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

COUNCIL OF GOVERNORS
13th September 2011

TITLE

Annual Report and Accounts December 2010- April 2011

EXECUTIVE SUMMARY

The Trust achieved Foundation Trust status with effect from 1st December 2010. As such we had to produce two Annual Reports and two sets of Accounts; one for the period pre Foundation Trust status and one for the period we were authorised.

The composite Annual Report and Accounts for the four month period 1st December 2010 to 31st March 2011 was agreed by the Board in June 2011 and submitted to Monitor and Parliament.

To appreciate the financial performance of the Trust over the year it is helpful to look at the combined picture of the two part year elements. This can be summarised as follows:

£m	NHS Trust part year	NHS FT part year	Full year	Budget	Variance
Income	149.6	75.0	224.6	219.1	5.5
EBITDA	11.5	5.2	16.7	18.6	(1.9)
Surplus	3.2	0.1	3.3	3.3	0

As a Foundation Trust we have to include a Quality Report. This is based on the Quality Account and is included in the main body of the Annual Report

A presentation on the Annual Report and Accounts will be made to the Council meeting.

The Annual General Meeting/Annual Members meeting will be held on 29th September 2011. In addition to the two formal sets of documents we produce an Annual Review giving an easy read view of the whole year.

The Council is asked to:

Discuss and note the Annual Report and Accounts for the period 1st December 2010 to 31st March 2011

Submitted by:

John Headley
Director Finance and Information

Date:

23rd August 2011

Decision:

For Discussion

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

ANNUAL REPORT AND ACCOUNTS December 2010-March 2011

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

CONTENTS

1. Introduction

Trust profile 3
Statement by the Chairman and Chief Executive 3

2. Directors' Report and Management Commentary

Management commentary 5
Progress against our corporate objectives 9
Our priorities for future development 30

3. Quality Report

Introduction 31
Our priorities for 2010/11..... 33
Our priorities for improvement 2011/12 46
Statements of assurance 54
Further performance information 62
Statements from other organisations 68
Statement of directors' responsibilities 71

4. NHS Foundation Trust Code of Governance

Board of Directors 73
Board sub committees..... 78
Council of Governors 80
Membership 82

5. Regulatory information

Monitor regulatory ratings 85
Sustainability report 86

6. Financial Report and Accounts

Financial review 88
Remuneration Report 90
Statement of Accounting Officer's Responsibilities 93
Statement of Directors' Responsibility in Respect on Internal Control 94
Financial Accounts 99

1. Introduction

This report covers the financial period from 1st December 2010, when we were authorised as a Foundation Trust, to 31st March 2011.

Trust profile

On 1st December 2010, Ashford and St Peter's Hospitals NHS Trust was authorised by Monitor as a Foundation Trust. 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 its success in becoming a Foundation Trust.

Ashford and St Peter's Hospitals NHS Foundation Trust currently serves a population of over 380,000 people living in the boroughs of Runnymede, Spelthorne, Woking and parts of Elmbridge, Hounslow, Surrey Heath and beyond. We employ around 3500 staff and in 2010/11 our turnover for the whole of the year was £224m, which equates to just under £75m from 1st December 2010 – 31st March 2011.

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

Statement by the Chairman and Chief Executive

We have just come to the end of what has probably been the most successful year ever for Ashford and St Peter's hospitals. We were delighted to be awarded Foundation Trust status by Monitor on 1st December 2010 which is a clear endorsement of the hard work and commitment made by our staff to provide high quality, safe care for our patients.

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

We have also been recently nominated as a CHKS top 40 hospital as part of their 2011 Top Hospitals Programme, based on an evaluation of a number of markers including safety, clinical effectiveness, outcomes, efficiency, patient experience and quality of care which is a great achievement for the Trust.

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

During the year we also received our best ever staff survey results which show that our staff rate us in the top 20% of hospital employers in the country. We know that staff satisfaction is reflected in high quality patient care and we are also beginning to see significant improvements in our patient survey results. We now rate amongst the middle 60% of trusts nationally against previous results which fell into the lowest 20% overall.

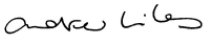
As we have settled into operating as a Foundation Trust, strengthening our relationships with our new Council of Governors and large membership body and putting our new governance arrangements in place, we have also experienced one of our busiest winters ever with continued pressure on both our hospitals in terms of activity and capacity. Our staff have risen to the challenge with commitment and professionalism, making sure patients continue to be treated safely and appropriately.

Moving forward, we want to continue the good working relationship we have started with our Governors and members and engage with the local community as widely as possible. Much of our internal focus will be on further improving patient experience and working to embed our values – putting *Patients First,* taking *Personal Responsibility,* having a *Passion for Excellence* and having *Pride in our Team* – so staff are always focused on providing the very best service, every patient, every time.

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

As we enter a difficult period, particularly financially but also a time of great structural change within the NHS, we are once again well placed to manage these challenges. We are ambitious in our plans for our patients and for our staff. Our driving force will continue to be making further improvements for our patients and to work towards achieving our overall aim of becoming one of the best hospital trusts 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 first four months as a Foundation Trust (1st December 2010 – 31st March 2011) 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 specifically from 1st December 2010. This includes a summary of our overall performance against our corporate objectives for 2010/11, with specific focus for the latter part of the year as a Foundation Trust.

Overview

Overall 2010/11 was an extremely successful year, the Trust having delivered well against its corporate objectives (see p. 9 for more details) and met all its financial and statutory duties including a planned surplus of £3.3 million and savings target of £9 million. The Trust began the year with an unconditional registration by the Care Quality Commission and has continued to score well against quality and performance standards throughout this period. The Trust continues to report a lower than average standardised mortality rate with the joint fifth lowest ratio nationally for a 'basket' of the most common causes of death in hospital – stroke, heart attack, congestive heart failure, pneumonia and falls (source: Dr Foster Good Hospital Guide 2010).

Since 1st December, the Trust has consistently scored a green rating against the Monitor Compliance Framework (Monitor is the independent Regulator of Foundation Trusts) and ended the year with the lowest ever hospital acquired infection rates (see p. 39 for details). The Trust has also worked hard to deliver substantial improvements in other key areas; for example, by the end of the year we were operating on 96% of patients with a fractured hip within 36 hours of admission (compared to only 52% last year) and are now one of the best performing Trusts in the country in this area. We have made significant improvements in reducing the number of falls in hospital, another important indicator of quality and safety, and were also rated as the 7th best Trust in the country for the number of operations we carry out as day surgery, an indicator of good surgical practice.

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

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

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

In addition, the Trust – in line with the rest of the local health economy – has been under severe pressure over the winter period, which began earlier than expected with particularly cold weather hitting in November and December. This brought inevitable increases in orthopaedic trauma and fracture work, with continuing high numbers of elderly, frail patients, often with complex conditions, requiring hospital admission. This has resulted in capacity issues for the Trust on many occasions and in response around 70 additional beds were opened over the winter period, which has not always resulted in the best patient experience. These pressures have also highlighted some changes needed in our discharge processes and a lot of focus has been put into improving these during the last quarter of the year.

However, despite these pressures, staff have risen to the challenge, maintaining their professionalism at all times and often working many additional hours to make sure patients continued to be treated safely and appropriately. The Trust has also received good support from external colleagues in social and community services, primary care and others, often resulting in improved working arrangements.

Many of these challenges are best met by working more proactively with other NHS and social care partners. As a result and also in readiness for the changes anticipated from the Government's draft Health and Social Care Bill, the Trust's strategic work over the last year and going forward, is focused on greater involvement with partners in North West Surrey through a local Transformation Board. Part of this work is to develop a new model of care for local patients which is focused on working to reduce emergency admissions, putting more care into the community and integrating services in a better way across acute, community and primary care. More details are given on p. 23.

Key activities

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

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

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, endoscopy (using cameras to look inside the body) and MRI scans

St. Peter's Hospital

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

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

Activity review

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

From 1st December 2010 – 31st March 2011 this equates to around 175,000 attendances across all activity types.

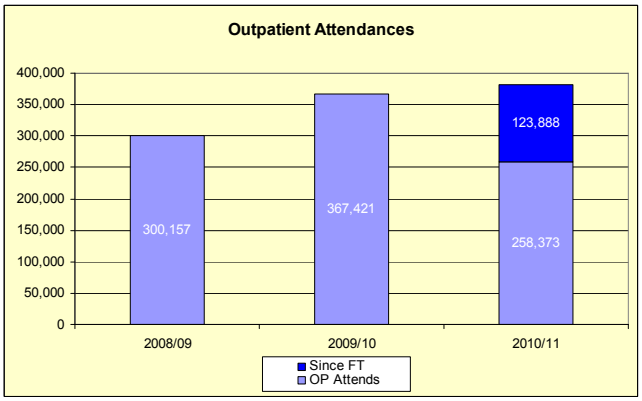
Over the year, the Trust has seen increases in the number of outpatient attendances, a small increase in the number of emergency admissions and in the number of births. An extremely busy winter period resulted in the Trust experiencing continuing high numbers of emergency admissions and, with a revenue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

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

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

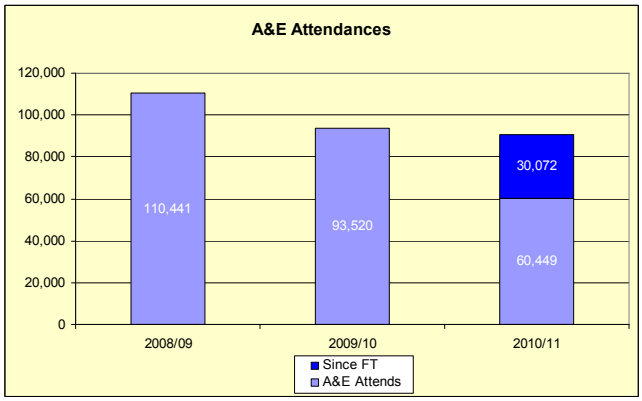
The following graphs demonstrate these overall trends, breaking down 2010/11 figures to show the Trust's actual activity for this reporting period (1st December 2010 – 31st March 2011).

Fig. 1: Outpatient Attendances



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

Fig. 2: A&E Attendances



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

Fig. 3: Emergency Admissions

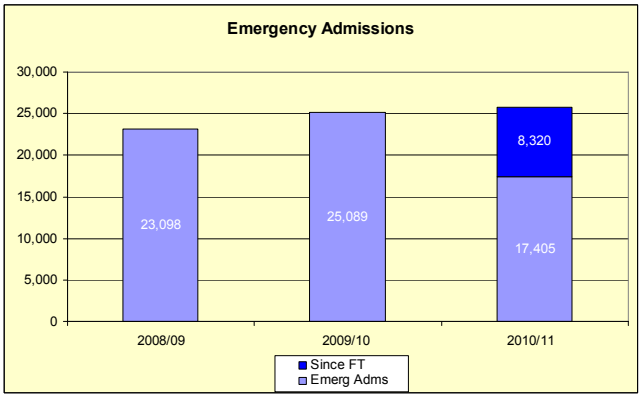


Fig. 4: Day Case Procedures

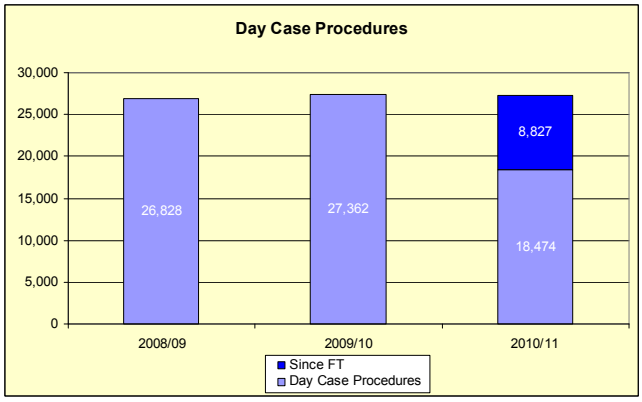


Fig. 5: Births

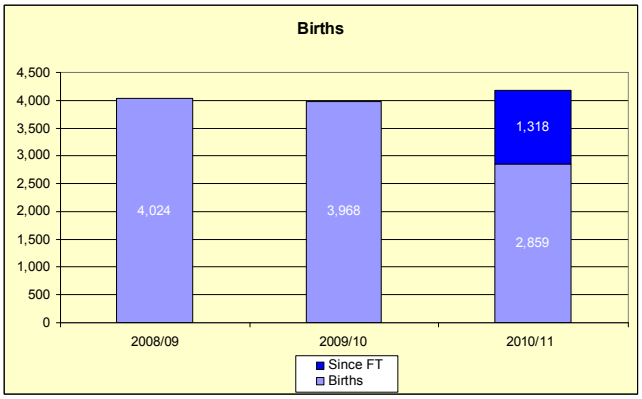
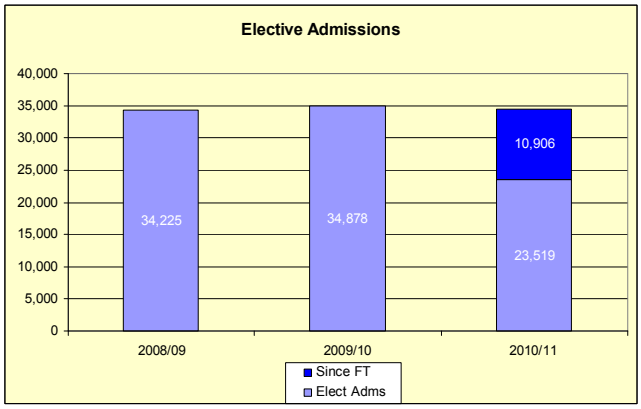


Fig. 6: Elective Admissions



Contract value by commissioner

The following table sets out the Trust's key commissioning contracts for 2010/11 in terms of planned contract values and actual year-end income.

Fig. 8: Commissioning contract values

Commissioner	Planned contract value £'000s	Year-end income
Surrey	167,223	173,250
Hounslow	15,795	14,350
Berkshire East	5,657	5,941
Richmond & Twickenham	2,137	2,014
Hampshire	927	806
Ealing	445	386
Hillingdon	214	367
Kingston	249	321
Sutton	176	250
Total	**192,823**	**197,686**

The Trust's final year-end income was just over £4.8 million above plan.

Our vision and strategy

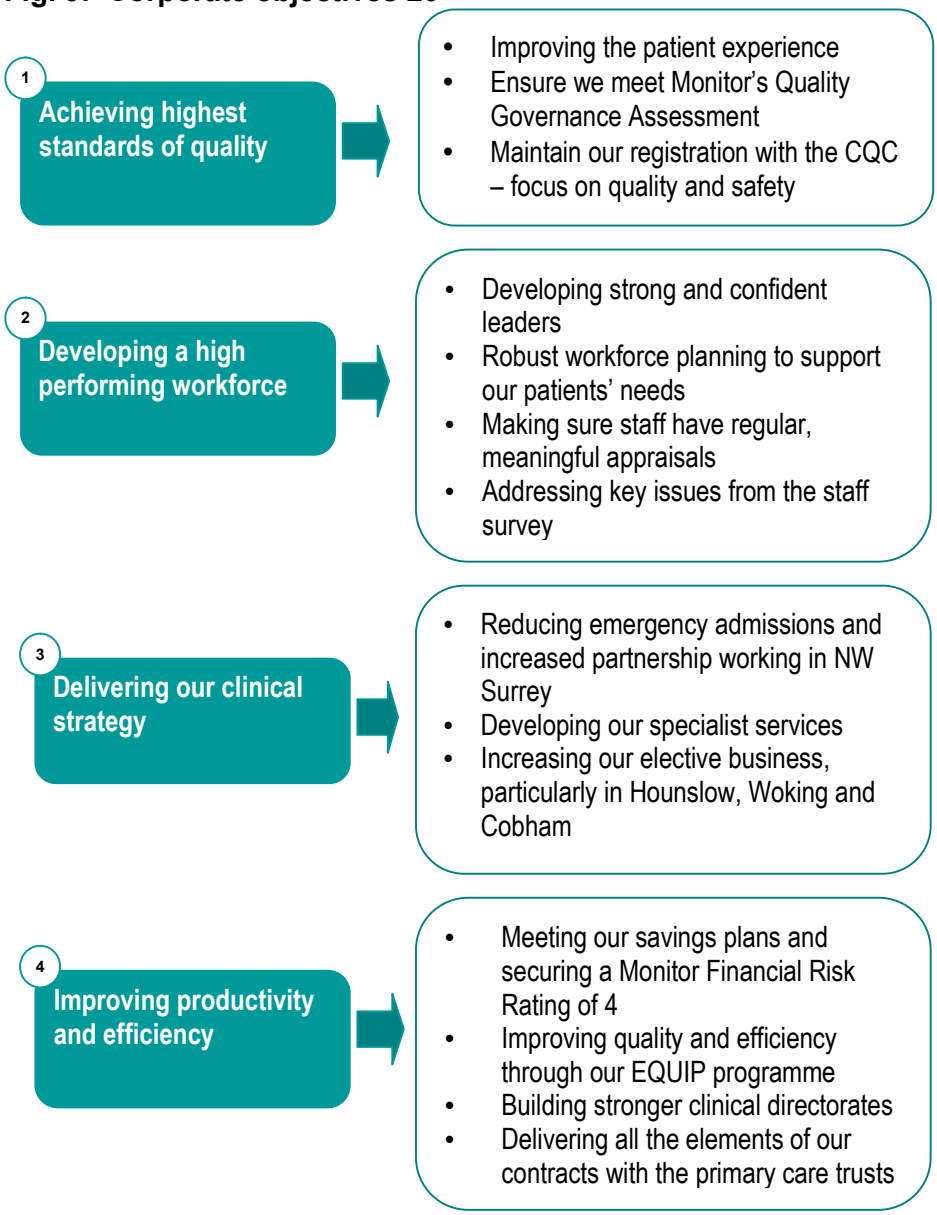
Our vision is to be one of the best healthcare Trusts in the country. In our 5 year Foundation Trust business plan we set out our four strategic objectives to deliver this vision – having the highest standards of quality, a high performing workforce, delivering our clinical strategy and improving productivity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

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

Progress against our corporate objectives

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

Fig. 9: Corporate objectives 20



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. 31 – but in terms of meeting this core objective our headline achievements are:

Improving the patient experience

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

Using patient feedback to drive improvements

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

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

Your Feedback - we introduced a new Feedback questionnaire giving all our discharged patients an opportunity to report their individual experiences, with quick turnaround. Ward teams were asked to discuss the feedback and develop actions in response. To date we have received 3,500 forms and over the year there has been an increasing number of patients saying they would recommend us to family and friends.

