashford and St Peter's in 1992 as a consultant diabetologist and endocrinologist and was appointed as Medical Director in 2002. During his time here his contribution to the Trust and to our patients has been considerable, both in his clinical role and, as Medical Director, overseeing much of our strategy over the last few years, most notably in the run up to becoming a Foundation Trust in 2010. We would like to take this opportunity to thank Mike for all he has done for the Trust. In his place we welcomed Consultant Cardiologist Dr David Fluck as interim Medical Director from 1st February.

We also say goodbye to our Director of Finance and Information, John Headley, as he takes on a new role as Director of Finance at Maidstone and Tunbridge Wells NHS Trust. John joined the Trust in January 2009, and was instrumental in guiding the Trust towards Foundation Trust status. We would like to thank him for his hard work over the last three years and to wish him well in his new role. In his place we will be welcoming Simon Marshall as our new Director of Finance and Information from May 2012.

Finally we would like to underline our thanks to everyone who has made a contribution over the last year; to our staff and volunteers 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, not to mention all those who give up their time to raise valuable funds for our hospitals. Thank you for all your support and co-operation.

Despite operating within an NHS which is experiencing organisational change at a time of increasing demand for services but reduced funding, the Board believes that the Trust is well placed to manage the challenges ahead. And, despite some of the difficulties experienced this year, there is no doubt that Ashford and St Peter's remains 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 coming year will see the possibility of expanding our organisation by acquiring Epsom Hospital, with opportunities for additional benefits for patients right across our catchment area and around Epsom. We remain ambitious in our plans, for patients and staff, and will focus on building on both our achievements and learning from this year to continue in our ambition to be one of the best healthcare organisations in the country.

Aileen McLeish
Chairman

Andrew Liles
Chief Executive

2. Directors' Report and Management Commentary

Management Commentary

Introduction

The Directors present their annual report for the financial year 1st April 2011 to 31st March 2012, 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 year, and a summary of our overall performance against our corporate objectives for 2011/12.

Overview

Overall the Trust has performed well against its corporate objectives (see p. 14 for more details) and has met its financial and statutory duties, finishing the year with a surplus of £1m and savings of £10.9m. Although slightly less than originally planned, with savings plans slow to take off during the first part of the year (see p. 36) the Trust maintained a Financial Risk Rating of 3 despite a challenging national and local economic environment.

The Trust also maintained its registration with the Care Quality Commission and has continued to score well against the majority of quality and performance standards throughout this period, comfortably meeting most of the 18 week and cancer waiting targets and celebrating its best ever year for infection control. This included just over a year without an MRSA hospital acquired bacteraemia (spanning two separate financial years), with a total of just 2 cases recorded against a target of no more than 4 within the financial year.

The Trust continues to report a lower than average mortality rate (Source: Dr Foster SHMI data), with good outcomes reported for many conditions most related to hospital admission including treating patients with hip fractures, following a heart attack and stroke.

However, the Trust has been struggling to meet and maintain the 4 hour waiting target since Quarter 3 due to particularly high capacity issues across both hospitals. This meant the Trust needed to open up escalation areas much earlier than anticipated and, during times of peak capacity, meant patients were accommodated overnight in less appropriate areas, such as the Day Surgery Unit. Whilst recognising this did not offer the very best levels of comfort and care, the Trust's decision was based on balancing the needs of many competing priorities and maintaining safety. Use of the Day Surgery Unit as escalation was one of a number of concerns picked up by the Care Quality Commission during an unannounced visit in December (see p. 20) the Board made the decision to close the unit to overnight patients with immediate effect.

The CQC review brought the Trust's Monitor Compliance rating down from amber-green and green in the first two quarters to amber-red for the final quarter. Going forward into 2012/13, the Trust has robust plans in place to significantly improve the emergency care pathway through the two hospitals in order to ease flow, alleviate the pressure in A&E and ensure it meets the four hour target.

The Trust's principal commissioner, NHS Surrey, was also under considerable financial pressure throughout 2011/12 and the Trust worked with NHS Surrey to manage its position by agreeing a risk share arrangement in the acute services contract, and seeking national 18 week funding to ensure national targets were met.

During 2011/12 the Trust began working with the newly formed North West Surrey Clinical Commissioning Group (NWSCCG) which is expected to replace NHS Surrey at the end of 2012/13 in accordance with the new Health and Social Care Act, and will be a key relationship going forward.

In terms of the Trust's longer term strategy, earlier last year we consolidated our position as a key working partner with Virgincare (formally Assura Medical), who are now responsible for providing community services across West and other parts of Surrey. We also submitted our plans to acquire Epsom Hospital to the Epsom and St Helier Transaction Board; whilst our plans have met the relevant criteria as this annual report goes to print we await the outcome as to whether or not the Trust will be announced as preferred bidder.

Key activities

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

- Admitted patient care for planned surgery and emergency medicine and surgery
- Accident and emergency services
- Critical care
- Outpatient services, both in the hospitals and across a number of community settings
- Community services, e.g. community midwifery

Services are 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, 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 (using cameras to look inside the body) and MRI scans
- pathology services

Activity review

Over the last year our total number of patients treated has remained relatively stable at just over half a million attendances overall for the year.

Whilst we have increased the number of first outpatient appointments, a reduction in follow up appointments and in some outpatient procedures means we show a slight decrease on total outpatient attendances overall (see Fig 1 below). We have also seen an overall increase in the number of emergency admissions and in the number of births. However, we have worked hard to reduce the numbers of emergency admissions in many areas – such as residents coming in from nursing homes – but different ways of recording some of our overnight stays mean the overall

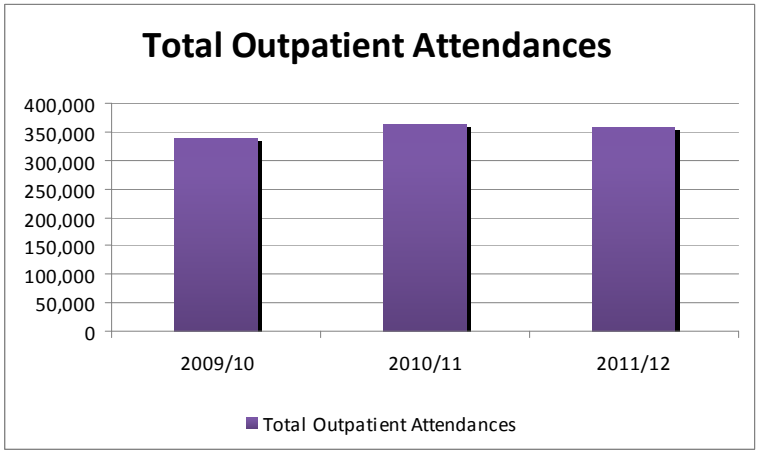
numbers show a slight increase. Overall another extremely busy winter period still resulted in the Trust experiencing higher numbers of emergency admissions than we would wish and, with continuing penalties for both emergency admissions (over 2008/09 rates) and on readmissions, reducing these numbers further will continue to be a key focus for us.

The Trust continues to perform well in terms of day case activity, although overall this has seen a slight decline in numbers this year with some procedures now being undertaken in outpatients instead. Elective, or planned, admissions have increased this year and this is partly explained by the continued development of our specialist services such as bariatric and vascular surgery resulting in higher numbers of referrals for these specialties.

Continued increases in the number of births at the Trust underlines the improving reputation of our maternity services over the last few years. The development of our new Midwifery Led Unit over the next 18 months will offer local women even greater choice and we will expect these numbers to increase significantly over the years to come.

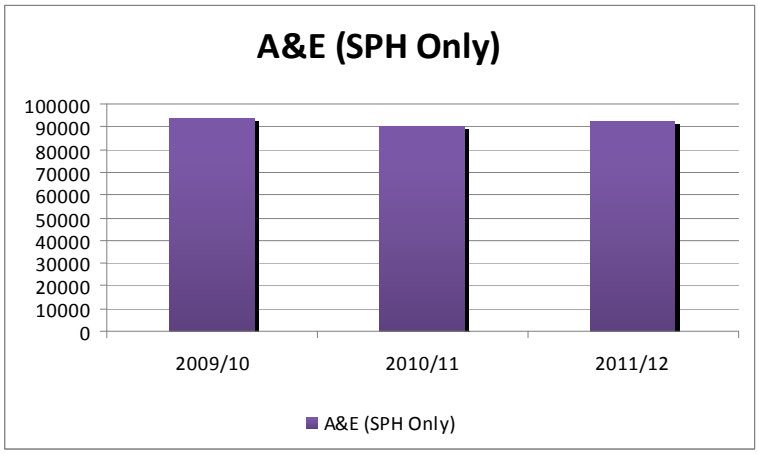
The following graphs illustrate these trends over the last three years:

Fig 1: Outpatient attendances



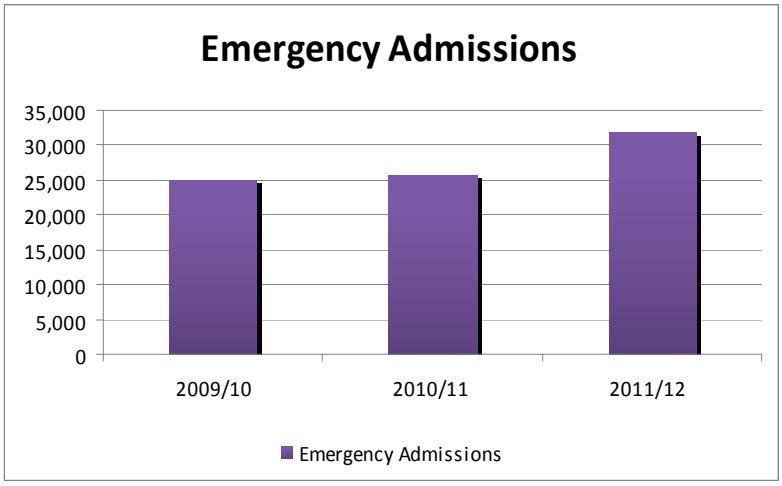
Note: The significant increase from 2009/10 to 2010/11 is partly explained by the move of physiotherapy services from NHS Surrey during 2009/10.

Fig 2: A&E attendances



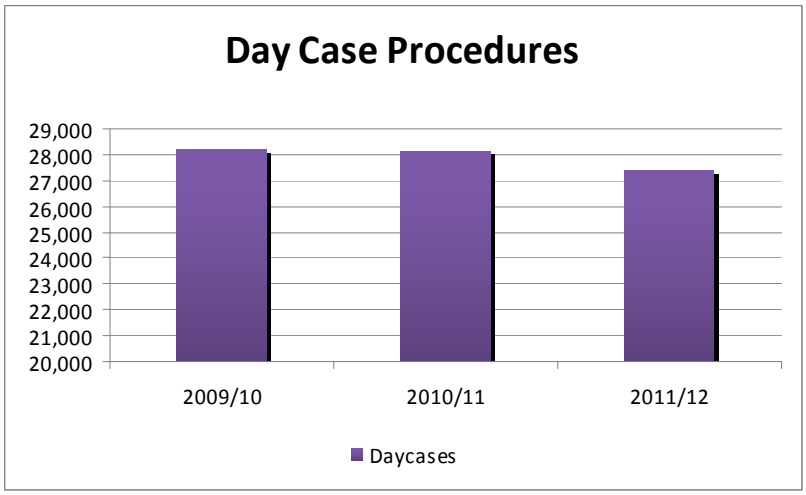
Note: A&E figures for 2009/10 include some attendances at the Ashford Walk-in Centre before it transferred to Greenbrooks Healthcare in July 2009, hence the drop in figures compared to 2010/11.

Fig 3: Emergency admissions



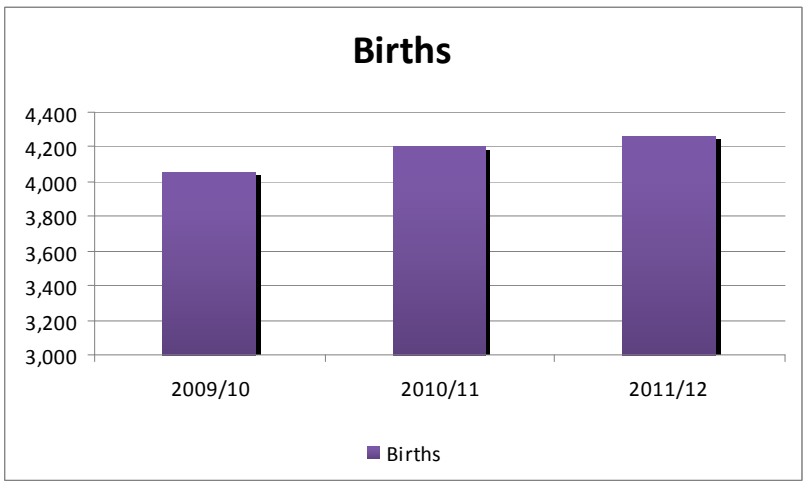
Note: Although overall emergency admission numbers have shown an increase this is partly due to different ways of recording some activity. We have in fact seen a reduction in some categories of emergency admissions and have worked hard to keep these as low as possible due to continuing penalties being applied to the number of admissions over 2008/9 levels.

Fig 4: Day case procedures



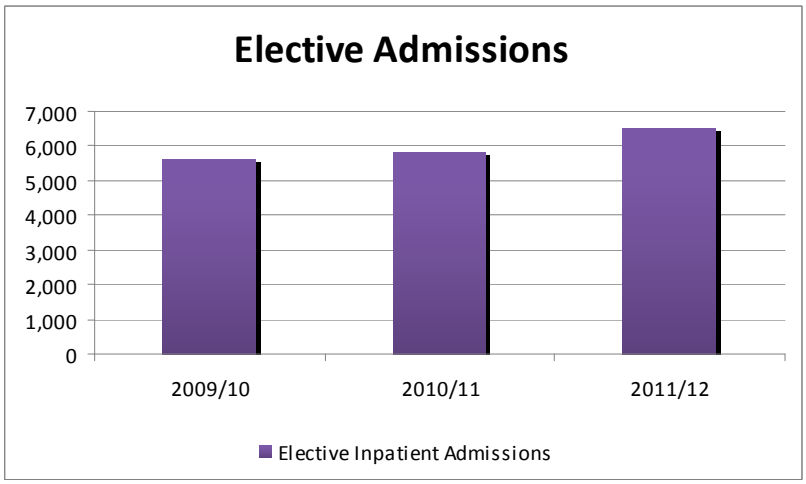
Note: Day case rates have decreased slightly due to some procedures now being undertaken in outpatients.

Fig 5: Births



Note: The numbers of births at the Trust shows a continuing rise, reflecting an improved reputation in our maternity services and positive patient feedback.

Fig 6: Elective admissions



Note: We continue to see a rise in elective admissions as we develop our specialist services such as vascular and bariatric surgery.

Contract value by commissioner

Fig. 7: Commissioning contract values

Commissioner	Planned contract value £'000s	Year-end income
Surrey	170,257	173,785
Hounslow	14,101	14,220
Berkshire East	5,846	5,872
Berkshire West	161	150
Richmond & Twickenham	1,953	2,081
Hampshire	874	895
Ealing	379	405
Hillingdon	366	361
Kingston	245	533
Sutton	212	251
Total	**194,394**	**198,553**

The Trust's final year end income from all income streams was just over £227 million.

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. This work is underpinned by our values – the 4 Ps – which we are using to 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 2011/12 were developed within the context of our four strategic objectives (as set out below), the NHS Operating Plan for 2011/12 and our contract with NHS Surrey, our main commissioner. In summary, our plan for the year was as follows:

1 **Achieving highest standards of quality**

- Making sure patients' needs are at the centre of what we do – 'no decision about me without me'
- A high quality patient experience for everyone – particular focus on discharge, care of the elderly and our more vulnerable patients
- High performance against all our targets, measuring ourselves against others so we improve

2 **Developing a high performing workforce**

- Planning our workforce to reflect patients' needs and what we can afford
- Creating a learning organisation with innovative training and embedding our 4 Ps
- Maximising and celebrating talent in an organisation with clear roles and responsibilities

3 **Delivering our clinical strategy**

- Redesign local health services to create seamless pathways for patients
- Better referral management and prioritisation of planned activity
- Work with our partners to create alternatives to hospital admission and reduce unnecessary admissions
- Continue to develop our specialist services, widen our market share and bring specialist work back from London

4 **Improving productivity and efficiency**

- Meeting our savings plans (£12 million)
- Promote a more commercial and business focused culture within Trust
- Improving the quality and efficiency of our services, particularly through EQUIP in key clinical areas e.g. theatres, outpatients and wards

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. Key quality priorities are described in more detail in the Quality Report – see p. 42 – but in terms of meeting this core objective our headline achievements are:

Improving patient experience

This year we continued with our key objective to make real improvements to the patient experience, in particular focussing on enhancing nursing care, upgrading more of our facilities and making big improvements to patient and visitor parking particularly at St Peter's. In more detail:

Enhancing Nursing Care

Over the year we have continued to reinforce traditional nursing values and to ensure our patients get the very best care and treatment during their time in hospital. Highlights from the year include:

Our Best Care Project – making sure patients get the *right care, first time, every time*. The Trust introduced a monthly audit which focuses on the following core elements of patient care; patient observation, nutrition, skin integrity, manual handling / falls assessment, medication, nursing documentation, consent form, privacy and dignity, communication, environment and infection control and nursing competencies. This is carried out by oure Matrons and reported to the Trust Board on a monthly basis providing benchmark data for each ward area against which improvements are being made.

Introducing care rounding – earlier last year we introduced regular patient care rounds to ensure patients are receiving the best care possible around the clock. Checking on basic elements of care regularly in a structured way has made noticeable improvements to patient care and to their overall experience; asking patients regularly if they have had enough to eat and drink, if they are in pain or need the bathroom and so on. As a result the Trust has seen reductions in the number of patient falls on the wards (6.8% overall) and a big improvement in pain management.

Chief Nurse's award for best improvements in patient experience - last year we introduced a monthly Chief Nurse award for the best improvements in patient care for our wards and other patient areas. Each month the Chief Nurse presents the team with their certificate and the winning team is able to display a special banner which promotes their achievement to patients and visitors and is a positive motivator for staff.

Continued investment in the patient environment

Creating the right environment for patient care is equally important in providing a good patient experience, from the minute a patient arrives on our hospital sites to when they leave. Over the year there have been a number of key improvements:

Car parking – during the year significant improvements have been made to patient and visitor car parking facilities as part of the Trust's implementation of its new Travel and Car Parking Policy. This included a new barrier system at St Peter's, to protect patient and visitor parking, and which has virtually eliminated queues for parking spaces (which had previously been a significant issue), a move very much welcomed by patients and visitors. Work is currently underway to install a similar system at Ashford Hospital. Two new decked car parks at St Peter's were also completed this year.

New payment machines (pay on foot) have now been installed, along with new charges, the first increase for 8 years. After consultation with local patient and community groups, the Trust subsequently took the decision to remove all parking charges for blue badge holders.

Good patient environment scores - our annual PEAT (Patient Environment and Action Team) inspection – which looks specifically at the environment, food and privacy and dignity issues – once again produced very good results at both hospitals:

Fig. 8: Patient Environment and Action Team scores

Site Name	Environment Score	Food Score	Privacy & Dignity Score
St Peter's Hospital	Excellent	Excellent	Good
Ashford Hospital	Good	Excellent	Excellent

Improving our catering services – this year the Trust's catering contract fell due for renewal and we have taken the opportunity to tender for a new, improved contract (which began on 1st April 2012). Most importantly this has allowed us to make significant improvements to inpatient food, with a much wider choice of meals, branded as *Essential Goodness*, catering for a variety of dietary and cultural needs and healthy eating options. The new service also includes new refurbished café facilities at both hospitals and a new branded shop at St Peter's.

Bringing all the catering and retail facilities under one new contract has, regrettably, meant that the Trust has had to lose the catering and retail facilities provided by both hospitals' League of Friends, although paid members of staff have all transferred over to the new provider, OCS. This was not a decision the Board took lightly but, in order to meet the changing needs of patients, visitors and staff, only a larger commercial supplier was felt able to offer the necessary investment and development opportunities required. The contributions made by both Leagues of Friends, to patients and staff, continue to be hugely valued by all concerned.

Upgrading our outpatient departments – we have recently completed the upgrading of our main outpatient department at St Peter's hospital, including a £100,000 refurbishment of our ENT (ear, nose, throat) department and new audiology booth. Within outpatients we have also opened a new communication resource room, equipped with the right communication equipment to help patients with hearing, visual, interpreting or other communication needs.

Detailed plans are in place to begin a major £2.5m redevelopment of our outpatient department at Ashford Hospital from June 2012.

Additional investments – we also invested around £500,000 to reconfigure and upgrade Kestrel ward at St Peter's (now renamed Maple ward), completed a final stage of a £800,000 replacement of X-ray equipment in A&E and the Rowley Bristow Orthopaedic Clinic with state of the art digital equipment and demolished the lower part of the Ramp, one of the oldest buildings at St Peter's Hospital to free up space for car parking.

Improving the Emergency Care Pathway

There has been a lot of focus during the year on working to improve the emergency care pathway – the journey emergency patients make through our hospitals, from admission (usually via A&E), treatment to final discharge – and on general capacity and flow issues. During a busy autumn/winter and spring period the Trust experienced significant capacity issues, often for prolonged periods of time, which did not always result in the best patient experience.

Over the year a number of developments and improvements have been put in place to ease capacity and help improve the flow of patients through our hospitals, including:

- Introducing a Pit Stop in A&E, a dedicated bay where patients coming in by ambulance are rapidly assessed (within 15 minutes) which also helps ambulance crews get back on the road more quickly;
- A Clinical Decisions Unit in A&E (which opened in December) to increase our emergency capacity – the new unit includes six beds where patients who are unlikely to need admitting to hospital can spend a bit longer being assessed and treated within A&E;
- Implementation of RealTime - a bed management software programme which keeps track of patients and beds throughout the hospital and which also monitors treatment and helps doctors and nurses to plan their discharge;
- Increased focus on discharge management to remind staff about the importance of discharge early in the day and to support good discharge planning, including early prescribing of medication for patients to take home;
- Introducing 8 am Board Rounds on our wards – when the whole team, including doctors, matron, ward manager and other nurses, therapists and social worker, gather to assess all the patients under their care including identifying who will be able to go home that day.

Using patient feedback to drive improvements

We have continued to actively encourage and collect patient feedback, using comments – good or otherwise – to make the right improvements to patient experience within our hospitals.

Using patient stories – several times a year we invite patients to present their 'story', good or bad, to our Trust Board so they hear directly from our patients. Board members are then able to directly monitor any resulting improvement plans or actions.

National surveys – during the year we participated in a number of national patient surveys, showing some overall improvement in patient satisfaction.

Our results from the *national inpatient survey* have continued to improve, with most scores (60 out of 64) falling into the middle category, termed 'about the same as other trusts'. We scored particularly well on copying patient letters to GPs, wording these in a way that can be easily understood, and on giving patients good answers to questions about their operation or anaesthetic. Going forward we will target those areas where we haven't done so well; in particular this will include involving patients more in decisions around their care and discharge (and we've already begun a 'Shared Decision Making' project), and ensuring patients have a better understanding of the side effects of any medications.

Our results from the *national outpatient survey* (undertaken every two years) also show some improvements, with the Trust making significant progress in seven areas including the availability of parking spaces, appointment times running well, patients being able to find the department, knowing what would happen during their appointment and the continuity of seeing the same doctor or member of staff. Areas to target going forward include appointments changed to a later day by the Trust and patients waiting longer than they were told or not being told how long they would have to wait.

Internal surveys - our internal patient survey, "Your Feedback", is made available to all patients attending our hospitals and provides a rich source of information about their experience.

Information from the survey is collated monthly and fed back to individual wards and departments to ensure the right learning can take place.

During 2011/12 we received feedback from over 7,500 patients. The following tables show our results for four key questions, broken down into inpatient and outpatient groups.

Fig 9. Feedback from inpatients over the last two years:

There has been a small improvement in satisfaction from our inpatients this year compared to 2010/11 which is positive indication that measures to improve patient experience are having an impact.

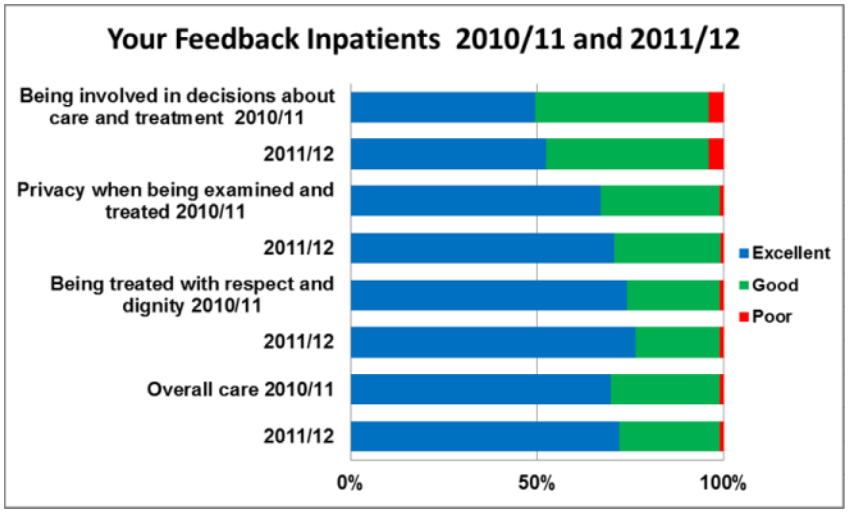
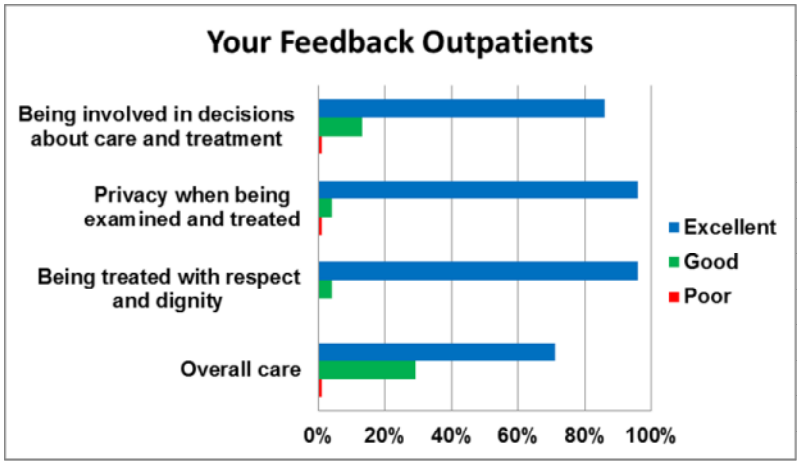


Fig 10. Feedback from outpatients for 2011/12

Overall we have seen good feedback from patients attending our outpatient clinics. Outpatients were not surveyed in 2010/11, but this data will now be used to benchmark patient feedback for next year.



Using a Net Promoter Score - this is a score based on questions used in businesses to gauge customer loyalty and has been adopted to enable us to measure this aspect of patient satisfaction which we introduced in January 2011. The question we ask is: "Would you recommend us to family and friends?"

Our average scores for 2011/12 are:

Specialty	Net Promoter Score
Inpatients	57%
Outpatients	72%
Day Surgery	77%
Children's Services	79%

We will be able to use these scores as a benchmark for future years.

We also run a variety of specialty specific patient surveys for example: day surgery, pain services, endoscopy, colorectal, cancer, maternity, all of which are used to improve the quality of the services provided. Some of the actions from these surveys include:

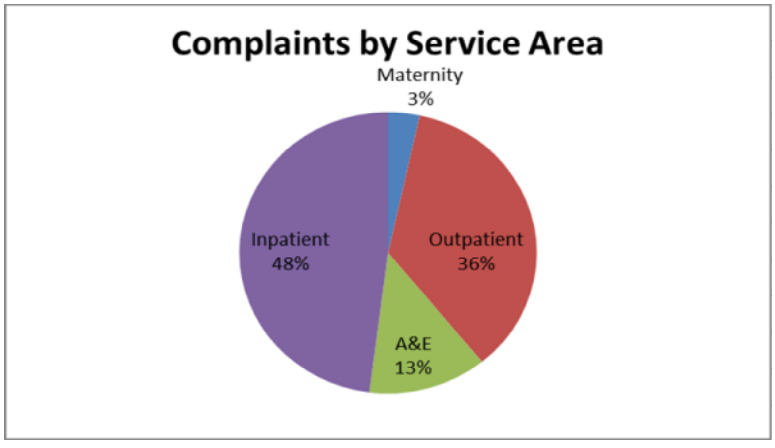
- Further follow-up phone calls to day surgery patients to answer queries, provide more information and reassurance about their recovery;
- Review and streamlining of patient pathways to reduce waiting times and delays;
- Improvements to aspects of communication and involving patients more fully in decision-making;
- Review of the information provided to patients e.g patient leaflets, hospital admission;
- Additional training for staff on a variety of topics e.g. nutritional needs, dementia care.

PALS – over the last year 1,354 people made contact with our *Patient Advice and Liaison Service* compared to 1,440 last year), with 84.5% of concerns resolved quickly through facilitation. As a direct result of issues raised through PALS we:

- Have undertaken an extensive consultation with wider disabled and access groups regarding parking facilities for blue badge holders;
- Changed our booking system in Ophthalmology to reduce cancellations;
- Used PALS data across all divisions to help focus training and support staff attending the Living our Values programme to improve communication with patients.

Learning from complaints – over the last year the Trust received 503 formal complaints, an increase of 40% compared with the previous year. Whilst we have been very active in encouraging honest feedback – good or otherwise - from patients, we are undertaking a detailed analysis to understand more about the key contributory factors to this increase. Considerable operational pressures over the winter period may have been a contributory factor although encouragingly we haven't seen an increase in serious complaints.

Fig. 11: Complaints by service area



The main themes emerging were issues around communication with medical and nursing staff and clinical decisions and treatment. As a direct result of complaints we have:

- Reviewed and improved our nursing documentation for inpatients;
- Introduced a new treatment policy in A&E around nerve blocks;
- Extended the telephone service in the anti-coagulant clinic.

We are also triangulating our complaints data with key themes from our inpatient and outpatient survey results in order to focus our key improvement programmes in the right areas.

Referrals for review by the Parliamentary and Health Service Ombudsman
During this period three new cases were referred to the Ombudsman for review. Of these, one was closed with no further action for the Trust, one is undergoing initial assessment and a further case is under full review.