National surveys – during the year the Trust participated in a number of national patient surveys.

Our results from the national inpatient survey improved significantly, and we moved from the bottom 20% of Trusts to the middle 60%. We scored particularly well on asking patients for views on their care whilst in hospital, copying patient letters to GPs, doctors and nurses talking about patients with dignity and respect, the number of nurses on duty, effective pain relief, patients being given clear written information about their medicines and getting good answers to questions about their operation or procedure. Going forward we will target those areas where we haven't done so well – patients being disturbed at night by other patients, making sure doctors and nurses demonstrate they are washing their hands between patients, and better overall communication.

A recent national maternity survey also showed good improvements compared to a similar survey undertaken in 2007 when our maternity services were rated in the lowest 20% nationally – see p. 13 for more details.

The Trust also scored well in a national children's services survey and in a peer review of our children's cancer services.

PALS – over the last year 1,440 people made contact with our *Patient Advice and Liaison Service* compared to 1,262 last year), with 86% of concerns resolved quickly through facilitation. Since 1st December the Trust has had 489 contacts, 84% of which were resolved quickly.

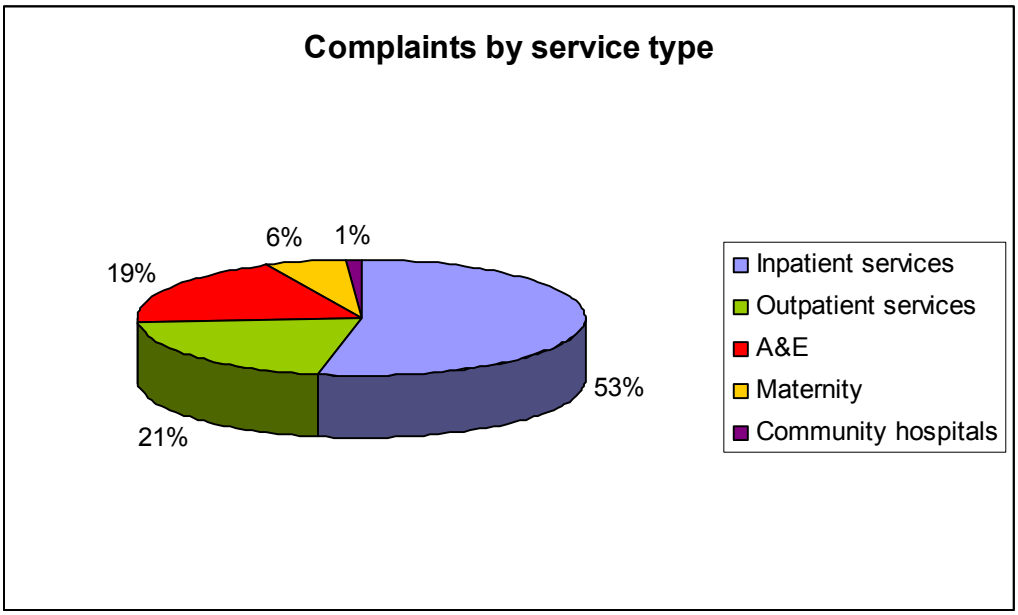
As a direct result of issues raised through PALS we:

- improved wheelchair access to the phlebotomy clinic at Ashford Hospital.
- have improved our discharge process to ensure that where patients live only with an elderly person, their discharge will be handled as though they live alone and they won't be discharged after 6pm.

- have improved our Ophthalmology appointment system to reduce the number of cancellations and waiting times.

Learning from complaints – over the last year the Trust received 361 formal complaints, a reduction of around 11%. Since 1st December, the Trust received 127 formal complaints – a 5% decrease in the number received during the same period in 2009/10 (134). The Trust achieved an 89% response rate within agreed timescales which reflects 14 missed deadlines. Fig. 10 illustrates the complaints received by service type:

Fig. 10: Complaints by service type



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

- Introduced care rounding at ward level which means our nursing staff are checking on patients regularly to make sure they are comfortable, to see if they need the bathroom, something to eat or drink and so on.
- Reviewed the way our wards process cancer referrals to make sure these are timely and are followed up appropriately.
- Developing a specific care pathway for patients who have difficulty eating and drinking properly ensuring they receive adequate nutrition, hydration and mouth care.

Referrals for review by the Parliamentary and Health Service Ombudsman

During this period four cases were referred to the Ombudsman for review. Of these, two are undergoing initial assessment and two have undergone initial assessment; one case was referred back to the Trust for further work and the other was closed with no further action required.
A fifth case previously considered by the Ombudsman was re-referred for their consideration by the complainant. Following assessment, this case was closed with no further action for the Trust.

Publication of Health Ombudsman's Report, February 2011

On 15th February 2011, the Health Ombudsman published a report into the care of the elderly based on findings from ten national complaints about NHS care for older people. This included a case from St Peter's Hospital concerning a gentleman with dementia discharged from hospital in December 2007, despite concerns from his daughter about his medical fitness.

We have worked closely with the Health Ombudsman to develop and agree a strong action plan of improvements which we are already putting in place. These include appointing a specialist nutritional nurse, better ways of undertaking ward rounds to involve the whole clinical team, and a review of our discharge process. We have apologised unreservedly to the family; this case falls far short of the high standards we set ourselves for patient care. We have commissioned an independent review of the actions we have taken which will be reported to the Board.

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

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

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

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

Working with our Governors and Members – during these first four months as a Foundation Trust we have been developing a positive working relationship with our Governors. They have particularly expressed an interest in being actively engaged in improving patient experience which we welcome. We continue to communicate regularly with our Members through a quarterly newsletter and a programme of Members' Health Events.

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

Strengthening our nursing leadership

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

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

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

Improving the patient environment

Improving car parking at St Peter's Hospital - by the end of the financial year work was well underway to construct two new modular parking decks at St Peter's Hospital, giving an increase of 92 parking spaces for patients and visitors. New barriers in the main car park will help to restrict it for the sole use of patients and visitors and a new dropping off zone will also help traffic flow. The Trust has also re-sited the main bus stop on the St Peter's site, bringing it much closer to the main entrance of the hospital and landscaping the surrounding area.

Continued improvements in patient areas - we invested £250,000 in improving facilities on Kingfisher ward at St Peter's, created a dedicated treatment/examination room on our Surgical Assessment Unit to improve patient privacy and dignity and completed our single sex accommodation programme ensuring we were compliant with the Department of Health's requirements by the end of the financial year.

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. 11: 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	Good

Pride in our Team – Housekeeping

Our housekeeping team has been shortlisted by the National Associated Healthcare-Cleaning Professionals (in the final three) for an award at their annual conference in June 2011 for their *'Pride in our Team – caring for our patients, our staff and ourselves'* event – a week long health and wellbeing programme that staff could dip in and out of, including managed fitness sessions, dance, Indian head massage treatments, sponsored lunches and other sessions.

Maternity services – a continual improvement

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

Other improvements during the year include:

- The unit was awarded the World Health Organisation's Baby Friendly Accreditation Stage 1 in March 2011
- All Party Parliamentary Award "Highly Commended" for Birth Reflections Service in July 2010
- Achievement of the highest patient safety standard from the NHS Litigation Authority – the Clinical Negligence Scheme for Trusts which measures the way maternity departments manage safety and risk. The Trust received the highest grading, a Level 3, the first Trust to achieve this under the NHS Litigation Authority's new stricter criteria.
- Opening of our new ensuite birthing rooms in May 2010

- Introducing recliners for all birthing rooms to enable birthing partners to be able to support the woman more comfortably
- Opening of a new birthing pool
- Launching of a new film for women on what to expect in the maternity unit.

Quality and safety

Quality and safety are of the upmost importance in the way we run our hospitals, from the Board to the front line. 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 2010 the Trust was officially registered under the Care Quality Commission's new monitoring standards for providing NHS healthcare. This is a legal requirement and the Trust was registered with no conditions. The new high standards cover issues such as cleanliness and safety, treating patients with dignity and respect and involving them in decisions about their care. Throughout the year the Trust has maintained its registered status and continued to meet quality and safety standards as set by the CQC.

Infection control

The Trust was set very tough infection control limits for 2010/11 – no more than five hospital acquired cases of MRSA bacteraemia to be reported, and a national target of no more than 103 cases of clostridium difficile with a local, stretch, target set by the PCT of no more than 67. The Trust achieved these limits (reporting 5 cases of MRSA bacteraemia and just 36 cases of hospital acquired clostridium difficile). This was one of our key quality priorities in last year's Quality Account and more details on our achievements are given on p. 39.

Safeguarding

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

Improving clinical outcomes:

Low mortality rates – Dr Foster's Hospital Guide for 2010 reports the Trust's standardised mortality ratio as 90 (where 100 would be considered the expected number of deaths taking into account variables such as age, diagnosis and other characteristics). For the 'basket of 5' common conditions which are some of the most common causes of death in hospitals (*heart attacks, stroke, pneumonia, congestive heart failure and broken hips)* the Trust was reported as having the fifth lowest mortality ratio of 83 in the country.

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

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

Improving our treatment for fractured hips – the Trust has dramatically improved the % of patients arriving with a fractured hip that are operated on within 36 hours. At the beginning of the year, just 52% of our hip fracture patients were operated on within 36 hours; by the end of the year this had risen to 96% and we are now one of the best performing Trusts in the country. Furthermore we are now operating on 75% of our patients within just 24 hours against our locally set target of 40%. This was one of our key priorities in our Quality Account and more information is given in our Quality Report on p. 42.

Falls – over the last year we have achieved a 50% reduction in harm caused to patients through falls and a 8.1% reduction in the overall number of falls compared to 09/10 although we had set a local target of 10%. More detail is given in our Quality Report on p. 40.

Enhancing Quality Programme – the Trust is now participating in a South East Coast wide programme called 'Enhancing Quality'. This is a clinical change programme covering four key clinical conditions: Heart attacks; heart failure; hip and knee replacements; and community acquired pneumonia. The programme aims to improve outcomes for patients by setting out and standardising the key clinical interventions or care each patient should have on their 'patient journey' and then monitoring Trusts against these. Our achievement against these standards accounts for 0.5% of the Commissioning for Quality and Innovation (CQUIN) payments for 2010/11 – see more details in our Quality Report on p. 59.

Accredited services

- The Pathology and Pharmacy department have met all standards in external inspections including MHRA (Medicines and Healthcare Regulatory Agency), CPA (Clinical Pathology Accreditation), HTA (Human Tissue Authority) and Royal Pharmaceutical Society for Great Britain)
- Our Maternity Services have achieved the highest standard for patient safety, CNST Level 3 (Clinical Negligence Scheme for Trusts) by the NHS Litigation Authority.
- The nursery at St Peter's Hospital, First Steps, was recently awarded the Quality Assurance Scheme standard, set by the Surrey Early Years Quality Improvement Board which is highly regarded by Ofsted. First Steps offers staff at the Trust high quality childcare for children up to school age on site.

Safer prescribing

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

Corporate objective 2: developing a high performing workforce

Our second corporate objective reinforces the fact that a high performing workforce will deliver better quality care for patients. During 2010/11 we focused on embedding our values and behaviours with staff, developing strong and confident leaders, our appraisal programme and addressing key issues raised by staff in the annual national survey.

Embedding our Values and Behaviours

Fig. 12: Our Pledge and Values

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

Workshops have been held at both hospital sites to inspire leaders and their teams to offer insight and open up discussion as to how they might 'live the values'. The Pledge wheel has become symbolic in the Trust as a reminder to staff how they do this by actions such as 'making everyone feel special' and 'smiling and being welcoming'.

All staff will be invited to further participate in workshops in the coming year to hear directly from patients who will feed back from their own perceptions and experiences of what it is like to receive care at Ashford and St. Peter's.

Learning and Development

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

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

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

Leadership development

One of our key objectives is to support and develop the best possible leadership across our organisation and across all staffing levels.

Open to all staff, the first year of our *Good to Great Leadership Programme* was based around the four strategic objectives and 100 of our employees attended a series of master classes led by best in class speakers from the NHS, private industry and academia including a full day event led by acclaimed patient experience guru, Fred Lee, author of *If Disney ran your hospital, 9 ½ things you would do differently*.

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

Early in 2011 we also launched a bespoke development programme for our ward sisters, particularly looking at strengthening their accountability for their ward areas and a further development programme for our new specialty leads to ensure they are equipped with the right tools and ideas to take forward and develop their areas of clinical specialty.

Supporting equality and diversity

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

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

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

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

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

Improving staff experience

Results from the latest staff attitude survey show that our staff are amongst the most motivated in the country, and rate Ashford & St. Peter's as one of the top 20% of Trusts for job satisfaction and recommending us as somewhere to work and receive treatment.

We were particularly pleased that over 2000 of our staff participated in the survey (71% of eligible staff) demonstrating a high level of engagement. Overall, the number of key scores where we ranked in the top 20% of acute Trusts increased from 3 to 18 which is a strong positive sign of staff attitudes.

Particular improvements include 87% of staff having received an appraisal this year (compared to 68% the previous year), 64% participating in equality and diversity training (compared to 25% in 2009) and good communication between management and staff.

Here are the key findings from the NHS Staff Survey 2010/11:

Fig. 13: Staff Survey Response Rate

	2009/10		2010/11		Trust position
Response rate	Trust	National Average	Trust	National Average	
	65%	55%	71%	64%	5% improvement

Areas of improvement from the previous year and deterioration

The overall change in scores since 2009/10 from the Trust's perspective was as follows:

- 13 key factor scores have improved from their position in 2009.
- No key factor scores have deteriorated from their position in 2009.

Compared with the 2009/10 national average:

- There are 25 key factor scores above average [out of 38 key factor scores], compared with 15 in 2009.
- There are eight key factor scores below average compared with 16 in 2009.

The one significant area for development (worst 20% of Acute Trusts) is as follows:

- Receiving health and safety training in the last 12 months.

Fig. 14: Staff Survey Top 4 Ranking Scores

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

	2009/10		2010/11		Trust position
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff	34%	30%	45%	33%	11% improvement

having well structured appraisals in the last 12 months					(now in top 20% of Trusts)
Percentage of staff reporting good communication between senior management and staff	29%	26%	37%	26%	8% improvement (now in top 20% of Trusts)
Staff motivation at work	3.93	3.84	3.94	3.83	Slight improvement, maintaining position in top 20% of all acute Trusts.
Staff Job Satisfaction	3.47	3.48	3.61	3.48	Significant improvement compared with 2009 results (national average was static) – top 20% of Trusts

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

Fig. 15: Staff Survey Bottom 4 Ranking Scores

	2009/10		**2010/11**		**Trust position**
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff receiving health and safety training in the last 12 months	70%	78%	71%	80%	1% improvement compared with previous year
Impact of health and well-being on ability to perform work or daily activities	1.63	1.57	1.61	1.57	Improvement compared with previous year
Percentage of staff suffering work-related injury in the last 12 months	19%	28%	18%	16%	1% improvement compared with previous year
Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	88%	90%	88%	90%	No change

A workshop was held in April 2011 to examine the findings of the National Staff Survey 2010 and all Divisions and Directorates were tasked to examine their top and bottom areas and complete an action plan. These action plans will be scrutinised by corporate committees and groups, such as the Health & Safety Committee and Employee Partnership Forum, as well as the Trust Board, in the coming year.

Relationship with unions and formal staff engagement

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

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

Health, safety and wellbeing

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

The following are our key areas of focus:

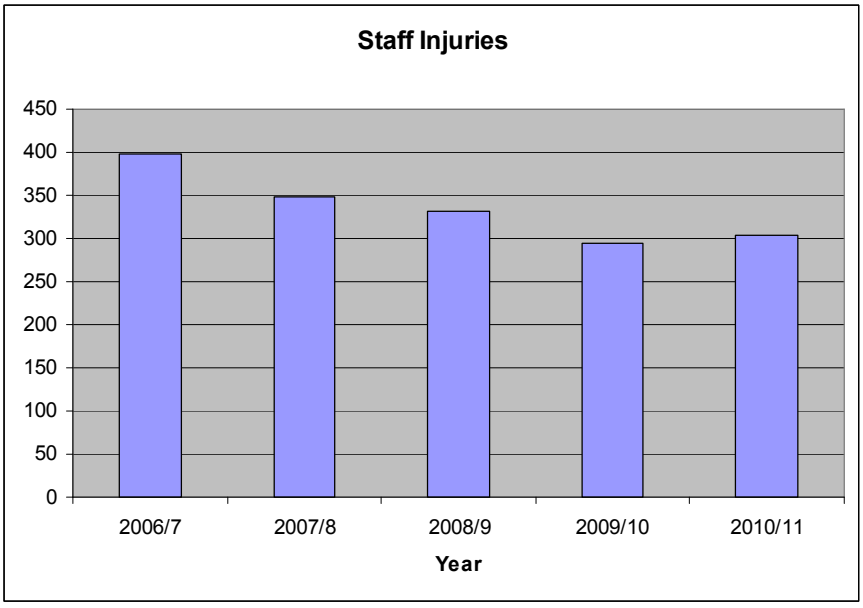
- Illness and injury prevention;
- Prompt rehabilitation;
- Providing a supportive working environment; and
- Staff engagement and involvement.

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

Reducing staff injuries at work

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

Fig. 16: Staff injuries at work by year



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

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

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

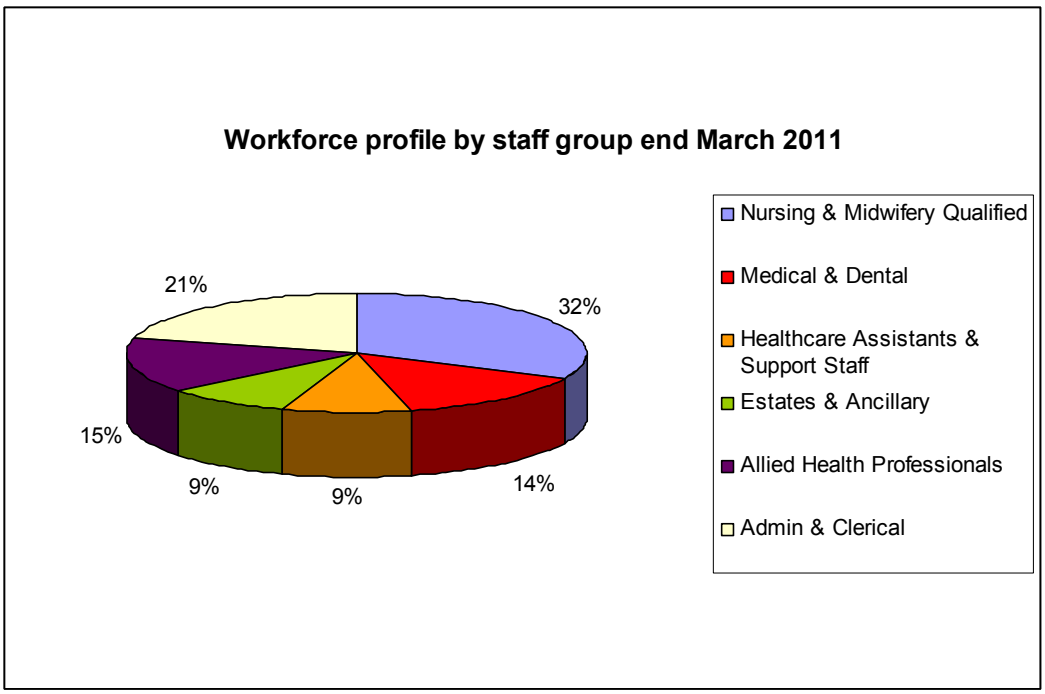
For the four months commencing 1st December 2010, sickness absence was 3.4%; whilst this is slightly higher than the Trust's year average, this period coincides with the winter months when sickness absence is normally higher than at other times in the year. This equates to an average of 2.6 days per employee during this period.

Workforce planning

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

Workforce profile – at the end of March 2011 the Trust employed 3,478 individual members of staff, excluding bank and agency staff (headcount); this equates to 3,003 full-time equivalent staff in post. The following chart shows the workforce profile by staff group at the end of March 2011.

Fig. 17: Workforce profile end March 2011



Voluntary services

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

Current projects/achievements:
Highlights of the service over the year have included:

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

Our 'Friends' – in a league of their own

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

Corporate objective 3: delivering our clinical strategy

Our clinical strategy in 2010/11 focused on increasing our elective work – particularly in Hounslow, Woking and Cobham – reducing emergency admissions and continuing to develop our clinical services. During the year we embarked on the following activities:

Reducing emergency admissions through partnership working in North West Surrey

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

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

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

Developing a new Model of Care for North West Surrey

Clinicians from primary care, community care, acute care and mental health services have been working together since October 2010 to develop a better way of delivering care to patients in North West Surrey. This has provided front line clinical leaders with an opportunity to start with a blank sheet of paper and describe how they would like to see care delivered locally. The work focused on five areas: planned care, urgent and emergency care, chronic care, end of life care and women's and children's services. Each of these groups reported their ideas to colleagues in March 2011.

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

Developing our specialist services

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

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

The Trust has also been working with other Surrey Trusts to develop a shared pathology service – the Surrey Pathology partnership – which will build on existing partnership arrangements between Frimley Park Hospital NHS Foundation Trust and the Royal Surrey County Hospital NHS

Foundation Trust. Earlier in the year Surrey and Sussex Healthcare NHS Trust withdrew from the partnership but work continues with the other two Trusts to develop this shared service which will allow for greater specialisation and enhanced quality as well as reducing overall costs.

Making best use of our hospital sites – day surgery

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

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

Overall market position

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

Expanding in the community

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

Working with GPs

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

Further clinical developments

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

- Introducing nurse-led rheumatology clinics at Ashford Hospital
- Opening our lithotripsy suite at St Peter's – the lithotripter breaks up kidney and other stones without surgery, using a high density acoustic pulse
- Introducing a sacral nerve stimulation service

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

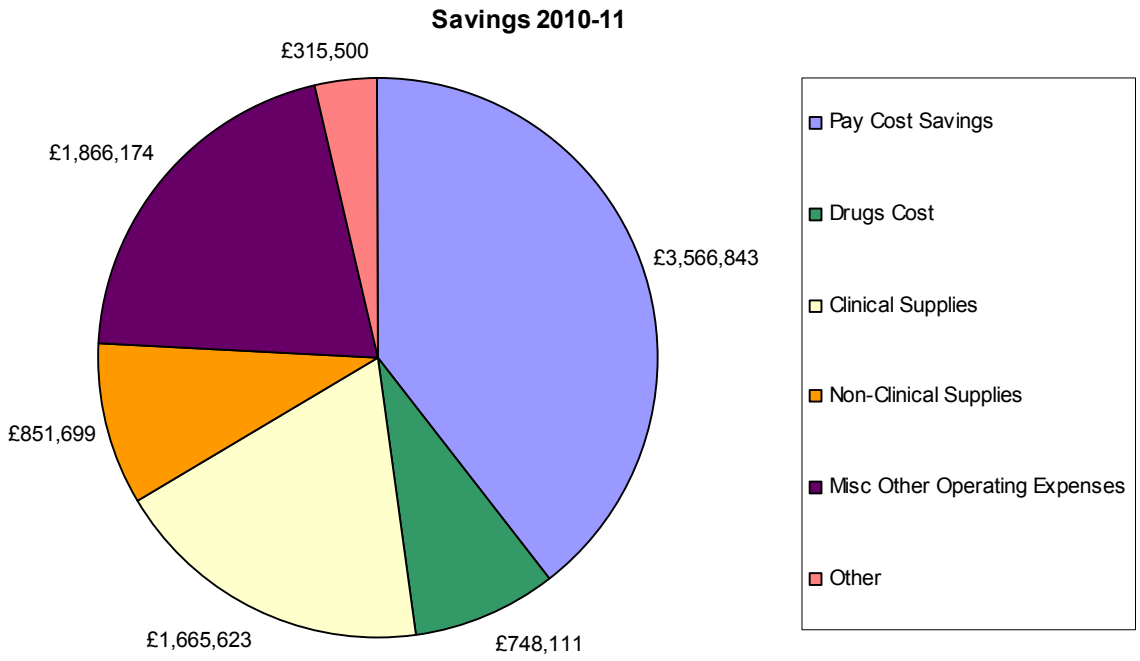
Corporate objective 4: improving productivity and efficiency

The Trust ended the year having achieved its planned £3.3 million surplus and £9 million cost savings and achieved a Monitor Financial Risk Rating of 4 (see below).

Achieving our cost improvement plans

This was achieved through changes in practice and particularly through the elimination of waste, demonstrated across areas as follows:

Fig. 18: Savings 2010/11



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

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

Other substantial savings were achieved by improving theatre utilisation (see below), a £550,000 saving by the Trust's procurement department in negotiating lower prices for a range of products and savings of over £370,000 by Trauma and Orthopaedics through negotiating lower prices for various prostheses.

Theatre and day surgery utilisation

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

The Trust has also seen an increase in day case rates, with better use of theatre space at Ashford Hospital and the introduction of 23 hour surgery (where patients benefit from one night in hospital) at St Peter's Hospital, making our theatres both more efficient and adhering to good practice. In 2010 the Trust was rated as 7th best in the country for its day case rates – that is the number of procedures being undertaken as day case surgery.

Waste management

The Trust now recycles 61% of all its domestic waste with the remainder going to a local waste plant to generate electricity, with no waste going to landfill sites. We now comply with the latest guidance in managing offensive (non-infectious) waste which will generate significant savings and are starting to introduce this new system in our Children's and Maternity Wards. (See also our sustainability report on p. 86).

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:

- A very successful event focused on improving the care we give to patients with Colorectal disease, which we are confident will reduce the time we take to diagnose patients' illness
- Working with colleagues from Workforce to facilitate a programme applying Lean to our executive team members' personal productivity. The team have been keen to demonstrate their commitment to EQUIP by applying the principles to how their everyday work and look set to free up time spent in meetings to focus on strategic activity.

Building stronger clinical divisions

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

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

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

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

Meeting our performance targets and delivering all the elements of our commissioning contracts

In line with our ambition to be one of the best Trusts in the country, Ashford and St Peter's Hospitals NHS Foundation Trust expects its performance to be excellent. The Trust continues to deliver local NHS Surrey targets and national Care Quality Commission targets and since becoming a Foundation Trust the Board and organisation are focused on securing and sustaining a green rating against the Monitor Compliance Framework. The Trust has achieved a green rating for both Quarter 3 and 4 of 2010/11, since it became a Foundation Trust on 1st December 2010.

Further performance information is given in our Quality Report on p. 59.

Information governance

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

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

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

These included issues such as sending the incorrect letter to a patient, recorded patient information dropped in a corridor and the inadequate securing of a confidential waste bin. 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 December 2010 to 31 March 2011		
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	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	3
V	Other	0

Our priorities for future development

Next year, 2011/12, will be our first full year as a Foundation Trust and we will want to continue to build on the gains we have made for both patients and staff and mature into one of the best acute Trusts in the country.

Our key priorities – matched against our strategic objectives – for this year will be:

Fig. 20: Strategic Objectives 2011/12

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

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

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

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

3. 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 2010/11 and sets out our key priorities for next year (2011/12). 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 second 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.

In December 2010 we became a Foundation Trust which in itself is a measure of the quality and safety of our services and shows the confidence Monitor, the regulatory body for Foundation Trusts, has in our organisation. We were the first Trust to become a foundation organisation under new, tougher criteria set by Monitor, which is a further indicator of the high levels of quality and safety in our two hospitals.

The Board at Ashford and St Peter's reviews a detailed quality report every month at our public board meeting and take it extremely seriously. 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 and bad. 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.

2010/11 has been another very good year for Ashford and St Peter's with some particular highlights in terms of quality achievements; our maternity services were awarded the highest standard for patient safety, the *Clinical Negligence Scheme for Trusts* Level 3, which is an assurance that we have put all the right processes and improvements in place to make our services as safe as possible. And in November 2010 the Clinical Pathology Accreditation Office

once again confirmed our pathology services had all retained their fully accredited status, the only pathology service within Surrey and Sussex to achieve this.

We were particularly pleased that results from the *Dr Foster Good Hospital Guide for 2010* showed that once again Ashford and St Peter's are demonstrating lower than average mortality ratios (90 overall against a norm of 100), with the joint fifth lowest ratio nationally for a 'basket' of the most common causes of death in hospital – stroke, heart attack, congestive heart failure, pneumonia and falls.

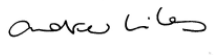
We have also been recently nominated as a CHKS top 40 hospital as part of their 2011 Top Hospitals Programme, based on an evaluation of a number of markers including safety, clinical effectiveness, outcomes, efficiency, patient experience and quality of care which is a great achievement for the Trust.

Earlier this year a complaint about a patient attending St Peter's Hospital in 2007 was featured in the Health Services Ombudsman's report about care of the elderly. This case highlighted several serious issues and we have worked closely with the Ombudsman to draw up an action plan of improvements which are now being closely monitored by our Board. Since 2007, we have made significant improvements, with close attention being paid to discharge planning, nutrition (particularly for elderly patients with complex needs) and improved communication training for staff. However, there is still more to do on these issues and this is reflected in our priorities going forward for 2011/12.

This case has drawn our focus even more sharply to our commitment to improving patient experience and, in May 2011, we launched a Trust-wide programme, '*Living our Values'*, which will involve every member of staff across our two hospitals. By exposing staff to real patient stories, and the emotions they generate, the programme will demonstrate the impact each and every one of our staff can have on a patient's experience.

Overall I am extremely pleased with the continued improvements Ashford and St Peter's continues to make in its vision to become one of the best healthcare Trust's in the country. 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

Our priorities for 2010/11

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 2010/11

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

Improving patient experience:

1. Increasing our accountability in meeting our patients' needs
2. Improving all aspects of communication with our patients

Safety:

3. Reducing hospital acquired infections
4. Reducing falls

Clinical outcomes:

5. Operating on patients with broken hips more quickly
6. Improving the effectiveness and efficiency of a patient's hospital stay

Improving our patient experience

Ashford and St Peter's Hospitals NHS Foundation Trust is recognised as having very good clinical outcomes. However, we know that the experience of some of our patients is not as good as we would like it to be. Improving patient experience is one of our key corporate objectives.

In last year's Quality Account we stated that our goal was to improve our patient survey results so that by 2012 we are among the top performing Trusts in the country. We chose two key priorities to help move towards this which can be measured specifically through a reduction in patient complaints and through the results of the national patient survey:

Priority 1 – Increasing our accountability in meeting our patients' needs

Why is this a priority?

We know it is crucial to have a clear understanding of how our patients feel about our services if we are to meet their expectations and provide a first class patient experience. Being more accountable to what our patients are telling us means we will make the right improvements to meet their needs.

What did we do in 2010/11?

- We introduced a new questionnaire, 'Your Feedback', to give to patients on discharge so they can report back quickly on their individual experience. Following analysis full reports and individual patient comments are shared with staff. Ward teams are then encouraged to discuss the feedback and develop any relevant actions in response. Since the new questionnaire was introduced we have had over 3,500 forms returned and, over the year, have seen improvements in the overall experience being reported with an increasing number of patients saying they would recommend us to family and friends.
- National patient surveys provide the Trust with a good opportunity to obtain feedback from patients and to know how well we are doing. We take the results of the surveys very seriously and following the results compile detailed action plans as a direct response to what patients are saying. In 2010, 850 patients were invited to give feedback on their inpatient experience. Collated results were compared nationally with 160 other acute and specialist Trusts and action plans – for the Trust overall and then more detailed plans for each of our clinical divisions – were drawn up in direct response.
- The visibility and engagement of our senior staff with our patients remains a priority. At the highest level, making 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 and bad. 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.