Our wider patient and stakeholder engagement

Continuing engagement with our patients and the wider community contributes to a fuller understanding of how we can best meet patients' needs, and also keeps our stakeholders up to date with what's going on within the Trust. Individual patient representatives also participate on many groups within the Trust, such as stroke, cancer, children's services, and continue to add valuable feedback.

We also have a proactive engagement programme with local stakeholders, patient groups and partner organisations. For example, we have recently held two meetings with disabled and local access groups to discuss parking facilities at the Trust; as a result we have decided to abolish parking charges for blue badge holders and are working with a small representative group on making further improvements to our hospital entrances and parking systems.

Working with our Patient Panel – our Patient Panel comprises 18 patient representatives who are involved with around 30 groups and committees across the Trust including:

- Clinical governance
- Infection control
- Complaints Monitoring Group

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

Working with our Governors and Members – we have continued to develop a positive working relationship with our Governors, who are active in a number of sub-groups including a dedicated Patient Experience Group. Governors have also been involved in helping evaluate the new catering tender, and have worked with the Trust in developing priorities for the Quality Account. We continue to communicate regularly with our Members through a quarterly newsletter and a programme of Members' Health Events – see more on p. 102.

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.

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. More details are included in our Quality Report, but in terms of meeting this core corporate objective our key achievements include:

Meeting Care Quality Commission quality and safety standards

On 1st April 2011 the Trust was officially re-registered under the Care Quality Commission's standards for providing NHS healthcare. The standards cover issues such as cleanliness and safety, treating patients with dignity and respect and involving them in decisions about their care. The Trust has maintained its registered status throughout the year.

Care Quality Commission visit to St Peter's Hospital

In December 2011 the CQC made an unannounced visit to St Peter's Hospital, visiting a number of different areas in the hospital and speaking to staff, patients and visitors. Their subsequent report – available on the CQC website (www.cqc.org.uk) highlighted many positive areas but also noted several areas of concern. Most of these were issues the Trust was already aware of, particularly the management of patients when demand for beds was overtaking normal capacity, as was the case during the winter across Surrey.

The Trust responded to these with a swift action plan, regularly monitored at Board and Executive level to ensure full compliance within the timescales agreed in the plan.

The CQC inspected six of the sixteen core standards, with the following outcomes:

- Outcome 1. Respect and involvement - Moderate Concern/not Compliant
- Outcome 2. Consent – Minor Concern/Compliant
- Outcome 4. Care and welfare – Major Concern/not Compliant
- Outcome 7. Safeguarding – Minor Concern/Compliant
- Outcome 14. Supporting staff – Moderate Concern/not Compliant
- Outcome 16. Governance - Compliant

The key concerns were around the use of our Day Surgery Unit as an escalation area (which has now stopped), lack of evidence around full compliance with mandatory training and the recording of (some) care records. The Trust continues to monitor implementation of the full action plan and is on track to meet all the timescales given.

Infection control

The Trust was set very tough infection control limits for 2011/12 – no more than four hospital acquired cases of MRSA bacteraemia to be reported, and a target of no more than 30 cases of clostridium difficile. The Trust achieved these limits (reporting just two cases of MRSA bacteraemia and 17 cases of hospital acquired clostridium difficile). This included a complete 365 days without an MRSA bacteraemia infection, which is a substantial achievement. This was one of our key quality priorities in last year's Quality Account and more details on our achievements are given on p. 49.

Improving clinical outcomes:

Mortality rates – the new Summary Hospital-level Mortality Indicator (SHMI) published by Dr Foster, demonstrates lower than expected mortality rates for the Trust. The Trust received a score of 95.7 [where 100 would be the expected level], which takes into account variables such as age, type of illness, social demography and other factors. For the first time, the new index considers all deaths that take place both in hospital and within 30 days of patients being discharged, offering a more comprehensive picture of deaths following hospital care.

Improving our treatment for fractured hips – we have continued to perform well on treatment for patients with fractured hips, with the latest National Hip Fracture Database (published in July 2011) reporting Ashford and St Peter's as one of the top performing Trusts in the country. Highlights for the Trust included:

- In the top 20% of Trusts (1st within the South East Coast) for getting patients to surgery quickly (the quicker a patient is operated on the better their chance of recovery) and in the top 15% of Trusts getting patients to a specialist ward within 4 hours;
- 1st (with 9 others) nationally for assessing patients on bone health and fall risk before discharge;
- 1st in the South East Coast for assessment by a specialist geriatrician within 72 hours of being admitted to hospital.

Our hospital standardised mortality rates for patients with fractured hips are also lower than expected at 85.7 (where 100 would be the norm), based on data from March 2011-February 2012.

Stroke – our hospital standardised mortality rates for stroke are also lower than expected, (currently 92.9 where 100 would be the norm), based on data from March 2011-February 2012. We are particularly successful at early intervention and diagnosis and in the latest NHS audit report from the Royal College of Physicians – based on data collected between July and September 2011 – the Trust is ranked in the top 25% of hospitals in the country for treating stroke patients and the top performing trust in Surrey.

However, in the Dr Foster Guide (published in November), the stroke data suggests that we have higher than expected rates of aspiration pneumonia for patients with swallowing difficulties and that we discharge less patients than other hospitals back to their usual place of residence. In the light of this report we are reviewing our services and in particular looking at our therapy input to ensure we are giving the best possible care to our patients.

Falls – we achieved a 6.8% reduction in the number of total falls compared to 2010/11. More detail is given in our Quality Report on p. 51.

Enhancing Quality Programme – the Trust is actively participating in The Enhancing Quality (EQ) Programme. This is a clinical change programme which has been covering four key clinical conditions: heart attacks; heart failure; hip and knee replacements and community acquired pneumonia. For 2012/13 this will be extended to cover dementia and acute kidney injury. 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 accounts for 0.5% of the Commissioning for Quality and Innovation (CQUIN) payments for 2011/12.

Overall, our outcomes show positive results for our patients:

- For the heart attack pathway there are 7 key measures monitored to improve patient care. The Trust achieved all the 7 measures for 97.4% of patients admitted with a heart attack during 2011/12;
- For pneumonia, there are 5 key measures, and all 5 measures were achieved for 89.9% of patients admitted with pneumonia;
- The heart failure pathway has 4 key measures, and we had a target of 61% of all patients to receive all 4 measures; we achieved 56.4%, so action plans have already been put place to improve this significantly in the coming months;
- For hip and knee, there are 5 key measures and we achieved these for 91.2% of all patients undergoing either a hip or knee replacement;
- The Trust has also participated in the development of a new pathway for dementia patients, which is now to be fully monitored in 2012/13;
- We are also participating in the development of a new pathway for acute kidney injury patients, which will affect the care of hundreds more patients each month, once implemented late this year.

Corporate objective 2: developing a high performing workforce

Delivering best quality care for our patients requires a high performing workforce that is inspired and supported to do the best we can. During 2011/12, we continued our focus on embedding our values and behaviours, and we embarked on a series of leadership development programmes and tools.

Embedding our Values and Behaviours

We already know, through our many compliments, that at our best Ashford and St Peter's provides a really good patient experience. During the past year, more than 75% of our staff have participated in a *Living our Values* programme so that we feel confident in understanding our pledge and values [as outlined here] and what they mean in our everyday working lives.

In doing so, teams of staff set out shared behaviour standards for themselves as individuals and with their colleagues. To help them to do this, they listened to patient experiences of what it is like to receive care at Ashford and St. Peter's and asked themselves what it would be like to be in the patient's shoes?

Remaining staff will be undertaking the training in the first quarter of 2012/13.

Learning and development and mandatory training

Over the year a comprehensive review of mandatory training has been undertaken so it is clear to staff exactly what training they need to do and how to access it. As releasing front-line staff for long periods of time can impact on service delivery, we have increased access to e-learning modules. By the end of the year the Trust met its target of completing 70% of all mandatory training, aiming to achieve 100% by the end of June.

The Trust continues to support undergraduate medical, nursing, midwifery and allied health professional students providing quality assured placements which enable the students to meet their learning outcomes. We also held a successful 'Introduction to the NHS week', a supervised 5 day programme for 14-16 year olds to give young people an insight into the NHS and career possibilities.

Earlier this year a new Simulation Suite was opened at Ashford Hospital. This state of the art training centre features a life-like mannequin which, via a high tech computer and other pieces of medical equipment, gives staff the most realistic training scenarios possible without using a 'real' patient. A variety of different scenarios can be enacted, and the Simulation Suite is already playing a major role in the training programmes of staff across the Trust. Our thanks to the Hospital Leagues of Friends for contributing to this.

We also had a very positive review by the Kent, Surrey and Sussex Deanery on our doctor training.

Leadership development

The second Good to Great programme took place over the year with 70 participants from across the Trust with expert speakers from industry and healthcare. This year speakers came from the Strategic Health Authority, The King's Fund, Lancaster Business School, TEREMA, Assura Medical, British Telecom, ending with Adrian Moorhouse from Lane 4. Participants on the

programme worked on a number of projects over the year, with a Dragon's Den style event held to evaluate their bids for funding. Successful bids included:

- Using new mobile technology to improve patient care;
- A dedicated discharge and admissions lounge on Dicken's ward at Ashford Hospital;
- A Trust-wide infusion service;
- Support to create a business case for a sexual health nurse role.

The North West Surrey Future Leaders Programme was launched in September 2011 with a welcome by Professor Steve Field from the NHS Future Forum, aimed at developing those individuals identified as having the potential to help shape and deliver the vision for health and social care in Surrey over the coming years. The Trust is one of five health partners (Surrey & Borders Partnership NHS Foundation Trust; local GPs; NHS Surrey; and Surrey County Council) which have designed the programme and assessed and assigned participants.

Supporting equality and diversity

The Trust is committed to making Ashford & St. Peter's a fair, equal and diverse place to work and to receive care and treatment. Fundamentally, our equality and diversity work is focussed on treating and valuing others as we would wish to be treated and valued ourselves.

In January, the Board received an update on the implementation of our Single Equality Scheme and approved an action plan for 2012. This embraces all the nine 'protected characteristics' as set out in the Equality Act, and describes our plans to challenge discrimination and promote equality in terms of race, disability, age, gender (including transgender), sexual orientation, religion and belief, marriage and civil partnership, and pregnancy . Each of these strands has a staff champion within the organisation who, through our Equality and Diversity Steering Group, leads staff engagement and develops action plans for improving each theme.

Also in January, we celebrated the graduation of the first cohort that participated in our 'Road to Success' programme - a leadership development programme for BME (black and ethnic minority) staff. The feedback from the participants was positive and we very much look forward to seeing them flourish in their future careers within our organisation.

Inspiring and Supporting Each Other To Live Our Values

The overall results of the National Staff Survey 2011 indicate that we need to do a lot more work on engaging our staff, with just 10 of the 38 key factor scores being average or above average, compared with other acute Trusts, which is a significant change from the 2010 survey results.

There were particular improvements in appraisal uptake, which were considered well-structured by more than a third of staff – higher than the national average – and training in equality and diversity and health and safety.

Once again, there was a high overall response rate with 1,847 staff (63.6%) of eligible staff participating in the survey.

Staff Survey Response Rate

Fig: 12 Response Rate

	2010/2011		2011/2012		Trust Position
Response Rate	Trust	National Average	Trust	National Average	
	71%	64%	64%	50%	14% higher than national average this year, compared with 7% higher in 2010/2011

Here are the key findings from the National Staff Survey 2011/12:

Areas of improvement from the previous year and deterioration

The overall change in scores since 2010/2011 from the Trust's perspective was as follows:

- 17 key finding scores have deteriorated from their position in 2010
- 1 key finding score has improved from its position in 2010

Compared with the national average:

- There are 5 key finding scores above average, compared with 25 in 2010
- There are 28 key finding scores below average, compared with 8 in 2010

Significant areas for development (worst 20% of Acute Trusts) are as follows:

- % agreeing their role makes a difference to patients
- % feeling valued by their work colleagues
- Quality of job design
- % working extra hours
- % receiving job-relevant training, learning or development in last 12 months
- Support from immediate managers
- % suffering work-related injury in last 12 months
- % saying hand-washing materials are always available
- % reporting errors, near misses or incidents witnessed in the last months
- Fairness and effectiveness of reporting procedures
- % experiencing harassment, bullying or abuse from staff in last 12 months
- Impact of health and wellbeing on ability to perform work or daily activities
- Staff job satisfaction
- Staff intention to leave jobs
- % believing the Trust provides equal opportunities for career progression or promotion

Staff Survey Top 4 Ranking Scores

The following table shows the top four ranking scores from the last two NHS Staff Surveys:

Fig 13: Top 4 ranking scores

	2010/2011		2011/2012		Trust Position
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
% witnessing potentially harmful errors, near misses or incidents in last month	30	37	32	34	2% improvement
% having equality and diversity training in last 12 months	64	41	56	48	8% deterioration
% appraised in last 12 months	87	78	84	81	3% deterioration
% having well structured appraisals in last 12 months	45	33	37	34	8% deterioration

Staff Survey Bottom 4 Ranking Scores

The following table shows the bottom four ranking scores from the last two NHS staff surveys:

Fig 14: Bottom 4 ranking scores

	2010/2011		2011/2012		Trust Position
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Impact of health and wellbeing on ability to perform work or daily activities	1.61	1.57	1.69	1.56	0.8 deterioration
% of staff feeling valued by their work colleagues	79	76	70	76	9% deterioration
% of staff suffering work-related injury in last 12 months	18	16	21	16	3% deterioration
% staff intention to leave jobs	2.46	2.53	2.84	2.59	0.38 deterioration

A workshop was held in April 2012 to examine the findings of the National Staff Survey 2011. All Divisions and Directorates were tasked to consider how they might inspire and support their teams to listen to the feedback and plan to take immediate or longer-term actions to address the improvements suggested by staff. These commitments to take such action will be scrutinised by corporate committees and groups, such as the Employee Partnership Forum, Workforce Strategy Steering Group and Equality & Diversity Group in the coming year and will be a key focus for the Trust going forward. Each Division and Directorate has drawn up an action plan known as Listen,

Plan, Act Commitments for the coming year to focus on those areas for improvement highlighted by their staff.

There are also 10 corporate commitments which include investment in an extensive high performing teams programme; the introduction of an awards scheme to enable patients to compliment staff for the care and support they receive; and to refresh a visibility and assurance programme for senior managers and the Board to spend time 'on the shopfloor' to get an in-depth examination of staff roles and responsibilities.

Relationship with unions and formal staff engagement

We enjoy good working relationships with our union and staff representatives. Our Employee Partnership Forum meets monthly and is where staff representatives meet with managers to share information and work together on important issues that are affecting our organisation. In addition, Staff Side representatives are invited to attend other groups and committees to fully develop true partnership working, e.g. the Workforce Strategy Steering Group. The Trust also has an active Local Negotiating Committee which is supported by the British Medical Association.

Health, safety and wellbeing

Occupational Health

Our Occupational Health Service (OHS) continues to focus on the fundamental relationship between health and work within a context of prevention with a focus on two key areas:

- Actively promoting health and wellbeing in the workplace focusing on staff becoming ill or injured at work;
- Maximising access to and return to work through timely rehabilitation as specified by the Department of Health in 2011.

Promoting health and wellbeing
We continue to promote a calendar of health and wellbeing events including a joint Pedometer Challenge in partnership with Active Surrey which helped the Trust achieve a Bronze Award for the NHS Sport and Physical Activity Challenge 2012.

This year we developed a Health, Safety and Wellbeing Strategy based on four key areas;

- Illness and injury prevention
- Prompt rehabilitation
- Improve Staff wellbeing - Promoting Active Healthy Lifestyle (NICE)
- Health Promotion

The OHS also supported the Trust in its objective to achieve over 40% uptake of seasonal flu vaccination for Trust staff.

In 2012/13, the health, safety and wellbeing of staff has been added as a priority objective. This demonstrates Board level support for staff in promoting the health, safety and wellbeing agenda within the Trust.

New physiotherapy service for staff
This year we introduced a new Occupational Health Physiotherapy service (one year pilot) for Trust staff - initiated through the *Good to Great* programme. Since May 2011 the service has seen over 400 staff, with a 27% reduction in sick days compared to the same period last year. Following its success the service will now be offered on a permanent basis.

Working towards accreditation for 'Safe Effective Quality Occupational Health Service'
Over the past year the service has been working towards SEQOHS (Safe Effective Quality Occupational Health Service) which represent the Faculty of Occupational Medicine's standards for accreditation. This has involved a review of all OH policies, procedures and practices, along with audit and business practices. As part of the national accreditation programme the department will be visited by a SEQOHS assessor this coming summer.

Creating additional income
The OHS continues to generate income from providing services to local organisations and also offers staff travel health clinics, and we will continue to tender for new business as it arises during 2012/13. The department also moved offices into the new and much brighter Chertsey House, offering much better facilities to staff attending the department.

Improving the staff environment

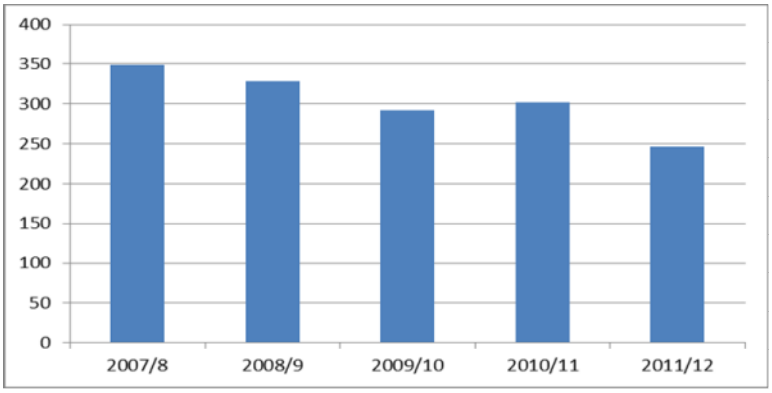
As part of our overall masterplan for St Peter's Hospital, this year saw the construction of a new corporate staff building, Chertsey House, on the St Peter's site. Staff from the lower part of the Ramp (some of our oldest hospital buildings and in poor repair) were moved to the new building in November including Occupational Health, Health Informatics, Finance, Quality, Business Development, Service Improvement and Communications. Our Workforce and Training teams also moved from their previous accommodation on the Ramp to newly refurbished offices at Ashford Hospital, along with some of the Finance team. Work continues to seek alternative accommodation for the remainder of staff working on the Upper Ramp at St Peter's.

Health and Safety

The Trust continues to take its health and safety responsibilities seriously recognising that staff are its most valuable asset and that protecting their health and wellbeing will benefit both staff and patients alike.

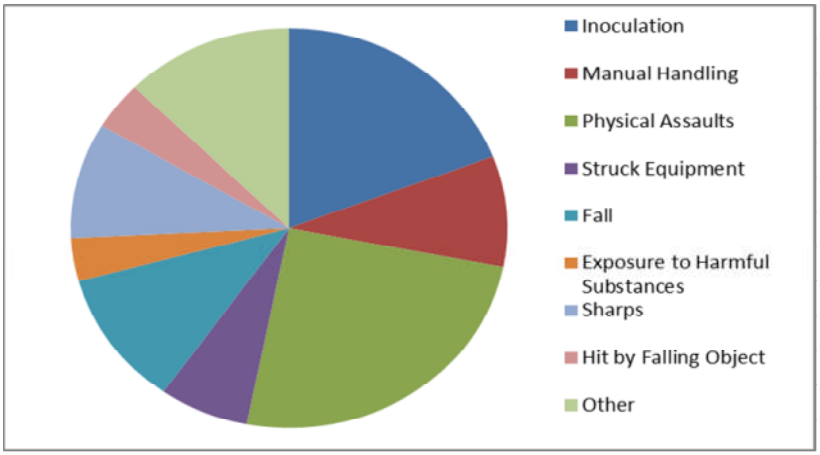
Injuries to staff
The number of staff injuries has fallen to 246 for the year which is a further improvement on previous years as the chart below shows.

Fig 15. Number of staff injuries over the last 5 years



All injuries are treated seriously and appropriate support to staff is available, however, the vast majority of injuries are minor resulting in no sickness absence. The chart below shows the break up by cause of injury for the year 2011/2012.

Fig 16: Injuries to staff by cause, 2011/12



Recognising that violence against staff is the greatest cause of staff injury, our research has shown that the majority of these incidents come from patients with dementia or from agitated patients in A&E.

Dementia patients often hit out at staff because they are frightened and confused. Nurses and health care assistants now receive training on how to nurse and treat this important group of patients so they can offer reassurance and consequently reduce the risk of a violent response.

A number of patients arrive in A&E who can be agitated but without a real need for acute medical care. The Trust is working with partner agencies to try to reduce the number of these patients and the time they spend in A&E.

Bariatric patients present particular manual handling risks to staff involved in their care, mobilisation and transport. In order to mitigate risk and protect staff the Trust is investing in additional equipment to allow staff to work as safely as possible. A bariatric simulation suit has also been purchased which will give staff excellent realistic practice when learning how to safely handle bariatric patients.

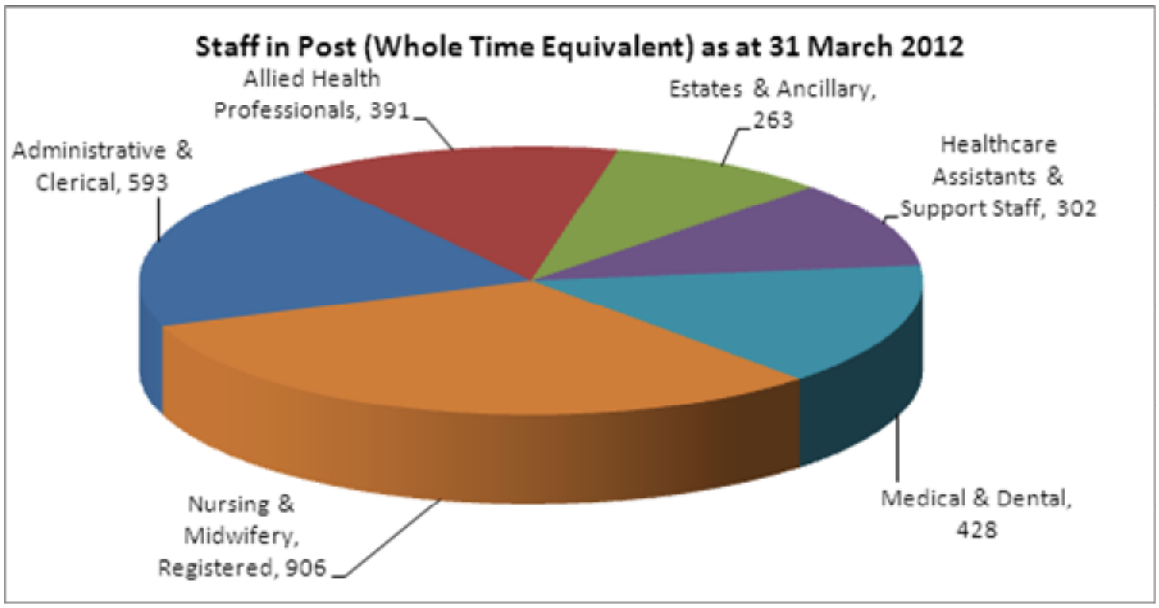
The manual handling team are working closely with the Occupational Health physiotherapist to review staff musculo-skeletal injuries to try and identify causes so we can change any relevant processes and procedures to further protect staff.

Sickness absence
Our sickness absence rate for the year was 3.0% - that is, the number of days of sickness as a percentage of the number of available working days of all staff. Our figure is well below the national average within the NHS of 4.5%, and an improvement on our rate of 3.3% last year. This equates to an average of 6.75 days per employee over the financial year, compared to 7.5 days per employee for 2010/11.

Workforce Planning

The Trust employed 2,883 (whole time equivalent) staff at 31 March 2012, this equates to an average over the year of 2,963 (whole time equivalent). There were 2,185 members of staff working full-time (66%) and 1,125 working part-time (34%), a total of 3,310 members of staff overall (headcount).

Fig 17: Number of staff in post



Our cost improvement plans

The Trust's Cost Improvement Programme plans resulted in a net reduction in the workforce establishment of 1.1% over the financial year. A reduction of 2% in the workforce establishment was achieved in accordance with our long term financial plans. This resulted in a decrease of 35 non-clinical posts due to modernisation of processes, including maximising the use of information technology. At the same time, we were also able to invest in the establishment, with funded growth of 64 whole time equivalent posts. New clinical posts were created, for example, consultant colorectal and bariatric surgeons, additional nursing and healthcare assistant posts to support the opening of the Clinical Decisions Unit and Swift Ward, and new posts in optometry, phlebotomy, speech and language therapy, dietetics, and pharmacy.

Reviewing our skill mix

During the year we focused on reviewing our workforce through a number of skill mix reviews. At the end of 2011 we engaged the Audit Commission to carry out a benchmarking exercise of all wards to support our nursing and midwifery review. This showed we have a relatively high number of fully qualified nursing staff compared to others. This information has been used to review and strengthen ward establishments including the staff to bed ratio and qualified nurse to healthcare assistant ratio.

We also began a comprehensive Corporate, Middle and Administrative Office review, aimed at redesigning our administrative functions to improve the patient experience through modernising systems and practices. The objectives are to

- Design structures, roles and processes to deliver work that adds value;

- Capture existing best practice and excellent standards;
- Make better use of technology to improve access for patients;
- Achieve flexibility and efficiency;
- Enable career development opportunities for administrative staff across the Trust.

This review is scheduled to be complete by 2013.

Voluntary Services

Staff, patients and visitors benefit greatly from the support of more than 380 volunteers across both our hospitals, providing a range of services from welcoming patients and visitors, directing and assisting them, to working with the pastoral care team, on the wards, with Hospital Radio Wey, hospitality services and clerical and administrative duties.

Highlights over the year:

- Development of a Volunteer Strategy – agreed in July 2011 – which focuses on the wider user of information technology to support our voluntary services;
- New Volunteer Policy – agreed September 2011 – providing a framework for the recruitment, placement, induction, training and ongoing support for volunteers;
- Development of a new volunteer website, providing extensive information for prospective volunteers;
- Increasing numbers of volunteers from around 350 last year to over 380 currently;
- Nomination by the local community for a Queen's Award.

Our Hospital Leagues of Friends

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.

With the advent of the new catering contract, which came into effect from 1st April 2012, regrettably we have had to lose the catering services which both Leagues of Friends had provided at both hospital sites. However, all paid staff working within the cafes and shop have been transferred over to the new provider at the same terms and conditions. To change the catering services in this way – in order to provide improved services to our patients, visitors and staff – was not a decision the Board took lightly and the Trust is exploring ways to ensure we continue to work closely with both Leagues of Friends, for the future benefit of both patients and staff.

At Ashford Hospital we have supported the League of Friends to develop a small charity shop within the hospital, selling gift and similar items in aid of the hospital. At St Peter's Hospital we are continuing our discussions with the Friends to find new ways to support them in their fundraising work.

Corporate objective 3: delivering our clinical strategy

Our clinical strategy in 2011/12 focused on developing our clinical services, particularly some of our more specialist services, to make sure we are meeting the needs of our patients and commissioners. We also focused on working with our partners to redesign local health services, creating alternatives to hospital admission and reducing emergency admissions.

During the year we embarked on the following specific activities:

Developing specialist services

Bariatric services - the Trust has now been accredited as a Bariatric Surgical Centre by the South Central Specialised Commissioners. The Trust is now able to offer the full range of bariatric surgery, from gastric banding and intragastric balloon procedures to the full range of specialist weight loss surgery including gastric bypass surgery and gastric sleeves. Reflecting the increase in this type of surgery, which is now offered to a wide catchment area including Sussex, Hounslow, Berkshire and Hampshire, the Trust opened a dedicated bariatric bay at St Peter's Hospital earlier this year. This has been purpose built to accommodate post-operative bariatric patients and was officially opened by the Mayor of Runnymede.

Developing specialist vascular services – with the appointment of two new consultants, we have continued to develop our specialist vascular work, participating in the Surrey Vascular Network rota. The Trust is now able to offer specialist endovascular surgery – keyhole surgery to repair major arteries – and is developing plans to become accredited as a specialist vascular centre.

We have also continued to strengthen our links with Epsom hospital through the appointment of joint posts in both vascular and cardiology services. These arrangements help to ensure that as much care as possible is provided locally in Epsom, with patients requiring the most complex care being transferred to St Peter's Hospital. Agreement was also reached with Surrey and Sussex Healthcare NHS Trust to appoint a joint vascular consultant, which will take effect later this year.

AAA (abdominal aortic aneurysm) screening - St Peter's has recently been accredited as a national screening centre on behalf of the Surrey Vascular Network, (covering a 1.5 million population), which will also bring further vascular work to the Trust.

Reaccreditation of our Major Trauma Unit status – earlier this year the Trust's A&E department had its major trauma unit status re-accredited following an official in-depth evaluation visit by the London Trauma Network. The Network conducted their visit in January with a team comprising three senior clinicians along with representatives from both the SHA and NHS Surrey. As well as achieving re-accreditation the feedback within the report was extremely complimentary on the commitment from the whole organisation to the treatment of patients with major trauma.

Pathology services - the Trust continued its work with Frimley Park and the Royal Surrey County Hospital Foundation Trusts to merge pathology services across West Surrey, known as 'the Surrey Pathology Partnership'. The newly merged service began on the 1st February 2012 and will support the needs of all three hospitals and neighbouring GP practices, serving a catchment population of 1.2 million patients and reporting on some 16.4 million tests per year. This move is in line with pathology services across the country which, following a national review and recommendations by Lord Carter in 2008, are consolidating services in order to maintain and improve quality and, at the same time, benefit from the economies of scale associated with larger organisations.

Expanding planned care

Market share - for our core target markets we have increased our planned market share by just under our target of 1%, predominantly as a result of an increase in orthopaedic activity due to the need to meet increases in referrals and the national 18 week target.

New services - the Trust participated in and won two tenders during 2011, one for the provision of community ophthalmology services in Hounslow and the second for the provision of neurophysiology services for Frimley Park Hospital NHS Foundation Trust. The community ophthalmology service in Hounslow will bring significant benefits to its commissioners, as referrals will be redirected from London Trusts to Ashford Hospital which operates at a lower Market Forces Factor, i.e. at lower cost.

The Trust's ongoing strategy is to continue to bid for services where we believe we can provide better care for patients and which also provide a positive financial return for the Trust.

Reducing Emergency Admissions

The National Operating Framework continues to penalise Trusts for any emergency admissions above the 2008/09 rates (which are only reimbursed at 30% of the full tariff rate). One of our key priorities therefore 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 – our Care of the Elderly Consultants have continued this project, working with a number nursing homes in our catchment area to provide support and advice so that, when a resident's health deteriorates, where appropriate, the patient isn't automatically admitted to hospital. The project team have linked with local GPs and nursing home managers and to date we have seen a reduction in patients from participating nursing homes (over 40%) being admitted to hospital.

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 are carefully selected and visited several times each day at their home by community matrons.

Ambulatory care pathways - the Trust has now developed 16 ambulatory care pathways – caring for and treating patients with urgent conditions, such as community acquired pneumonia, pulmonary embolism, deep vein thrombosis, chest pain, acute abdominal pain and cellulitis, in a way that avoids admitting them to hospital. This programme will continue into 2012.

Working with our local partners

The Trust continues to be proactive in developing relationships between partner organisations in North West Surrey, particularly through the North West Surrey Transformation Board. Work has focused on working in a more joined up way, and looking at new and innovative ways to provide healthcare in this area, keeping patients out of hospital wherever possible and developing alternative healthcare services within the community. The Trust has been particularly well supported by community and social care in its work to alleviate capacity issues over the winter and to improve the emergency care pathway overall.

Specific projects include:

Community Hub – we have recently opened a Community Hub on the Medical Admissions Unit (MAU) at St Peter's in conjunction with Surrey County Council, Surrey Community Health and the British Red Cross. The hub is aimed at supporting safe and timely discharge from MAU and A&E and providing information and signposting to other appropriate services for wards around the hospital.

Partnership working with the ambulance services – we have also started a new programme in partnership with South East Coast Ambulance Trust (SECAMB), to improve the experience of patients arriving at hospital by ambulance and to provide education and training opportunities for paramedics.

Part of this programme looks at improving care for patients with very urgent conditions, such as trans-ischaemic attacks (mini strokes) and heart attacks. For example, a new electrocardiography (ECG) telemetry advice line allows paramedics to perform an ECG test onboard the ambulance to detect problems with a patient's heart rhythm and send the results straight to the Coronary Care Unit at St Peter's, allowing specialist input at a much earlier point than previously possible. In addition SECAMB Critical Care Paramedics are taking part in a rotation programme to spend time working in our emergency department and the Intensive Care Unit.

Working with GPs

We have continued to develop our relationship with local GPs, particularly as they develop their commissioning role. Our business development team has regular contact with practices within our catchment area and provides a GP liaison service. Our Spotlight Seminars for GPs provide another forum for discussion and learning, and where new care pathways can be discussed.

We also hold regular clinical interface meetings between our consultants and GPs, to help improve communication and resolve issues. We distribute our GP newsletter, *'GP News'* to around 700 practices across our catchment area and beyond, and have improved our service directory to ensure our clinical services are easily accessed by GPs.

Virgincare

The Trust has developed a partnership with Virgincare, the new provider of community services across West Surrey. The Trust is working with Virgincare on a number of joint projects including telemedicine for prison health and the provision of community respiratory services for Hounslow. We will continue to explore opportunities with Virgincare over the coming year to integrate care pathways across Surrey for the benefit of patients, and which contribute to the financial sustainability of both organisations.

Our plans for acquiring Epsom Hospital

Following the announcement last year by Epsom & St Helier University Hospitals NHS Trust that they would not be able to become a Foundation Trust in their own right, the Trust has been considering the option of acquiring Epsom Hospital and becoming a bigger, three hospital Foundation Trust. Earlier this year the Board agreed our detailed plans which were submitted to the Transaction Board last November.

In undertaking this work, the Trust has asked two key questions:

- Would acquiring Epsom Hospital make Ashford and St Peter's Hospitals a stronger organisation?
- Would we be able to do a good job for patients and staff at Epsom Hospital and Ashford and St Peter's?

Our plans, which have been approved by the Transaction Board, include innovative partnerships with Surrey and Sussex Healthcare NHS Trust, Central Surrey Health and The Royal Marsden NHS Foundation Trust, which would bring significant benefits for patients served by the new Foundation Trust.

Further clinical developments

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

1. Introduction of an acute oncology service in A&E to help avoid unnecessary admission to hospital and improve care for patients with cancer;
2. Formation of an organ donation committee within the Trust to raise awareness of organ transplant issues, and which led to the Trust's first ever organ donation via A&E;
3. Introduction of telemedicine for stroke thrombolysis;
4. Opening of a refurbished Young Person's Unit on Ash Ward at St Peter's Hospital - a dedicated inpatient area for adolescents/teenagers which has been designed to give them a more appropriate environment while they are in hospital rather than being placed in a young children's ward or an adult area. Thank you to Proctor and Gamble for their significant fundraising which contributed towards the new unit.
5. Development of a 9 bedded Special Care Unit for mothers and babies (replacing our previous Transitional Care Unit) – which allows mothers to stay with their babies who need additional care but who don't need the full services of the Neonatal Intensive Care Unit;
6. The Introduction of Metavision in our Intensive Care Unit – a new electronic system to record patients' observation data while they are in the unit;
7. Improvements in the way we use of theatres as part of our *Excellence in Theatres* project;
8. Introduction of follow-up telephone calls to patients following day surgery, which has improved patient experience and helped to ensure the right support is given to patients post-surgery when required;
9. Improving our length of stay for several specialties, including stroke, due to the implementation of RealTime, an electronic bed management system (see more on p. x);
10. Successful recruitment of 20 new midwives in our maternity department and agreement to develop a Midwifery Led Unit at St Peter's Hospital;
11. Introduction of a consultant-led urology service which is helping to speed up care and treatment for emergency patients and improve their overall experience.

Corporate objective 4: improving productivity and efficiency

The Trust ended the year having achieved a planned £1 million surplus and £10.9 million cost savings, achieving a Monitor Financial Risk Rating of 3.

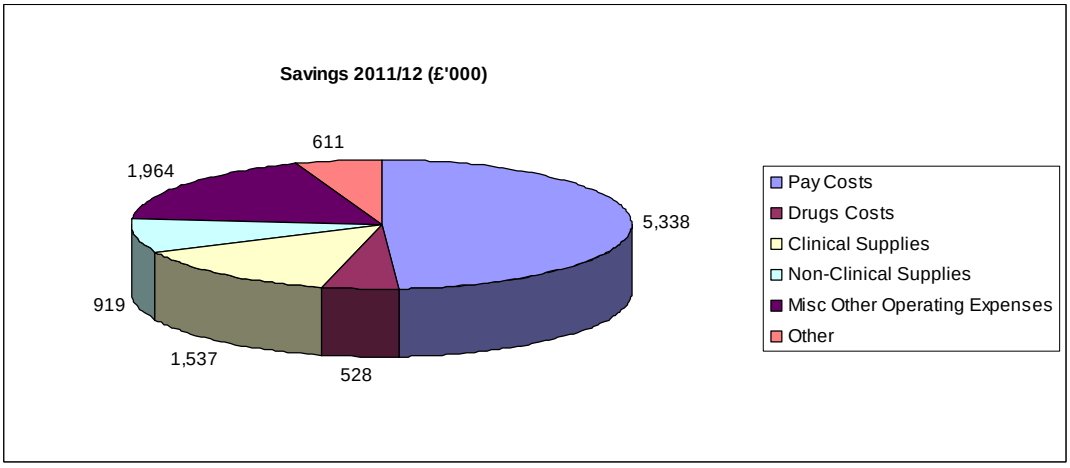
Achieving cost improvements

Over the year we achieved nearly £11 million of cost improvements (against an original plan of £12 million), mainly through changes in practice and particularly through reduction in pay costs.

Pay cost savings were primarily achieved through a combination of skill mix reviews, a reduction in posts – mainly in back office functions – and a reduction in temporary staffing.

Of particular significance are the drug savings, achieved through national and local negotiation of prices, and through reducing usage and waste of some medicines and on procurement savings (see below).

Fig 18: Our savings



Procurement savings

Other substantial savings were achieved by our procurement team, exceeding their target of £800,000 with savings totalling £824,000 over the year. Significant results were achieved in the procurement of trocars (instruments used in theatres for inserting cannulas), which saved £92,000 over the year. A procurement project working with NHS Supply Chain on the purchase of gravity sets (for administering fluids) brought a further saving this year of £14,000 (46% savings overall). Changing supply route, for example working on large projects with NHS Supply Chain, will offer further savings in the future including hidden costs such as invoicing and delivery charges.

Adopting a programme management approach

This year we have put in place a Programme Management Office (PMO) to oversee improvement programmes across the Trust and to ensure a more robust approach to delivering projects and programmes, by:

- Defining and managing standards for programme and project management;
- Monitoring the delivery of projects and programmes and their benefits;
- Providing support to those delivering projects and building capability and maturity in project skills;

- Defining governance.

The PMO was introduced following recognition that a greater focus on benefits realisation and a more robust framework for delivery were required to tackle the more complex and challenging projects and programmes. There was also recognition of the need to increase the pace of our delivery if we are to compete in a more demanding market and achieve our vision of being one of the best Trusts in the country.

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 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:

- Significant improvements to our ophthalmology services including introducing a number of measures to speed up waiting times, nurses administering dilating drops to speed up appointments and improved referral processes for GPs.
- Improving our discharge process for patients requiring further rehabilitation to Ashford, Walton and Woking Hospitals. As a result actions have been agreed to reduce length of stay, reduce transfers at inappropriate times of day, reduce readmissions from the rehabilitation hospitals and significantly improve the quality of referrals.

Making our outpatient services more efficient

Through our outpatient efficiency programme, introducing a new patient telephone reminder service, we have reduced missed outpatient appointments by 50% over a six month period, benefiting the Trust by around £500,000. This has brought our 'do not attend' figures down from over 10% to just 7.8% by the end of the year and helps to make our outpatient clinics run more efficiently with less clinical time wasted and which ultimately will help to bring down waiting times.

A more business focused approach

During 2011/12 the Trust undertook a number of initiatives to develop the commercial skills within the Trust. These included:

- The development of a business development strategy;
- The creation of a Commercial Group to review business cases and other key developments in the Trust;
- The appointment of a new lead for the Business Development Department to an existing vacancy with bidding and tender experience;
- The appointment of a GP/practice Liaison Manager to work with local GPs within Surrey to design new care pathways;
- Provision of training and education to the senior nurses.

As a result of these developments the Trust won two tenders for the provision of services for Hounslow PCT and Frimley Park Hospital (see p. 33).

Harnessing information technology to drive efficiencies

During the year the Trust continued to implement its new Health Informatics strategy, which is focused on using information technology to its maximum to improve efficiency, help our hospitals run more efficiently and ultimately provide a better experience for patients. Developments during the year include:

- Implementing new RealTime software – a bed management programme keeping track of patients and beds throughout the hospital and which also monitors treatment and helps doctors and nurses to plan their discharge;
- Rolling out wireless technology throughout our two hospitals;
- Introduction of new wireless workstations on wheels to all wards at both our hospitals, including A&E and other clinical areas, which allow instant access for clinicians to X rays and many other test results so doctors can make on the spot decisions about individuals' treatment, speeding up the process and making it run more smoothly for patients;
- The Trust has also piloted the use of IPADs for senior clinicians and Trust Board members to access information that is publicly available as part of a wider scheme that uses wireless technology to help us streamline management processes, improve efficiency, and make a contribution to our carbon reduction plans.

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 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 internally report any incident regarding personal data, however minor. There is also a requirement to report any Information Governance issues that are rated as 1-5 (according to severity) to the Strategic Health Authority. These incidents also have to be included within the annual report. Any incidents rated between 3-5 (with 5 being the most severe) will be notified to the Department of Health by the Strategic Health Authority, which are regarded as Serious Untoward Incidents (SUIs). There were no Information Governance SUI rated breaches for the financial year 2011/12.

However, with increased emphasis on reporting we have recorded 17 incidents which were not classified as serious and rated as either a 1 (least severe) or 2 as shown in the table below. Incidents are also categorised by *category* or *type* which is the classification given in the left hand column. These include incidents such as patient information being found in a public place and incorrect forms being given to patients.

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. 19: Summary of other personal data related incidents

Summary of other personal data related incidents – 1 April 2011 to 31 March 2012 rated as either 1 or 2 in severity		
Category	**Nature of Incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment, devise or paper documents from outside secured NHS premises	6
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	9
V	Other	0

Our priorities for future development

Next year, 2012/13, will be our second full year as a Foundation Trust and will be a critical year in which we need to consolidate our position as a successful organisation. Most importantly we will be working hard to fix our emergency care pathway so we consistently meet the four hour waiting target, and will be looking to get our finances on track early in the year to ensure we meet our £12m savings target.

Going forward, we will build on the achievements we have already made against our four strategic objectives as follows, and importantly have added a fifth objective for this coming year, to successfully integrate with Epsom Hospital.

1 Achieving highest standards of quality	Continuing to improve patient experience - right care, in the right place, at the right time, with a particular focus on caring for older people.
2 Developing a high performing workforce	Creating the right workforce, with the right training and skills to meet our patients' needs, with staff who feel valued and inspired.
3 Delivering our clinical strategy	Developing joined up care pathways with our partners, expanding our specialist services and promoting innovation in the way we deliver care.
4 Improving productivity and efficiency	Meeting our savings plans and improving the quality and efficiency of our services, focusing on income growth rather than cost cutting.
5 Successful integration with Epsom Hospital	Undertaking the preparatory work for successful integration with Epsom, including stakeholder engagement and robust mobilisation plans.

These priorities have been developed within the context of a continuing period of financial challenge, the Operating Framework for this year and a period of significant structural change in the NHS as set out in the new Health and Social Care Act. The national context includes a further 1.8% reduction in tariff for 2012/13, with continued penalties for readmissions and over performing on emergency activity. At the same time, the Operating Framework for next year sets out an expectation on Trusts to maintain strong performance on service quality and patient experience, whilst addressing the urgent need to ensure that elderly and vulnerable patients receive compassionate care in every part of the NHS.

A key theme going forward will focus on 'creating joined up healthcare', something we know patients want to see and which will play into virtually all aspects of how we do business. From

good communication and joined up working between individuals and teams, improving internal processes and patient pathways, to how we work across the local health economy - with local GPs, community, social and mental health services. And of course this will also play into new partnerships, for example our work with Virgincare, the new provider of community services in our area, and our ambition to integrate with Epsom Hospital.

4. Quality Report

Introduction

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement. The purpose of Quality Accounts is to enable:

- Patients and their carers to make well informed choices about their providers of healthcare;
- The public to hold providers to account for the quality of the services they deliver;
- Boards of NHS providers to report on the improvements made to their services and set out their priorities for the following year.

There are three important quality improvement areas:

- Safety;
- Patient experience and;
- Clinical effectiveness.

We have included our full Quality Account here as part of our Annual Report, which contains information about the quality of our services, the improvements we have made during 2011/12 and sets out our key priorities for next year (2012/13). This report also includes feedback from our patients, governors and commissioners on how well they think we are doing.

Foreword from the Chief Executive

Welcome to our third Quality Account for Ashford and St Peter's Hospitals NHS Foundation Trust. This publication describes just how seriously we consider quality and safety issues in our two hospitals and how we work continuously to make the right improvements. We want both patients and visitors to feel confident of the quality of our services and this Quality Account sets out our priorities for improvement and details how we have performed against some key quality measures over the last year.

However, it's important to note that this is just one part of our approach to improving quality, and we have in place a number of other monitoring processes and initiatives – for example our monthly Quality Report which goes to the Trust Board – which help us to make continual improvements on behalf of our patients.

And, to make sure the Board is fully engaged with care right on the front line, we regularly invite patients to come and present to the Board – describing their individual experiences, good or otherwise. In addition, regular walkabouts around our hospitals, talking to patients and staff, also help our Board members have a good understanding of what it is like to be a patient in our hospitals.

Overall 2011/12 has seen many positive highlights for the Trust and many assurances that we continue to offer high quality and safe care to our patients. On 1st April last year we maintained our registration with the Care Quality Commission and have continued to score well against the majority of quality and performance standards, including the 18 week and cancer waiting targets and celebrating our best ever year for infection control, with just over a year without an MRSA hospital acquired bacteraemia (see page 49 for more details).

I am also pleased that we continue to have good clinical outcomes, including being rated as a top performer nationally for patients with broken hips, and demonstrating good results for many of the

most common conditions needing hospital admission such as care following a heart attack, pneumonia, stroke, hip and knee replacements, with lower than expected mortality rates. We have been successful in reducing the overall number of falls taking place in our hospitals (see page 51) and are making continual improvements to patient experience both on our wards and in our outpatient areas.

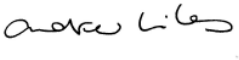
However, an unannounced visit by the Care Quality Commission (CQC) in December last year, whilst highlighting many positives, also raised a number of concerns which we recognised needed focused attention. Most of these were issues we were already addressing, particularly how we manage patients through our hospitals when demand for beds overtakes normal capacity (as was the case across Surrey this winter).

The key concerns raised were around the use of our Day Surgery Unit as an escalation area (which has now stopped), lack of evidence around full compliance with mandatory training and the recoding of (some) care records. We take these issues extremely seriously and responded with a swift action plan which has been monitored regularly at both Board and Executive level to ensure we meet the agreed timescales.

As this publication goes to press we are confident that we have fully addressed the issues raised and continue to work hard across our hospitals to ensure we meet all 16 of the CQC's quality and safety outcomes.

Overall I am pleased with the improvements we continue to make at Ashford and St Peter's; our performance to date and our quality reports confirm that our two hospitals continue to be safe places for patients to receive care and treatment.

The information provided in this Quality Account is provided from our data management systems and our quality improvement systems and to the best of my knowledge is accurate, and provides a true reflection of our organisation.



Andrew Liles
Chief Executive

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Our priorities

We want to ensure the highest possible standards of quality for our patients, meeting and exceeding their expectations in terms of patient experience, safety and clinical outcomes. Each year we set ourselves a number of key priorities under each of these headings which helps us to focus on those areas most in need of our attention and continued vigilance.

In this section we describe our achievements against each of the key priorities we set ourselves last year and our plans for further improvement this year.

Review of our key priorities for 2011/12

Last year we set ourselves seven priorities under the following headings:

Improving patient experience:

1. To provide safe, high quality discharge for patients
2. To provide high quality experience relating to nutrition and hydration

Safety:

3. To provide confidence and reassurance for patients on infection control, including MRSA and clostridium difficile as well as other preventable infections
4. To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators

Clinical outcomes:

5. To reduce the hospital emergency and elective readmission rate
6. To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure
7. To improve the experience and clinical outcomes for those with long term conditions by improving the outpatient management and collaborative working with primary and community services for patients with COPD (chronic obstructive pulmonary disease).

A summary of our progress and achievements is shown below; further details are provided in the pages following.

Achieved	Improved	Further work
2. Nutrition and hydration **3. Infections** **7. COPD**	**4. Nursing care** **5. Readmissions**	**1. Discharge** **6. Heart failure, pneumonia**

Our key quality achievements for the year relating to these priorities are:

1. Improving the mealtime service and quality of catering;
2. Improving the services to patients who are nutritionally at risk and providing more dedicated staff to support our patients;
3. One of the top regional performers for prevention of MRSA and Clostridium difficile with only 2 cases of MRSA (target = 4) and 19 cases of C.difficile (target = 33);
4. Reduction in the total number of falls by 6.8%;
5. A 21% reduction in emergency readmissions and 19% reduction in elective readmissions;
6. Overall within our complaints we have reduced the number of issues relating to discharge by 17% and have seen a 7% reduction in the number of complaints relating to discharge.
7. Improving the provision of advice and counselling to smokers;
8. A 12.5% reduction in the admission rate for patients already diagnosed with COPD.

Improving our patient experience 2011/12

Ashford and St Peter's Hospitals NHS Foundation Trust is acknowledged to have very good clinical outcomes. However, we know that the experience of some of our patients could be better and work to improve patient care and experience is a continuous process. Improving patient experience is one of our key corporate objectives and is at the heart of our values: Patients First, Passion for Excellence, Personal Responsibility and Pride in Our Team.

Priority 1 – To provide safe, high quality discharge for patients

Why was this selected as a priority?

Patients and their carers tell us that their experience of being discharged from hospital is not always as good as it should be. We also know that poor discharge can lead to preventable readmissions.

What did we do in 2011/12?

A range of actions have been undertaken including:

- A series of discharge road-shows across our hospitals to reinforce the importance of good quality discharge to our staff;
- An improvement programme focusing on staff training, enabling ward staff to be more accountable for good and efficient discharge;
- Piloting telephone calls to patients to follow-up on how they are doing the day after they have been discharged from hospital;
- Development of electronic prescribing is underway to speed up the dispensing of medicines for patients going home;
- Improving how our Discharge Lounge is working to make sure we meet the needs of patients and their families;
- Working together with Surrey Social Services, Surrey Community Health and the British Red Cross in our Medical Assessment Unit and A&E.

How did we perform in 2011/12?

Overall within our complaints we have reduced the number of issues relating to discharge by 17%. Our target was to reduce the number of patient concerns measured through formal complaints with an element relating to discharge by 30% of the 2010/11 value, we achieved a reduction of 7%.

Comment

The priority for safe discharge continues to be closely monitored and we are looking at other options for safe discharge and improving management of the discharge lounge. Following review of our current programme we have identified further areas for improvement and this priority is being taken forward into 2012/13; see page 57 for details.

Priority 2 - To provide high quality experience relating to nutrition and hydration

Why was this selected as a priority?

Feeding our patients appropriately and making sure they have enough to drink is an essential component of good, quality care and is vital for a speedy recovery. This is particularly important for our most vulnerable patients and links to our ongoing work to provide high quality care for the vulnerable and elderly including those with dementia and patients who are at the end of their life.

What did we do in 2011/12?

1. Our 'Best Care' nursing programme[1] includes a focus on improving nutrition and hydration and we have re-launched our protected mealtimes for patients.
2. Our Nutrition Support Nurse works with ward staff to ensure that best practice is being followed and undertakes regular reviews showing that patients have the right food and enough to drink and that extra support is provided to those who need it most.
3. Matrons report monthly on standards requiring patients to be screened for malnutrition and whether care plans are in place and being updated regularly.
4. We held a Nutrition Focus Month in June which gave all staff the opportunity to consider the importance of nutritional assessment and support and to reflect on their practice.
5. We introduced Care Rounds on our wards (where nursing staff check on patients on a regular, usually hourly basis) which include making sure patients are having the right food and enough to drink.
6. We have reviewed our catering service and awarded a new catering contract to improve the quality of catering for inpatients.

How did we perform in 2011/12?

We measured our improvement through regular nutrition audits and by our monthly Matron Best Care audits which are presented to the Trust Board and have seen good progress. Results are shared within areas to drive improvements and monitored through divisional performance meetings and by the Senior Nursing and Midwifery Leadership Committee.

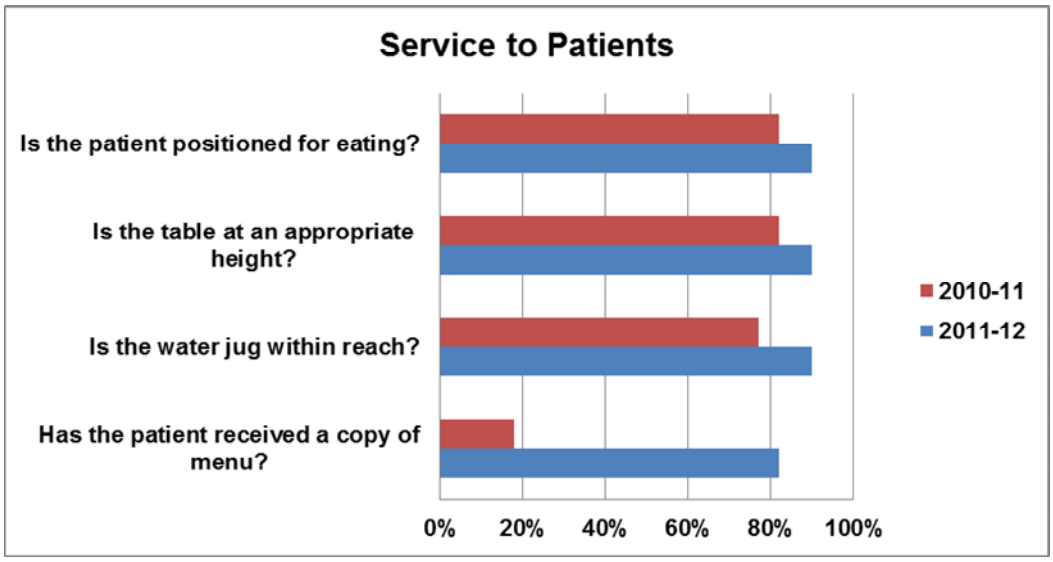
The following chart is an extract from detailed audits undertaken in 2010/11 and 2011/12. Results indicate improvements to the mealtime service to patients in 2011/12.

[1] The Best Care Programme

The Best Care Programme aims to ensure that all our patients receive the very best care which is planned and delivered in a personalised way in order to best meet each patient's particular needs. The programme is delivered via 3 main projects:

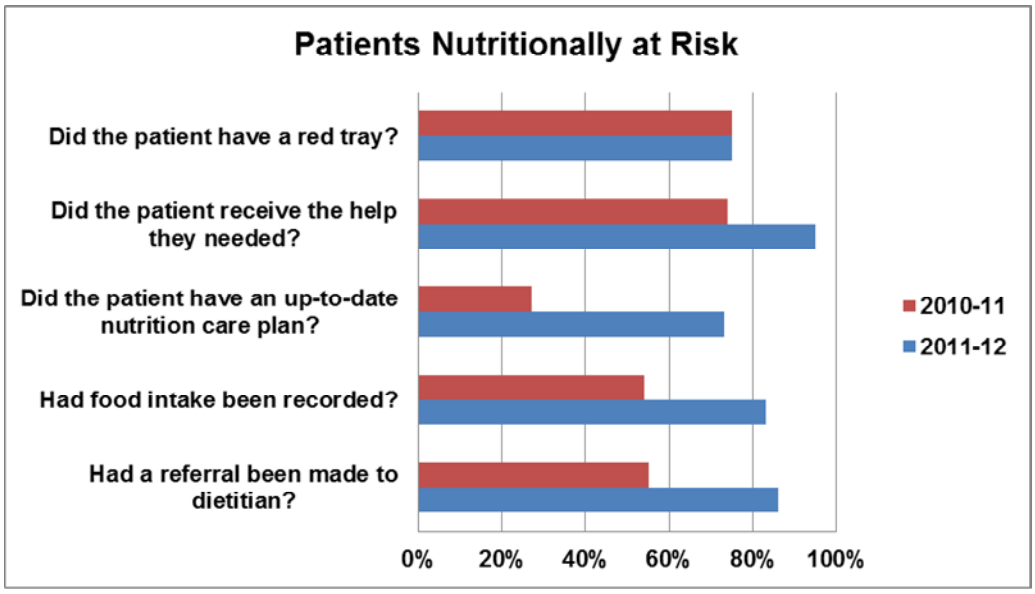
1. Essential Care – focusing on the delivery of the very best fundamentals of care such as privacy and dignity, nutrition and hydration, prevention of pressure ulcers and falls and so on.
2. Specialist Care – focusing on the delivery of the best evidenced based care to those with a particular need such as those at end of life, with a learning disability and those with dementia.
3. Mental Health – focusing on the delivery of the best care to those with a co-existing mental health problem within the acute setting.

Fig: 20: Nutrition audit information (1)



The following chart shows improvements during 2011/12 for those patients who are nutritionally at risk and require more dedicated staff support to maintain good nutrition and hydration.

Fig: 21: Nutrition audit information (2)



Comment

Further work is underway to reinforce best practice to improve nutrition and hydration for all patients and especially those at risk and to improve the overall experience that patients have of mealtimes. Although not included in our priorities for this year, this remains an area of special focus for the Trust. Work will continue overseen by our Nutrition Support Nurse. We will continue to monitor patient experience via our monthly matron audits and six monthly detailed Essence of Care[2]

[2] Essence of Care is guidance issued by the Department of Health to enable localised quality improvement. A set of 12 benchmarks are provided (including continence, communication, personal hygiene, food and drink) to support front line care across care settings at a local level.

nutrition audits and findings will be reported to our Senior Nursing and Midwifery Leadership Committee and our Patient Experience Group.

Maintaining high safety standards 2011/12

Priority 3 – To provide confidence and reassurance for patients on infection control, including MRSA and Clostridium difficile as well as other preventable infections

Why was this selected as a priority?
Although the Trust has performed well in the reduction of hospital acquired infections, this remains a key indicator of clinical quality and patients continue to require assurance that we are maintaining an emphasis on infection control. Both MRSA bacteraemias and C.difficile have been a national priority for many years with every infection reported to the Health Protection Agency as part of a national surveillance programme.

What did we do in 2011/12?
We have focused on our good practice to reduce infections, working with staff to:

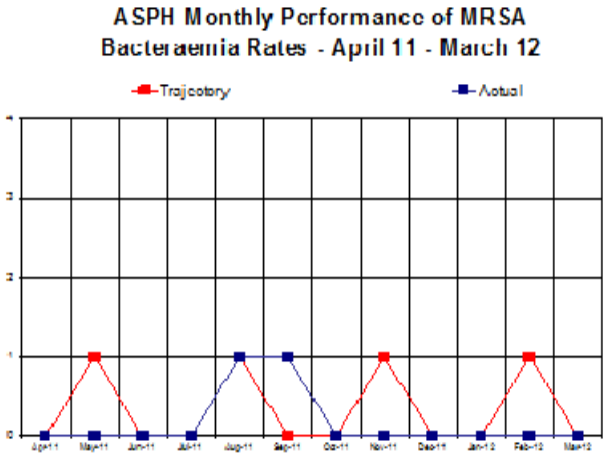
- Prevent peripheral and central line acquired infections;
- Prevent urinary catheter - acquired infections;
- Promote good infection control including hand hygiene.