  More widely, Divisional General and Clinical Managers undertake regular walkabouts and 'spot checks' of their areas making sure they pick up and respond to any concerns being raised by patients or their families.
- We have continued to engage with our patient representatives and have engaged more widely with our community seeking opportunities for good dialogue with patients and members of the public. For example, we continue to have an active and engaged Patient Panel and patient representatives on most major sub-committees of the Board, and on many of our specialty groups. As a Foundation Trust we are developing our relationship and communications with our Governors and Members. We also held regular Members' Health Events during the year where our members have been invited to hear presentations from a number of clinicians.

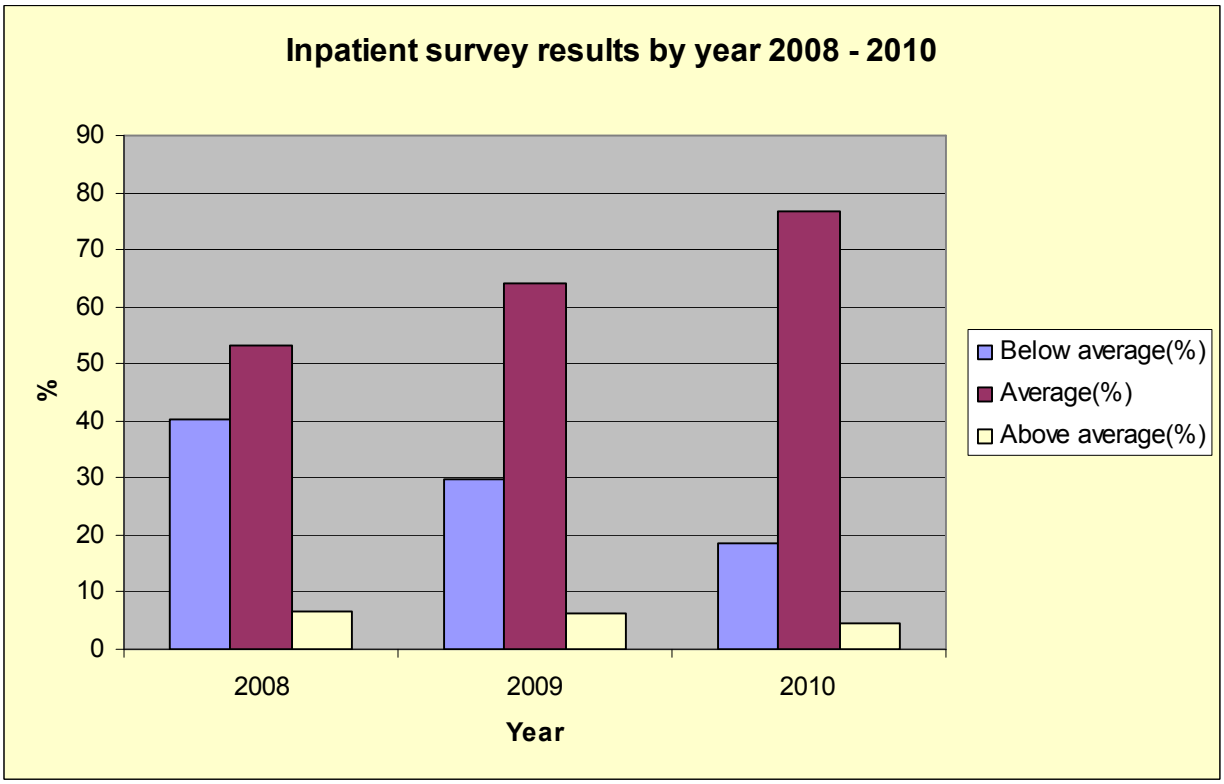
How did we perform in 2010/11?

- Over the last year the Trust has seen a 10% reduction in both the number of formal and informal concerns raised by patients and their carers.

  The Trust continues to welcome and respond to feedback it receives on the patient experience through concerns raised. All concerns are investigated and patients provided with a response which, where appropriate, will fully apologise for any failing in patients' care and explain what actions will be taken to prevent recurrence.
- Results from the National Inpatient survey indicate that patients value the opportunity to give feedback with the Trust assessed as being in the top 20% of organisations who, while in hospital, asked patients to give their views on the quality of their care.
- Overall, our patient survey results are showing an improvement and our performance has moved from the bottom 20% of Trusts (2009 survey) to the middle 60% of Trusts (2010 survey). Our ambition however is to be one of the best performing Trusts and we aim to be in the top 20% of Trusts by 2012/13.

The following graph shows our overall improvement in the national inpatient survey results over the last three years. The maroon bars demonstrate our improvement in the number of questions being scored as 'average', with the declining blue bars showing the number of 'below average' scores for the Trust.

Fig. 21: Graphical presentation of the % spread of Trust Inpatient survey scores by year: 2008 – 2010



Source CQC National Inpatient Survey Benchmark Reports: 2008, 2009, 2010

Priority 2 – Improving all aspects of communication with patients

Why is this a priority?

Good communication – both face to face and in terms of written information – makes a big difference to a patient's overall experience. A significant proportion of complaints that come into the Trust focus on communication issues and communication remains an area for continued focus and improvement.

Last year we set this as a key quality priority to be measured through the number of complaints resulting from poor communication and elements of the national patient survey.

What did we do in 2010/11?

- We have used our Trust values (the 4 Ps: *Patients First, Personal Responsibility, Passion for Excellence, Pride in our Team*) and behaviours to stress the importance of good communication, particularly around putting *Patients First.* Particular emphasis has been made on using phrases such as 'Is there anything else I can do for you?' and these have been reinforced through communication training and a number of staff focus groups. We have worked to embed these values and behaviours with staff and for 2011/12 are taking this a step further through a Trust-wide programme, '*Living our Values'*. This will use real patient stories, delivered by the patient to all the Trust's staff, to emphasise the impact an individual's behaviour (good or bad) can have on a patient.
- We have redrafted our standard first outpatient appointment letter to make it clearer for patients and developed an accompanying information leaflet (one for each hospital) setting out useful information such as how to get to hospital, where to go on arrival, how to park and so on. We piloted these new letters through ophthalmology and dermatology as these are both high volume outpatient specialties and are currently rolling the new letters out to all other specialties.
- Improved our patient information leaflets, making sure they are written in a clear and jargon free way and set out in an easy to read format and standard template. All departments across our two hospitals are being encouraged to review their written patient information to make sure it is current and up to date, produced in a professional way and made easily available to patients.
- Improved the way we communicate information about medicines to our patients, particularly when they are being discharged from hospital. This has included the introduction of a medicines hotline for patients to call when they arrive home and better printed information. Staff have also been trained in how to explain medicines to their patients when they leave hospital.
- Over the last three years the Trust has consistently been assessed as being in the top 20% of Trusts copying letters to patients between the hospital and the patient's family doctor. This continues to be important in ensuring that patients remain fully informed about their care.

How did we perform in 2010/11?

The following graphs demonstrate improvements made in communicating with our patients as shown in the results of last year's inpatient survey. When looking at the graphs it is important to note that **lower scores are better**.

Graphs two and three below indicate that we have improved the availability of information for our patients on their condition and treatment and on their medicines when they are discharged, with a lower number of patients reporting that they did not have enough information.

Fig. 22 and Fig. 23: Trust 2010 Inpatient Survey Results demonstrating improvements in communication
Source: Picker Institute Europe Report. Note: Lower scores are better

Fig. 22:

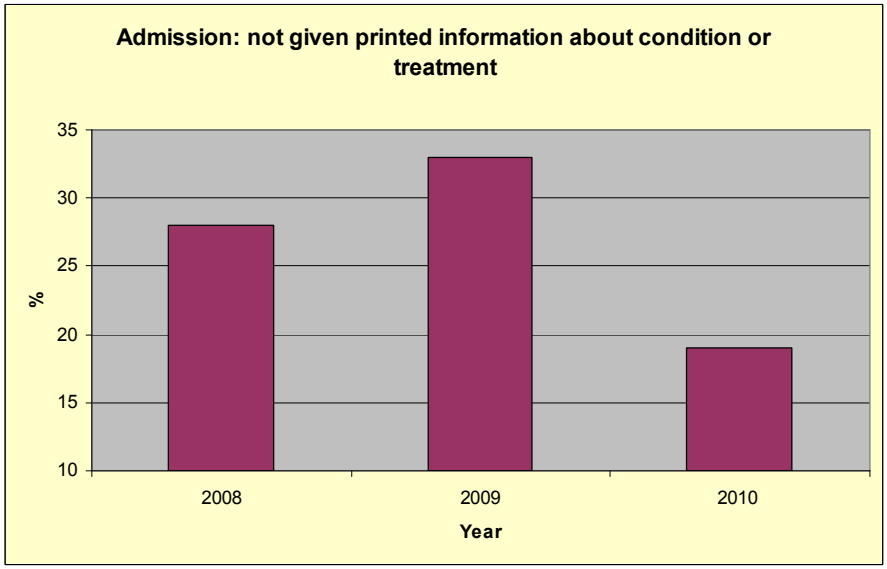
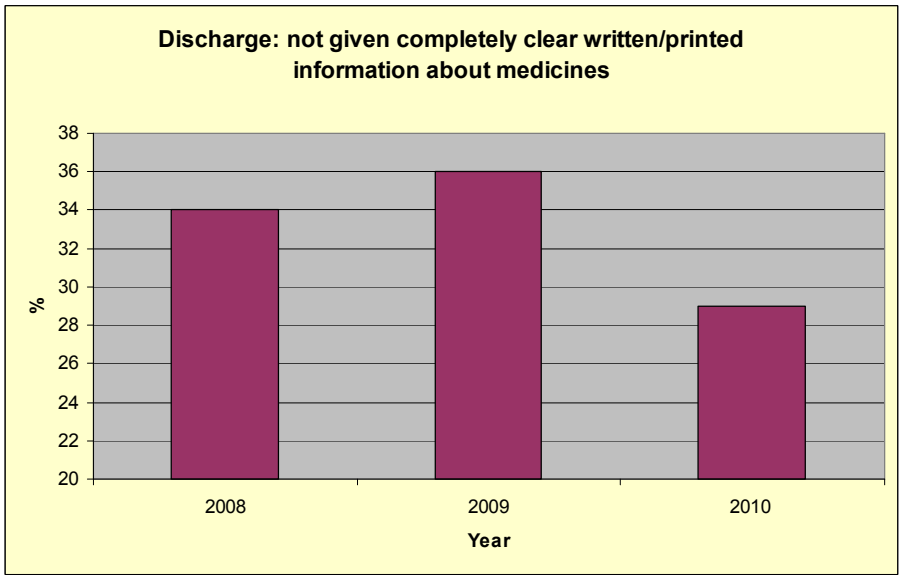


Fig. 23:

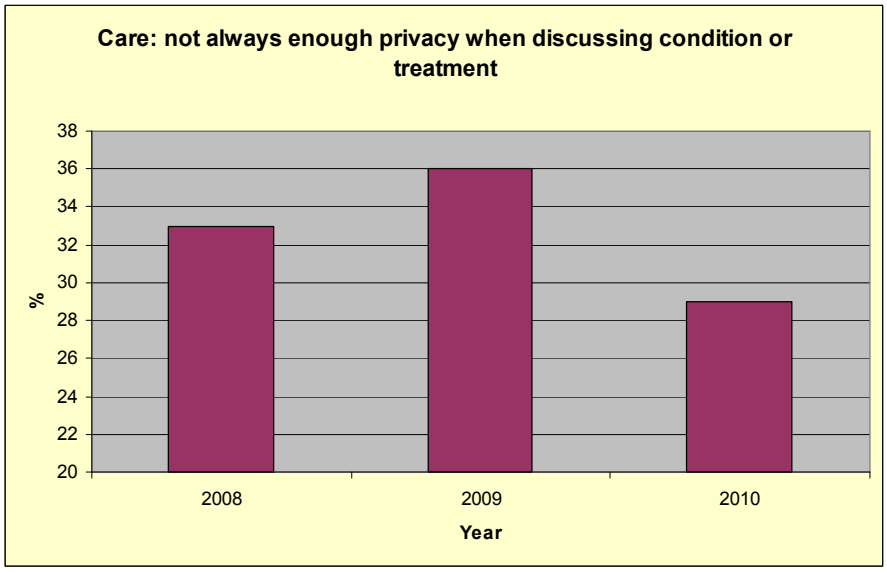


Graphs four and five below indicate that our patients have more confidence in our nurses with a lower number of patients reporting that they did not have confidence. We believe an element of this improved confidence is due to better communication. Privacy is also an important element of good communication. Graph five indicates that the number of patients that report not having enough privacy has reduced.

Fig. 24 and Fig. 25: Trust 2010 Inpatient Survey Results demonstrating improvements in communication
Source: Picker Institute Europe Report. Note: Lower scores are better

Fig. 24:

Fig. 25:



Maintaining high safety standards

Our next two priorities for last year were set around maintaining high safety standards:

Priority 3 – Reducing hospital acquired infections

Why is this a priority?

It is vital that we do everything we can to reduce the likelihood of patients getting an infection whilst they are in hospital as a result of the care they receive. Although we have significantly reduced the levels of hospital acquired infections over the last few years, we are committed to reducing these even further.

Last year the Department of Health set us very tough infection control limits – no more than five hospital acquired cases of MRSA bacteraemia, and no more than 103 cases of clostridium difficile with a more stretching local limit (set by the Strategic Health Authority) of no more than of 67. We met both of these. The delivery of the MRSA limit represented a particularly significant achievement, but the reduction in the incidence of clostridium difficile, and the reduction in mortality associated with this condition was also a strong performance

What did we do in 2010/11?

Over the course of the year we undertook a number of key actions to continue to improve our infection control. These included:

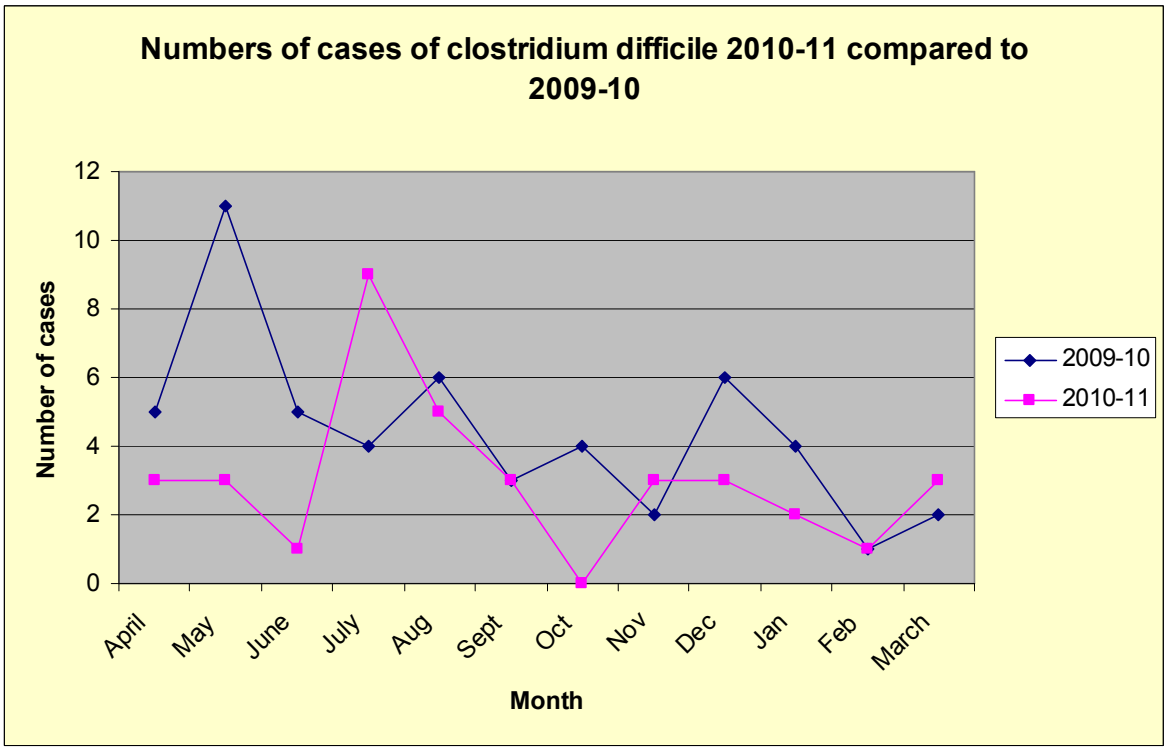
- Updating the Trust's policy for taking Blood Cultures.
- A mandatory requirement that a Consultant or Registrar sign off all blood culture requests.
- The development of a 24/7 blood culture taking service which meant that all cultures were taken by a highly trained member of staff.
- Introducing a standard that no member of staff is allowed, under any circumstance, to take blood cultures unless they had successfully completed specific training.
- Introducing urinary catheter packs with pre-connected catheters throughout the Trust.
- Screening all patients admitted to the Trust for MRSA, deferring admission of elective patients until treated and actively treating emergency patients who screened positive.
- Further review of antibiotic protocols, dosing and timings to help prevent post surgical site infections and reduce the risk of clostridium difficile.
- Further reinforcement of the importance of hand hygiene and our overall hygiene code (including bare below the elbow) and 6 monthly hand hygiene roadshows.