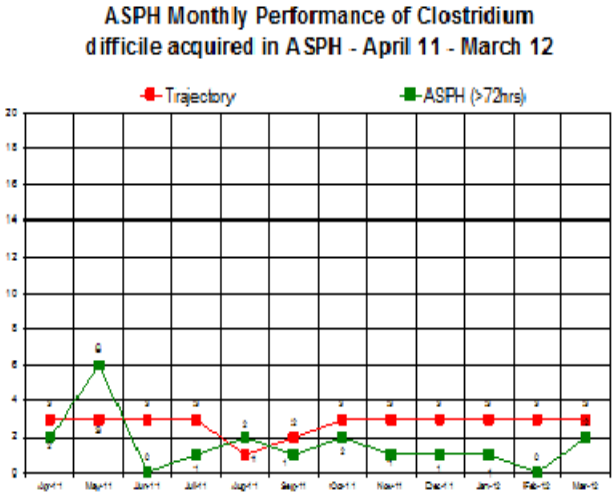
How did we perform in 2011/12?

We have achieved and surpassed our targets to reduce hospital acquired infections for 2011/12 which were:

- No more than 4 MRSA bacteraemia cases; we had **2 cases**.
- No more than 33 cases of C.difficile; we had **19 cases**.

Figs 22/23: Infection control





Comment
Our levels of hospital acquired MRSA bacteraemia and of C. difficile continue to remain low and are better than the national target. We will continue to closely monitor and report on these indictors next year. The new targets set by the Department of Health are no more than 20 cases of C.difficile and one case of hospital–acquired MRSA bacteraemia.

Priority 4 – To improve the quality of nursing care by setting and measuring a number of nursing sensitive indicators

Two key areas of focus have been the prevention of hospital acquired pressure ulcers and a reduction in patient falls.

Why was this selected as a priority?

The incidence of hospital acquired pressure ulcers and falls are known to be credible indicators of nursing quality which respond well to high quality nursing intervention. As our patient population becomes increasingly elderly and vulnerable we want to ensure that our nursing care meets their needs and promotes well-being.

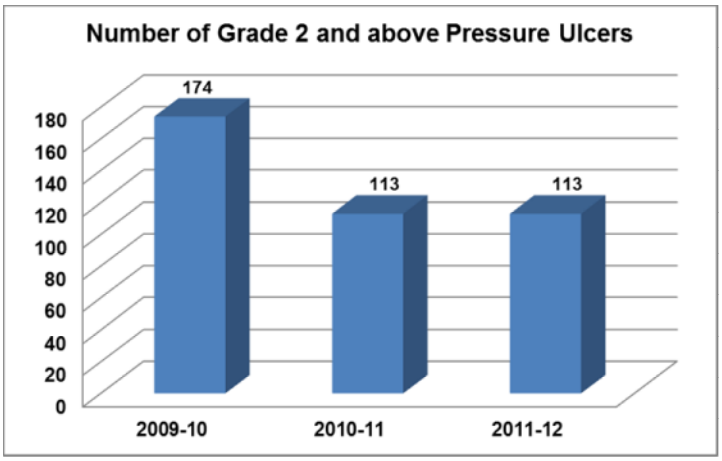
What did we do in 2011/12?

- Implementation of the Best Care Programme and the High Impact Interventions for Nursing and Midwifery[3];
- Staff training and development to ensure the use of best practice nursing care and a nurse leadership programme for ward sisters;
- We appointed a Lead Nurse for Falls Prevention;
- We provided targeted support from the Senior Specialist Nurse in Wound Management;
- We undertake ward level measurement and response to incidence of falls and pressure ulcers together with regional and national benchmarking.

How did we perform in 2011/12 for pressure ulcers?

Target: A 5% reduction in grade 2 or above hospital acquired pressure ulcers year on year.

Fig 24: Pressure ulcers



[3] The High Impact Actions for Nursing and Midwifery were developed following a 'call for action' which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference. A large group of experienced nurses and midwives identified eight high impact actions:

Your skin matters; Staying safe - preventing falls; Keeping nourished - getting better; Promoting normal birth; Important choices - where to die when the time comes; Fit and well to care; Ready to go - no delays; Protection from infection

The Chart shows the decrease in the number of Trust acquired pressure ulcers since 2009. We saw a marked improvement in 2010/11 with a 35% reduction, however, we have not met the target set for 2011/12. During 2011/12 we recorded: 104 grade 2 ulcers, 5 grade 3 ulcers and 4 grade 4 ulcers (comparative data is not available for 2009/10).

Comment

The national terminology for pressure ulcers changed in 2011/12 to be classified as 'staging'. We continue to closely monitor all patients to prevent the development of pressure ulcers. All our patients are risk assessed on admission, an appropriate care plan is put in place and this is regularly reviewed via matron monthly audits. Training and education of staff and persistent surveillance of patients are supported by our Senior Specialist Nurse in Wound Management. Going forward we will aim to eliminate all severe stage 3 and 4 pressure ulcers and reduce the number of stage 2 ulcers.

Review of current actions is underway, some of our plans include:

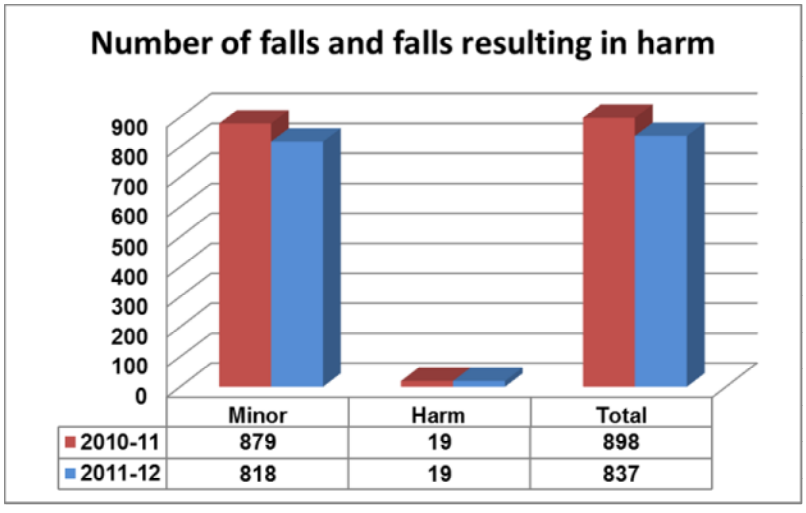
- A detailed action plan has been developed which focuses on the care given to prevent development of pressure ulcers including training and education and close surveillance aiming to follow the significant improvements seen with infection control priorities;
- Planned pressure ulcer focus afternoon for nurses on 15 June 2012;
- Advice and liaison to learn from a best-performing Trust;
- There is a new requirement from the Department of Health to submit monthly figures from April 2012;
- Managers' report to ensure all care and documentation is in place;
- Included in reports to Trust Board and in the Trust quality dashboard for monthly reporting.

We will report on our progress again next year.

How did we perform in 2011/12 for falls?

Targets: 1. Overall a 10% reduction in all reported falls year on year
2. 10% reduction in falls that result in harm year on year

Fig: 25: Falls



We have achieved a 6.8% reduction in the total number of falls but have not managed to reduce the number of falls which result in harm during 2011/12.

Comment

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. Wards are recognising that there is an increase in patients with cognitive impairment, frail and elderly, which is backed up by regional demographics, and that this has had an impact on the level of falls. Falls care is improving and staff have a greater awareness of risk reduction tools; all our patients are risk assessed on admission and plans put in place to reduce the risk of falls. The Lead Nurse for Falls Prevention has been in post since May 2011; benchmarking has shown that our figures for falls are comparable with other, similar hospital wards. Where patients are at an increased risk of falling there is a process of referral to the Lead Nurse to support further review of risk prevention measures. Work contributing to our reduction in falls includes:

- Core Care Plans and documentation changed to meet National Patient Safety Agency (NPSA) requirements;
- Our wards are responding to monthly data containing details of time of day and number of falls and this is enabling a review of work patterns and driving actions around prevention measures;
- Range of practical measures including special equipment purchased for all wards and new awareness via falls champions and a poster campaign.

We continue to work to reduce falls across all areas and specifically to reduce those resulting in harm; our progress will be monitored by the Clinical Outcomes Steering Group and reported in next year's Quality Account.

Achieving high quality clinical care 2011/12

Priority 5 – To reduce the hospital emergency and elective readmission rate

Why was this selected as a priority?

It is important for patients to have the most effective care that leads to discharge in a timely and safe manner with the required support to avoid being readmitted back into hospital.

What did we do?

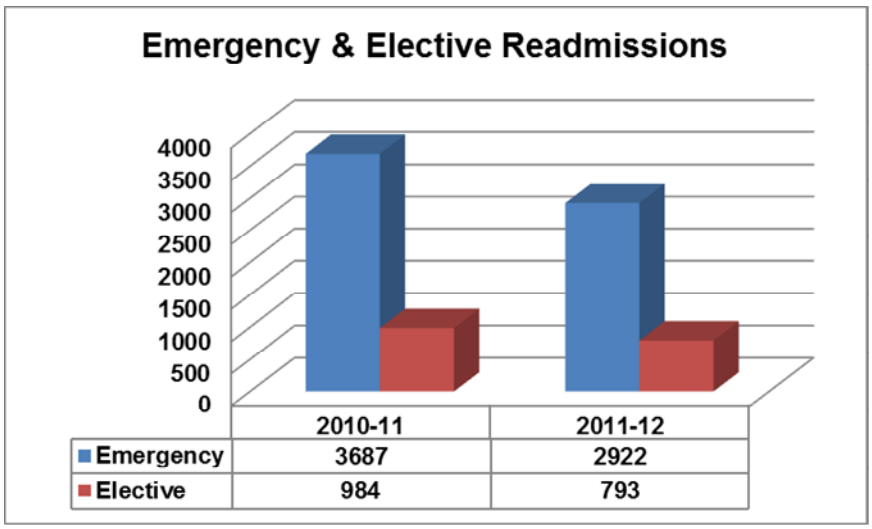
- A range of improvements around discharge including: staff training and roadshows to reinforce the importance of good quality discharge, telephone follow-up calls to patients and improvements to the working of the discharge lounge;
- Continued with our 'Experience Based Design' project where we work with patients and community staff to understand the reasons for coming back into hospital after they have been discharged;
- Operated a 'Virtual Ward' – where patients who still need some additional care once they are discharged from hospital receive this in the community;
- Our nursing home project - regular input of consultant geriatricians to nursing homes has supported reduction of avoidable emergency readmissions. Patients and relatives may prefer care in this setting to hospitalisation; full access to hospital services is still available where necessary.

How did we perform in 2011/12?

Target for readmissions within 28 days of discharge

1. For elective procedures = 50% of the 2010/11 value.
2. For emergency procedures = 15% of the 2010/11 value.

Fig: 26: Readmissions



We have seen a reduction in both emergency (21%) and elective (19%) readmissions. Possibly the 50% target set to reduce elective readmissions was unrealistic.

Comment

It has been reported[4] that significant variations in emergency readmission rates occur between medical specialties, suggesting that differences between hospital trusts are influenced by differences in specialties and thus case mix. The majority of emergency readmissions occurred in patients with an underlying chronic condition, and many had a history of multiple previous hospital admissions. A more recent article[5] has highlighted the difficulties in considering hospital performance relating to readmission rates.

Our stakeholders recommended that we continue with this priority in 2012/13, see page x for details of our actions going forward.

Priority 6 – To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

Why was this selected as a priority?

The Trust is actively participating in The Enhancing Quality (EQ) Programme[6]. This work includes measuring the care given to every patient against a set of standards to improve care. We agreed with our stakeholders to focus on two common conditions – to improve care and reduce the number of deaths of patients with pneumonia and heart failure.

What did we do?

A series of process measures and outcomes were identified within the EQ programme. Doctors and nurses are responsible for ensuring the clinical process measures are followed and that data is collected and outcomes monitored. Improvement targets and milestones are set by the Strategic Health Authority and enable the Trust to benchmark its performance against all hospital trusts across the South East and identify actions to improve patient care. Data submissions are monitored on a monthly basis.

How did we perform in 2011/12?

The Trust has been monitoring improvements by looking at the Crude Mortality Rate (CMR) and Standardised Mortality Rate (SMR) for pneumonia and heart failure patients.

Targets:
1. Reduction of 5% SMR for Heart Failure by 2013/14.
2. Reduction for hospital acquired Pneumonia of 1% SMR year on year.

The target set for Heart Failure was to be achieved by the end of March 2014; currently, we have not seen a reduction in SMR for heart failure. Similarly, for pneumonia the aim for a 1% reduction has not been achieved and the rate is 8% higher than the outturn for 2010/11. We are looking closely into the quality of the data used to produce the mortality rates and also reviewing the quality of care given to our patients. During 2011/12 the improvements we have made include:

[4] Quality in Health Care 1999;8:234-238
[5] "Hospital readmission rates: signal of failure or success?" Imperial College London Business School (2012)
[6] Enhancing Quality (EQ) is a South East coast regional programme focused on improving standards in patient care to give patients a better experience of health services. Four high frequency clinical areas are being targeted: heart failure, heart attack, hip and knee surgery, community acquired pneumonia, with two more for 2012/13 - dementia and acute kidney injury. It is anticipated the programme will improve patients' care and save money in the NHS.

Heart Failure:

- Strengthened integration of services between acute and community services following a rapid improvement event in July 2011.
- Made changes to the electronic system supporting the discharge process by setting triggers and prompts enabling clinical staff to improve safe discharge and provide information to patients on discharge.
- Improved documentation and delivery of smoking cessation advice – from 18% in January 2011 to 38% of patients receiving advice and onward referral in December 2011.

Pneumonia:

- Staff education programme to improve understanding of antibiotic guidance and support blood culture prior to administration of antibiotics.
- Improved advice and counselling to smokers – from 20% in Jan 2011 to 75% in Dec 2011;
- Improved awareness and education and improvements in the documentation of some measures e.g. CURB65 measure increased from 23.53% in April to 69.74% of patients in December 2011.

Comment

Note that December 2011 is the latest update on progress within the Enhancing Quality programme that is available at the current time. Our stakeholders recommended that we continue with this priority in 2012/13, see page 61 for details of our actions going forward.

Priority 7 – To improve the experience and clinical outcomes for those with long term conditions by improving outpatient management and collaborative working with primary and community services

Why was this selected as a priority?

On average, 250 patients per day attend the A&E Department with around 20% being admitted. Evidence suggests patients with a long term condition are more appropriately managed in partnership with colleagues in the community and that better patient care pathways should be developed.

We chose COPD (Chronic Obstructive Pulmonary Disease) as a focus for improvement. COPD is characterised by airflow obstruction which is usually progressive, not fully reversible and does not change markedly over several months. The disease is predominantly caused by smoking.

What did we do?

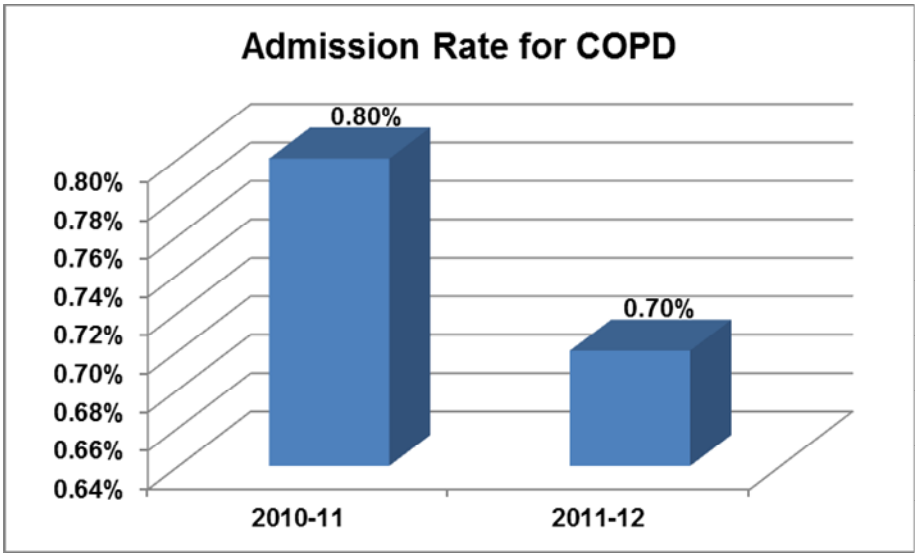
In partnership with NHS Surrey and Surrey Community Health, we developed a series of care pathways across our organisations to improve safe discharge of patients and ensure that sufficient support is available following discharge. We actively advise patients to stop smoking and provide information and referrals to smoking cessation support groups.

Patients can be managed at home, in the community hospital or in the acute setting. We also launched 'Expert' patient programmes to promote and sustain patient self-management and reduce the need for patients to come back into hospital.

How did we perform?

Our target was to reduce the number of COPD patients being admitted to hospital by 2.5% by Mar 2012; we have reduced the admission rate for patients already diagnosed with COPD by 12.5%.

Fig: 27: Admission rate for COPD



Comment

This achievement will continue to be monitored to ensure that the improvements and new ways of working are fully embedded and that patients receive the most appropriate care whether this is in hospital, at home or in the community.

Our Priorities for Improvement for 2012/13

All our priorities will be monitored via our Quality Account Dashboard which is reported to the Trust Board on a quarterly basis.

How our priorities were chosen

In drawing up our priorities for improvement for 2012/13 we have taken into consideration our progress against last year's priorities, some of which are now secured as business as usual whilst others require more continued focus. We have also considered the local, regional and national picture, our overall performance and the views of patients, our Governors, Commissioners and patient representatives from our Local Involvement Network (LINk) and the Patient Panel.

Following a process of engagement, including an afternoon of debate with representatives from our staff, Governors, the LINk and our Patient Panel we identified five key priorities for this coming year which we believe should be our focus in improving patient experience, safety and clinical outcomes.

The following priorities have been endorsed by the Trust Board. In addition, there is a good deal of other work to improve the quality of patient care and patient experience which is also reported at Trust Board.

Improving our Patient Experience 2012/13

Priority 1 - To provide safe and high quality discharge for patients

(Continues from 2011/12)

Why have we chosen this priority?
We did not fully achieve our targets last year and, during engagement with stakeholders at our Quality Account workshop, safe discharge remains a key priority for our patients. We are continuing our work and introducing new actions to meet and embed the improvement targets we set in 2011.

How will we improve?

- A joint venture which comprises our staff, Surrey Social Services, Surrey Community Health and the British Red Cross who work together to assess, arrange or liaise with the most appropriate support services is focusing on patients in our Medical Assessment Unit and A&E.
- We have introduced a new electronic system to help us monitor patients during their stay and ensure that all care is delivered in a timely manner to achieve safe and efficient discharge.
- Each ward undergoes daily review and planning ahead for safe discharge.
- Staff receive regular training on the discharge process.
- We have updated our discharge project with key actions including:
    - Ensuring senior clinical decision-making happens daily and embed multi-disciplinary team Board Rounds;
    - Performance management of Board Rounds by setting targets to reduce length of stay;
    - Piloting an intensive improvement programme working with the multi-disciplinary teams on two wards, and evaluate its impact.

How will we measure our improvement?

We will measure improvement by monitoring our discharge and readmission rates, by considering the number of complaints relating to discharge and patient experience reported in the national surveys.

What will our targets be for 2012/13?

1. Reduce the number of patient concerns measured through formal complaints relating to discharge by 10% of the 2011/12 value. (The number for 2011/12 = 82 which is a 7% reduction on 2010/11).
2. Increase timely discharge of patients (before 12pm). This is currently running at ~17%; our aim is to improve this rate to 25% of patients before 12 pm.

How will we monitor and report our improvement?
The number of discharge related complaints will be monitored by the Clinical Outcomes Steering Group. Progress will also be reviewed using interim surveys based on the annual national inpatient survey and results from the national survey for 2012. We will record the number of discharges before 12 pm via weekly Trust Performance Dashboards.

Priority 2 - To improve all aspects of communication with patients

Why have we chosen this priority?
Discussion with stakeholders highlighted that good communication, verbal and written information, remain priorities for continued focus. The need for improvement is seen from our inpatient and outpatient national survey results, PALS contacts and within complaints. We need to ensure that patients have all the information they want about results, diagnosis and treatment and that there is shared decision-making.

How will we improve?
A range of work is already underway including the Trust Living Our Values project[7] and a new project on shared decision making. We aim to inspire, support and develop every one of our teams to consistently deliver the very best experience - every patient, every colleague, every day. We also invite patients to attend workshops to engage with staff and enable reflection on how to provide the best patient experience; patients also come to the Trust Board and tell us about their experience of care in our Trust.

Other areas of work include review of written information that we provide to our patients and the quality of outpatient appointment letters.

How will we measure our improvement?
We will consider the following five areas:

[7] Living Our Values

The Trust has adopted a set of values:

- Putting Patients First;
- Personal Responsibility;
- Pride in our Team; and a
- Passion for Excellence.

The living our values project aims to:

1. Give teams the tools to enable them to set their own behaviour standards in their own working environment.
2. Inspire and support teams to enhance their communication and listening skills and have a positive attitude to living the values.
3. Give teams the organisational support they need to live our values everyday – (employee pathway, planning performance and measurement, other support).

1. The feedback response rates of patients completing our internal survey: "Your Feedback"; this questionnaire is available to all inpatients on discharge and a version is also available for outpatients and for patients accessing diagnostics and therapeutic departments.
2. Results from the national patient survey and our internal surveys relating to the question: "*Were you involved as much as you wanted to be in decisions about your care and treatment?"*
3. Audited improvements in response to our Essence of Care benchmark audit on communication. Current baseline results for documentation of: patients views used for care plan updates, discharge plan updates provided to patients and carers and evidence that support for patients and carers has been identified.
4. The quality of outpatient appointment letters and we will undertake 6 monthly audits of our discharge letters.
5. The feedback received by the Trust relating to communications with patients, both directly through complaints or PALS contacts (e.g. by letter, e-mail) and via online and social media including NHS Choices, Patient Opinion, Twitter. This feedback will be reviewed and themes of positive and negative comments will be analysed and reported.

What will our targets be for 2012/13?

1. For shared decision-making, the CQC benchmarked results for the Trust for 2011 indicate that we sit in the average range (value = 6.6). The best performing Trusts' range is between 7.6 to 8.6; we will aim to improve our score by 5% at the end of March 2013 and to achieve the best performing range by the end of March 2015.
2. Increase to 60% patients who know how to access PALS/ make a formal complaint (currently ranges from 10%-40% within our internal Essence of Care communication audit and reported as 38% in the national, annual inpatient survey);
3. Increase our response rates for patients completing "Your Feedback" surveys to achieve 100% compliance with the targets set for each ward.
4. Improvements to scores within the Essence of Care communication audit for documentation. The average result from the baseline = 55%; target to achieve 75%.
5. To have revised the outpatient appointment letter templates for 18 specialties.
6. Improvements in the quality of discharge letters – we will run a baseline audit by July 2012 and following review aim for 100% compliance to the NHS standard.

How will we monitor and report our improvement?
Progress with improvements will be monitored by the Patient Panel, the Patient Experience Group and the Improving Patient Experience Programme Board with reports to Trust Board.

Maintaining high safety standards 2012/13

Priority 3 - To provide effective risk assessment and prophylaxis for venous thromboembolism (VTE) and reduce hospital acquired VTE

Why have we chosen this priority?

VTE (venous thomboembolism)[8] can cause death and long-term morbidity, but many cases acquired in healthcare settings are preventable through effective risk assessment and prophylaxis (actions to reduce the risk e.g. the use of drugs and anti-embolism compression stockings).

How will we improve?

A range of work is underway to ensure that every appropriate patient is assessed for risk of developing venous thromboembolism and monthly figures are submitted to the Department of Health.

How will we measure our improvement?

We submit monthly reports to the Department of Health on numbers of patients risk assessed for VTE. In addition, from April 2012, a monthly audit of VTE within the "Safety Thermometer"[9] audit will capture risk assessment and whether patients have received appropriate medication and / or stockings to prevent the occurrence of VTE.

What will our target be?

Our targets will be to meet and exceed the national benchmark for risk assessment and prevention of VTE. In addition we will also monitor the rate of hospital associated VTE and aim for a reduction of 25% based on our results for 2011/12.

How will we monitor and report our improvement?

Progress with improvements will be monitored by the Clinical Outcomes Steering Group and reported to the Trust Board.

[8] A venous thrombosis is a blood clot (thrombus) that forms within a vein. Thrombosis is a medical term for a blood clot occurring inside a blood vessel. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE). The conditions of DVT and PE are referred to collectively with the term venous thromboembolism.

[9] The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care relating to: pressure ulcers, falls, catheters with UTIs and VTEs.

Achieving high quality clinical care 2012/13

Priority 4 - To reduce the hospital emergency and elective re-admission rate

(Continues from 2011/12)

Why have we chosen this priority?
Whilst some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided by delivery of optimal treatment according to each patient's needs, careful planning and support for self-care.

How will we improve?

- Ensuring that care and treatment is of high quality to reduce preventable harm or complications that can lead to readmissions;
- Implementing further changes to improve safe and timely discharge and monitoring patients using a newly implemented real-time electronic solution;
- Continuing with 'Experience Based Design' working with patients and Community staff to understand the need to come back into hospital after being discharged. This includes working closely with nursing and care homes;
- Operating a 'Virtual Ward' – where patients who still need some additional care once they are discharged from hospital receive this in the community by visits several times a day by community staff;
- Our nursing home project - regular input of consultant geriatricians to nursing homes.

How will we measure our improvement?
Reduction in readmissions within 28 days of discharge for elective and emergency procedures.

What will our target be for 2012/13?

- Reduction in readmissions for an elective procedure of 25% of the 2011/12 value.
- Reduction in readmissions for an emergency procedure of 25% of the 2011/12 value.

How will we monitor and report our improvement?
Progress with improvements will be monitored by the Clinical Outcomes Steering Group and reported to the Trust Board.

Priority 5 - To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure (Continues from 2011/12)

Why have we chosen this priority?

The Trust is actively participating in a regional programme - The Enhancing Quality (EQ) Programme (see page x for details) - to improve care and reduce the number of deaths of patients with pneumonia and heart failure; common cardiovascular and respiratory conditions.

How will we do this?
The Trust's Enhancing Quality Programme includes improvement work on these key, high volume, pathways with the aim of reducing readmissions, rate of complications and with improved patient experience and outcomes.

How will we measure our improvement?
The EQ Programme has continuous data collection with improvement targets and milestones set (by the Strategic Health Authority) to allow the Trust to benchmark its performance. The Trust will be reporting Crude (CMR) and Standardised Mortality Rates (SMR) for pneumonia and heart failure patients.

What will our target be for 2012/13?

Based on our previous results we are reviewing the quality of the data provided to give our Standardised Mortality Rates (SMR) – we are auditing the patient records to identify whether the cases diagnosed as heart failure are correct.

- Reduction of 5% SMR for Heart Failure by 2013/14.
- Reduction for hospital acquired Pneumonia of 1% SMR year on year.

How will we monitor and report our improvement?

Information will be collected monthly and reported to:

- Trust Clinical Effectiveness and Audit Group and the Clinical Outcomes Steering Group.
- To Trust Board through the Monthly Quality report.

STATEMENTS OF ASSURANCE

These statements of assurance follow the statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health's Quality Accounts regulations.

Review of services
Between April 2011 and March 2012 Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 21 NHS services.

Ashford and St Peter's Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 21 of these NHS services

The income generated by the NHS services reviewed in 2011/2012 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Foundation Trust for 2011/2012.

Participation in clinical audit and review
Clinical audit is a simple tool to review clinical practice against best evidence standards identifying actions to improve the quality of patient care and treatment.

National confidential enquiry is a form of national clinical audit looking at potentially avoidable factors associated with poor outcomes.

During 2011/12, 48 national clinical audits and 6 national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2011/12 Ashford and St Peter's Hospitals NHS Foundation Trust participated in (83%) of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Ashford and St Peter's Hospitals NHS Foundation Trust was eligible to participate in during 2011/2012 and those that the Trust participated in are identified in the tables below.

These tables also contain details of the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

It can be seen from the following evidence that the Trust is undertaking national audits relevant to its services. We also have an active programme of local audits to support improvements in the quality of patient care.

Fig 28: National Clinical Audits – continuous with no planned end date

Topic	Eligible to participate	Participated	%cases submitted
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100%
Adult critical care (Case Mix Programme)	Yes	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100%

Diabetes (National Adult Diabetes Audit)	Yes	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	No[1]	N/A
National Elective Surgery PROMs: Hip Replacements	Yes	Yes	74.5%[2]
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	59.8%[2]
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	53.5%[2]
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	28.6%[2]
Coronary angioplasty (NICOR Adult cardiac interventions)	Yes	Yes	100%
Peripheral vascular surgery (VSGBI Surgery Database)	Yes	Yes	TBC
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	111%[3]
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	100%
STEMI (ST Elevated MI)			TBC
Heart failure (Heart Failure Audit)	Yes	Yes	100%
Acute stroke (SINAP)	Yes	Yes	100%
Hip fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	72%
Lung cancer (National Lung Cancer Audit)	Yes	Yes	119%[4]
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	97.9%
Head & neck cancer (DAHNO)	Yes	Yes	N/A[5]
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	Yes	N/A[6]
Renal replacement therapy (Renal Registry)	Yes	Yes	N/A[7]
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	N/A[7]
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric cardiac surgery (NICOR)	No	N/A	N/A
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
CABG and valvular surgery (Adult cardiac surgery audit)	No	N/A	N/A

Notes: For some submissions reports are not yet available; we consider that we have identified all eligible patients

1. All data for the national registry has been captured internally, however, we have been unable to submit to the national database. We have explored the issues with a representative from NJR and a solution is planned which will enable us to upload all of our data.
2. PROMs: Participation from April 2011 to September 11 (pre-operative questionnaires); these rates are an estimate of the true rate (http://www. hesonline.nhs.uk/).
3. Carotid Interventions participation considered to be 111% as 21 cases were submitted but only 19 cases coded in HES (Hospital Episode Statistics) data – the Trust was rated amber for the indicator as this higher number could indicate an issue with coding.
4. Lung Cancer indicates number of cases actual is greater than that expected – again this could reflect an issue with coding.
5. Head and Neck cancer data is submitted jointly through the Royal Surrey County Hospital Foundation Trust.
6. Pulmonary Hypertension: Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals
7. Our patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Fig 29: National Clinical Audits – intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	%cases submitted
Paediatric pneumonia (British Thoracic Society, BThSoc)	Yes	No[1]	
Paediatric asthma (BThSoc)	Yes	No[1]	
Pain Management in Children (College of Emergency Medicine)	Yes	Yes	100%
Paediatric epilepsy (RCPH National Childhood Epilepsy)	Yes	Yes	100%
Emergency use of oxygen (BThSoc)	Yes	Yes	100%
Adult community acquired pneumonia (BThSoc)	Yes	TBC	TBC
Pleural procedures (BThSoc)	Yes	No*	
Adult asthma (BThSoc)	Yes	No*	
Bronchiectasis (BThSoc)	Yes	No*	
COPD (BThSoc / European Audit)	Yes	TBC	
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No*	
National Health Promotion in Hospitals Audit	Yes	No*	
National Audit of Seizure Management	Yes	No*	
National Sentinel Stroke Audit	Yes	Yes	117%[2]
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%
Chronic pain (National Pain Audit)	Yes	Yes	TBC
National Oesophago-gastric Cancer Audit	Yes	Yes	TBC
National Care of the Dying Audit – Hospitals (RCP)	Yes	Yes	167%[3]
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	TBC
Severe sepsis & septic shock (CEM)	Yes	Yes	TBC
Heavy menstrual bleeding (RCOG)	Yes	Yes	TBC
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%
Medical use of blood (Nat Comp Audit Blood Transfusion)	Yes	Yes	100%
Patient transport (National Kidney Care Audit)	Yes	Yes	N/A[4]
Depression & anxiety (National Audit of Psychological Therapies)	No	N/A	N/A
Prescribing in mental health services (POMH)	No	N/A	N/A
National Audit of Schizophrenia (NAS)	No	N/A	N/A

Notes:
*Non-participation for these national audits is due to lack of resources to undertake the work.
N/C (Not Confirmed) - data submitted but participation rates not confirmed.
For some submissions, reports are not yet available; we consider that we have identified all eligible patients.

1. Paediatric asthma and pneumonia: decision not to participate as we undertake regular, local audits and this would cause duplication of work will little gain to our practice.
2. 60 cases were required but we submitted 70 cases which were included in the audit. Note this audit took place during 2010/11 with results published in May 2011.
3. National Care of the Dying Audit – Hospitals we exceeded the minimum request of 30 cases and submitted 50 cases to provide a better sample and give more robust results.
4. Our patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Fig 30: National Confidential Enquiries

Topic	Eligible to participate	Participated	%cases submitted
NCEPOD Bariatric Surgery	Yes	Yes	100%
NCEPOD Cardiac Arrest Procedures	Yes	Yes	90%
NCEPOD Paediatric Surgery Study	Yes	Yes	100%[1]
NCEPOD Alcohol Related Liver Disease	Yes	Yes	TBC[2]
NCEPOD Subarachnoid Haemorrhage	Yes	Yes	TBC[2]
National Review of Asthma Deaths	Yes	Yes	TBC[3]
CISH (suicide and homicide by people with mental illness)	No	N/A	

Notes:
1. We submitted data, none of our patients were included in the study
2. New study with some data submitted
3. Data collection for this study is ongoing (1 Feb 2012 to 31 Jan 2013).

National and local clinical audits reviewed

The reports of 16 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2011/2012 and as a result the Trust intends to take actions to improve quality of care. An outline of some of our improvement work is shown in the table below.

National Audit Report	Areas of action
PROMs: hip and knee replacement, groin hernia and varicose vein operations.	Practice is within the national range for these procedures. Actions for hip and knee surgery include ensuring that all patients receive antibiotic prophylaxis within one hour prior to surgery.
Adult critical care (Case Mix Programme)	Reports are reviewed six monthly and our results are benchmarked with other units – we sit within the national ranges for this audit of critical care patients.
National Audit of Dementia Care	The dementia strategy was approved in Jan 2011 and a range of achievements have been made since then. The Trust has an appointed lead for dementia and a Dementia Steering Group has been working to develop the service ensuring that dementia care has a 'whole' Trust focus. Actions include: • Introduction of the Patient Passport (or 'ME') document, • Recruitment of a consultant geriatrician and a specialist nurse • Training and education of staff across all areas • Refurbishment of wards.

Sentinel Stroke Audit	Improvement areas: • Screening and function assessment after admission; • Promotion of continence care, • Communications with patients and carers regarding diagnosis and prognosis. Further work is underway to improve safe discharge through the Early Supportive Discharge Pilot with Surrey Community Health.
National Audit of Falls and Bone Health	The introduction of a Lead Nurse for Falls Prevention to focus on the root causes of patients who fall whilst in our care, the early identification and implementation of prevention strategies and training.
National Inpatient Diabetes Audit	Development of an inpatient diabetes strategy with plans to introduce an adult patient passport to the safer use of insulin.
National Lung Cancer Audit	The quality of the data submitted to this study is being reviewed.
National Care of the Dying Audit	Focus on training and education of staff to ensure that the Liverpool Care Pathway for the dying is in place for patients where appropriate.
National Heart Failure Audit	Previously registered but unable to submit data due to differences in electronic data capture systems. Work has progressed to capture and submit data monthly during 2011-12. For actions refer to the Enhancing Quality section below.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Actions include review of data submission to improve the quality of the data.
NCEPOD: Surgery in Children	• Development of a paediatric network across Northwest Surrey to manage the clinical care of children undergoing surgery. • Trust internal actions include: review of our transfer policy and general paediatric surgery and anaesthetic policy; identification of Trust clinical leads; establishment of a competency framework and a database to monitor clinical activity.
National Comparative Audit of Blood Transfusion	Medical use of blood and bedside practice audits – key actions include: • Education and training of staff, • Close monitoring of the usage of blood products and • Regular awareness via monthly "Blood Drops" newsletter.
National Obstetric Anaesthetic Database (NOAD)	Focus on reducing the elective caesarian section rate through improved counseling by consultant teams.

National Inpatient Survey	Improvement work focused via 3 main programmes: • Living Our Values working with staff to improve attitudes by reinforcing Trust values and behaviours; • Best Care Programme to improve the provision of essential and specialist care to the vulnerable, elderly and those with dementia and at end of life; • Discharge Project to learn from investigations of poor discharge practice with specific training for staff to understand their responsibility to the patient.
National Outpatient Survey	The improvement strategy is being delivered with a range of actions within each of the following categories: • Appointments and waiting times, • Staff behaviour and communication with patients, • Work to improve the outpatient department environment, • Review and evaluation of progress.
Enhancing Quality	Actions for the Heart Failure team include: • Ensuring patients have a clear management plan; • Provision of safe discharge instructions; • Referral to community heart failure services where appropriate; • Recruitment of a heart failure nurse working across organisational boundaries • Implementation of an Integrated care Pathway. Actions for the pneumonia team include early antibiotic therapy and the delivery of smoking cessation advice activities.

The reports of 76 local clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust 2011/2012 and actions have been taken to improve the quality of healthcare provided. Note that some audits occur on a regular basis therefore the clinical audit activity is much higher e.g.

- Matron monthly Best Care audits across every ward and outpatients, day surgery and theatres – a total of 34 areas undertake a detailed audit of the quality of patient care each month;
- Quarterly Safety Thermometer Census looking at patient care relating to pressure ulcers, catheter associated infections, patient falls and venous thromboembolism;
- Pharmacy quarterly audits of antibiotic prescribing

Results from clinical audits were presented within specialties and included in various reports e.g. to the Clinical Effectiveness and National Audit Review Group, Clinical Governance Committee, Trust Board. Learning from audits is shared across departments during educational meetings and included in the bimonthly audit newsletter. All issues which were considered to be urgent were addressed by the areas immediately and progress reported directly to the Clinical Governance Committee.

Some common areas of action:

- Focus on improving the safe care of patients through a range of training and educational events;
- Review and updates to policies, procedures and guidelines including review and development of proforma to support data capture and assist review of patient care;
- Review and streamlining of patient pathways to reduce delays;
- Improvements relating to the essentials of nursing care including: privacy and dignity, food and nutrition, personal hygiene and care of patients with dementia and patients at the end of life;
- Focus on improving the documentation of patient care: in medical records, nursing care plans, discharge plans and communication with other NHS partners;
- Review of information provided to patients e.g. patient leaflets, hospital admission packs;
- Introduction of management walkabouts to observe patient care in action, routine care rounds to enable wards to tailor their approach and meet individual patient needs and essential care spot-checks;
- Additional training sessions for staff on a variety of topics (nutritional needs, dementia care, palliative care, administration of medicines, cardiology, breast care, infection control, respiratory medicine).

Participation in clinical research

Research enables NHS organisations to improve the current and future health of their patients and is an important element in driving quality improvements. Highlighting our support for clinical research our Chief Executive, Andrew Liles, is the Chair of the Surrey and Sussex Local Research Network.

The number of patients receiving NHS services provided or subcontracted by Ashford and St Peter's Hospitals NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by a research and development committee was 683 compared with 556 patients in 2010/11 and 215 patients in 2009/10.

Care Quality Commission (CQC) Registration

Ashford and St Peter's Hospitals NHS Foundation Trust is required to register with the Care Quality commission and its current registration status is that we are not fully compliant with the registration requirements of the Care Quality Commission.

The Care Quality Commission has not taken enforcement action against Ashford and St Peter's Hospitals NHS Foundation Trust during 2011/12.

Ashford and St Peter's Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12. On the 1st December 2011 the Trust underwent an unannounced visit with the compliance report published on 25th January 2012:

- **Outcome 1** Respecting and involving people who use services. Judged to be non-

compliant with Moderate concerns.

- **Outcome 2** Consent to care and treatment. Judged to be compliant with Minor concerns.
- **Outcome 4** Care and welfare of people who use services. Judged to be non-compliant with Major concerns.
- **Outcome 7** Safeguarding people who use services from abuse. Judged to be compliant with Minor concerns.
- **Outcome 14** Supporting Staff. Judged to be non-compliant with Moderate concerns.
- **Outcome 16** Assessing and monitoring the quality of service provision. Judged to be fully compliant.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

A tripartite action plan was put in place to address all of the issues raised in the compliance review; actions include:

- Immediate closure of the Day Surgery Unit as an escalation area for inpatients
- Review of nursing documentation
- Commissioning of more community beds to help with the discharge pathway
- Improve levels of staff mandatory training to 70% by the end of March 2012.

Ashford and St Peter's Hospitals NHS Foundation Trust has made the following progress by 31 March 2012 in taking such action:

- The Day Surgery Unit is no longer utilised as an escalation area for inpatients
- We have achieved the staff mandatory training target of 70%
- Improvements have been made to the discharge pathway
- Monthly reviews are supporting improvements to nursing documentation.

The Trust Board has monitored the implementation to the plan and the plan's tests of effectiveness have demonstrated steady progress. The projected date for full completion of the action plan is July 2012 and therefore full compliance against outcomes 1, 4 and 14 cannot yet be declared.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion (up to 1.5% which equates to £3.0m) of Ashford and St Peter's Hospitals NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and NHS Surrey as lead commissioner through the 'Commissioning for Quality and Innovation payment framework (CQUIN)'.

Incentive payments through CQUIN help to reinforce quality as a driving factor for NHS services and mean that quality issues are at the heart of discussions between providers and their commissioners. The Trust worked with NHS Surrey to agree which quality measures would be measured through CQUIN for 2011/12 and these are listed below:

- To reduce avoidable death, disability and chronic ill health from venous thrombo-embolism.
- To improve the way the Trust responds to patients' personal needs.
- Increase the number of emergency patients being treated on an ambulatory care basis.
- To support the wider NHS Surrey public health programmes by:
    - Encouraging patients to stop smoking
    - Working towards implementing the national Baby Friendly Initiative
    - Increasing the awareness of alcohol abuse.
- To improve the services provided to patients with mental health problems.
- To improve quality through the regional Enhancing Quality programme which will measure our results in terms of patient care and treatment for five specific clinical conditions: heart attacks / failure; pneumonia; hip replacements; knee replacements; dementia.

During 2011/12 the Trust achieved 75% of our CQUIN target which equates to £2.25m (2010/11 £2.5m). Further details of the agreed goals for 2011/12 and for the following 12 month period are available on request from the Business Development Team, c/o St Peter's Hospital, Guildford Rd, Chertsey, KT16 0PZ or via the Trust website at: www.ashfordstpeters.nhs.uk

Data Quality

Ashford & St Peter's Hospitals NHS Foundation Trust takes Data Quality very seriously and has a dedicated Data Quality Team who proactively engage with data inputting staff to encourage best practice. The team also addresses quality issues and has rigorous processes in place to ensure timely identification of quality issues and the remedial steps required. In addition, a robust and bespoke training programme, run by the dedicated IT Training Team ensures that staff are provided with sufficient training opportunities. Training on the Patient Administration System and other key systems is mandatory at Induction, and is followed up by an ongoing programme of training sessions on offer throughout the year.

Ashford & St Peter's Hospitals NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. Details for the percentage of records in the published data are shown in the table below and compared with 2010/11:

	2010/11			2011/12		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Practitioner Registration Code	100%	99.76%	99.66%	100.00%	99.89%	99.82%
NHS Number	98.06%	90.45%	98.34%	99.08%	91.42%	98.70%

All metrics for recording of NHS number and GP code show a slight improvement in 2011/12 from the figures for 2010/11, excepting those that were already at 100%, which

remained so.

Information Governance Assessment

Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Toolkit Score for 2011/12 was 69% and was graded red. Of the 45 IG Toolkit requirements the Trust obtained the required level 2 assessment on 42. It is the intention of the Trust to ensure that the remaining 3 requirements currently at level 1 will achieve a level 2 assessment in 2012/13.

Clinical Coding

Clinical coders translate the medical terminology written by clinicians into a standard (international) code to describe a patient's diagnosis and treatment. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and also contributes to costing and monitoring hospital activity and performance.

Ashford & St Peter's Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reported period by the Audit Commission in March 2012 and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) will be published nationally in August 2012.

The Audit Commission looked at Cardiology as a specialty chosen by the PCT and then a random sample from the remaining Specialties. The results show the actual sample and should not be extrapolated further than the actual sample audited.

Further information about the Payment by Result Data Assurance Framework clinical coding audit is available from the Audit Commission.

The quality of coded data is internally monitored through regular Information Governance (IG) Clinical Coding Audits. Accuracy figures for the 2011/12 IG audit showed a level 2 score.

	May 2011	August 2011	November 2011
Primary diagnosis correct	94.55%	93.68.%	97.00%
Secondary diagnoses correct	94.27%	92.32%	97.92%
Primary procedure correct	95.89%	95.28%	94.37%
Secondary procedures correct	95.92%	91.83%	94.89%

Ashford & St Peter's Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Data Quality Committee to be re-instated with a wider remit and membership.
- Data Quality Working Groups to be formed to action the findings of the Data Quality Committee.
- Clinical Outcomes Steering Group was launched in April 2012 to consider outcomes and data quality and recommend improvements.
- Clinical Outcomes Working Groups to be formed with Consultants to review and improve quality and recording of data.

National Quality Board Core Quality Indicators 2011/12

In 2009, the Department of Health established the National Quality Board (NQB) bringing the Department of Health, the Care Quality Commission (CQC), Monitor, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) together to look at the risks and opportunities for quality and safety across the whole health system.

The National Quality Board has recommended the introduction of mandatory reporting against a small, core set of quality indicators for the 2012/13 reporting period (DH_122545; Gateway ref no. 17240). These indicators align closely with the NHS Outcomes Framework. The intention is that trusts will report:

- Performance against these indicators;
- The national average; and
- A supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

We have decided to incorporate these indicators as far as we are currently able into our Quality Account for 2011/12.

Domain 1: Preventing People from Dying Prematurely 2011/12

1. Summary hospital-level mortality indicator (SHMI)

SHMI measures whether mortality associated with hospitalisation was in line with expectations. Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts.

How did we perform in 2011/12?
(Note Jan 2012 data available for July 2010-June 2011)

The SHMI value = 0.9458
SHMI banding = 2 (average)

Commentary
SHMI is not an absolute measure of quality, however, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.

Further work
For the following associated indicators, the Trust is developing a mechanism to identify palliative care patients and link this to deaths within the hospital.

- The percentage of patients admitted to hospital within the trust whose treatment included palliative care; and

- The percentage of patients admitted to hospital within the trust whose deaths were included in the SHMI and whose treatment included palliative care.

Domain 2 2011/12: Note that no targets have been identified (refer to DH_122545).

Domain 3: Helping People to Recover from Episodes of Ill Health Following Injury 2011/12

2. Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures, PROMs, provide an indication of a patient's health status or health-related quality of life from the patient's perspective. This information is gathered from a questionnaire that patients complete before and after surgery. Patients undergoing hip and knee replacement and groin hernia and varicose veins procedures are invited to take part in this mandatory, national study.

How did we perform in 2011/12?

Note that only provisional data is provided by the Department of Health for 2010/11 and complete data for 2011/12 is not yet available.

Provisional data from the Department of Health available on 12 May 2012 indicates that we undertook a total of 1291 eligible episodes for these four procedures from April 2010 to March 2011. Our overall participation rate for patients completing pre-operative questionnaires was 73.3%; this is higher than the overall rate for England = 69.8%. For further details refer to: http://www.hesonline.org.uk.

The table below shows data for 2010/11 provided by the NHS Quality Observatory on the percentage of patients who have reported an improvement in their quality of life following surgery.

% Patients Reporting an Improvement	Trust Score	National Ave	
Following hip replacement surgery	87.8%	86.3%	
Following knee replacement surgery	74.6%	77.9%	
Following groin hernia surgery	55.4%	51.2%	
Following varicose veins surgery	N/A	50.2%	

Commentary

PROMs scores are an important means of capturing the extent of patients' improvement in health following ill health or injury. Our results for patient outcomes are not significantly different to the national average for 2010/11 and provisional results for 2011/12 also indicate that we lie within the national average. For varicose veins surgery, there are too few patients undergoing this procedure at the Trust; as requested by the PCT we only operate on patients who have further complications.

3. Emergency readmission to hospital within 28 days of discharge.

This indicator is included within our list of priorities for 2011/12 (see page 12) and going forward is our Priority 4 for 2012/13, see page x.

Domain 4: Ensuring that People have a Positive Experience of Care 2011/12

Patient experience is a key measure of the quality of care. The NHS should continually strive to be more responsive to the needs of those using its services, including needs for privacy, information and involvement in decisions.

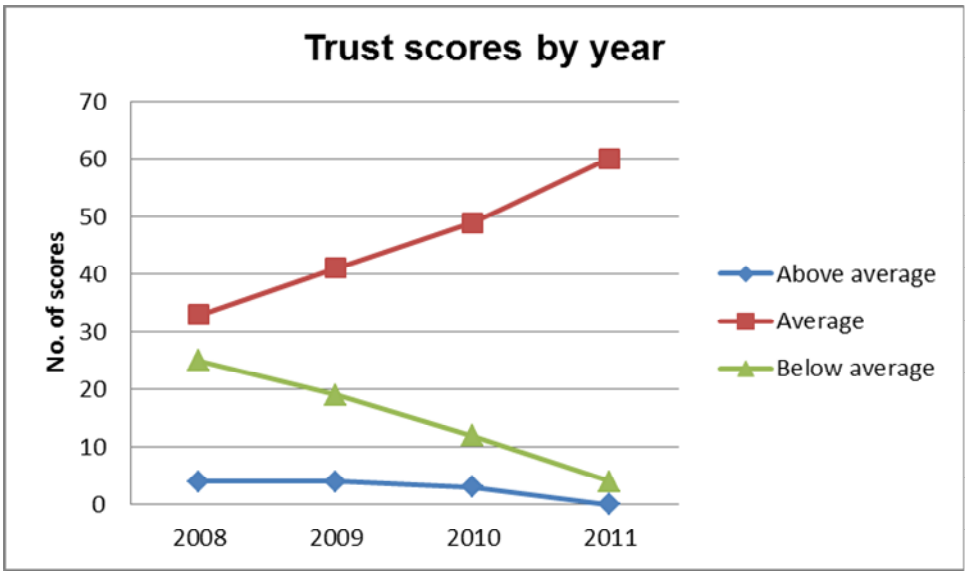
4. Responsiveness to inpatients' personal needs

Overall, the CQC report indicates the Trust performance has improved each year since 2008. For 2011, out of 64 questions, the Trust performance is about the same as other Trusts for 60 questions and worse than other Trusts for 4 questions:

1. Noise at night from other patients
2. Patients involved in decisions about their discharge from hospital
3. Explanations around side effects of medications following discharge
4. Wait to be allocated a bed on a ward (the Trust also scored worse than the previous year on this question)

This is an improvement because last year we were worse than other Trusts for 12 questions.

Graphical representation of the spread of Trust Scores by year: 2008-2011



Commentary

The overall results for the inpatient survey for 2011-12 indicate that we have made some improvements on last year's results and further work is underway:

A business case to implement a "Shared Decision Making" approach has been approved and project design is underway. This approach helps people to choose the treatment which is best suited to their personal needs, values and preferences and ensures they

and clinicians are supported with high quality information and decision support tools.

Other work underway includes a new discharge booklet given to patients on admission. The aim is to involve patients and carers in discharge arrangements from an early stage. Patients are also given a day of discharge summary sheet, which provides information about follow up services and advice on who to contact if they have concerns and details of the medication help line.

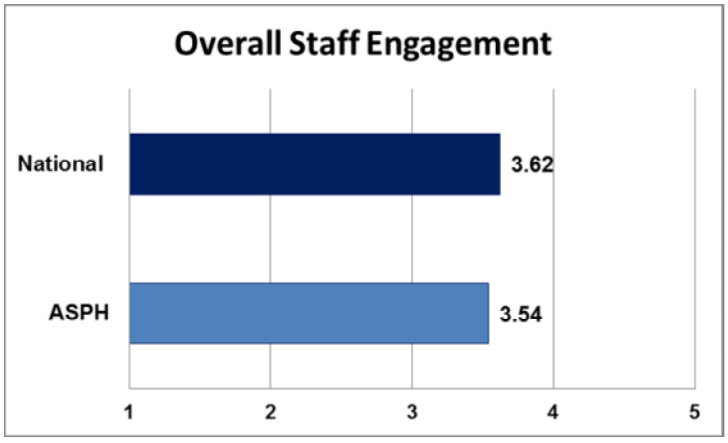
Further work involves the use of the NICE Quality Standard to improve the quality of the patient experience for people who use adult NHS services. An integrated approach to provision of services is fundamental to the delivery of high-quality care to patients and we are working in partnership with external services across the region including: Surrey Social Services, Surrey Community Health and the British Red Cross. We also employ a range of patient experience surveys to obtain feedback from our inpatients, outpatients and those attending other departments and clinics.

5. Overall Staff Engagement Indicator

This overall indicator of staff engagement has been calculated from the annual NHS staff survey using questions with the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work; their willingness to recommend the trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

How did we perform in 2011/12?

The figure below shows how we compare with other acute trusts on the overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.



Commentary

The overall results of the ASPH survey indicate that staff engagement needs attention with just 10 of the key findings average or above. This is a significant change from last year's survey results when 18 key findings were scored in line with the top 20% of other acute Trusts in the country.

At a workshop on April 13, staff from both clinical and corporate divisions; the Employee Partnership Forum; the Workforce Strategy Steering Group; the Equality & Diversity Group; and a patient representative, reviewed the results at corporate and team levels. Going forward, there will be a focus on listening further to each other within the organization about what is important to us and our patients and acting on what needs to be improved. This includes the need to put in place a high impact intervention to create high performing teams with the necessary leadership, management and coaching capability and capacity – from ward to board, in 2012/3.

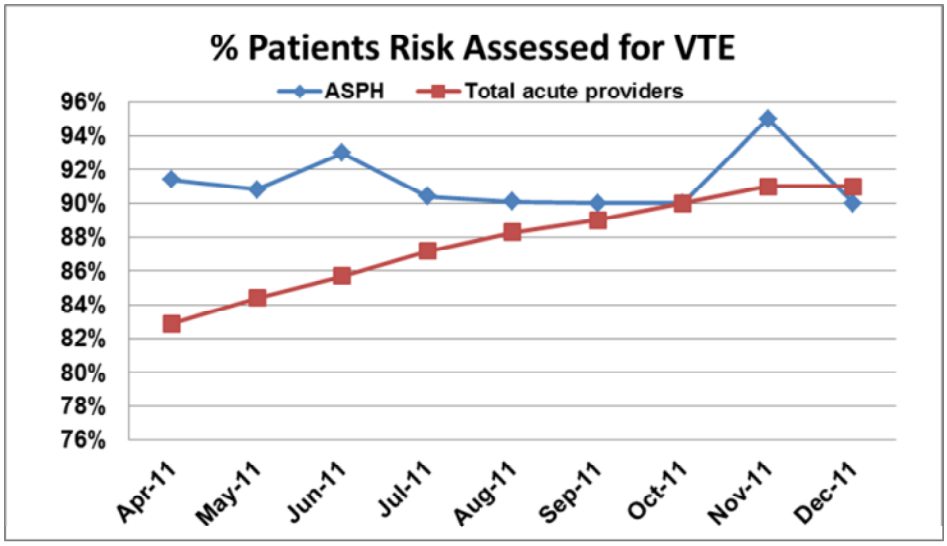
Domain 5: Treating and Caring for People in a Safe Environment and Protecting them from Avoidable Harm 2011/12

6. Percentage of admitted patients risk-assessed for Venous Thromboembolism

VTE (deep vein thrombosis and pulmonary embolism) can cause death and long-term morbidity, but many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis.

How did we perform in 2011/12?
Measure is the percentage of admitted patients who were risk-assessed for VTE: results are shown for April to December 2011 (these are the latest results available May 2012).

ASPH = 91.1%
National = 87.8%.



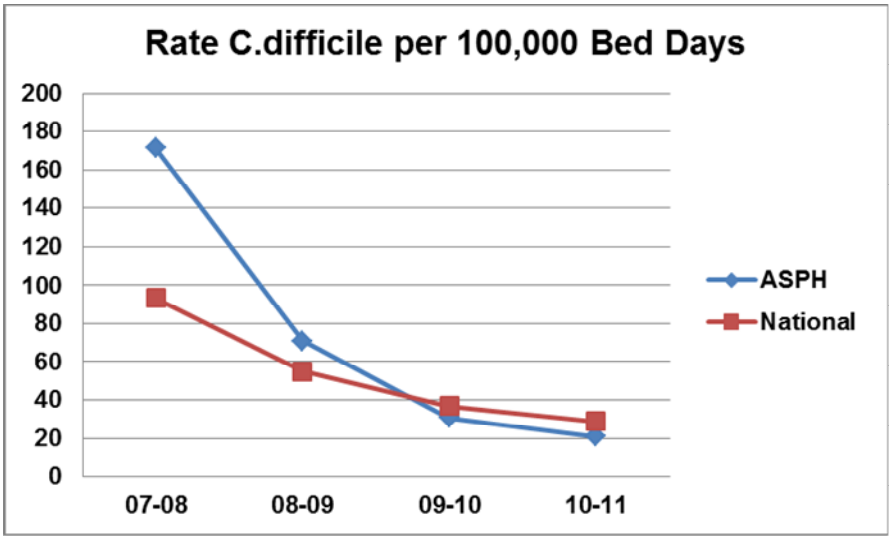
Commentary
This has been identified as a key priority going forward for 2012/13 (see page 60).

7. Rate of C. Difficile

The Department of Health will be issuing revised guidance in early March 2012 on a new testing protocol for C.difficile. The new protocol will bring about more consistent testing and reporting of cases of C.difficile infection.

How did we perform in 2011/12?
Measure is the rate of C.difficile infections per 100,000 bed days amongst patients aged two years and over.

We are awaiting release of this national data which is not expected until later in 2012 following this publication. Previous results are shown below.



Commentary
Results for 2011/12 are presented on page 49.

8. Rate of patient safety incidents and percentage resulting in severe harm or death

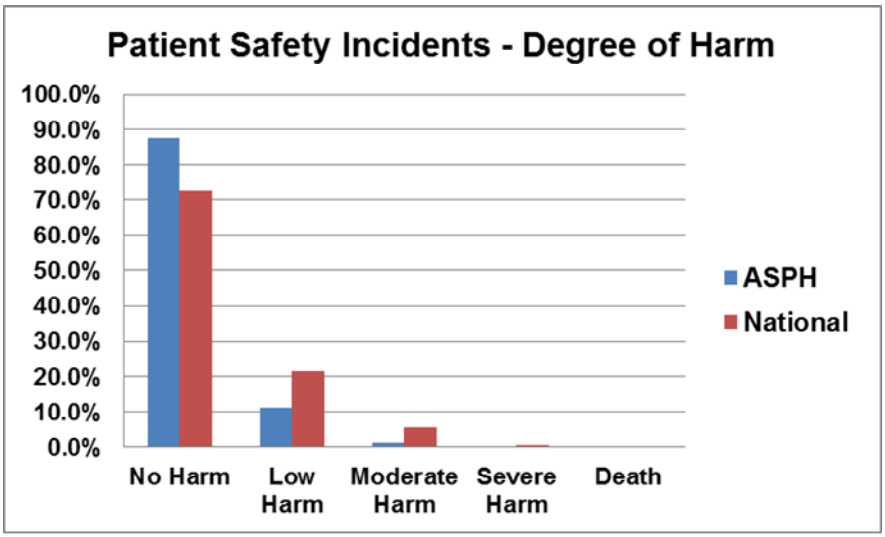
An open reporting and learning culture is important to identify trends in incidents and implement preventative action. Based on evidence about the frequency of adverse events in hospital, it is likely that there is significant under-reporting. The rate of reported patient safety incidents – i.e. unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving NHS-funded healthcare – should therefore increase in the short term as the reporting culture improves.

How did we perform in 2011/12? Results below for April – Sept 2011

The rate of patient safety incidents reported per 100 admissions for ASPH = 6.2

The median for 49 acute medium-sized Trusts = 6.3

The proportion of patient safety incidents that resulted in severe harm or death for ASPH = 0%; the national value is under 1%.



Commentary

Note these results are the latest available (May 2012). The Trust is in the middle 50% of reporters which indicates a good level of reporting for patient safety incidents and we are working to increase our reporting rate. Our commitment to continually improving patient safety includes:

- Multi-disciplinary attendance at the Leading Improvement in Patient Safety (LIPS) Programme facilitated by the Institute of Health Improvement; we are developing our Trust LIPS programme which will be launched on 23rd May 2012;
- A team of junior doctors involved in a range of projects: Doctors Advancing Patient Safety;
- Introduction of a new, web-based system with refresher training to enable improved management and response to incidents;
- On-going mandatory training for all staff on reducing risk, improving patient safety and reporting and management of incidents.

Further performance information

The following table outlines our performance against indicators we have chosen for 2011/12 for patient safety, clinical effectiveness and patient experience. These also include locally agreed targets that have been set by NHS Surrey.