How did we perform in 2010/11?

By the end of the year our increased vigilance and focus meant that we did not exceed our infection control limits for either MRSA bacteraemia or clostridium difficile. During the year we also demonstrated an impressive 246 days MRSA free. Our MRSA limit for 2011/12 has been set at no more than 4 hospital acquired cases and our ongoing vigilance and focus on infection control will be essential.

Graph six below presents the Trust performance against our clostridium difficile limits. Again the Trust has performed well, reporting 36 hospital acquired cases for the whole year against our limit of no more than 67 cases

Fig. 26: Clostridium difficile cases



4. Reducing falls

Why is this a priority?

In helping patients recover while they are in hospital, particularly when they are regaining their independence, there will inevitably be some slips, trips and falls as patients regain their mobility. Our aim is to make sure that these are kept to an absolute minimum and that we do all we can to reduce harm to patients who do experience a fall. The measure we put in place to monitor our performance was the number of falls which resulted in harm.

What did we do in 2010/11?

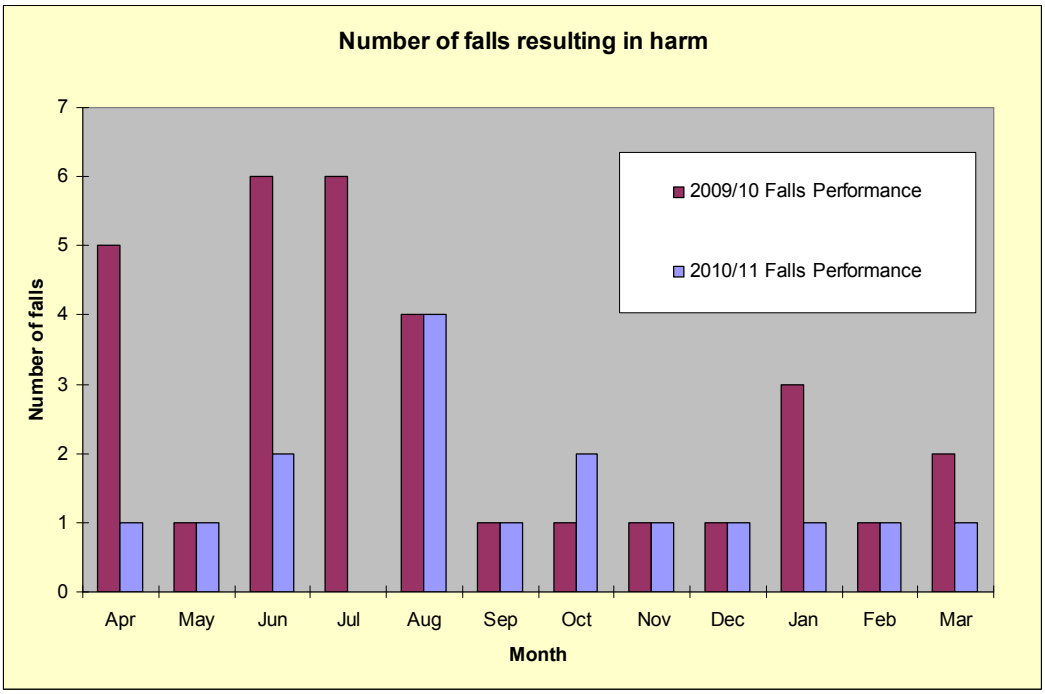
During 2010/11 we initiated a number of actions to reduce the number of falls resulting in harm across the Trust. This included identifying champions for prevention of falls, more carefully assessing patients at risk of a fall and analysing the cause of a patient fall as follows:

- Falls 'champions' identified on wards including Elm, Juniper, Kestrel and Maple with local responsibility for preventing falls.
- Following a successful pilot, the implementation of a 'safety cross' visually displaying on ward notice-boards the number of days that have passed since a patient fell so staff patients and visitors can see the results.
- A continuing project to revise and develop a falls risk assessment for all patients on admission. For those patients assessed at being most at risk, we are also developing a multi-disciplinary care plan to ensure they receive the most appropriate care.
- Development of an analysis tool aimed at understanding the 'root cause' of a patient fall.
- Analysis of falls data by ward to identify trends in falls for example, particular times of patient falls so that appropriate action can be taken. This may include carefully looking at and changing ward routines to minimise risk.

How did we perform in 2010/11?

In 2009/10 the Trust reported a total of 32 falls that resulted in harm. For 2010/11 we set ourselves a target of no more than 29 falls that resulted in harm. At the end of the year we had reported to the Trust Board a total of 16 falls that had resulted in harm; thus reducing the total number of falls resulting in harm by 50%. Our progress is demonstrated in Graph Seven below.

Fig. 27: Number of falls resulting in harm



We believe that there is more to do to reduce the number of falls and injury from falls within our hospitals and this will continue to be one of our chosen quality priorities for this year 2011/12. Most recently, the Trust has appointed a Falls Coordinator who will work with staff to take this important preventative work forward.

Achieving high quality clinical care and effectiveness

We want to make sure that patients who come to Ashford and St Peter's Hospitals have the best possible clinical outcomes and last year we chose two targets to focus on where we knew improvements would make a big difference to our patients' recovery.

Priority 5 – Ensuring that patients with a fractured hip that are fit for undergoing surgery get their operation within 36 hours of admission

Why is this a priority?

Patients who come into hospital with a fractured hip will recover much more quickly, with better long-term results, the quicker they have their operation. Any delay in surgery for these patients can also increase the risk of death.

The Primary Care Trust set us a target to operate on 85% of patients within 36 hours of arriving in hospital and, over the last year, we have dramatically improved against this target. We are very proud of this achievement.

What did we do in 2010/11?

The Trust accepted that the Primary Care Trust target was important particularly because it reflected the quality of care we provided to this group of patients. All staff within the Orthopaedic Service fully accepted the clinical argument that early operative intervention would reduce hospital length of stay, reduce mortality and morbidity and improve patient experience. The Trust's performance review process identified and publicised the problem and analysed the underlying causes.

The Divisions of Acute Medicine, Theatres and Anaesthetics took joint responsibility for delivering a solution to this complex problem. Following initial cross divisional discussions, a multidisciplinary service improvement event with patient representation was held. This mapped the patient's journey and identified a number of "early quick win" interventions and some areas which needed further improvement events.

Over the year we have introduced a number of improvements to our patient pathway which have contributed to reducing the time taken for eligible patients to have their surgery. These include:

- The creation of an Orthogeriatric Service, offering rapid preoperative assessment of all patients presenting with fractured hip and a fast track service for optimisation of the patient's medical condition.
- Formation of an Orthopaedic Trauma Team highly skilled in this area of intervention and committed to provide a 24/7 service.
- Prioritising theatre time – moving patients up the priority list for surgery; introducing lists at weekends so patients who are brought in, for example on a Friday night, don't have to wait until Monday to have their operation.

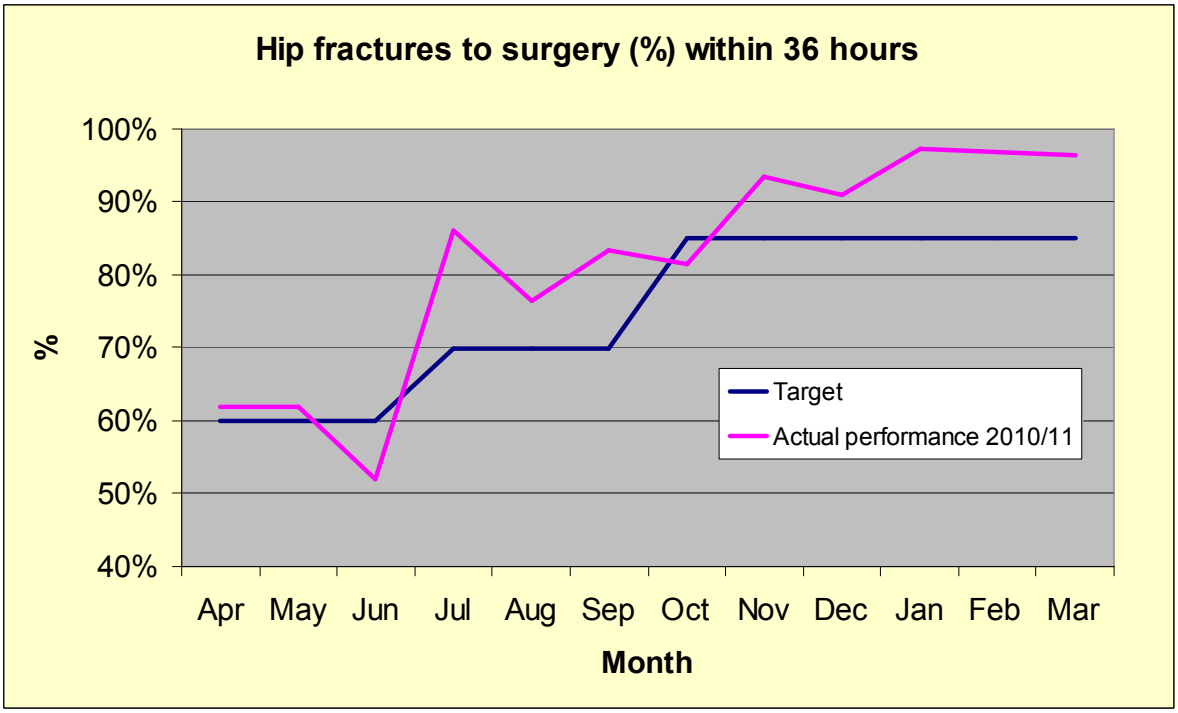
In addition, we are improving recovery and shortening these patients' length of stay in hospital by:

- Mobilising the majority of patients within 24 hours of their operation which we know improves their recovery.
- Providing physiotherapy 7 days a week.

How did we perform in 2010/11?

At the beginning of the year, just 52% of our hip fracture patients were operated on within 36 hours; by the end of the year this had risen to 93% and we are now one of the best performing Trusts in the country. Furthermore we are now operating on 75% of our patients within just 24 hours against our locally set target of 40%.

Fig. 28: % of hip fracture patients to surgery within 36 hours



In addition, Trust data submitted to the National Hip Fracture Database (NHFD) indicates an improvement in the Trust's mortality rates for patients presenting with a fractured hip from 8.8% in 2009/10 to 6.4% in 2010/11. This compares favourably with a nationally reported mortality of 7.7% in 2009/10. Patients are also recovering more quickly and staying in hospital for an average of only 22.1 days in 2010/11 compared to 25.2 days in 2009/10. This compares with a nationally reported average of 25 days in 2009/10.

Priority 6 – Improving the effectiveness and efficiency of a patient hospital stay

Why is this a priority?

Most people want to stay in hospital for as short a time as possible and we know that patients recover better out of hospital and in their own surroundings. Reducing the amount of time a patient spends in hospital is about improving the whole quality of care – providing the best care first time, every time. In other words, reducing those things that can keep people in hospital longer than they need to be – complications like chest infections, reducing wasteful steps in our processes and reducing variations in the way we treat people with similar conditions.

What did we do in 2010/11?

Over the year we have taken a number of actions to improve the patient's quality of care and therefore reduce the time they spend in hospital. We have:

- Where possible, continued to undertake elective surgical procedures as day cases – we now undertake 83% of planned procedures as day case and last year were rated 7th best performing in the country for our day case rates.
- Increased the level of medical consultant presence in our assessment areas with consultants available from 7am in the morning to 8pm in the evening, seven days a week, undertaking ongoing reviews of all our emergency admissions.
- Engaged in service improvement events to reduce the amount of time patients spend in hospital and to improve patient pathways. Some of this work involves making sure we are doing the right things at the right time in the right place so patients are not waiting unnecessarily – for example for investigations to take place and treatment plans to commence.
- Introduced 'ward boards' which give much more visible detail about each patient's status on the ward so staff can make sure that the right actions are undertaken promptly thereby speeding up each patient's treatment.

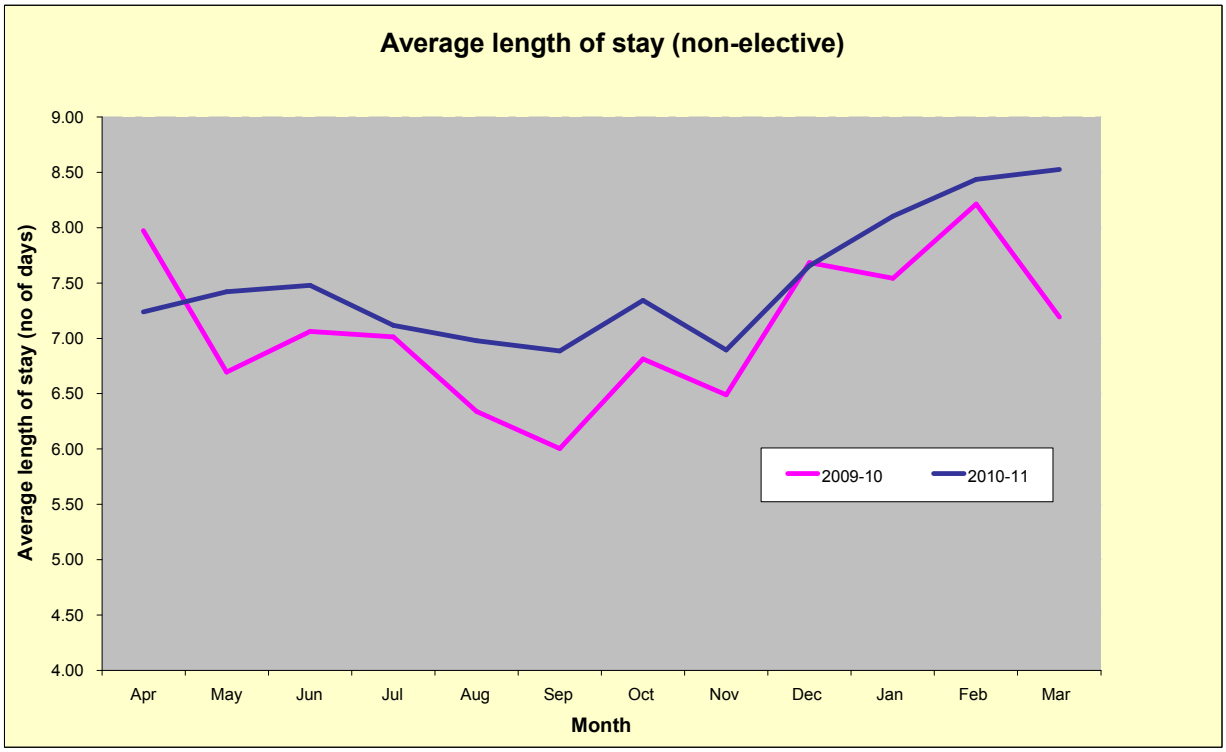
Most recently we have also bought together a team of people from across hospital disciplines to look critically at our processes for discharge and how we can make these more streamlined and effective. Not only are we aiming to improve the timeliness of the discharge but importantly, make the experience more positive for our patients.

How did we perform in 2010/11?

Although we continue to benchmark well against other Trusts, when looking at the average length of stay for both elective and non elective patients, the Trust has not made the progress that it hoped and, when compared with our 2009/10 figures, we have seen a slight increase in the average number of days non elective patients have stayed with us. (This is demonstrated in Graph nine below). This has been driven by a range of factors, some of which are internal and some external:

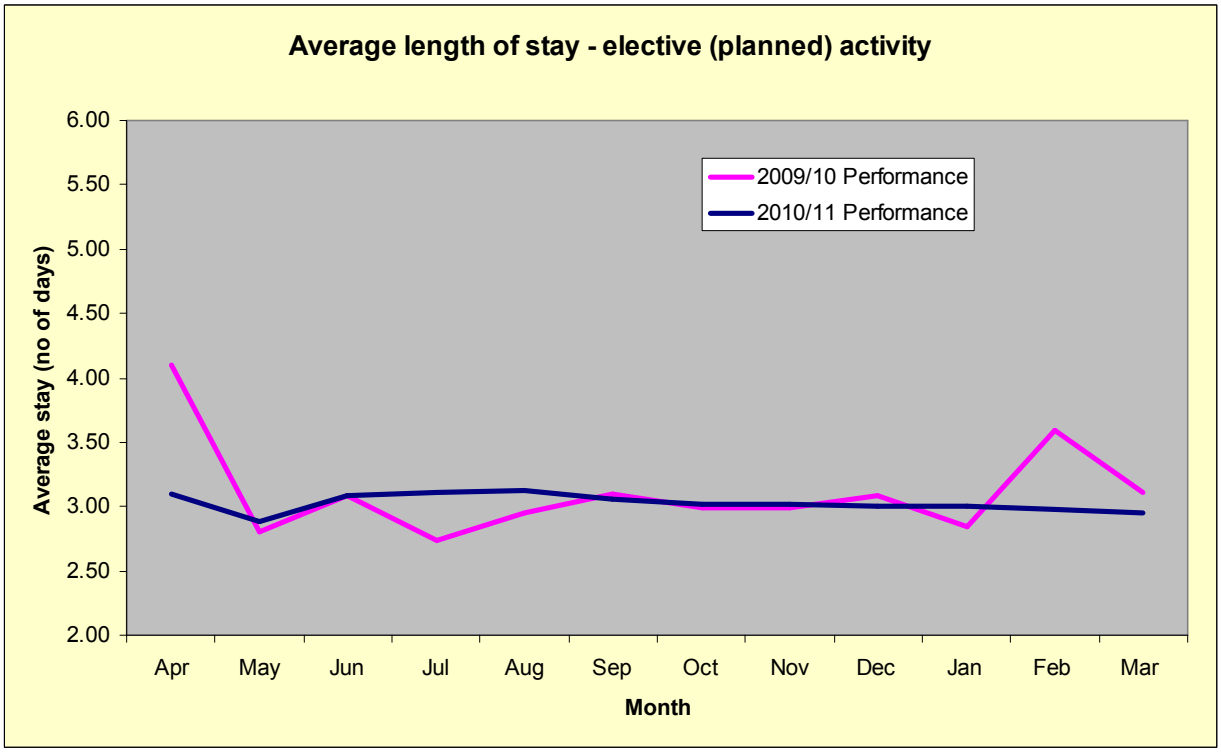
- A long and stretching winter with increased demand for emergency services and patients not always being accommodated in the right areas, which can decrease efficiency across the hospital.
- The availability of appropriate, home based support and services for a growing very elderly population with complex needs, which has increased the number of people waiting in hospital for the care they need to be arranged in the community.

Fig. 29: The average length of stay for our non elective patients



However, the average length of stay for our elective patients (routine admission for planned surgery at a time convenient for the patient) has seen a slight reduction and finished the year on target. This can be seen in Graph ten.

Fig. 30: The average length of stay for our elective patients



Our Priorities for Improvement for 2011/12

How our priorities were chosen

In drawing up our priorities for improvement for 2011/12 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 continued focus. We have also considered the local, regional and national picture, our overall performance as well as the views of patients, our Governors, commissioners and patient representatives from our LINk and patient panel.

Following a process of engagement, including an afternoon of debate with representatives from our staff, Governors, LINks and Patient Panel we identified seven key priorities for this coming year which we believe should be our focus in improving patient experience, safety and clinical outcomes. These priorities have been endorsed by the Trust Board.

Improving our Patient Experience

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

Why have we chosen this priority?

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

How will we improve discharge?

A range of actions are already underway and will continue through the year, which include:

- A programme of discharge road-shows across the hospitals to reinforce the importance of good quality discharge to our staff.
- An improvement programme focussing 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 e-prescribing to speed up the dispensing of medicines for patients going home.
- Improving the operation of our Discharge Lounge to make sure we meet the needs of the patients and their families.

How will we measure our improvement?

We will monitor our overall patient experience of their care looking at the results from our "Your Feedback" questionnaires and the National Inpatient Survey.

We will measure improvement by monitoring the number of complaints received by the Trust that relate to discharge issues and practice and the patients reported experience of discharge through the results achieved in the National Inpatient Survey.

What will our target be?

- To reduce the number of patient concerns measured through formal complaints relating to discharge by 2013/14 as follows:

2011/12	30% (of the 2010/11 value)
2012/13	15% (of the 2011/12 value)
2013/14	15% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total numbers of concerns recorded at the end of 2010/11 (87 concerns) as the baseline measurement

- To improve on the nationally benchmarked score of patient experience of discharge as reported through the Care Quality Commission report of the Trust's Inpatient survey results.

How will we monitor and report our improvement?

'Your Feedback' results will be reported quarterly to the Trust Board as part of the Trust's Quality Report. The Trust will be aiming for an improvement in the number of patients stating they would recommend the Trust to family and friends.

Complaints and concerns received regarding the discharge process will be reported quarterly at the Complaints Monitoring Group with progress noted against the targets set. Progress will also be reported to the Trust Board as part of the Trust's Quality Report.

The benchmarked Care Quality Commission report of the Trust's Inpatient survey results will be reported to the Trust Board with specific reference to those measures that look at patients' experience of discharge.

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

Why have we chosen this priority?

Feeding our patients appropriately and making sure they have enough to drink is essential for all patients receiving care in the Trust. This is particularly important for our most vulnerable patients where this links to our ongoing work to provide high quality care for the vulnerable and elderly including those with dementia and who are at the end of their life.

How will we improve patient nutrition and hydration?

- Our 'Best Care' programme includes a dedicated workstream to improve nutrition and hydration.
- Our Lead Practitioner Nurse in Nutrition and Dietetics will complete regular audits to make sure patients are having the right food and enough to drink, and will work with ward staff and clinical areas to give additional support to those who need it most.
- We will re-launch our protected mealtimes for patients.
- Monthly audits of screening patients for malnutrition using the Malnutrition Universal Screening Tool. We will make sure our staff are fully trained in using this tool. This is important as early identification of any nutritional issues mean treatments, referrals and support can be initiated in a timely manner.
- We plan to hold a Nutrition Focus Month in June which will give all staff the opportunity to consider the importance of nutritional assessment and support and to reflect on their practice.

- We have introduced Care Rounds on our wards (where nursing staff check on patients on a regular, usually hourly basis) which will include making sure patients are having the right food and enough to drink.

How will we measure our improvement?

We will measure improvement through regular Essence of Care Nutritional Audits. Our work on nutrition will be monitored by the Nutrition Steering Group who in turn report to the Trust's Clinical Governance Committee.

What will our target be?

To improve the Essence of Care Nutritional Audit results by 10% against the baseline nutrition audit conducted in December 2010.

How will we monitor and report our improvement?

We will report the results of our Essence of Care Nutritional Audits and our progress against the agreed targets to the Trust Board quarterly as part of the Trust's Quality Report

Maintaining high safety standards

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

Why have we chosen this 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 a heavy emphasis on infection control persists.

How will we do this?

We will continue to build on our good practice and in particular we will focus on:

- Prevention of peripheral and central line acquired infections.
- Preventing urinary catheter acquired infections.
- Good infection controls and hand hygiene.

How will we measure our improvement?

While it is a Trust priority to eliminate all infections, we believe that the incidence of MRSA and clostridium difficile infections remain strong markers of good infection control. We will therefore record any incidence of an MRSA or clostridium difficile infection.

What will our target be?

- No more than 4 MRSA bacteraemia cases for 2011/12.
- No more than 33 cases of clostridium difficile for 2011/12.

How will we monitor and report our improvement?

Regular reports of the numbers of acquired infections will be made to our Clinical Governance Committee, Trust Executive Committee and the Board as part of our monthly Quality Report.

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

Two key areas of focus will be the prevention of pressure ulcers and falls.

Why have we chosen this priority?

We know that sometimes our nursing care falls short of the very high standards our patients deserve. The incidence of pressure ulcers and falls are known to be credible indicators of nursing quality and also 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.

How will we do this?

- Implementation of the Best Care Programme and the High Impact Interventions for Nursing and Midwifery.
- Undertake staff training and development ensuring the use of best practice evidence based nursing care.
- Appointing a Lead Nurse for Falls Prevention.
- Ward level measurement and response to incidence of falls and pressure ulcers together with regional and national benchmarking.

- Targeted support from Tissue Viability Specialist Nurse.

How will we measure our improvement?

All incidence of falls and grade 2 or above hospital acquired pressure ulcers will be reported as part of the Trust's risk management processes and recorded on the Trust risk management database.

What will our target be?

- 10% reduction in falls that result in harm year on year.
- Overall a 10% reduction in all reported falls year on year.
- 5% reduction in grade 2 or above hospital acquired pressure ulcers year on year.

How will we monitor and report our improvement?

We will monitor these indicators at ward level via the Ward Quality Indicators which are reported to the Board monthly. The incidence of falls and grade 2 or above hospital acquired pressure ulcers will also be monitored at the Trust Safety and Risk Committee and also reported to the Trust Board.

Achieving high quality clinical care

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

Why have we chosen this 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 readmissions to hospital within 30 days of discharge.

How will we do this?

- Ensuring that care and treatment is of high quality and that we drive reductions in preventable harm or complications that can lead to readmissions.
- Implementing a programme to improve discharge.
- we will continue our 'Experience Based Design' project where we work with patients and Community staff to understand why they need to come back into hospital after they have been discharged.
- 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.

How will we measure our improvement?

We will measure our improvements against agreed targets.

What will our target be?

Reduction in readmissions following an elective procedure within 28 days of discharge by 2013/14 as follows:

- 2011/12 50% (of the 2010/11 value)
- 2012/13 25% (of the 2011/12 value)
- 2013/14 15% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total number of elective readmissions recorded at the end of 2010/11 (976 readmissions) as the baseline measurement

Reduction in readmissions following an emergency admission within 28 days of discharge by 2013/14 as follows:

- 2011/12 15% (of the 2010/11 value)
- 2012/13 10% (of the 2011/12 value)
- 2013/14 5% (of the 2012/13 value)

In measuring this reduction, the Trust will use the total number of non elective readmissions recorded at the end of 2010/11 (3711 readmissions) as the baseline measurement

How will we monitor and report our improvement?

Readmission rates are included on our monthly quality report to the Trust Board.

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

Why have we chosen this priority?

The Trust is actively participating in a national programme – The Enhancing Quality (EQ) Programme – 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 EQ Programme is guiding improvement work on these key, high volume, pathways with its objective to reduce readmission rates, complication rates 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 nationally. Data submissions are monitored on a monthly basis and reported via the EQ Steering Group. The Trust will be reporting Crude (CMR) and Standardised Mortality Rates (SMR) for pneumonia and heart failure patients.

What will our target be?

- 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 (which meets every 6 – 8 weeks).
- To Trust Board through the Monthly Quality report.

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 have we chosen this priority?

On average, 250 patients per day attend the A&E Department. Approximately 20% are admitted and are treated in the emergency inpatient setting. There is evidence to suggest that this is not the best way to treat patients with a long term condition. In order to improve the experience and outcomes for these patients the Trust, in partnership with colleagues in the community, has made it a priority to develop better pathways of care for these patients. The Trust has recently won designation as Surrey's Asthma Centre and, as a centre of excellence our aim is to deliver the best care based on the evidence available and to be able to publish improved outcomes.

How will we do this?

The Trust will, with NHS Surrey and Surrey Community Health, develop a better understanding of our treatment of patients with the most common conditions coming into hospital and compare this information with national data to identify areas for improvement. We will then develop and implement a series of care pathways for these conditions. Part of the service improvement will include development of the care delivered in the community and the Trust. It will also include launching 'expert patient' programmes to promote and sustain self management and an improved discharge process to prevent readmission.

How will we measure our improvement?

We will do this through our rates of attendance and subsequent admission for those patients in a selected high volume pathway. We have chosen COPD (Chronic Obstructive Pulmonary Disease) for this purpose.

What will our target be?

- To reduce our admission rate for COPD by 2.5% by March 2012.

How will we monitor and report our improvement?

Progress will be monitored by eth Emergency Services and Acute Medicine Division and reported 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 2010 and March 2011 Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 19 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 19 of these NHS services

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Trust for 2010/11.

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 2010/11 (48) national clinical audits and (6) national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2010/11 Ashford and St Peter's Hospitals NHS Foundation Trust participated in (79%) 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 2010/11 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 all relevant national audits and has an active programme of local audits to support improvements in the quality of patient care.

Fig. 31: 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	Yes	100%
National Elective Surgery PROMs: Hip Replacements	Yes	Yes	80%[1]
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	69%[1]
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	65%[1]
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	23%[1]
Coronary angioplasty (NICOR Adult cardiac interventions)	Yes	Yes	100%
Peripheral vascular surgery (VSGBI Surgery Database)	Yes	Yes	80%
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	100%
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	60%
STEMI (ST Elevated MI)			100%
Heart failure (Heart Failure Audit)	Yes	No[2]	
Acute stroke (SINAP)	Yes	Yes	60%
Hip fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	64%
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	100%
Head & neck cancer (DAHNO)	Yes	Yes	N/A[3]
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	N/A[4]	N/A
Renal replacement therapy (Renal Registry)	Yes	Yes	N/A[5]
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	N/A[5]
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. Participation from April 09 to November 10 (pre-operative questionnaires); these rates are an estimate of the true rate (http://www.hesonline.nhs.uk/).
2. Heart Failure: planning continues as there are issues relating to capture of the data and linking to the national database.
3. Head and Neck cancer data is submitted jointly through the Royal Surrey County Hospital NHS Foundation Trust.
4. Pulmonary Hypertension: Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals
5. Ashford and St Peter's patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Fig. 32: 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)	Yes	No*	
Paediatric asthma (British Thoracic Society)	Yes	No*	
Paediatric fever (College of Emergency Medicine)	Yes	Yes	100%
Paediatric epilepsy (RCPH National Childhood Epilepsy)	Yes	Yes	N/A[1]
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	100%
Adult community acquired pneumonia (British Thoracic Society)	Yes	No*	
Non invasive ventilation (NIV) – adults (British Thoracic Society)	Yes	No*	
Pleural procedures (British Thoracic Society)	Yes	Yes	N/C
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	N/A[1]
Vital signs in majors (College of Emergency Medicine)	Yes	Yes	100%
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Yes	N/A[2]
Chronic pain (National Pain Audit)	Yes	Yes	N/A[1]
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No*	
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%
COPD (British Thoracic Society/European Audit)	Yes	Yes	N/C
Adult asthma (British Thoracic Society)	Yes	No*	
Bronchiectasis (British Thoracic Society)	Yes	No*	
Familial hypercholesterolaemia (National Clinical Audit of Management of FH)	Yes	No[3]	
Stroke care (National Sentinel Stroke Audit)	Yes	Yes	117%[4]
Renal colic (College of Emergency Medicine)	Yes	Yes	100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	Yes	100%
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	Yes	100%
Patient transport (National Kidney Care Audit)	Yes	Yes	N/A[5]
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 epilepsy, Cardiac arrest, Chronic pain audits: the Trust is registered to participate, data submission has not started
2. Heavy menstrual bleeding audit – data collection period runs from 01.02.11 to 31.01.12; the Trust has started data collection.
3. Familial hypercholsterolaemia: the Trust does not run outpatient clinics specifically for the condition and cannot identify these patients
4. 60 cases were required but 70 cases were returned and included in the audit.
5. ASPH patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Fig. 33: National Confidential Enquiries

Topic	Eligible to participate	Participated	%cases submitted
CEMACE Perinatal mortality	Yes	Yes	100%
NCEPOD Parenteral Nutrition Study	Yes	Yes	73%
NCEPOD Surgery in the Elderly	Yes	Yes	88%
NCEPOD Paediatric Surgery Study	Yes	Yes	100%[1]
NCEPOD Peri-operative Care Study	Yes	Yes	100%
NCEPOD Cardiac Arrest Procedures	Yes	Yes	-[2]
NCEPOD Cosmetic Surgery Study	No	N/A	N/A
CISH (suicide and homicide by people with mental illness)	No	N/A	N/A

Notes: 1. We fully participated in the study; our submissions were that we had no paediatric cases which met the criteria for the study.
2. Data collection for this study is ongoing.

National and local clinical audits reviewed

The reports of 8 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2010/2011 and as a result the Trust intends to take actions to improve quality of care.

Fig. 34: National Clinical Audits

Audit Report	Areas of action
National Audit of Continence Care	New Best Care nursing programme with workstreams of essential and specialist care led by the Deputy Chief Nurse with Heads of Nursing and Matrons.
National Dementia Care Audit	Dementia Steering Group leading on: • Development of a dementia strategy • Introduction of new procedures and guidelines • Provision of training for staff in special aspects of care for patients with dementia.
National Sentinel Stroke Audit	The Stroke team is working to increase the number of patients experiencing all the best practice interventions and improving: • Screening and function assessment after admission • Promotion of continence care • Communications with patients and carers
Use of Emergency Oxygen in Adult Patients	• Training of all nurses and healthcare assistants joining the Trust and training on the use of devices as part of acute skills day • Further training for pharmacy staff with the aim of increasing oxygen prescription rates • Involvement of the acute pain team in the prescription of oxygen for patients with epidurals and patient controlled analgesia

NCEPOD Deaths in Acute Hospital	• Revision of junior staff rota to improve continuity of care • Improvements to the communication of critical radiological findings • Development of a 7/7 radiology service linking with St George's Healthcare NHS Trust

NCEPOD Surgery in the Elderly	• Junior doctor training during their educational programme and via online training relating to:
	  ○ Acute kidney injury
	  ○ Abdominal symptoms
	  ○ Pain as the 5th vital sign
	  ○ Assessment of malnutrition status
	• Continued training for frontline A&E staff

NCEPOD Parenteral Nutrition Care	• New lead nutrition nurse undertaking educational sessions with nursing staff • Development of online compulsory training for junior doctors • Review of the parenteral nutrition policy and changes to the parenteral nutrition prescription form • Production of a neonatal guideline • Nutrition focus month in June 2011
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.