Locally agreed targets & *Source of Data*	**Performance**	**10/11 (if available)**	**11/12 targets**	**11/12 actual**	**12/13 plan**	**Benchmark Comments**
Patient safety						
Standardised mortality (Relative Risk)* *Dr Foster*		89.4	82	99.2	<100	National peer group benchmark by Dr Foster. The Trust has a slightly higher crude mortality rate compared to the South East Coast average but we have a lower than average risk adjusted mortality.
Crude mortality *PAS*		1.60%	1.60%	1.65%	1.60%	
Standardised mortality for Heart Failure		0.050%	0.048%	0.065%		We are looking closely at the quality of the data and also reviewing the care given to our patients.
Standardised mortality for Pneumonia		0.320%	0.316%	0.347%		
MRSA (Hospital only) *ASPH weekly HCAI Reporting*		5	4	2	1	Trusts across South East Coast have differing thresholds (ranging from 1 - 3) based on continual improvements and case-mix.
C.Difficile *ASPH weekly HCAI Reporting*		36	33	19	20	Trusts across South East Coast have differing thresholds (ranging from 14 - 75) based on continual improvements

Locally agreed targets & *Source of Data*	**Performance**	**10/11 actual (if available)**	**11/12 targets**	**11/12 actual**	**12/13 plan**	**Benchmark Comments**
Clinical effectiveness						
Falls in hospital - resulting in significant injury (grade 3) *Quality Department – Patient Safety Administrator*		19	15	19	<15	ASPH falls with significant injury have not improved and remain the same.
Hip fractures treated within 36 hrs *PAS and Orthopaedic Trauma Nurse Practitioner validations*		93.00%	85.00%	95.3%	TBC	ASPH is doing well within Trusts in the South East Coast that submitted comparative data.
Emergency readmissions within 28 days *PAS*		3687	3134	2922	TBC	
Elective readmissions within 28 days *PAS*		984	492	793	TBC	We achieved a 19% reduction in elective readmissions and consider the 50% target for reduction was unrealistic.
Admission rate for COPD PAS		0.8%	0.78%	0.70%	TBC	
VTE Assessment *In Patient List System (IPL details)*		85.2%	90.00%	90.52%	90%	The Trust is achieving the national target and sits well within the performance of the South East Coast SHA Trusts.
Pressure Ulcers* *Matron's ward quality indicators data submission*.		113	103	113	Standard not being measured by the PCT	The Trust has action plans underway to improve performance in 12/13.
Access to midwifery/Maternity services *Clinical Midwifery Manager, Community & Outpatients - Monthly booking report*		89.30%	90.00%	91.45%	> 90%	This % is above target with the main issue related to GP misinforming patients. 12/13 target will remain above 90% but that will be considered in light of national guidance suggesting that booking should be completed by 10 complete weeks. Work on this is in its early phase of consideration.
Caesarean Section Rate* *Maternity Systems & Coding Administrator weekly and monthly reporting*		25.90%	23.00%	26.6%	Aim to reduce to 25%	Normalising birth working group in place and plans for MLU to be completed in October 2013 should influence progress towards reducing this rate. The national rate is 24%.

Patient Satisfaction – Trust internal inpatient survey -Net Promoter Score Net Promoter Score from 'Your feedback' data collection	N/A	N/A	70.00%	57.0%	60%	Note that the format of this question changed in Jan 2011 and a new target = 70% was set without benchmarking .
Formal complaints Head of Patient Experience		361	320	503	Maintain stable position	We are developing a SMART target which will reflect both PALs concerns and complaints with the aim of seeing increasing PALs indicating earlier intervention and resolution.
Complaints - % actioned within agreed timescales Head of Patient Experience		96.75%	100%	45%	TBC	Complaints handling was devolved to Divisions and performance decreased; prompt action was taken with a corporate action plan implemented which has improved performance.
Formal complaints relating to discharge Head of Patient Experience		87	61	81	10%	There has been an increase in complaints in general and our target to reduce complaints relating to discharge by 30% was an unrealistic target; similar findings across the region.
Nutrition and Hydration – Service to patients Nutrition Support Nurse		64.8%	N/A	88.0%	TBC	This remains an area for special focus and will be reported again in 2012/13.
Nutrition and Hydration – Patients nutritionally at risk Nutrition Support Nurse		57.0%	N/A	82.4%	TBC	This remains an area for special focus and will be reported again in 2012/13.

The following table outlines our performance against key national priorities contained within the Monitor Compliance Framework and other key Care Quality Commission indicators.

Performance against key national priorities 2010/11 & *Source of data*	**Performance**	**10/11 actual (if available)**	**11/12 targets**	**11/12 actual**	**12/13 plan**
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge *AE_CSEUR - A&E daily siterep database.*		97.65%	95%	93.84%	<=4hrs
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals. *CWT - Cancer system*		98.25%	93.00%	97.6%	93%
A maximum wait of one month from diagnosis to treatment for all cancers *CWT - Cancer system*		99.15%		99.23%	96.00%
A maximum wait of two months from urgent referral to treatment of all cancers. *CWT - Cancer system*		92.69%	85.00%	92.2%	85.00%
Breast symptoms referred to a specialist who are seen within two weeks of referral *CWT - Cancer system*		95.77%	93.00%	95.4%	93.00%
31 days for second or subsequent cancer treatment(drug) *CWT - Cancer system*		100.00%	98.00%	100%	98.00%
31 days for second or subsequent cancer treatment (surgery) *CWT - Cancer system*		100.00%	94.00%	99.5%	94.00%

Performance against key national priorities 2011/12 & *Source of data*	**Performance**	**10/11 actual (if available)**	**11/12 targets**	**11/12 actual**	**12/13 plan**
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment *CWT - Cancer system*		98.92%	90.00%	95.6%	90.00%
Clostridium difficile *APSH weeky HCAI Reporting*		36	33	19	20
18 weeks Referral to Treatment (RTT) Completed Pathways - Admitted patients *PAS – Referral to Treatment (RTT) database*		94.11%	90.00%	90.69%	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 *PAS - RTT database*		98.19%	95.00%	97.94%	95% of patients wait 18.3 weeks or less. The Trust will report on the average wait of 95% of our patients.

Statements on the engagement process for the development of the quality accounts

Ashford & St. Peter's Council of Governors

As documented in the minutes of 20 February 2012, the governors were well informed of the Quality Account and some individuals participated in the Quality Account workshop on 5th March to identify the priorities for improvement for 2012/13. Feedback was received from the Public Governor for Runnymede on 2 April 2012:

"Thank you for opportunity of commenting on Draft Quality Report. We were pleased to see that the Patient Experience Group- PEG- is mentioned a few times as this highlights that we do have a duty to keep all elements of this Account on our agenda. The need for monitoring and improving communication, effective management of complaints, improved discharge and training and development are some of the ongoing key priorities for PEG. In terms of the content, we have to rely on the accuracy of the data produced and I am pleased to see comments on the areas where there is a need for improvement."

Ashford & St Peter's Local Involvement Network (LINk):

"The Action Group for ASP of the Surrey LINk are grateful for the exchanges of ideas and comments between ourselves and the hospital in the preparation of the Annual Quality Accounts for 2011/2012.

The points we have raised have all been addressed with great courtesy and are incorporated in the final version of the Accounts, though we would have wished to have this version in front of us before being asked for these paragraphs; certain elements of data in the closing pages are still not to hand as we write.

The hospital has been punctilious in informing us about their work and the difficulties encountered, as for example with the problems in meeting 95% values for 4-hour waits in A&E, in inviting one of us into the Nutrition Steering Group, in informing us about developing the Dashboard system of reporting, with the inclusion as we had wished of pressure ulcers information, about the training of Healthcare Assistants, and with the progress of the bid for Epsom.

We have no hesitation in commending these Quality Accounts."

Surrey County Council Health Overview and Scrutiny Committee

"The Health Overview & Scrutiny Committee is pleased to be invited to comment on the Trust's Care Quality Account for 2011/12. At present the Health Overview & Scrutiny Committee does not have a comprehensive process in place for commenting fully on a trust's Care Quality Accounts; however, we would like to make the following comment:

The main priority for Health Overview & Scrutiny Members is to seek assurances that any planned changes to the way health services are commissioned and delivered in the future will not have a detrimental impact on the health of people living in Surrey. Also, as discussed at the March meeting, the HOSC will also continue to press Ashford & St Peters Hospitals to improve its A&E waiting times.

In May, the Committee will look at setting its priorities and work programme for the next year. We look forward to working with the Trust on any areas of scrutiny in which you may be asked to be involved."

NHS Surrey Primary Care Trust

The host commissioning PCT, NHS Surrey has reviewed Ashford and St Peter's Hospitals NHS Foundation Trust's draft Quality Account document for 2011/2012 and believes that this provides a fair reflection of the work of the hospital and includes the mandatory elements required. The priorities have been discussed and will be further developed with input from commissioners including Clinical Commissioning Groups.

We have reviewed the data presented and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by Ashford and St Peter's Hospital during the year and reviewed as part of their performance under the contract.

We continue to work with the Hospital to ensure that data accuracy at all levels remains a key priority, including the application of clinical coding.

The account identifies significant success in relation to:

- Infection control
- Falls prevention
- Patient experience

We will continue to work with Ashford and St Peter's Hospitals to raise the profile for quality improvement and regularly review the continuous improvement cycle. The engagement of clinicians close working with primary care will remain crucial in monitoring standards, and improving services for local people. The Trust is commended for their continued good work and emphasis on quality of patient care.

2011/12 Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

  1. Board minutes and papers for the period April 2011 to June 2012**;**
  2. Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
  3. Feedback from the commissioners, NHS Surrey, dated: 25th May 2012
  4. Feedback from Governors dated: 2 April 2012
  5. Feedback from LINks dated: 10 May 2012
  6. The Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012.
  7. The national patient survey, 2011 (published April 2012);
  8. The national staff survey, 2011 (published March 2012);
  9. The Head of Internal Audit's annual opinion over the Trust's control environment dated: 18th May 2012
  10. Care Quality Commission quality and risk profile dated: April 2012

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;
- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations, published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support

data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board:

Aileen McLeish Chairman
Date: 28th May 2012

Andrew Liles
Chief Executive
Date: 28th May 2012

Your feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback. Please contact: Suzanne Rankin, Chief Nurse via email: suzanne.rankin@asph.nhs.uk or telephone 01932 722216

5. Regulatory information

Monitor regulatory ratings

The Trust is regulated by Monitor, to whom it submits its annual plan. On the basis of the information contained in the annual plan, including financial plans, and the national targets set by the Care Quality Commission (CQC), Monitor will assess and assign risk ratings for the Trust.

Every quarter all NHS Foundation Trusts are required to self-certify compliance in three areas: quality, risk and governance, or identify any areas where they are failing to do so. Each trust is then assigned an overall financial or governance risk rating for the quarter based on the declarations they make to Monitor. These are described in more detail below:

Financial risk rating

Financial risk ratings are allocated using a scorecard which compares key financial metrics consistently across all foundation trusts. The rating reflects the likelihood of a financial breach of an NHS foundation trust's terms of authorisation. A rating of 5 reflects the lowest level of financial risk and a rating of 1 the highest.

Governance risk rating

All NHS Foundation Trusts are subject to their terms of authorisation, which include:

- Compliance with their constitution
- Growing a representative membership
- Maintaining appropriate board skills and structures
- Co-operating with other NHS bodies
- Risk management
- Service performance and continuing improvement in clinical quality

Governance risk ratings are assigned as follows:

- Red – likely or actual significant breach of terms of authorisation
- Amber-red – material concerns surrounding terms of authorisation
- Amber-green – limited concerns surrounding terms of authorisation
- Green – no material concerns

The following table gives our ratings for each quarter of 2010/11:

Risk Ratings 2010/11

2010/11	**Quarter 4***	
	Actual	Plan
Financial risk rating	**4**	4
Governance risk rating	**Green**	Green

***** As the Trust became a Foundation Trust on 1st December 2010, only Quarter 4 is relevant to 2010/11.

The following table gives our risk ratings compared to our annual plan for 2011/12:

Risk Ratings 2011/12

2011/12	**Quarter 1**		**Quarter 2**		**Quarter 3**		**Quarter 4**	
	Actual	Annual Plan	**Actual**	Annual Plan	**Actual**	Annual Plan	**Actual**	Annual Plan
Financial risk rating	**3**	3	**3**	4	**3**	4	**3**	3
Governance risk rating	**Amber Green**	Green	**Green**	Green	**Amber Red**	Green	**Amber Red**	Green

Financial risk ratings – the Trust was able to deliver the planned Financial Risk Rating of 3 for the year end despite having to reduce its surplus from £2.1.m to £1.0m. The reduction in surplus was due to operational pressures relating to emergency and capacity demands, combined with some slippage in savings programmes. This meant that, as shown in the table above, the Financial Risk Ratings for quarters 2 and 3 were below plan.

Governance risk ratings – during the first quarter of the year the Trust failed to achieve one of the key waiting targets, whereby 95% of all patients having planned treatment should have waited no more than 23 weeks. This meant a governance risk rating of amber-green for the quarter. Whilst we pulled back our position during quarter 2, the major concern raised by the CQC, coupled with our failure to consistently meet the four hour waiting target meant our governance risk rating fell back to amber-red. Our main focus during the first half of 2012/13 will be to recover this position and ensure we get back on track with the four hour target.

Sustainability Report

The NHS Carbon Reduction Strategy, *Saving Carbon, Improving Health*, was launched in 2009 and sets out key commitments and timeframes associated with carbon reduction in the NHS.

The NHS Carbon Reduction Strategy states a requirement to reduce the carbon footprint of NHS Trusts by 10% by 2015. The reduction is based on a 2007/08 baseline. Further commitments include a reduction of 26% carbon emissions by 2020 and 80% by 2050. To support this, a carbon emissions 2007/08 baseline estimate has been developed for the Trust. Changes will be measured against the baseline to identify the Trust's performance in future years and these will be reported.

The Trust has developed a Sustainable Development Management Action Plan, agreed by the Board, which indicates the physical and managerial changes required to support the reduction of the Trust's carbon footprint. The Management Action Plan is an initial step for taking forward Sustainability Development.

With the introduction of more and more technology there is a consequential increase in energy usage. The Action Plan aims to reduce usage and balance the needs of new technologies.

Specific actions taken during the year include:

- Demolition of old, energy inefficient buildings at St Peter's Hospital (The Ramp), replaced with modern, energy efficient accommodation with heat recovery plant (the new Chertsey House);
- Lighting improvements with replacement of inefficient and old fittings;
- Completion of the roof replacement and insulation projects;
- Replacement of energy inefficient systems e.g. chillers and boiler economisers;
- The new staff car park installed at St Peter's during the year is based on a system of permeable layers to reduce surface water run off and put water back into the substructure, using local materials from a recycled source;
- Refurbishment of Kestrel Ward (converting to Maple Ward) with replacement of single glazed windows with high performance double glazing, and replacing old external walls with new walls increasing the thermal insulation from 50mm to 150mm cellular foam;
- Over the last 3 years energy use across both our hospital sites has dropped from 130kw to 56kw;
- Through our new catering contract we have made a stipulation that, over its five-year term, the amount of local and/or organic food served is to be 10% of routine catering provision;
- Waste Management:
- We recycled 61% of all general household waste;
- Increased the amount of clinical waste diverted to offensive waste stream increased from 2% to 41% - this waste can then be diverted from landfill into energy use;
- Introduction of a Sustainable Travel Plan to promote single car occupancy and other means of sustainable travel.

The Trust's Carbon Footprint

The Trust's carbon footprint* has been defined by using information available from;

- Energy and Utilities.
- Transport (including staff business mileage).
- Procurement (including pharmacy)
- Patient and staff food
- Waste production
- Water and waste water

The overall baseline Carbon Footprint for 2007/08 has been assessed at 42,536 t CO2 emissions. All future emissions will be compared to this baseline with adjustments where necessary to improve the accuracy of figures submitted as data capture methods improve.

The Trust's carbon footprint is broken down into the following elements;

Site	tCO2	%
Ashford energy	4,370	10.27
St Peter's energy	8,665	20.37
Owned Transport	162	0.38
Business Travel	199	0.47
Staff Travel	3,525	8.29
Waste	16	0.04
Water/Waste	180	0.42
Procurement	25,419	59.76
	42,536	**100.00**

* Measurement of the Trust's carbon footprint relies on the extrapolation of information which is not always readily available. Where data and agreed methodologies are available, precise calculations have been completed but where data is unavailable (e.g. not previously captured, or too uneconomic or time consuming to capture) assumptions are made e.g. the use of an average figure. Where 2007/08 figures are considered to be too unreliable, assessed figures for 2008/09 have been used where this data has been considered sufficiently accurate and the same assumptions then used to measure progress in future years.

6. NHS Foundation Trust Code of Governance

Ashford and St Peter's Hospitals NHS Foundation Trust recognises that our capability as a Trust Board of Directors and Council of Governors is critical to the success of our hospitals. Our ability to do what we do, and to do it well, will help us to serve our patients and our community.

The Trust strives to continuously improve its processes, in line with key national guidance, to ensure safe, high quality services for our patients, and to provide a clear framework within which our staff can operate effectively.

Each year we review our governance arrangements against the provisions of Monitor's Code of Governance which sets the standard for best practice and the following disclosures give a clear and comprehensive picture of the Trust's governance arrangements and how we apply the main principles.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code in particular circumstances. For the year ending 31 March 2012 the Trust complied with all the provisions of the Code of Governance published by Monitor in 2010.

Board of Directors and the Council of Governors

The Board has agreed a Trust Governance Framework which describes the roles of the Board and the Council. This confirms that the Council will carry out its statutory duties (further detail is given in the section on the Council below) and also be consulted on the Trust's forward plans.

The Board has agreed to meet formally and in public at least nine times per year, and considers items under four broad agenda headings:

- Quality and safety
- Performance
- Strategy and planning
- Regulatory

In addition the Board meets in closed session, having published a framework setting out the types of matters normally dealt with in private. These typically include matters relating to individuals or matters of a commercial nature.

The Unitary Board of Directors is responsible for ensuring the Trust complies with its terms of Authorisation, its Constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. The Board of Directors sets the Trust's strategic aims, taking into consideration the views of the Council of Governors. The Board of Directors as a whole is responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust.

The Council of Governors represents the interests of the local community – both members of the public and staff who are Foundation Trust members - and local stakeholders. The Council of Governors is not responsible for the day-to-day management of the organisation which is the responsibility of the Board of Directors, but the Council holds the Board to account.

The Board has approved a formal Scheme of Delegation of Authority and Responsibility and within this Scheme there is a Schedule of Matters Reserved for the Board. This Scheme forms an important part of the Trust's system of internal controls.

In the event of a dispute between the Board and the Council a disputes procedure is described in the Constitution.

Composition of the Board

The Board is made up of the Chairman, 6 Non-Executive Directors and 6 Executive Directors. The Head of Corporate Affairs attends all Board meetings as company secretary.

At the end of 2011 Dr Mike Baxter retired from the NHS having worked for the Trust as a consultant since 1992 and as the Medical Director since 2002. As the Board was considering a major transaction at the time involving the possible acquisition of Epsom Hospital it was agreed to defer a permanent appointment to the vacant role and through an internal, competitive process, appointed Dr David Fluck as Interim Medical Director.

John Headley, Director of Finance and Information leaves in May 2012 to take up a new post in the NHS and is replaced by Simon Marshall.

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, Fellow of the Institute of Directors, as well as a Fellow of the Chartered Institute of Management Accountants.

The Chairman's appointment was confirmed by the Council on 1 December 2010 and continues until 30 September 2012. At the Council of Governors meeting held on 17 May 2012 Aileen was reappointed for a further term until 30th September 2015.

Professor Philip Beesley, Non-executive Director and Deputy Chairman

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 and was appointed as the Deputy Chairman by the Council of Governors for a one year initial period from 11 February 2011 which they then extended for the remainder of his Term of Office i.e. 15 July 2012. At the Council of Governors meeting held on 17

May 2012 Philip was reappointed as Non Executive Director and Deputy Chairman for a further term until 15th July 2015.

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 (OD). 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. She currently works for BT.

Sue joined the Board in February 2009 and her appointment is until 8th February 2013.

Jim Gollan, Non-executive Director

Jim's career until 2010 was in banking (Lloyds TSB, Standard Chartered), investment management (Gartmore), financial markets (virt-x, Eurex) and management consultancy (KPMG). His executive Board experience comprises 4 roles as CFO, 2 as CEO and 1 as Chairman. He has worked in the UK, Asia and Europe. He is a Chartered Accountant and graduate of Bristol University. He is also a Non-Executive Director of LIFFE and of Kent Reliance, a Trustee of the Brain Research Trust and a member of the Finance Committee of the Open University. He and his family (all of whom have had patient experiences at the hospital) have lived in the area for over 15 years.

Jim joined the Board in March 2011 and his appointment is until 30th March 2014.

Clive Goodwin Non-executive Director

Clive Goodwin graduated from the University of Salford with a Bachelor of Science degree in Modern Languages and International Business. With 14 years of operating at Board level, he has been a Commercial Director at British Telecom since 2008, having previously been the Finance Director for BT Wholesale, before which he led Asia-Pac corporate finance activity. He has extensive experience of commercial negotiations and agreements, organisational transformation and continuous improvement as well as broad-ranging corporate finance transactions, most notably acquisitions, divestments and IPOs. Clive was a Non Executive Director and Audit Committee member for Tech Mahindra, a Bombay listed company. He became a member of the Institute of Chartered Accountants in 1997.

Clive joined the Board in March 2011 and his appointment is until 30th March 2014.

Terry Price, Non-executive Director

Terry Price has wide ranging experience in both the public and voluntary sectors. He relinquished full time employment in 2006 and now holds a number of Non Executive Director roles with Thameswey Group Ltd and Woking Borough Homes Ltd, (both companies owned by Woking Borough Council), East Thames Housing Group, the Office of the Independent Adjudicator for Higher Education Ltd, and Community Building Services Ltd (a subsidiary of Affinity Sutton Housing). He is also a member of the Audit Committee for the National Fire Service College and the Immigration Services Commissioner, and is a member of the Audit and Standards Committee of Elmbridge Borough Council.

Until 2006 Terry was Director of Strategic Finance for the Metropolitan Police and from 1998 until 2003 was Director of Corporate Services for Sport England. Prior to this, Mr Price held various posts in local authority finance in the London Boroughs of Hammersmith and Fulham, and Hounslow.

In the voluntary sector Terry is Chair of the Board of Governors at Esher Sixth Form College and past Chair of the Governors at St. Lawrence C of E (Aided) Junior School in East Molesey. He has previously served as Treasurer and Vice Chair of St. Mungo's Housing Association. Terry is a fully qualified CIPFA accountant.

Terry joined the Board in September 2008. At the Council of Governors meeting held on 17 May 2012 Terry was reappointed as Non Executive Director for a further term until 14th September 2015.

Peter Taylor, Non-executive Director and Senior Independent Director

Peter Taylor worked until he retired 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 is a member of Runnymede Borough Council where he is chairman of the Environment and Sustainability Committee.

Peter started as a Non Executive in July 2008, chairs the Remuneration Committee and is a member of the Finance, Nominations and Audit Committees at Ashford and St. Peter's. Peter is also the Senior Independent Director.

Peter joined the Board in August 2008 and was appointed Senior Independent Director with effect from 24th November 2010. He continues in this role to the end of his term of office. At the Council of Governors meeting held on 17 May 2012 Peter was reappointed as Non Executive Director for a further term until 31st October 2013.

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 became 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. Andrew is the Chief Executive lead for leadership and talent management for the NHS in the South East, is Chairman of the Surrey and Sussex Research Network and sits on the Board of the Kent, Surrey and Sussex Deanery.

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, and 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 has experience of project directing a Foundation Trust application where she developed a membership scheme, produced an Integrated Business Plan and also delivered a programme of Board development. 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.

Raj Bhamber, Director of Workforce & Organisational Development

Raj Bhamber graduated with a Bachelor of Arts Degree 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 opportunity 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 is co-chair of the Medical Workforce Forum (NHS Employers) and a member of the Professional Standards Board (Department of Health). Raj was the Project Director for the Monitor [independent regulator] phase of the Foundation Trust application.

Raj joined the Board in April 2009.

Dr David Fluck - Interim Medical Director

Previously the Trust's Deputy Medical Director, Dr Fluck first joined St Peter's hospital as a Consultant Cardiologist in 1996. He has since introduced many service improvements and developments as well as undertaking a number of roles including Clinical Director for Medicine and Clinical Lead for the Surrey Cardiac Network. David was appointed Interim Medical Director from 30th January 2012.

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 and leaves in May 2012 to take up a new post in the NHS. John is succeeded by Simon Marshall who joins the Trust on 14 May 2012 having been the Finance Director at West Middlesex University hospitals NHS Trust since 2005.

Suzanne Rankin, Chief Nurse

Suzanne joined Ashford and St. Peter's in December 2010. She was most recently Deputy Chief Nurse for NHS South Central. Prior to that, her nursing and management career has been exclusively with the Royal Navy.

Suzanne's naval career has included deployment during the 1990 Gulf War; a spell as Senior Nursing Officer at NATO Headquarters in Lisbon; and Nursing Officer in charge of the 56-bed Trauma and Orthopaedic Unit at the former Royal Hospital Haslar in Gosport, Hampshire, when the unit was integrated into the NHS and at the time of the outbreak of the war in Afghanistan.

Suzanne attended the Joint Services Command and Staff College in 2005 where she undertook an MA in Defence Studies and undertook advanced staff and command training.

Suzanne left the Royal Navy in 2008 following appointment at the Ministry of Defence where she supported and advised the Surgeon General on all nursing leadership and professional matters, spent time in Iraq and Afghanistan and lead the development of the Nursing Services Strategy.

Significant Commitments of the Trust Chairman

Aileen McLeish is a Governor of The Mount School, York. She is a member of both the NHS Employers reference group on Pensions and Total Reward and the Foundation Trust Network's Quality Working Group. She is also a member of the Advisory Group for Career Savvy Women.

Balance of Board Membership and Independence

The Board of Directors is satisfied that its balance of knowledge, skills and experience is appropriate to the Board and its sub-committees. This conclusion is supported by the results of a skills audit of the Board conducted by Foresight Partnership, an independent consultancy.

The Board has evaluated the circumstances and relationships of individual Non-Executive Directors which are relevant to the determination of the presumption of independence. The Board determines all of its Non-Executive Directors to be independent in character and judgement.

All Non Executive Directors, including the Chairman, have made declarations concerning their Independence. The last annual review took place in November 2011.

Performance evaluation

The Board recognises that a regular evaluation of its collective and individual director performance is critical to continuous development and high performance. The Board had worked with an external Consultancy to undertake a Board development programme, part of which was the conducting of a skills audit. The report concluded that there is a good balance of skills on the Board and advocates maintain continuity at this time.

The Board of Directors have designed and implemented robust performance evaluation processes, structures and systems in accordance with the Code of Effective Corporate Governance within the public sector and the Guide to statutory duties for NHS Foundation Trust Governors (published by Monitor). The Senior Independent Director is the Chairman of the Board of Directors' Remuneration Committee which oversees the remuneration and performance of Executive Directors. The Chairman of the Trust undertakes the appraisal of the Chief Executive and the Non-Executive Directors. The appraisal of the Non Executive Directors was conducted by the Chairman in accordance with the process agreed by the Council of Governors. The Chief Executive undertakes the appraisal of the Executive Directors.

The appraisal processes for all Board directors included the use of a bespoke 360 degree review with inputs from a range of external and internal stakeholders.

The Senior Independent Director has led the process for the appraisal of the Chairman in accordance with the process agreed by the Council of Governors. The outcome of the evaluation has been discussed and endorsed by the Remuneration and Appraisal Committee and reported to the Council of Governors.

In addition the performance of members of the Board is assessed in terms of the following:

- Attendance at Board and Committee meetings
- Independence of individual directors
- An effective contribution to the Board and Committees through the range and diversity of experience and skills

- Strategic decision making and delivery of the Trust's forward plan

The Council of Governors holds the Board collectively to account through the Non Executive Directors, and does this through receiving performance information and a process of constructive challenge at Council of Governor meetings.

Access to the 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 , either at St Peter's Hospital, Guildford Rd, Chertsey, KT16 0PZ , or via email jane.gear@asph.nhs.uk or on 01932 723110.

Board meetings

The Board has agreed to meet in public a minimum of nine times during a year. The Board also met in closed session 12 times.

Directors' attendance at Board meetings 2011/12

Name	End of term of office	Open Board Meetings attended	Closed Board Meetings attended
Non Executive Directors			
Mrs Aileen McLeish	30/09/2015	9/9	12/12
Prof Philip Beesley	15/07/2015	9/9	12/12
Mr Clive Goodwin	30/03/2014	8/9	11/12
Mr Jim Gollan	30/03/2014	7/9	10/12
Ms Sue Ells	08/02/2013	8/9	11/12
Mr Terry Price	13/09/2015	9/9	12/12
Mr Peter Taylor	30/07/2013	9/9	12/12

Re appointment agreed by Council of Governors at their meeting on 17 May 2012

Executive Directors	Position	Open Board Meetings attended	Closed Board Meetings attended
Mr Andrew Liles	Chief Executive	7/9	9/12
Mrs Valerie Bartlett	Deputy Chief Executive	8/9	11/12
Dr Mike Baxter	Medical Director	7/8*	9/10
Mrs Raj Bhamber	Director of Workforce and Organisational Development	8/9	9/12
Dr David Fluck	Interim Medical Director	2/2**	3/3
Mr John Headley	Director of Finance & Information	8/9	11/12
Mrs Suzanne Rankin	Chief Nurse	8/9	11/12

*left February 2012
** Started January 2012

Board Sub Committees

The Board of Directors has the following sub committees:

- Audit Committee
- Remuneration Committee (Executive Directors)
- Integrated Governance and Assurance Committee (IGAC)
- Nominations Committee (Executive Directors)
- Finance Committee

Audit Committee

Membership and Attendance

The Audit Committee is chaired by a Non-Executive Director, and includes two other Non-Executive Directors. There were four meetings held in the period and attendance was as follows:

	Meetings attended
Terry Price (Chair)	4/4
Peter Taylor	4/4
Jim Gollan	4/4

Internal audit (Chantrey Vellacott DFK), external audit (KPMG LLP) and the Local Counter Fraud Specialist (Chantrey Vellacott DFK) are all invited to attend the meetings.