The reports of 73 local clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust 2010/11 and actions have been taken to improve the quality of healthcare provided. Results from these clinical audits were presented within specialties and included in reports to the Clinical Effectiveness and Audit Group. Learning from the audits was 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 from our local audits were:

- Review and updates to policies, procedures and guidelines;
- Review and streamlining of patient pathways to reduce delays;
- 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;
- Reducing unnecessary admissions by working on a joint project with Surrey Community Health to assess patients on arrival to A&E;
- Additional training sessions for staff on a variety of topics (nutritional needs, dementia care, palliative care, administration of medicines, male catheterisation, wound management, cardiology, maxillofacial, safeguarding, 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, has been elected as the new Chair of the Surrey and Sussex Local Research Network. The number of patients receiving NHS services provided or sub-contracted by Ashford and St Peter's Hospitals NHS Foundation Trust in 2010/11 that were recruited during that period to participate in research approved by a research and development committee was 556, more than double that of 2009/10 (215).

Care Quality Commission (CQC) Registration

The Trust received an unconditional registration on 1st April 2010 by the new Care Quality Commission in recognition of our high quality services. We have continued to provide safe, quality services to our patients with good clinical outcomes and continued low mortality rates. The Care Quality Commission has not taken enforcement action against Ashford and St Peter's Hospitals NHS Foundation Trust during 2010/11 nor has the Trust participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion (up to 1.5% which equates to £2.9m) of Ashford and St Peter's Hospitals NHS Foundation Trust's income in 2010/11 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 helps to reinforce quality as a driving factor for NHS services and means 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 2010/11 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
- To improve patient safety by implementing electronic discharge summaries
- To encourage patients to stop smoking before their operations
- To screen women (under the age of 25 years) attending maternity services for uthoriza, as part of NHS Surrey's screening programme
- Improve data and the way we notify GPs of patients attending A&E with alcohol related diagnosis
- 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
    - Heart failure
    - Pneumonia
    - Hip replacements
    - Knee replacements

During 2010/11 the Trust achieved 87.7% of our CQUIN target which equates to £2.5m.

Further details of the agreed goals for 2010/11 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

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. "We can only be sure to improve what we can actually measure," Lord Darzi, *High Quality Care for All, June 2008.*

General medical practice codes and NHS numbers
Ashford and St Peter's Hospitals NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of valid general medical practice codes and NHS numbers are shown in Table 2 below and reports a decrease in the use of the NHS number for A&E patients. A new national Personal Demographics Service (PDS) was implemented approximately 18 months ago. As a result of this change, the Trust experienced some technical difficulties with completing the NHS number verification process. These difficulties were resolved in November 2010 and since that time the Trust has been undertaking a comprehensive revalidation process. On a day to day basis, the Data Quality Team is reviewing A&E patient data in real time to ensure a valid NHS number is assigned.

Fig. 35: Percentage of valid general medical practice codes and NHS numbers

	2009/10			2010/11		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Medical Practice Code	100%	99.93%	99.74%	100%	99.76%	99.66%
NHS Number	99.21%	95.50%	99.15%	98.06%	90.45%	98.34%

General Medical Practice Code – the code given nationally to each practising GP
NHS Number – NHS numbers link patients to the treatment they have received and are unique to the patient

Information Governance Assessment
Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 71% and was graded Green.

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 not subject to the Payment by Results clinical coding audit during 2010/11 carried out by the Audit Commission due to high accuracy rates achieved in previous years' audits.

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 Clinical Coding Audits. Accuracy figures for the 2009-10 Information Governance audit were:

Fig. 36: Information Governance Audit

	March 2010	September 2010
Primary diagnosis correct	94.00%	91.50%
Secondary diagnoses correct	88.17%	92.04%
Primary procedure correct	96.67%	92.81%
Secondary procedures correct	95.33%	93.59%

Ongoing actions to improve data quality include:

- Sharing of local activity data with consultants and divisional managers in order to increase their involvement in the collection, validation and use of coded data.
- Clinical coders continuing to be situated within ward areas in order to facilitate access to clinical teams and consultants.
- Regular training and education sessions being carried out for junior medical staff to provide a better understanding of how clinical information is collected and the importance of their contribution towards well documented source information supporting the coding process.
- Carrying out an internal quarterly audit of data quality
- Participating in an external annual audit of data quality

Further performance information

The following table outlines our performance during 2010/11 against indicators we have chosen for 2010/11 for patient safety, clinical effectiveness and patient experience. These also include locally agreed targets that have been set by NHS Surrey.

Fig. 37: Trust Performance against local indicators – patient safety

Locally agreed targets & *Source of Data*	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Patient safety						
Standardised mortality (Relative Risk)* *Dr Foster*		89.8	82	89.4	82	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 (this means our rates are good)
Crude mortality *PAS*		Data unavailable	2.60%	1.60%	1.60%	
MRSA (Hospital only) *ASPH weeky HCAI Reporting*		9	5	5	4	Trusts across South East Coast have differing thresholds (ranging from 2 – 5) based on continual improvements and case-mix.
C.Difficile *ASPH weekly HCAI Reporting*		53	67	36	33	Trusts across South East Coast have differing thresholds (ranging from 25 – 70) based on continual improvements
SUIs (Serious Untoward Incidents) *Quality Department – Clinical Risk Manager*		Data unavailable	14	14	14	

SUI – root cause analysis within 60 Days* *Quality Department – Clinical Risk Manager*		100%	N/A (no threshold agreed with the PCT)	100%	100%	Note: The National Reporting Framework for Reporting and Learning from Serious Incidents suggest 45 days. The Trust will be monitoring against this standard in 2011/12.

Fig. 38: Trust Performance against local indicators – clinical effectiveness

Locally agreed targets & *Source of Data*	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Clinical effectiveness						
Falls in hospital – resulting in significant injury (grade 3) *Quality Department – Patient Safety Administrator*		32	29	16	14	ASPH fall rates were higher than the South East Coast SHA rates. The Trust was in the bottom quartile for performance (9/12 Trusts).
Hip fractures treated within 36 hrs *PAS and Orthopaedic Trauma Nurse Practitioner validations*		83.6% within 48hrs	85.00%	93.00%	85.00%	Comparative data is only available for treatment within 48hrs. ASPH ranked 2nd out of the 10 Trusts in South East Coast that submitted data.
Emergency readmissions within 14 days *PAS*		2.90%	3.70%	3.50%	The Trust will undertake a new measure at 28 days	The Trust performance was 3.5% which is below the England average of 5.5%. The Trust was ranked at 55 out of 164 Trusts.
VTE Assessment *In Patient List System (IPL details)*		N/A	90.00%	85.20%	90.00%	The Trust demonstrated the 2nd best performance of the South East Coast SHA Trusts (12), assessing over 90% of patients against a South East Coast SHA average of 52.9% and a national average of 68.4%.
A&E Attendances Resulting In Admission* *PAS – Ardentia SQL data warehouse*		20.90%	23.45%	22.14%	Awaiting confirmation from the PCT	Admission rates in A&E across the South East Coast SHA varied from 17.67% to 35.55%. The Trust admission rate was 23.25% ranking at 6 out of 11 Trusts that admit patients. (Benchmarking used Q4 data)
Pressure Ulcers* *Matron's ward quality indicators data submission*.		160	153	108	Standard not being measured by the PCT	The Trust incidence of pressure ulcers was generally lower than the average South East Coast SHA rates for 10/11. The Trust ranked 2nd out of 12 Trusts in South East Coast.
Access to midwifery/Maternity services *Clinical Midwifery Manager, Community & Outpatients – Monthly booking report*		86.30%	80.00%	89.30%	90%	The Trust performance of 89.3% was above the South East Coast SHA average of 66.2% and a national average 65.6%. We rank 6/12 within South East Coast.
Caesarean Section Rate* *Maternity Systems & Coding Administrator weekly and monthly reporting*		27.70%	25.00%	25.90%	23%	NHS comparators: SHA Average is 24.5% National: Average is 23.9% (Spread across South East Coast is from 20 – 30%)

Fig. 39: Trust Performance against local indicators – patient experience

Locally agreed targets & *Source of Data*	Performance	09/10 actual (if available)	10/11 targets	10/11 actual	11/12 plan	Benchmark Comments
Patient experience						
Patient Satisfaction – Net Promoter Score *Net Promoter Score from 'Your feedback' data collection*			90.00%	77.30%	90.00%	
Formal complaints *Complaints Manager*		401	361	360	320	
Complaints - % Actioned within 25 Days* *PA / Complaints Team Co-ordinator*		98.36%	100.00%	96.75%	New standard for 2011/12	

* Primary Care Trust Targets

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

Fig. 40: Trust Performance against national priorities

Performance against key national priorities 2010/11 & *Source of data*	**Performance**	**09/10 actual (if available)**	**10/11 targets**	**10/11 actual**	**11/12 plan**
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge *AE_CSEUR – A&E daily siterep database.*		98.89%	95.00%	97.65%	<=4hrs
A maximum two-week wait standard for Rapid Access Chest Pain Clinics. *Cardiology – PRISM system monthly reporting*			98.00%	100.00%	Not applicable Not a national priority for 11/12
Thrombolysis 'call to needle' of at least 68 per cent within 60 minutes, where thrombolysis is the preferred local treatment for heart attack. *Cardiology – PRISM system monthly reporting*		100.00%	68.00%	92.90%	Not applicable Not a national priority for 11/12
Elective admissions cancelled on the day offered a date within 28 days *PAS and validation of clinical/non clinical reasons from specialty managers*		2.90%	5.00%	1.64%	Not applicable Not a national priority for 11/12
Delayed transfer of care - % of patients whose transfer was delayed *PAS*		4.09%	3.50%	2.37%	Not applicable Not a national priority for 11/12
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals. *CWT – Cancer system*		97.24%	93.00%	98.25%	93.00%
A maximum wait of one month from diagnosis to treatment for all cancers *CWT – Cancer system*		99.25%	96.00%	99.15%	96.00%
A maximum wait of two months from urgent referral to treatment of all cancers. *CWT – Cancer system*		91.20%	85.00%	92.69%	85.00%
Breast symptoms referred to a specialist who are seen within two weeks of referral *CWT – Cancer system*		95.11%	93.00%	95.77%	93.00%
31 days for second or subsequent cancer treatment(drug) *CWT – Cancer system*		100.00%	98.00%	100.00%	98.00%
31 days for second or subsequent cancer treatment (surgery) *CWT – Cancer system*		96.71%	94.00%	100.00%	94.00%
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment *CWT – Cancer system*		97.10%	90.00%	98.92%	90.00%

Performance against key national priorities 2010/11 & *Source of data*	**Performance**	**09/10 actual (if available)**	**10/11 targets**	**10/11 actual**	**11/12 plan**
MRSA number of infections *APSH weeky HCAI Reporting*		9	5	5	4
Clostridium difficile *APSH weeky HCAI Reporting*		53	67	36	33
Number of diagnostic waits > 6 weeks *DM01 – monthly UNIFY returns*		0.00%	0.00%	0.00%	Not applicable Not a national priority for 11/12
18 weeks Referral to Treatment (RTT) Completed Pathways – Admitted patients *PAS – Referral to Treatment (RTT) database*		93.37%	90.00%	94.11%	95% of patients wait 23 weeks or less. The Trust will report on the average wait of 95% of our patients.
18 weeks RTT Completed Pathways Non-Admitted patients *PAS – RTT database*		97.87%	95.00%	98.19%	95% of patients wait 18.3 weeks or less. The Trust will report on the average wait of 95% of our patients.
MRSA Screening – Elective admissions *PAS and Microbiology database WINPATH*		99.10%	100.00%	99.40%	Not applicable Not a national priority for 11/12
Cancelled Operations *PAS and validation of clinical/non clinical reasons from specialty managers*		0.79%	0.80%	0.79%	Not applicable Not a national priority for 11/12
48 Hours GUM access *From Clinic and Information Systems Co-ordinator daily reports*		100.00%	100.00%	100.00%	Not applicable Not a national priority for 11/12

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

Ashford and St Peter's Hospitals NHS Foundation Trust Local Involvement Network (LINk):

The Ashford and St Peter's Action Group have pleasure in commenting on the Quality Accounts prepared by the twin hospitals for 2011. One of our number joined the team invited to work on the initial drafting of these Accounts; he was surprised not to receive any further feedback thereafter, while we should all have welcomed more than 11 calendar days to prepare our response, with more than 500 words available to us. During the time allowed us, there has been a fruitful exchange of thoughts which we believe has made the LINk a useful contributor to these Accounts.

We are very impressed by the standard reached in this document. There is the right balance between what happened in the year 2010/20111 and what it is hoped will happen in the coming years, with in some cases targets set as far ahead as 2014. The language is clear and accessible, with jargon largely avoided (health service professionals must find it hard to remember that expressions such as "patient pathways" are not readily recognised by the public). The text includes all the information called for by the guidelines, the topics chosen correspond closely to those which we too consider most significant, such as discharge arrangements.

Certain details call for comment. In the first section, Graph one illustrates a decline over the three years shown in the (already small) category "Above Average", although the hope is expressed that the hospitals will soon merit universal membership of this category. Perhaps the Accounts should explain how this is to come about. In the next four graphs we should have welcomed explanation of why 2009 was so poor compared to 2008 and 2010. Graph seven repays attention; in most months the numbers are identical year-on-year, so that it is three or four months which made all the difference, notably July, where in 2010 there were apparently no falls at all.

There is a good section on A&E, which does not however mention the quite real problem of Mental Health patients who disrupt the department, for whom during the 128 hours of the week known as "out-of-hours", no trained attention has been possible in the past. We know that an attempt is being made to address this issue, and consider the Accounts could have included this information.

We are concerned with the information presented on the length of stay in hospital. Including a field where the results were not as good as hoped is admirably candid; this said, the analysis could have been better. It is not clear that the winter had much to do with the problem – December 2010 was indeed an appalling month*, but did not show up in the graph as significant, and patients getting older cannot occasion surprise.
Our overall verdict must be to congratulate the hospitals on preparing such good Accounts, and to welcome the opportunity afforded us to contribute to them.

* Clarification provided by the LINK Chair dated 3 June 2011: 'December 2010 was extremely cold, grey, and depressing. It could easily have led to an increased number of patients attending hospital, but the numbers illustrated in the graph do not suggest that month was especially bad.'

The Overview and Scrutiny Committee:
No comment received.

NHS Surrey Primary Care Trust:

NHS Surrey has reviewed the Ashford and St Peter's Hospitals NHS Foundation Trust Quality Account document for 2010–2011 and believes that this provides a fair reflection of the work of the Trust and includes the mandatory elements required.

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 Hospitals NHS Foundation Trust during the year and reviewed as part of their performance under the contract.

We continue to work with the Trust to ensure that data accuracy and information governance at all levels remains a key priority.

The account identifies significant progress in relation to:

- Reduction of HCAI; MRSA and clostridium difficile levels compared to 2009-2010
- Ensuring that patients with a fractured hip that are fit for undergoing surgery get their operation within 36 hours of admission. It is noted that Ashford and St Peter's Hospitals NHS Foundation Trust is one of the best performing trusts in this area.

Ashford and St Peter's Hospitals NHS Foundation Trust has identified in its Quality Account a number of improvements in the patient experience evidenced in outcomes such as results of the National Inpatient Survey.

NHS Surrey will continue to work with Ashford and St Peter's Hospitals NHS Foundation Trust to raise the profile for quality improvement. The ongoing 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.

Having followed the framework with the Quality Accounts toolkit, we would like to share the following more specific observations:

Fig. 41: NHS Surrey observations

Part 1	Statement on quality from Chief Executive, senior employee, stating document is accurate.	Statement, signed by CEO and senior clinical staff provided stating report content is accurate.
Part 2	Priorities for improvement	Compliant: Trust have identified 7 quality priorities for action for 2011/12, have set clear goals and have provided evidence of how these will be monitored and measured.
	Review of Services	Compliant: 6 key priorities for 2010/11 are reviewed
	Participation in Clinical Audits	Compliant
	National Audit	Compliant

	Participation in Clinical Research	Compliant
	CQUIN	Compliant
	CQC	Compliant
	Data Quality	Compliant
	Information Governance Toolkit	Compliant

2010/11 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:
    - Board minutes and papers for the period April 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners, NHS Surrey, dated 2/06/2011
    - Feedback from Governors dated 18/05/2011
    - Feedback from LINks dated 01/06/2011
    - The Trusts complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 March 2010.
    - The national patient survey, 2010 (published April 2011)
    - The national staff survey, 2010 (published March 2011)
    - The Head of Internal Audit's annual opinion over the Trust's control environment dated 25/05/2011
    - Care Quality Commission quality and risk profile dated April 2011
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm 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; and 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:

…… Date……Chairman

…… Date…… Chief Executive

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.