Discharging its responsibilities

The Terms of Reference of the Audit Committee are approved by the Trust Board and these set out the duties and key responsibilities. The Committee prepares an annual report to the Trust Board setting out its operations during the year.

The Audit Committee assures the Trust Board that there is an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the organisation's objectives. In addition financial reporting and counter fraud measures are also reviewed. In doing this the Audit Committee primarily utilises the work of internal audit, external audit and other external bodies. The Audit Committee approves the annual work plans of internal audit, external audit and the Local Counter Fraud Specialist.

Policy for safeguarding external auditors' independence

The external auditors were appointed by the Council of Governors at their meeting on 1 December 2010.

In so far as the Trust has purchased work from its external auditors outside the Audit Code in 2011/12, the external auditors' objectivity and independence have been safeguarded.

Responsibility for preparing the annual accounts

The Chief Executive is the Trust's designated Accounting Officer with the duty to prepare the financial statement for each financial period in accordance with the National Health Service Act 2006.

Disclosure of information to auditors

The Directors who held office at the date of the approval of the Directors' report confirm that, so far as they are aware, there is no relevant audit information of which the Trust's external auditors are

unaware and that they have taken all steps necessary as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of any such information.

Other Committee Membership

Finance Committee
The Committee is chaired by a Non Executive Director, and includes two other Non Executive Directors, the Deputy Chief Executive, Director of Finance and Information and the Director of Workforce and Organisational Development. The Chief Executive and Chief Nurse attend alternate meetings.

The Finance Committee's role is to review the financial performance, position, risks and decision-making of the Trust. It gives assurance to the Board that this process of review is satisfactory and draws matters of importance to their attention.

Nominations Committee (Executive Directors)
The Nominations Committee comprises the Trust Chairman, who chairs the Committee, the Senior Independent Director, two further Non Executive Directors and the Chief Executive.

The Committee has been established to appoint the Executive Directors including Interim appointments. The Committee is also responsible for evaluating the balance of skills, knowledge and experience on the Board of Directors and, in the light of this evaluation, preparing a description of the role and capabilities required for the appointment of Executive Directors.

During 2011/12 the Committee met three times.

Remuneration Committee (Executive Directors)
A description of the work of the the Remuneration Committee can be found within the Remuneration Report at the end of this chapter. Attendance at meetings by its members is set out in the table below.

Integrated Governance and Assurance Committee
The Committee is chaired by a Non Executive Director, and includes one other Non Executive Director (who also chairs the Audit Committee) and all the Executive Directors.

The Integrated Governance Assurance Committee has a duty to ensure that the Trust's governance systems, behaviours and processes relating to risk management, clinical and non-clinical governance, and the achievement of organisational objectives are effective, and provide the Board with the assurance required to govern effectively. The Committee works in association with the Audit Committee in matters of corporate governance.

Details of Directors' membership of the other Board sub committees and the number of meetings they attended are (including attendance at formal Council of Governors meetings)

	Member of Remuneration Committee	Member of Finance Committee	Member of Integrated Governance and Assurance Committee	Member of Nominations Committee	Council of Governors (in attendance)
Valerie Bartlett		7/12	3/5		4/4
Mike Baxter			3/4		1/1
David Fluck			1/1		2/4
Philip Beesley			5/5 Chairman		2/4
Raj Bhamber		10/12	5/5		4/4
Sue Ells	4/4			3/3	2/4
Jim Gollan		11/12 Chairman			1/4
Clive Goodwin	4/4	8/10*		3/3	1/3
John Headley		11/12	3/5		4/4
Andrew Liles		11/12	3/5	2/3	4/4
Aileen McLeish	4/4			3/3 Chairman	4/4
Terry Price		1 /2 **	5/5		4/4
Suzanne Rankin		3/6***	5/5		3/4
Peter Taylor	4/4 Chairman	12/12		3/3	3/4

* joined Finance Committee from June 2011
** Member of Finance Committee for April and May 2011
*** Attends alternate meetings

Council of Governors

How the Board of Directors and the Council of Governors operate

The Board recognises the value and importance of engaging with Governors in order that the Governors may properly fulfil their role as a conduit between the Board and Ashford and St. Peter's Hospitals' stakeholders. Governors are developing their role of listening to the views of the membership and reflecting them to the Board, and vice versa.

The Board of Directors is responsible for the effective running of the organisation, whilst the Council of Governors holds the Board to account for the stewardship of the organisation. The Council does not delegate any of its statutory decision making to its committees or individual Governors, since the Constitution provides for committees to undertake advisory work only, with all decisions requiring ratification in a general Council meeting.

In addition to the role of listening to, and reflecting back, the views of the membership to the Board and vice versa, the Council of Governors exercises statutory duties enshrined in law. These include the appointment of, and, if necessary, the removal of Non Executive Directors and determining their remuneration. The Council also appoints the External Auditor, and ratifies the appointment of the Chief Executive. The Council has the right to be presented with the Annual Report and Accounts and to be consulted on forward plans being made by the Board. These roles provide a clear context for the Board to run the Trust, the execution of which is achieved through the Chief Executive and his Executive Team.

The Governors were presented with the Annual Report and Accounts 2010/11 at their meeting in September 2011. During 2011/12 a working group was established to lead the process of appointing the External Auditor from 2012. The Governors have been involved in developing the Annual Plan 2012/13 from the start of the planning cycle (towards the end of 2011) and this has included 2 workshops. Governors have also been involved in agreeing the priorities for the Quality Account.

Understanding the views of the Council and Members

Engagement by the Board with Governors takes many forms. Since becoming a Foundation Trust the Governors and Directors have been building an increasingly closer relationship. A number of seminars have been held on strategic topics which provide an opportunity for informal networking and a *One Year On* Seminar was held in January 2012 to reflect on the first year and to start to agree a work plan for the coming year.

There are regular informal meetings open to all Governors and hosted by the Chairman and Chief Executive. All Governors have a 'buddy' Director who is available as a point of contact or support in addition to that routinely offered by the Membership Office.

All Directors are encouraged to attend the Council of Governors' formal meetings. Governors have continued to take up the opportunity to attend the open Board meetings.

Composition of the Council

There are 28 Governors including:

- 16 public governors covering 9 constituencies
- 5 staff governors covering 5 staff constituencies
- 7 appointed governors from partnership organisations

The Chairman of the Board is also the Chairman of the Council of Governors. The Council of Governors appointed David Frank (Governor for Surrey Heath) as the Lead Governor for one year from February 2011 and in February 2012 reappointed him for the remainder of his Term of Office.

The Council meets formally four times each year. Details of the membership of the Council and the attendance of Governors are included in the table 'Register of Governors'. Executive and Non-Executive Directors are also invited to attend the Council meetings.

Governors' initial terms of office started from the day that the Trust was authorised; 1 December 2010. Both the elected and appointed Governors hold office for three years but for the initial period seven Governors were appointed for two years to ensure that not all Council members were due for re-election/appointment at the same date.

During the year there have been a small number of changes to the Council. One of the three public Governors for Spelthorne resigned. An election was initiated in February 2012 with the close of poll

being 4th April 2012 and Brian Catt was elected. Andreas Lambrianou, NHS Hounslow's Appointed Governor resigned with effect from 15th April 2011 and was replaced by Martin Roberts. Finally, Dr. Ann Gallagher has replaced Professor John Hay as the Appointed Governor of the University of Surrey with effect from 16th March 2012.

Access to the Register of Interests

Members of the public can gain access to the Register of Governors' Interests by making a request via 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.

Contacting a Governor

Members who wish to contact their Governor can do this via the membership office at St.Peter's Hospital, Guildford Road, Chertsey, KT16 0PZ or calling 01932 72 3110. In addition, a special e-based communication form is available via www.ashfordstpeters.nhs.uk

Statutory Council of Governors' Committees

The Council of Governors has two Committees carrying out specific statutory duties. Details are given below.

1. Nomination and Appointments Committee

The Nominations and Appointments Committee has been established to provide the Council of Governors with independent and objective recommendations in respect of the names of those individuals they consider suitable for appointment as Non-Executive Director to the Board of Directors.

The Nominations and Appointments Committee undertook a recruitment process in early 2012 leading to the appointment of two new Non Executive Directors in March 2012.

No further vacancies have occurred since then, although the Chairman and the three Non Executive Directors' Terms of Appointment are due for review later in 2012. As a result the Committee has met twice. It has recommended the reappointment of Philip Beesley as Deputy Chairman and also recommended the process to be followed in considering the reappointments later this year. Both recommendations were accepted by the Council of Governors.

Nominations and Appointments Committee	Meetings attended 11/12
Maurice Cohen	2/2
Godfrey Freemantle	2/2
Chris Howorth	2/2
Steve McCarthy	2/2
Aileen McLeish (Trust and Committee Chairman)	2/2
Diana Manthorpe	1/2
Peter Taylor (Senior Independent Director)	2/2

2. Remuneration and Appraisal Committee

The Remuneration and Appraisal Committee has been set up to make recommendations to the Council of Governors concerning the remuneration and terms of appointment of any Non-Executive Director.

The Committee met four times in 2011/12 and made recommendations to the Council on the appraisal processes for the Chairman and Non Executive Directors. The Committee also reviewed the outcomes of the appraisals for 2011/12. In addition the Committee considered the Terms of Service of the Non Executive Directors, and made a recommendation to the Council on remuneration for 2012/13.

Membership and attendance is given below:

Remuneration and Appraisal Committee	Meetings attended
David Frank (Chairman)	4/4
Judi Linney	4/4
Michèle Low	3/4
Hugh Meares	3/4
Paul Wills	2/4

Foundation Trust membership

Members fall into two constituencies:

*Public Constituency; a*nyone living in the boroughs of Elmbridge, Runnymede, Spelthorne, Woking and parts of the following boroughs; Windsor and Maidenhead, Richmond upon Thames, Surrey Heath, and Guildford. These 9 'areas' are defined by electoral wards, each of which can elect one or more Governors as set out in the Constitution. Full details of the electoral wards included can be seen on the Trust's website.

Staff Constituency; any permanent member of staff, including registered volunteers, can be a staff member. There are 5 classes which each elect one Governor; nursing and midwifery, medical and dental, ancillary/admin/clerical/managerial, allied health professionals and volunteers. Staff are automatically members unless they decide to opt out.

Membership numbers as at 31 March 2012

Public: 6034
Staff: 3310
Total: 9344

Developing our membership

The Membership and Communication Engagement Group of the Council of Governors was set up in March 2011 and leads on developing and implementing the Membership Strategy together with improving two way communications between Governors and members. The strategy was

thoroughly overhauled in 2011 and contains targets for membership with a particular focus on areas where we know the Trust needs to develop a more representative membership:-

- Increasing representation especially around Runnymede, Elmbridge, Hounslow and Richmond
- Increasing membership in the young age range with a particular focus on the 14-21 age group
- Addressing the very marginally under represented socio demographic categories 'C2', 'D' and 'E'.

The Group has been keen to encourage membership engagement activities and also consider ways of facilitating two way communications with members. One achievement has been that all Governors were able to send a personalised annual report to their constituents.

We have also revitalised our Members Health Events and have held talks on orthopaedics, falls, stroke and diabetes over the second half of the year. These are appreciated by the members and give the opportunity for the Governors to meet and chat to their members.

We have also been able to seek the views of a range of members as part of a major refurbishment project on improving the outpatient department at Ashford Hospital. We did this via an on-line questionnaire and received many constructive suggestions on how we could improve the environment. Two Governors are involved in the project team.

Register of Council of Governors

Name (Constituency / Organisation)	Date elected or appointed	Term of office	Meetings attended
Ms. Linda Abbott (Public – Spelthorne)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**
Ms. Neelam Bains (Public – Spelthorne) resigned 16 October 2011	**1st Dec 2010**	**3 Years to 30/11/13**	1/2 resigned 16 October 2011
Dr. Tanya Bernard (Staff – Medical and Dental)	**1st Dec 2010**	**2 Years to 30/11/12**	**3/4**
Mr. Simon Bhadye (Public – Spelthorne)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mr. Keith Bradley (Public – Woking)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Dr. Maurice Cohen (Public – Woking)	**1st Dec 2010**	**3 Years to 30/11/13**	**3/4**
Mr. David Frank (Public – Surrey Heath)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mr. Godfrey Freemantle (Public – Hounslow)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mr. Keith Goodger (Public – Richmond)	**1st Dec 2010**	**2 Years to 30/11/12**	**4/4**
Mr. Graham Hanson (NHS Surrey)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**
Mrs. Sue Harris (Staff- Nursing and Midwifery)	**1st Dec 2010**	**3 Years to 30/11/13**	**3/4**
Prof. John Hay (Surrey University)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mr. Chris Howorth (Royal Holloway University)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mrs. Janice Ketley (Public – Runnymede)	**1st Dec 2010**	**2 Years to 30/11/12**	**2/4**
Mrs. Samantha Lamb (Staff – Admin and Clerical / Ancillary)	**1st Dec 2010**	**3 Years to 30/11/13**	**3/4**
Mr. Andreas Lambrianou (NHS Hounslow)	**1st Dec 2010**	**3 Years to 30/11/13**	**1/1 Resigned 15th April 2011**
Mrs. Margaret Lenton (Public – Windsor and Maidenhead)	**1st Dec 2010**	**2 Years to 30/11/12**	**4/4**
Mrs. Ajbha Linney (Public – Runnymede))	**1st Dec 2010**	**2 Years to 30/11/12**	**4/4**
Ms Michèle Low (Public – Hounslow)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**

Name (Constituency / Organisation)	Date elected or appointed	Term of office	Meetings attended
Mr. Steve McCarthy (Public – Elmbridge)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Mrs. Diana Manthorpe (Staff – Volunteers)	**1st Dec 2010**	**3 Years to 30/11/13**	**4/4**
Dr. Howard Manuel (Public – Woking)	**1st Dec 2010**	**3 Years to 30/11/13**	**1/4**
Cllr. Hugh Meares (Runnymede Borough Council)	**1st Dec 2010**	**3 Years to 30/11/13**	**3/4**
Mrs. Judith Moore (Public – Guildford)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**
Cllr. Jean Pinkerton (Spelthorne Borough Council)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**
Mr. Martin Roberts (NHS Hounslow)	**16th April 2011**	**to 30/11/13**	**3/3**
Mr. Andrew Ryland (Public – Runnymede)	**1st Dec 2010**	**2 Years to 30/11/12**	**3/4**
Cllr. Michael Smith (Woking Borough Council)	**1st Dec 2010**	**3 Years to 30/11/13**	**2/4**
Mr. Paul Wills (Staff – Healthcare Assistants / Allied Health Professionals / Healthcare Scientists)	**1st Dec 2010**	**2 Years to 30/11/12**	**2/4**

6. Financial Report and Accounts

Financial review

For the year to 31 March 2012 the Trust achieved a surplus of £1.0m against a plan of £2.1m. An analysis is set out below – this is in the format reported to Monitor as part of the Compliance Framework and as such differs slightly from the Annual Accounts analysis.

	2011/12			2010/11 (4 months)		
	Plan £m	Actual £m	Var £m	Plan £m	Actual £m	Var £m
Income						
Clinical Income	202.5	209.2	6.7	67.8	70.0	2.2
Non-Clinical Income	17.1	18.1	1.0	4.9	4.9	-
Total Income	219.6	227.3	7.7	72.7	74.9	2.2
Expenses						
Pay Costs	-136.2	-140.6	-4.4	-45.2	-47.2	-2.0
Non-Pay Costs	-66.0	-72.2	-6.2	-22.0	-22.6	-0.6
Total Expenses	-202.2	-212.8	-10.6	-67.2	-69.8	-2.6
EBITDA	17.4	14.5	-2.9	5.5	5.1	-0.4
Depreciation & Amortisation	-8.3	-7.7	0.6	-3.4	-2.5	0.9
Impairments	-1.7	-1.0	0.7	-	-	-
Non-operating expenses	-0.5	-	0.5	-	-1.0	-1.0
Charitable contributions	0.3	0.2	-0.1	0.1	0.1	-
Interest (net)	-0.2	-0.2	-	-0.1	-0.1	-
Dividend on PDC	-4.9	-4.8	0.1	-1.6	-1.5	0.1
Net surplus	2.1	1.0	-1.1	0.5	0.1	-0.4

Key variances from plan are set out below: -

- NHS clinical income was £6.7m above plan due to activity over-performance across most specialties. There was also a more complex case mix than planned which saw an increase in the average income per spell.

- Pay costs were £4.4m higher than plan due a number of factors, including escalation beds being opened to meet demand, for example the opening of a new ward. In addition high cost medical agency generated an overspend in the Trust's A&E department as the Trust looked to improve its performance against the A&E target. Despite this the Trust spent £0.5m less on pay when compared to the whole of 2010/11.

- Non-pay costs were £6.2m higher than plan was mainly overspent on clinical supplies in delivering the additional income. In addition £0.5m of the non-pay cost variance relates to the non-operating costs plan set below the line – the net variance therefore £5.7m

- Depreciation and impairment costs were underspent by £0.6m and £0.7m respectively. This was due to a slower start to the 2011/12 capital programme combined with the valuation of new buildings being higher than forecast and hence reducing the level of impairments needed.

- Non-operating expenses are under plan as costs were classified as non-pay costs (see above).

The cost improvement programme delivered £10.9m of savings in 2011/12 against a plan of £12.0m (90.1%).

The Trust spent £11.5m on purchased capital during the period and ended the financial year with a cash balance of £16.1m.

The Trust's financial performance for the whole of the financial year was given a Financial Risk Rating of 3, which is what the Trust set out in its Plan. Financial Risk Ratings are given between 1 and 5, where 5 is 'low risk'. The metrics making up this rating are set out in the table below (note that for 2010/11 the rating is based on the whole financial year, not just the four months that the Trust was a Foundation Trust): -

	2011/12		2010/11	
	Metric	Score	Metric	Score
EBITDA margin (%)	6.4%	3	7.4%	3
EBITDA against plan (%)	83.1%	3	89.8%	4
Return on assets employed (%)	4.3%	3	5.8%	4
I&E surplus margin (%)	1.0%	2	1.9%	3
Liquidity ratio (days)	21.4	3	26.3	4
Weighted score		3		4

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

2012/13 Plan

The 2012/13 financial year will provide further challenges for the Trust as the economic climate gets tougher and public finances tighter. The Trust Board has approved an annual budget that will deliver a surplus of £3.3m on planned income of £226.3m and a cost improvement programme of £12.0m. This will deliver a Financial Risk Rating of 3.

Remuneration Report

Remuneration Committee and Policy on Remuneration of Senior Managers

The Remuneration Committee consists of four Non-Executive Directors chaired by Senior Independent Director, Peter Taylor. It met four times during this reporting period, attended by Peter Taylor, Aileen McLeish, Sue Ells and Clive Goodwin.

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 Executive 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. During 2011/12 all Executive Directors were paid through the Trust's payroll.

Remuneration of Chairman and Non-Executive Directors

The remuneration of the Chairman and Non-Executive Directors is agreed by the Council of Governors following review by its Remuneration and Appraisal Committee. Details of this Committee are set out on page 105.

Median Salary

The median remuneration of the Trust is £27,625. This calculation is based on the full-time equivalent staff of the Trust on an annualised basis. The median is the total remuneration of the staff member lying in the middle of a linear distribution of the total staff of the Trust. Remuneration includes all aspects of pay included in the table below and excludes employers pension contributions.

The mid-point of the banded remuneration of the highest paid Director is £177,500. The ratio between the highest paid Director and the median salary is 6.4.

Salary and pension entitlements of senior managers for the year to 31 March 2012

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.

The tables below sets out remuneration and pension benefit details for the reporting period.

A) Remuneration

	2011-12			4 month period to 31 March 2011		
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	175-180	-	28	55-60	-	10
John Headley Director of Finance	125-130	-	42	35-40	-	14
Dr Mike Baxter Medical Director (to 31 January 2012)	40-45	125-130	39	15-20	50-55	16
Dr David Fluck Acting Medical Director (from 1 February 2012)	5-10	20-25	-	-	-	-
Valerie Bartlett Deputy Chief Executive	130-135	0-5	-	40-45	-	-
Raj Bhamber Director of Workforce and Organisational Development	110-115	0-5	-	35-40	-	-
Susan Osborne Interim Chief Nurse (to 22 December 2010)	-	-	-	10-15	-	-
Suzanne Rankin Chief Nurse (from 20 December 2010)	95-100	-	-	25-30	-	-
Chairman and Non-Executives						
Aileen McLeish Chairman	40-45	-	-	5-10	-	-
Peter Taylor Non-Executive Director	10-15	-	-	0-5	-	-
Philip Beesley Non-Executive Director	10-15	-	-	0-5	-	-
Terry Price Non-Executive Director	10-15	-	-	0-5	-	-
Sue Ells Non-Executive Director	10-15	-	-	0-5	-	-
Nadeem Aziz Non-Executive Director (to 31 December 2010)	-	-	-	0-5	-	-
Jim Gollan Non-Executive Director (from 31 March 2011)	10-15	-	-	-	-	-
Clive Goodwin Non-Executive Director (from 31 March 2011)	10-15	-	-	-	-	-

Notes

a) Amounts shown under Other Remuneration for Dr Mike Baxter and Dr David Fluck relate to medical work as Consultants 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 in line with Monitor guidance).

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 31 March 2012 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2012	Cash Equivalent Transfer Value at 31 March 2011	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	2.5-5.0	7.5-10.0	30-35	90-95	486	369	74	-
John Headley Director of Finance & Information	0.0-2.5	-	5-10	-	83	45	26	-
Dr Mike Baxter Medical Director (to 31 January 2012)	(5.0)-(7.5)	0.0-2.5	55-60	195-200	n/a	1,357	n/a	-
Dr David Fluck Acting Medical Director (from 1 February 2012)	0.0-2.5	0.0-2.5	45-50	140-145	871	728	14	
Valerie Bartlett Deputy Chief Executive	0.0-2.5	2.5-5.0	35-40	115-120	677	548	79	-
Raj Bhamber Director of Workforce and Organisational Development	0.0-2.5	2.5-5.0	15-20	50-55	294	238	34	-
Suzanne Rankin Chief Nurse (from 31 December 2010)	0.0-2.5	-	0-5	-	49	27	15	-

Note

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

Andrew Liles
Accounting Officer
28th May 2012

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Ashford and St. Peter's Hospitals NHS Foundation Trust

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

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

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

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

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

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

Andrew Liles
Chief Executive
28th May 2012

Annual Governance Statement 2011/12

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Ashford and St. Peter's Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Ashford and St. Peter's Hospitals NHS Foundation Trust for the year ended 31 March 2012 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 Trust 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 identification and management of risks.

Through the Integrated Governance Assurance Committee (IGAC), which is chaired by a Non-Executive Director and which I attend together with the Chair of the Audit Committee, 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 (both Trust-wide and division-specific) and the Board Assurance Framework, and to cascade this information both to and from relevant Divisional teams through constructive challenge, training and support.

The Clinical Governance Committee (CGC) has responsibility for overseeing progress and assurance for clinical quality standards. Divisions report to the CGC annually with a full report on clinical governance activities. The Committee reviews Divisions' risk registers at every bi-monthly meeting to provide input into action plans and progress, and to ensure risks are appropriately mitigated. Where further actions are required, the Committee requests an update on those actions at the next meeting or earlier if required. The CGC has responsibility for overseeing the Committees or Groups shown under the CGC arm of the Integrated Governance and Risk Management structure.

The Safety & Risk Committee (S&RC) has responsibility for overseeing the Committees or Groups shown in the safety and risk arm of the Integrated Governance and Risk Management structure The Committee will ensure adequate assurance is provided to IGAC to assure the Committee, Audit Committee and Trust Board that all regulation requirements are being met, or being actioned, where appropriate. The S&RC has responsibility for reviewing the organisation wide risk register and providing a level of scrutiny and support to ensure risks are appropriately mitigated and actions are progressing. The S&RC has responsibility for considering the themes identified from incident reporting, and ensuring Divisions and Departments' issues and learning relating to clinical incidents are shared across the Divisions and wider organisation. The Committee co-ordinates relevant benchmarking activities relating to key reports from the Care Quality Commission or National Patient Safety Agency (NPSA). The Committee ensures that risks identified by other safety committees are discussed and wider action taken if necessary. This is co-ordinated by the Head of Patient Safety.

The risk and control framework

The current Integrated Governance and Risk Management Strategy is undergoing an extensive review and consultation by senior managers, clinicians and staff across the Trust.

Management decide, taking into account the grading of each risk, whether it is appropriate to tolerate, transfer, terminate or treat the risk. The score an appraisal generates for each risk will be matched to a certain level of management within the organisation.

All Divisions monitor their quality and financial risks on a monthly basis whilst the Trust Board monitors high score risks every two months and IGAC every three months.

Compliance with, and delivery of, the quality indicators within the Trust contract is actively monitored through a robust process with monthly internal scrutiny at a corporate level to manage the potential and active risks to quality and the delivery of clinical services.

In respect of data quality, the Trust is participates in the national data assurance audit as part of the Payment by Results Data Assurance Framework. This audit provides the Trust with assurances about the accuracy of data collected and coded. To ensure compliance and the appropriate management of data, the Trust has dedicated Data Quality and Clinical Coding Teams which proactively engage clinicians and clerical staff to encourage best practice in data entry and coding. These teams also address quality issues and processes are in place to ensure timely identification of data quality issues and the remedial steps required. Training on the Trust's Patient Administration System and other key systems is mandatory at Induction, and is followed up by an ongoing programme of training sessions that is available to staff throughout the year.

The Trust has a well developed Information Governance Framework to ensure that its obligations are discharged appropriately. Through the implementation of this framework, the Trust is committed to:

- Establish an environment that facilitates the secure sharing, protection, preservation and availability of person identifiable and corporation information
- Deliver a set of rules, measures and procedures that determine the physical, procedural and logical security controls imposed on the management, distribution and protection of assets.

The Trust has established governance arrangements to manage risks to data. The Information Governance Steering Group (IGSG) is responsible for all aspects of Information Governance. The Group reports through the Safety and Risk Committee to the Integrated Governance Assurance Committee and, ultimately, to Trust Board.

There are clear lines of accountability from the Chief Executive through all levels of staff and externally with our third party suppliers. Compliance with the Trust's Information Governance Framework is compulsory. All staff are required to undertake Information Governance training annually either via traditional methods or online. Any data related incidents are reported through the Trust's existing incident management process.

The Trust annually undertakes a self-assessment of compliance and supporting evidence against the 45 standards contained in the NHS Information Governance Toolkit. This self-assessment and evidence is independently scrutinised and verified by Internal Audit to provide assurances to the Trust Board on compliance.

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.

The Foundation Trust is not currently fully compliant with the registration requirements of the Care Quality Commission.

The Trust underwent an unannounced visit from the Care Quality Commission on 1 December 2011 and the review of compliance report was published on 25 January 2012. Six standards were inspected and the results were:

- **Outcome 1** Respecting and involving people who use services. Judges to be non-compliant with **Moderate** concerns.
- **Outcome 2** Consent to care and treatment. Judged to be compliant with **Minor** concerns.
- **Outcome 4** Care and welfare of people who use services. Judged to be non-compliant with **Major** concerns.
- **Outcome 7** Safeguarding people who use services from abuse. Judged to be compliant with **Minor concerns.**
- **Outcome 14** Supporting Staff. Judged to be non-compliant with **Moderate** concerns.
- **Outcome 16** Assessing and monitoring the quality of service provision. Judged to be fully compliant.

A tripartite action plan was put in place to address all the issues raised in the compliance review and the intended outcomes of the changes continue to be tracked. The Trust Board has monitored the implementation to the plan and the plan's tests of effectiveness demonstrated steady progress. The projected date for full completion of the action plan is July 2012 and therefore full compliance against outcomes 1, 4 and 14 cannot yet be declared.

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.

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

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

The resources of the Trust are managed through various measures, including an established and tested budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The Finance Committee is a sub-committee of the Trust Board and meets monthly, chaired by a Non-Executive Director. It reviews the monthly activity, workforce, operational and finance reports as well as progress against the cost improvement programme. The Trust Board obtains assurance from the Finance Committee in respect of financial and budgetary management across the Trust.

Each Division has a Divisional Director who is a clinician and who is actively involved in the business and devolved financial management of clinical services. Divisional scorecards are used to assess each Division's performance and these are reviewed at performance reviews held with key Executive Directors.

The Trust has continued to use and further develop Service Line Reporting and Patient Level Costing during the year and clinical specialty leads have been appointed within Divisions amongst whose responsibilities is the use and review of this data. The Trust Board receives quarterly updates on profitability by Service Line.

Business cases and the financial evaluation of new investments are reviewed by the Commercial Group which meets on a monthly basis, with subsequent approval by Executive Committee, Finance Committee or Trust Board according to the Scheme of Delegation. Service line information is used in support of clinical business cases.

Our Internal Auditors include value for money considerations in their audit scope and action points and they have undertaken a review of stock management during the year.

Annual Quality Report

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

Prior to being finalised the Quality Report has been reviewed by the Trust Board on a number of occasions and has been shared with external stakeholders for comment.

Review of effectiveness

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

The following information highlights some of the key methods that the Trust Board uses to be assured its system of internal control is effective.

The Trust Board ensures the effectiveness of the system of internal control through clear accountability and reporting arrangements. The Trust Board has reviewed its Standing Orders, Standing Financial Instructions and Schemes of Delegation during the year.

The Trust Board has reviewed the Board Assurance Framework on a quarterly basis and also receives regular information from the Integrated Governance and Assurance Committee on the operation of the Board Assurance Framework. In addition, the Board has received regular reports on incidents, claims and complaint trends, and has reviewed various significant policies including the Health and Safety Policy.

The Trust Board has established the Audit Committee and Integrated Governance Assurance Committee with specific focus on risk management; the Chairs of these Committees report to the Board at the first available Board meeting after each committee meeting. Urgent matters are escalated by the Committee chair to the Board as deemed appropriate.

The Audit Committee is a formal sub-committee of the Trust Board and is accountable to the Trust Board for reviewing the establishment and maintenance of an effective system of internal control and risk management. The Committee meets at least four times per year. The Audit Committee approves the Annual Audit plans for internal and external audit activities and ensures that recommendations to improve weaknesses in control arising from audits are actioned by executive management. The Annual Internal Audit Plan enables the Board to be reassured that key internal financial controls and others matters relating to risk are regularly reviewed. During the year, the Committee has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the Assurance Framework.

The Integrated Governance Assurance Committee (IGAC) has a duty to ensure that the Trust's governance systems, behaviours and processes relating to risk management, clinical and non-clinical governance, and the achievement of organisational objectives are effective, and provide the Trust Board with the assurance required to govern effectively. The Committee met five times in the year and has been reviewing key areas of risk to ensure the Trust Board can have sufficient assurance. The Committee is supported by a range of groups including the Clinical Governance Committee and Safety and Risk Committee.

Over the year the Committee has reviewed progress on compliance with Essential Standards, the CQC action plan, and an action plan on NHS Litigation Authority compliance.

The Committee is currently involved in a review of the Integrated Governance and Risk Management Strategy and on behalf of the Trust Board has initiated a major review of the Board Assurance Framework for 2012/13.

The Finance Committee's remit is to review the financial performance, position, risks and decision-making of the Trust. To the Board it gives assurance that this process of review is satisfactory and draws matters of importance to their attention.

Executive Directors have clear responsibilities for internal control and risk management within their area of control. They also have corporate responsibility as Trust Board members.

Internal Audit: The Trust has contracted with Chantrey Vellacott DFK LLP as the providers of internal audit services for a number of years. The contract specifies that the delivery of the internal

audit function will continue to be in compliance with the NHS Internal Audit Standards and those of the Institute of Internal Auditors (UK).

The annual opinion provided by the Head of Internal Audit for 2011/12 stated that **significant assurance** can be given that there is a generally sound system of control designed to meet the organisation's objectives and that controls are generally being applied consistently.

External agencies: Our Maternity Services have achieved the highest standard for patient safety, CNST Level 3 (Clinical Negligence Scheme for Trusts) by the NHS Litigation Authority. In addition we have achieved Level 2 for general hospital services.

The Trust failed to meet the four hour target for two quarters during 2011/12 and this, coupled with the CQC concerns, saw the Monitor Governance risk rating fall to amber-red. The Trust has action plans in place to address these issues.

During 2010/11 we underwent the authorisation process to become a Foundation Trust and completed the Quality Governance assessment. We have addressed the three minor areas we identified where improvements were desired, and have revisited this assessment during 2011/12.

Conclusion

I am reporting one significant internal control issue within the NHS Foundation Trust, being the CQC review of compliance and their finding that the NHS Foundation Trust was non-compliant against three outcomes. As described above, action plans are in place with a target date of July 2012 to achieve full compliance.

Andrew Liles
Chief Executive
28th May 2012

ANNUAL ACCOUNTS

1 APRIL 2011 - 31 MARCH 2012

FOREWORD TO THE ACCOUNTS

These Accounts for the year ended 31 March 2012 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Andrew Liles
Accounting Officer
Ashford and St. Peter's Hospitals NHS Foundation Trust
28th May 2012

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST

We have audited the financial statements of Ashford and St. Peter's Hospitals NHS Foundation Trust for the year ended 31 March 2012 on pages 125 to 159. 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 Council of Governors of Ashford and St. Peter's Hospitals NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors 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 Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 115 the accounting officer is 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 Practice's 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 accounting officer 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 state of Ashford and St. Peter's Hospitals NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and

- Have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

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

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

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

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

Chartered Accountants
15 Canada Square
London
E14 5GL

30th May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2012

	Note	2011/12	4 Month Period 2010/11 Restated
		£'000	£'000
INCOME			
Income from patient care activities	3	210,878	69,996
Other operating income	4	16,545	5,065
Operating expenses	6	(221,444)	(73,255)
OPERATING SURPLUS		5,979	1,806
FINANCE COSTS:			
Finance income	12	98	18
Finance expense	13	(267)	(107)
Public dividend capital dividends payable		(4,771)	(1,500)
RETAINED SURPLUS FOR THE PERIOD		1,039	217
OTHER COMPREHENSIVE INCOME			
Gains on revaluations		1,460	-
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		2,499	217

The notes on pages 129 to 159 form part of these accounts.

The annual accounts have been restated following a national restatement exercise changing the treatment of donated assets.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	Note	31/03/12	31/03/11 Restated
		£'000	£'000
NON-CURRENT ASSETS			
Property, plant and equipment	14	153,383	148,576
Intangible assets	15	1,196	1,489
Trade and other receivables	19	1,085	1,044
TOTAL NON-CURRENT ASSETS		155,664	151,109
CURRENT ASSETS			
Inventories	18	3,660	3,788
Trade and other receivables	19	11,951	9,388
Cash and cash equivalents	20	16,085	18,657
TOTAL CURRENT ASSETS		31,696	31,833
TOTAL ASSETS:		187,360	182,942
CURRENT LIABILITIES			
Trade and other payables	21	(26,218)	(21,986)
Other liabilities	21	(352)	(1,864)
Borrowings	22	(2,899)	(2,450)
Provisions	25	(901)	(1,565)
TOTAL CURRENT LIABILITIES		(30,370)	(27,865)
TOTAL ASSETS LESS CURRENT LIABILITIES		156,990	155,077
NON-CURRENT LIABILITIES			
Borrowings	22	(1,846)	(2,450)
Provisions	25	(568)	(628)
TOTAL ASSETS EMPLOYED		154,576	151,999
FINANCED BY TAXPAYERS' EQUITY:			
Public dividend capital		85,784	85,706
Income and expenditure reserve		8,031	6,965
Revaluation reserve		60,761	59,328
TOTAL TAXPAYERS' EQUITY		154,576	151,999

The financial statements on pages 125-159 were approved by the Board on 28th May 2012 and signed on its behalf by:

Andrew Liles
Accounting Officer
Ashford and St. Peter's Hospitals NHS Foundation Trust
28th May 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2012

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Total
	£'000	£'000	£'000	£'000
BALANCE AT 1 APRIL 2011	85,706	6,965	59,328	151,999
CHANGES IN TAXPAYERS EQUITY FOR THE YEAR ENDED 31 MARCH 2012				
Retained surplus/(deficit) for the year	-	1,039	-	1,039
Transfers between reserves	-	27	(27)	-
Net gain on revaluation of property, plant and equipment	-	-	1,460	1,460
Public Dividend Capital received	78	-	-	78
BALANCE AT 31 MARCH 2012	85,784	8,031	60,761	154,576

	Public Dividend Capital (PDC)	Retained Earnings Restated	Revaluation Reserve Restated	Total
	£'000	£'000	£'000	£'000
BALANCE AT 1 DECEMBER 2010	85,706	6,554	59,522	151,782
CHANGES IN TAXPAYERS EQUITY FOR THE 4 MONTH PERIOD ENDED 31 MARCH 2011				
Retained surplus/(deficit) for the year	-	217	-	217
Transfers between reserves	-	194	(194)	-
Net gain on revaluation of property, plant and equipment	-	-	-	-
Public Dividend Capital received	-	-	-	-
BALANCE AT 31 MARCH 2011	85,706	6,965	59,328	151,999

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2012

	Note	2011/12	4 Month Period 2010/11 Restated
		£'000	£'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating surplus/(deficit)		5,979	1,806
Depreciation and amortisation		7,705	2,505
Impairments		972	-
(Increase)/decrease in inventories		128	(655)
(Increase)/decrease in trade and other receivables		(2,682)	8,827
Increase/(decrease) in trade and other payables		3,969	(5)
Increase/(decrease) in other current liabilities		(1,512)	(530)
Increase/(decrease) in provisions	25	(724)	972
Other movements in operating cash flows		9	(206)
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		13,844	12,714
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest received		99	18
(Payments) for property, plant and equipment		(8,546)	(4,100)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(8,447)	(4,082)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		5,397	8,632
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital received		78	-
Loans repaid to the DH		(2,450)	(1,225)
Capital element of finance lease rental payments		(763)	-
Interest paid		(232)	(164)
Interest element of finance lease		(41)	-
Dividends paid		(4,561)	(2,267)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(7,969)	(3,656)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		(2,572)	4,976
CASH (AND) CASH EQUIVALENTS AT THE BEGINNING OF THE PERIOD		18,657	13,681
CASH (AND) CASH EQUIVALENTS AT 31 MARCH	20	16,085	18,657

NOTES TO THE ACCOUNTS 31 MARCH 2012

1. Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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 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

The Trust charges depreciation on revalued assets based on their revalued amount and not their cost. It then transfers a portion of the revaluation reserve to the general reserve as the asset is depreciated, with the balance being transferred on ultimate disposal. The amount transferred is based on information held on the value of assets and the Trust does not have complete records of the historical cost of its assets. IAS 16 is not prescriptive on the accounting policy to be adopted by reporting entities and the Trust has followed this approach on the grounds that there is no impact on the total of taxpayers' equity as a result of making this judgement.

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

1.3 Income

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

1.4 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.

1.5 Other goods and services

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.

1.6 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.

1.7 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.

1.8 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.

1.9 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.10 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.

1.11 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.

<u>The Trust as lessee</u>

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.

1.12 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.

1.13 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.

1.14 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 the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% (2010/11: 2.9%) 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.

1.15 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 25.

1.16 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.

1.17 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.

1.18 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.

1.19 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.

Loans 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.

1.20 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.

1.21 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.

1.22 Corporation Tax

The Trust has reviewed its operating activities and determined that as other trading activities are ancillary to the Trust's core activities then the Trust has no liability for corporation tax.

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 30 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 excluding cash balances held at GBS that relate to a short-term working capital facility. 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).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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'

Until 1 April 2013, NHS charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor.

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.

1.30 Change in accounting policies

There has been a change in accounting policy between financial years in respect of the treatment of donated assets (see note 1.9). The primary statements for 2010/11 have been restated for this change.

1.31 Accounting standards issued but not yet adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011/12. The application of the Standards as revised would not have a material impact on the accounts for 2011/12, were they applied in that year:

- IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
- IAS 12 - Income Taxes (amendment) - subject to consultation
- IAS 19 Post-employment benefits (pensions) - subject to consultation
- IAS 27 Separate Financial Statements - subject to consultation
- IAS 28 Investments in Associates and Joint Ventures - subject to consultation
- IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
- IFRS 9 Financial Instruments - subject to consultation - subject to consultation
- IFRS 10 Consolidated Financial Statements - subject to consultation
- IFRS 11 Joint Arrangements - subject to consultation
- IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
- IFRS 13 Fair Value Measurement - subject to consultation
- IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Operating Segments

The Trust Board receives financial information for the Trust as a whole, making decisions based on this. The Trust Executive Committee meets twice monthly and consists of the Trust Executive Directors and Divisional Directors for the Trust's seven clinical Divisions. Segmental analysis is provided below for the total of these seven Clinical Divisions and Other, which includes the Corporate areas. The key data for this operating segment is: -

	2011/12			4 months 2010/11		
	Clinical Divisions	Other	Total	Clinical Divisions	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Income	225,196	2,227	227,423	70,371	4,690	75,061
Expenditure	(174,484)	(51,900)	(226,384)	(56,630)	(18,214)	(74,844)
Contribution	50,712	(49,673)	1,039	13,741	(13,524)	217

3. Income from patient care activities

3.1 Income from activities

	2011/12 £'000	4 months 2010/11 £'000
Analysis by activity		
Elective income	48,086	14,522
Non-elective income	65,195	23,155
Outpatient income	45,180	14,687
A & E income	10,166	3,242
Other NHS clinical income	38,541	13,111
Private Patient income	2,388	745
Other non-protected clinical income	1,322	534
	210,878	69,996
Activity by source		
NHS Foundation Trusts	5	-
Primary Care Trusts	207,163	68,717
Local Authorities	78	35
Non- NHS - Private patients	2,292	674
- Overseas patients (non reciprocal)	96	71
- Injury cost recovery	910	425
- Other	334	74
	210,878	69,996

Injury cost recovery income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection.

	2011/12	4 months 2010/11
	£'000	£'000
Mandatory/Non-Mandatory Income		
Mandatory income	207,163	68,717
Non-mandatory income	3,715	1,279
	210,878	69,996

3.2 Private patient income

	2011/12	4 months 2010/11	Base Year
		£'000	£'000
Private patient income	2,388	745	2,729
Total patient related income	210,878	69,996	127,128
Private patient proportion as percentage	1.13%	1.06%	2.15%

Section 44 of the National Health Service Act 2006 and the Terms of Authorisation requires that the proportion of private patient income to the total patient related income of the NHS Foundation Trust should not exceed its proportion whilst an NHS Trust in its base year (2002/03).

4. Other operating income

	2011/12	4 months 2010/11
	£'000	£'000
Research and development	529	116
Education and training	8,770	2,655
Charitable and other contributions to expenditure	193	207
Non-patient care services to other bodies	2,142	775
Other income:		
Car parking	1,224	293
Estates recharges	672	215
Pharmacy sales	832	255
Nursery	919	298
Other	1,264	251
	16,545	5,065

5. Revenue

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

6. Operating expenses

	2011/12 £'000	4 months 2010/11 £'000
Services from NHS Foundation Trusts	933	242
Services from NHS Trusts	1,340	67
Services from PCTs	1,047	668
Services from other NHS bodies	66	8
Purchase of healthcare from non NHS bodies	4,192	1,263
Employee benefits – Executive Directors	1,071	356
Employee benefits – Non-Executive Directors	130	16
Employee benefits - staff	139,369	46,806
Drugs costs	12,785	4,030
Supplies and services – clinical (excluding drugs)	29,671	8,877
Supplies and services – general	3,813	1,367
Establishment	1,893	645
Transport	455	154
Premises	7,597	2,471
Increase/(decrease) in provision for impairment of receivables	(10)	279
Depreciation and amortisation	7,705	2,505
Impairment of property, plant and equipment	972	-
Auditors' remuneration	167	65
NHS clinical negligence scheme	4,294	1,413
Profit/(loss) on disposal of plant and equipment	9	(1)
Legal fees	211	10
Consultancy costs	2,510	750
Training, courses and conferences	840	174
Redundancy	-	991
Insurance	103	79
Losses, ex gratia and special payments	62	(78)
Other	219	98
	221,444	73,255

Auditors' remuneration

	2011/12	4 months 2010/11 £'000
Audit services – statutory audit	83	57
Audit services – audit related regulatory reporting	18	8
Internal Audit Services	66	-
	167	65

Audit Liability Cap

An engagement letter was signed on 12th December 2011 with KPMG. Currently the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £5,000,000 in the aggregate in respect of all such services.

7. Operating leases

As lessee:

	2011/12 £'000	4 months 2010/11 £'000
Payments recognised as an expense:		
Minimum lease payments	474	180
	474	180

	31/03/12 '000	31/03/11 £'000
Total future minimum lease payments:		
Not later than one year	334	444
Between one and five years	352	614
Total	686	1,058

8. Employee costs and numbers

8.1 Employee costs

	2011/12			4 months 2010/11		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	106,571	106,571	-	35,758	35,758	-
Social security costs	8,935	8,935	-	2,857	2,857	-
Employer contributions to NHS Pension scheme	11,700	11,700	-	3,913	3,913	-
Termination benefits	-	-	-	991	991	-
Agency/contract staff	13,616	-	13,616	4,634	-	4,634
	140,822	127,206	13,616	48,153	43,519	4,634

Of which £382,000 is capitalised as part of capital projects.

8.2 Average number of people employed

	2011/12			4 months 2010/11		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	No.	No.	No.	No.	No.	No.
Medical and dental	429	429	-	433	433	-
Administration and estates	806	806	-	823	823	-
Healthcare assistants and other support staff	384	384	-	399	399	-
Nursing, midwifery and health visiting staff	940	940	-	950	950	-
Scientific, therapeutic and technical staff	397	397	-	415	415	-
Other	7	7	-	5	5	-
Bank and agency staff	361	-	361	363	-	363
	3,324	2,963	361	3,388	3,025	363

Of which 7 are employed on capital projects. The figure 3,324 represents the average full time equivalent workforce utilised over the period, including substantively employed staff and the contingent workforce of bank and agency staff.

8.3 Directors' remuneration

	2011/12					4 months 2010/11
	Remuneration	Employer's Pension Contributions	Employer's NI	Benefits in Kind	Total	Total
	£'000	£'000	£'000	£'000	£'000	
Executive Directors	855	111	105	11	1,082	360
Non Executive Directors	120	-	10	-	130	16

Further details can be found in the Remuneration Report which forms part of the Annual Report.

8.4 Staff sickness absence

	2011/12	4 months 2010/11
Total days lost	20,937	7,490
Total staff years worked	2,970	1,003
Average working days lost (annualised)	7.0	7.5

The note above is based on data for the calendar year 2011 in line with national guidance.

9. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, 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.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

(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. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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 AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10. Retirements due to ill-health

During the year ended 31 March 2012 there were two early retirements (2010/11 – none) from the Trust agreed on the grounds of ill-health with a value of £280,000.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	2011/12		4 months 2010/11	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the period	54,750	82,819	18,281	27,949
Total Non-NHS trade invoices paid within target	50,236	77,657	17,172	26,214
Percentage of Non-NHS trade invoices paid within target	91.76%	93.77%	93.93%	93.79%
Total NHS trade invoices paid in the period	2,137	12,877	741	4,532
Total NHS trade invoices paid within target	1,497	9,167	527	3,327
Percentage of NHS trade invoices paid within target	70.05%	71.19%	71.12%	73.41%

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 (2010/11 – nil) is included within Finance Expense (Note 13) arising from claims made under this legislation. No compensation was paid to cover debt recovery costs under this legislation.

12. Finance income

	2011/12	4 months 2010/11
	£'000	£'000
Interest revenue		
Bank accounts	98	18

13. Finance expense

	2011/12	4 months 2010/11
	£'000	£'000
Interest costs		
Interest on loans	226	107
Interest on obligations under finance leases	41	-
Interest on late payment of commercial debt	-	-
Total	267	107

14. Property, plant and equipment

2011/12:	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 2011	32,700	106,763	4,555	25,808	22	7,086	3,484	180,418
Additions purchased	-	1,173	9,486	526	-	29	182	11,396
Additions donated	-	-	-	193	-	-	-	193
Reclassifications	-	7,989	(9,726)	727	-	683	111	(216)
Disposals other than by sale	-	(156)	-	(2,137)	-	(345)	(41)	(2,679)
Revaluation/indexation gains	-	1,460	-	-	-	-	-	1,460
Impairments	-	-	-	-	-	-	-	-
At 31 March 2012	32,700	117,229	4,315	25,117	22	7,453	3.736	190,572
Depreciation at 1 April 2011	-	4,174	-	19,645	21	5,342	2,660	31,842
Reclassifications	-	-	-	-	-	-	-	-
Disposals other than by sale	-	(156)	-	(2,128)	-	(345)	(41)	(2,670)
Impairments	-	972	-	-	-	-	-	972
Charged during the period	-	4,520	-	1,675	1	640	209	7,045
Depreciation at 31 March 2012	-	9,510	-	19,192	22	5,637	2,828	37,189
Net book value at 31 March 2012								
Net book value								
Purchased	32,700	104,503	4,315	4,939	-	1,788	886	149,131
Finance leased	-	2,468	-	-	-	-	-	2,468
Donated	-	748	-	986	-	28	22	1,784
Total at 31 March 2012	32,700	107,719	4,315	5,925	-	1,816	908	153,383
Net book value								
Protected assets	32,700	97,238	-	-	-	-	-	129,938
Unprotected assets	-	10,481	4,315	5,925	-	1,816	908	23,445
Total at 31 March 2012	32,700	107,719	4,315	5,925	-	1,816	908	153,383

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 December 2010	32,700	102,048	4,641	26,223	73	6,616	3,457	175,758
Additions purchased	-	1,094	4,359	242	-	60	-	5,755
Additions donated	-	-	-	206	-	-	-	206
Reclassifications	-	3,621	(4,445)	181	-	410	27	(206)
Disposals other than by sale	-	-	-	(1,044)	(51)	-	-	(1,095)
Revaluation/indexation gains	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-
At 31 March 2011	32,700	106,763	4,555	25,808	22	7,086	3,484	180,418
Depreciation at 1 December 2010	-	2,750	-	20,135	67	5,098	2,590	30,640
Reclassifications	-	-	-	(44)	-	44	-	-
Disposals other than by sale	-	-	-	(1,050)	(46)	-	-	(1,096)
Impairments	-	-	-	-	-	-	-	-
Charged during the period	-	1,424	-	604	-	200	70	2,298
Depreciation at 31 March 2011	-	4,174	-	19,645	21	5,342	2,660	31,842
Net book value at 31 March 2011								
Net book value								
Purchased	32,700	101,820	4,555	5,126	1	1,703	795	146,700
Finance leased	-	-	-	-	-	-	-	-
Donated	-	769	-	1,037	-	41	29	1,876
Total at 31 March 2011	32,700	102,589	4,555	6,163	1	1,744	824	148,576
Net book value								
Protected assets	32,700	97,764	-	-	-	-	-	130,464
Unprotected assets	-	4,825	4,555	6,163	1	1,744	824	18,112
Total at 31 March 2011	32,700	102,589	4,555	6,163	1	1,744	824	148,576

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

	Minimum life (years)	Maximum life (years)
Land	-	100
Buildings excluding dwellings	-	88
Assets under Construction & POA	-	-
Plant & Machinery	-	11
Transport Equipment	-	1
Information Technology	-	7
Furniture & Fittings	-	10

15. Intangible fixed assets

2011/12:	**Software Licences** £'000	**Total** £'000
Gross cost at 1 April 2011	4,362	4,362
Reclassifications	216	216
Additions purchased	151	151
Additions donated	-	-
Gross cost at 31 March 2012	4,729	4,729
Amortisation at 1 April 2011	2,873	2,873
Charged during the period	660	660
Amortisation at 31 March 2012	3,533	3,533
Net book value		
- Purchased	1,167	1,167
- Donated	29	29
Total at 31 March 2012	1,196	1,196

2010/11:	**Software Licences** £'000	**Total** £'000
Gross cost at 1 December 2010	4,071	4,071
Reclassifications	206	206
Additions purchased	85	85
Additions donated	-	-
Gross cost at 31 March 2011	4,362	4,362
Amortisation at 1 December 2010	2,666	2,666
Charged during the period	207	207
Amortisation at 31 March 2011	2,873	2,873

Net book value		
- Purchased	1,450	1,450
- Donated	39	39
Total at 31 March 2011	1,489	1,489

The Revaluation Reserve balance for intangible assets is £nil.

The remaining economic lives of intangible assets are:

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

16. Impairments

Impairments of property during the year to 31 March 2011 totalled £972,000 (2010/11 - £nil).

17. Capital commitments

Contracted capital commitments were as follows:

	31/03/12 £'000	31/03/11 £'000
Property, plant and equipment	84	4,106
Total	84	4,106

18. Inventories

	£'000	£'000
Drugs	701	771
Consumables	2,911	2,969
Energy	48	48
Total	3,660	3,788

19. Trade and other receivables

19.1Trade and other receivables

	Current		Non-current	
	31/03/12	31/03/11	31/03/12	31/03/11
	£'000	£'000	£'000	£'000
NHS receivables – revenue	2,181	2,264	-	-
NHS receivables - capital	42	9	-	-
Provision for the impairment of receivables	(1,011)	(1,051)	-	-
Prepayments	2,024	1,908	-	-
Accrued income	5,601	2,936	-	-
VAT	511	365	-	-
Other receivables	2,603	2,841	1,085	1,044
PDC dividend receivable	-	116	-	-
Total	11,951	9,388	1,085	1,044

19.2 Receivables past their due date but not impaired

	31/03/12	31/03/11
	£'000	£'000
By up to three months	368	110
By three to six months	33	107
By more than six months	-	98
Total	401	315

19.3 Provision for impairment of receivables

	31/03/12	31/03/11
	£'000	£'000
Balance at 1 April 2011/1 December 2010	1,051	792
Amount utilised	(30)	(20)
Unused amounts reversed	(131)	-
(Increase)/decrease in receivables impaired	121	279
Balance at 31 March	1,011	1,051

20. Cash and cash equivalents

	31/03/12 £'000	31/03/11 £'000
Cash with Government Banking Service	16,019	18,604
Commercial banks and cash in hand	66	53
Balance at 31 March	16,085	18,657

21. Trade and other payables

	Current		Non-current	
	31/03/12 £'000	31/03/11 £'000	31/03/12 £'000	31/03/11 £'000
NHS payables – revenue	253	477	-	-
Non NHS trade payables – revenue	4,376	3,272	-	-
Non NHS trade payables - capital	2,343	2,168	-	-
Other payables	4,812	4,747	-	-
Accruals	14,340	11,322	-	-
PDC dividend payable	94	-		
Trade and other payables	26,218	21,986	-	-
Deferred income	352	1,864	-	-
Other liabilities	352	1,864	-	-

22. Borrowings

	Current		Non-current	
	31/03/12 £'000	31/03/11 £'000	31/03/12 £'000	31/03/11 £'000
Department of Health loan	2,450	2,450	-	2,450
Finance lease liabilities	449	-	1,846	-
Total	2,899	2,450	1,846	2,450

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.

23. Prudential Borrowing Limit

	31/03/12	31/03/11
		£'000
Total long term borrowing limit set by Monitor	21,300	25,500
Working capital facility agreed with Monitor	15,000	15,000
Total Prudential Borrowing Limit	36,300	40,500
Long term borrowing at start of period	4,900	6,125
Net actual borrowing/(repayment) during period	(155)	(1,225)
Long term borrowing at 31 March	4,745	4,900

The Trust did not utilise the Working Capital Facility during the period.

Financial Ratios

	31/03/12	31/03/11	Limit
Minimum Dividend Cover	3.0	3.3	>1.0
Minimum Interest Cover	54.4	43.8	>3.0
Minimum Debt Service Cover	4.2	5.6	>2.0
Maximum Debt Service to Revenue	1.53	1.25%	<2.5%

The Trust is required to comply and remain within a Prudential Borrowing Limit. This is made up of two elements: -

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

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

24. Finance lease obligations

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease payments	
	31/03/12	31/03/11	31/03/12	31/03/11
		£'000		£'000
Within one year	590	-	568	-
Between one and five years	2,063	-	1,746	-
Less future finance charges	(358)	-	(326)	-
Net lease liabilities	2,295	-	1,988	-

25. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Restructuring	Other	Total
	£'000	£'000	£'000	£'000	£'000
At 1 April 2011	477	110	1,079	527	2,193
Arising during the year	-	67	-	74	141
Used during the year	(41)	(10)	(310)	(129)	(490)
Reversed unused	-	(19)	(161)	(195)	(375)
At 31 March 2012	436	148	608	277	1,469

Expected timing of cashflows:

In the remainder of the spending					
Period to 31 March 2013	52	148	608	93	901
Between1 April 2013 and 31 March 2017	212	-	-	76	288
Later than five years	172	-	-	108	280
As at 31 March 2012					
Current	52	148	608	93	901
Non-Current	384	-	-	184	568
As at 31 March 2011					
Current	53	110	1,079	323	1,565
Non-Current	424	-	-	204	628

Of the provisions a total of £nil (2010/11 - £158,000) is recoverable from PCT's under back to back arrangements.

Clinical negligence provisions

Included in the provisions of the NHS Litigation Authority at 31 March 2012 is £26,642,000 (2010/11 - £26,025,000) in respect of clinical negligence liabilities of the Trust.

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 27.

Other provisions

Other provisions at 31 March 2012 include: -

- Two injury benefit cases of £203,000 as notified to the Trust by the NHS Business Services Authority - Pensions Division;
- Restructuring costs of £608,500 for restructuring the pathology service.

26. Contingent assets/(liabilities)

Other

Other Contingent Liabilities for non-clinical negligence incidents total £nil (2010/11 - £(35,000))

27. Financial instruments

28.1 Financial assets

	31/03/12		31/03/11	
	Loans & Receivables	Total	Loans & Receivables	Total
	£'000		£'000	£'000
Trade Receivables	11,951	11,951	9,388	9,388
Cash at bank and in hand	16,085	16,085	18,657	18,657
Total at 31 March 2012	28,036	28,036	28,045	28,045

28.2 Financial liabilities

	31/03/12		31/03/11	
	Other	Total	Other	Total
	£'000	£'000	£'000	£'000
Trade Payables	26,218	26,218	21,986	21,986
Other borrowings	4,745	4,745	4,900	4,900
Other financial liabilities	352	352	1,864	1,864
Total at 31 March 2012	31,315	31,315	28,750	28,750

28.3 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 31 March 2011 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 its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

28. Events after the reporting period

There are no events after the reporting period having a material effect on the accounts.

29. 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 Foundation Trust.

The Department of Health is regarded as a related party. During the period Ashford and St Peter's Hospitals NHS Foundation 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:

Brighton and Sussex University Hospitals NHS Trust
South East Coast Strategic Health Authority
London Strategic Health Authority
NHS Surrey
Hounslow PCT
Berkshire East PCT
NHS Richmond
Hampshire PCT
West Kent PCT
Surrey and Borders Partnership NHS Foundation Trust
Frimley Park Hospital NHS Foundation Trust
Royal Surrey County NHS Foundation Trust
Epsom and St. Helier University Hospitals NHS Trust
NHS Business Services Authority
NHS Blood and Transplant
NHS Professionals
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.

30. Third Party Assets

The Trust held £9,000 cash at bank and in hand at 31 March 2012 (2010/11 - £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.

31. 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 282 cases of losses and special payments totalling £46,000 paid between in 2011/12. There were no cases where the net payment exceeded £100,000. Total costs included in this note are on an accruals basis excluding provisions for future losses.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ASHFORD AND ST. PETER'S HOSPITALS NHS FOUNDATION TRUST ON THE ANNUAL QUALITY REPORT

We have been engaged by the Council of Governors of Ashford and St. Peter's Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Ashford and St. Peter's Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium difficile – all cases of Clostridium difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

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

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below:

The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to April 2012;

- Papers relating to Quality reported to the Board over the period April 2011 to April 2012;
- Feedback from the Commissioners dated 23 May 2012;
- Feedback from LINKs dated 30 April 2012;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 11 April 2012;
- The national outpatient survey 2011 and national inpatient survey 2011;
- The national staff survey dated 2011;
- Care Quality Commission quality and risk profiles dated April 2011 to May 2012;
- The Head of Internal Audit's annual opinion over the trust's control environment dated 18 May 2012; and
- Feedback from other named stakeholders involved in the sign off of the Quality Report – London Borough of Hounslow, dated 09 May 2012 and Health Overview and Scrutiny Committee, dated 04 May 2012.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Ashford and St. Peter's Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Ashford and St. Peter's Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Ashford and St. Peter's Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;

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

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts/organisations/entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Ashford and St. Peter's Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

KPMG LLP, Statutory Auditor
London
30 May 2012

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Ashford and St Peter's Hospitals NHS Foundation Trust
May 2012

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