4. NHS Foundation Trust Code of Governance

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

The organisation recognises that the process for governance and risk management in the NHS is constantly evolving. 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.

These disclosures give a clear and comprehensive picture of the Trust's Governance arrangements and demonstrate the application of the main Principles of the Code of Governance; the beacon of good practice.

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 2011 the Trust complied with all the specific provisions for disclosure of the Code of Governance published by Monitor in 2010.

Board of Directors

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) and also be consulted on the Trust's forward plans.

The Board of Directors is responsible for ensuring compliance by the Trust 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.

Further detail is given in the Scheme of Delegation and Matters reserved to the Board. 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.

Five Non-executives and the Chairman were appointed prior to the Trust achieving Foundation Trust status. In accordance with the Constitution they transferred to the Foundation Trust and have been confirmed to remain until the end date of their original appointments (given in table below) although Nadeem Aziz resigned in December 2010. All future appointments and reappointments will be made by the Council of Governors and will be for three year periods. Two Non-executive Directors were appointed by the Council with effect from 31 March 2011.

Following a recommendation from the Remuneration and Appraisal Committee the Council agreed the Terms of Service for the Non Executive Directors.

Introducing our Board of Directors …

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

The Chairman's appointment was confirmed by the Council on 1 December 2010 and continues until 30 September 2012.

Nadeem Aziz, Non-executive Director
Nadeem Aziz was Director for Group Financial Planning at Actavis, a leading generic pharmaceutical drugs manufacturer and distributor and has worked as financial director in a range of industries including EA Games, American Express, Seagrams, Emirate Airlines, and Sony. He started his career at BBC Television. Nadeem has an MBA (Sheffield Business School), is a Chartered Management Accountant, and has a Diploma in Marketing (Chartered Institute of Marketing).

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

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.

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

Sue joined the Board in February 2009.

Jim Gollan, **Non-executive Director**

Jim Gollan graduated from Bristol University in 1976 with a Bachelor of Arts degree in Spanish and Portuguese. He has a strong business profile with experience as Chairman of a Stock Exchange Board, subject to the Combined Code of Corporate Governance. He was also Chief Executive of a UK equities exchange and a financial services consultancy in the Asia Pacific. Jim has held several CFO positions in international financial services organisations and brings senior risk management consultancy experience from KPMG. He has extensive experience of businesses operating with different governance models: UK plcs, private companies, joint ventures, not for profit organisations and partnerships. Jim gained his Full Chartered Accountancy qualification in 1981.

Jim joined the Board in March 2011.

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. He is a highly accomplished senior executive with 14 years of operating at Board level and has been a Commercial Director at British Telecom since 2008, having previously been the Finance Director for BT Wholesale. He has extensive experience of commercial negotiations and agreements, organisational transformation and continuous experience. 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.

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

Terry joined the Board in September 2008.

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

Peter joined the Board in August 2008 and was appointed Senior Independent Director with effect from 24th November 2010.

Andrew Liles, Chief Executive
Andrew Liles joined the Trust in January 2009 from the Royal West Sussex NHS Trust, where he had been Chief Executive for three years. After University he was an NHS Management Trainee for 2 years, completing his training in 1992. Since then his career has progressed through general management and operational posts in acute NHS Trusts and Executive Director posts in Winchester, Southampton and Epsom and St Helier Hospitals trusts. Andrew is the Chief Executive lead for leadership and talent management for the NHS in the South East. In 2011 Andrew was elected as the new Chair of the Surrey and Sussex research network.

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

Valerie 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.

Valerie joined the Board in April 2009.

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

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

Raj joined the Board in April 2009.

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

John was appointed Director of Finance and Information at the Trust in January 2009.

Suzanne Rankin, Chief Nurse
Suzanne joined Ashford and St. Peter's in December 2010* as Chief Nurse. 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 holds an MA in Defence Studies and was responsible for developing the Nursing Services Strategy in her role as Deputy to the Defence Nursing Adviser at the Ministry of Defence.

**Until the middle of December 2010, Susan Osborne held the position of interim Chief Nurse at the Trust, having taken over from previous Chief Nurse, Caroline Becher who retired in July 2010.*

We would like to extend our thanks and appreciation to Nadeem Aziz and Susan Osborne for their hard work and contribution during their time with the Trust.

Significant commitments of the Trust Chairman

Aileen McLeish is a Governor of The Mount School, York, and is also a member of the NHS Employers reference group on Pensions and Total Reward.

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. 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.

Performance evaluation

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 Director's 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 Chief Executive undertakes the appraisal of the Executive Directors.

The Lead Governor is the Chairman of the Council of Governor's Remuneration and Appraisal Committee which takes the lead on determining a process for the performance evaluation of the Chair. The Senior Independent Director will lead the process for the evaluation of the Chairman and the outcome of the evaluation will be discussed and agreed with 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 successful licensing of the Trust as a Foundation Trust on 1st December 2010 and feedback from Monitor on the Foundation Trust application and the delivery of the business plan (2010/11) were positive indicators of a high performing board.

Access to register of Directors' Interests

Members of the public can gain access to the register of Directors' interests by making a request to the Trust secretary , 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 meets each month. There were 4 ordinary meetings during the period December 2010 to March 2011. Directors' attendance was as follows:

Fig. 42: Directors' attendance at Board meetings 2010/11

Name	End of term of office	Meetings attended
Non Executive Directors		
Ms. Aileen McLeish	30/09/2012	4/4
Mr Nadeem Aziz	Resigned 31/12/2010	0/1
Prof Philip Beesley	15/07/2012	4/4
Mr Clive Goodwin	30/03/14	0/0
Mr Jim Gollan	30/03/14	0/0
Ms Sue Ells	08/02/2013	4/4
Mr Terry Price	13/09/2012	3/4
Mr Peter Taylor	15/08/2012	4/4

Executive Directors	Position	Meetings attended
Mr Andrew Liles	Chief Executive	4/4
Mrs Valerie Bartlett	Deputy Chief Executive	4/4
Dr Mike Baxter	Medical Director	4/4
Mrs Raj Bhamber	Director of Workforce and Organisational Development	4/4
Mr John Headley	Director of Finance & Information	4/4
Ms. Susan Osborne	Interim Chief Nurse (18 August 2010—19 December 2010)	1/1
Mrs Suzanne Rankin	Chief Nurse (from 20 December 2010)	3/3

Jim Gollan and Clive Goodwin commenced their appointments as Non-executive Directors on 31 March 2011 and both their Terms of Office will end on 30th March 2014.

Board Sub Committees

The Board of Directors has the following sub committees:

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

Audit Committee

Membership and Attendance

The Audit Committee is chaired by Terry Price, a Non-Executive Director, and includes two other Non-Executive Directors, currently Peter Taylor and Jim Gollan (from 31 March 2011). There were three meetings held in the period (December 2010 to March 2011) and attendance was as follows:

Fig: 43: Attendance at Audit Committee meetings, December 2010 to March 2011:

	Meetings attended
Terry Price	3/3
Peter Taylor	3/3
Nadeem Aziz	0/1

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 of the Audit Code in 2010/11, 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.

Committee Membership

Fig. 44: Details of Directors' membership of the other Board sub committees

	Remuneration Committee	Finance Committee	Integrated Governance and Assurance Committee	Nominations Committee
Nadeem Aziz	✔	✔ Chair man to Dec10		To be established
Valerie Bartlett		✔	✔	
Mike Baxter			✔	
Philip Beesley			✔ Chairman	
Raj Bhamber		✔	✔	
Sue Ells	✔			
John Headley		✔	✔	
Andrew Liles		✔	✔	

Aileen McLeish	✔			
Terry Price		✔	✔	
Suzanne Rankin			✔	
Peter Taylor	✔ Chairman	✔ Chairman Jan to March		

Council of Governors

How the Board of Directors and the Council of Governors operate
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 shares information about key decisions with Foundation Trust members and 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.

Duties of the Council of Governors are to:

- Appoint or remove the Chairman and other Non-Executive Directors and approve the appointment (by Non-Executive Directors) of the Chief Executive
- Decide the remuneration, allowances and other terms and conditions of office of Non-Executive Directors
- Appoint or remove the Foundation Trust's External Auditors
- Review the Trust's constitution and consider changes
- Review and develop the Trust's Membership Strategy
- Advise the Board on strategic matters

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 has appointed David Frank (Governor for Surrey Heath) as the Lead Governor for one year from February 2011.

The Council will meet four times each year. Since establishment there have been two formal meetings. Details of the attendance of Governors are included in the table 'Register of Governors' below.

Executive and Non-executive Directors are 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.

No elections have been held during the period December 2010 to March 2011.

Fig. 47 below shows the membership of the Council.

Access to 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.

Understanding the views of the Council and Members
The members of the Council have participated in an extensive induction programme to enable them to understand their role and the activities of the Trust. The Chairman has held one to one meetings with most of the Governors. Executive and Non-executive Directors have attended meetings of the Council to gain an understanding of the views of Governors and the constituencies they represent. The Deputy Chairman, Senior Independent Director and Lead Governor have met jointly to forge a relationship. A special meeting focusing on the Annual Plan 2011/12 was led by the Chief Executive and Chairman, giving Governors the opportunity to contribute views on the Plan.

Contacting a Governor
Members who wish to contact their Governor can do this via the membership office St.Peter's Hospital, Guildford Road, Chertsey, KT16 0PZ or calling 01932 722063. 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.

Nomination and Appraisal 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 of the Council adopted the *Chairman and Non-Executive Director Recruitment and Selection Policy and Procedure* at its inaugural meeting on 14 December 2010. Thereafter, it followed this policy and procedure and acted in accordance with the Constitution and Code of Governance leading to a recommendation to the Council in February 2011 to appoint two new Non-executive Directors. The Nominations and Appointments Committee agreed the job description, national advertisement, applicant pack and appointment of search consultants on the basis of a value for money exercise. Committee members then shortlisted candidates and formed two interview panels.

There was an excellent response to the recruitment drive, with a very high calibre of applicant resulting in the Council agreeing the appointment of two new Non-executive Directors, Mr Jim Gollan and Mr Clive Goodwin who took up their positions on 31 March 2011.

The Nominations and Appointments Committee met twice prior to 31 March 2011 with all members attending (membership shown in table below).

Fig. 45: Nominations and Appointments Committee attendance

Nominations and Appointments Committee	**Meetings attended 10/11**
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	2/2
Peter Taylor (Senior Independent Director)	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.

Membership and attendance is given below:

Fig. 46: Remuneration and Appraisal Committee attendance

Remuneration and Appraisal Committee	**Meetings attended**
David Frank (Chairman)	1/2
Judi Linney	2/2
Michelle Lowe	2/2
Hugh Meares	2/2
Paul Wills	2/2

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. There are 9 'areas' 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 2011

Public: 5961
Staff: 3431
Total: 9392

Developing our membership
The Membership and Communication Engagement Group of the Council of Governors was set up in March 2011 and will be leading on developing the Membership Strategy and improving two way

communications between Governors and members. The existing strategy contains targets for membership over the coming two years which have already been exceeded so the intention will be to focus on areas where we know we needed to develop a more representative membership:-

- Increasing representation especially around the Hounslow and Elmbridge areas
- 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'.

During 2010 a mail drop was undertaken in targeted areas with a very successful outcome. Other initiatives have included inviting all new outpatients to become members.

Register of Council of Governors

Fig. 47: Council of Governors

Name (Constituency / Organisation)	Date elected or appointed	Term of office	Meetings attended
Linda Abbott (Public – Spelthorne)	1st Dec 2010	3 Years	2/2
Neelam Bains (Public – Spelthorne)	1st Dec 2010	3 Years	0/2
Tanya Bernard (Staff – Medical and Dental)	1st Dec 2010	2 Years	2/2
Simon Bhadye (Public – Spelthorne)	1st Dec 2010	3 Years	½
Keith Bradley (Public – Woking)	1st Dec 2010	3 Years	2/2
Maurice Cohen (Public – Woking)	1st Dec 2010	3 Years	2/2
David Frank (Public – Surrey Heath)	1st Dec 2010	3 Years	2/2
Godfrey Freemantle (Public – Hounslow)	1st Dec 2010	3 Years	2/2
Keith Goodger (Public – Richmond)	1st Dec 2010	2 Years	½
Graham Hanson (NHS Surrey)	1st Dec 2010	3 Years	0/2
Sue Harris (Staff- Nursing and Midwifery)	1st Dec 2010	3 Years	2/2
John Hay (Royal Surrey University)	1st Dec 2010	3 Years	2/2
Chris Howorth (Royal Holloway University)	1st Dec 2010	3 Years	½
Janice Ketley (Public – Runnymede)	1st Dec 2010	2 Years	2/2
Samantha Lamb (Staff – Admin and Clerical / Ancillary)	1st Dec 2010	3 Years	2/2
Andreas Lambrianou (NHS Hounslow)	1st Dec 2010	3 Years	2/2
Margaret Lenton (Public – Windsor and Maidenhead)	1st Dec 2010	2 Years	2/2
Ajbha Linney (Public – Runnymede))	1st Dec 2010	2 Years	2/2
Michele Low (Public – Hounslow)	1st Dec 2010	3 Years	2/2
Steve McCarthy (Public – Elmbridge)	1st Dec 2010	3 Years	2/2
Diana Manthorpe (Staff – Volunteers)	1st Dec 2010	3 Years	½
Howard Manuel (Public – Woking)	1st Dec 2010	3 Years	½
Hugh Meares (Runnymede Borough Council)	1st Dec 2010	3 Years	0/2
Judith Moore (Public – Guildford)	1st Dec 2010	3 Years	½
Jean Pinkerton (Spelthorne Borough Council)	1st Dec 2010	3 Years	2/2
Andrew Ryland (Public – Runnymede)	1st Dec 2010	2 Years	2/2
Michael Smith (Woking Borough Council)	1st Dec 2010	3 Years	2/2
Paul Wills (Staff – Healthcare Assistants / Allied Health Professionals / Healthcare Scientists)	1st Dec 2010	2 Years	½

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 and the national targets set by the Care Quality Commission (CQC) in respect of service performance and improvements in clinical quality, Monitor will assess and assign a risk rating for the Trust for the year.

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.

Red concern that issue(s) significantly breaches authorisation
Amber concerns about one or more aspects of governance
Green governance arrangements comply with authorisation

Mandatory services risk rating
Mandatory services are the services which each NHS foundation trust must provide as detailed in their terms of authorisation.

Red concern that issue(s) significantly breaches authorisation
Amber concerns about one or more aspects of mandatory services
Green mandatory services comply with authorisation

Every quarter, NHS foundation trust boards are required to self-certify compliance in each of these areas or identify any areas where they are failing to do so. Each trust is assigned an overall financial or governance risk rating for the quarter based on the declarations they make to Monitor, which takes into account each of the areas above.

The following table reports on our first quarter as a Foundation Trust.

Fig. 48: Risk Ratings

	Annual Plan 2010/2011	Actual
Financial Risk Rating	4	4
Governance Risk Rating	Green	Green
Mandatory Services Risk Rating	Green	Green

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. Part of this is to reduce carbon emissions by 26% by 2020 and 80% by 2050. There is also a commitment to reduce the carbon footprint by 10% by 2015.

The Trust has signed up to the national Carbon Reduction Commitment (CRC) energy efficiency scheme which commits it to collating energy use information, submitting reports and maintaining evidence reports. The results will be published in national performance league tables from 2012.

The Trust joined the carbon 10:10 scheme and its 10:10 Group undertook various carbon reduction projects throughout 2010. The Group has now been disbanded and is to be replaced by a Sustainable Development Group which will continue this work and develop further workstreams.

Review of Work to Date

An independent review on behalf of the Strategic Health Authority concluded that the Trust has implemented sufficient measures to meet its carbon reduction commitments and has a significant system of control. The report identified a number of actions and recommendations – a full copy of the report is available on request from our Estates and Facilities department.

The Trust is undertaking a survey of energy usage and is developing a site wide strategy for a tri-generation strategy for the St Peter's Hospital campus. It has commissioned advice which is currently being prepared in regard to renewable energy strategies for the future which will help to inform the Trust's sustainable strategy.

In addition, the Trust has identified funding within its backlog maintenance capital allocation to develop schemes that reduce backlog maintenance but also reduce carbon usage including:

- Replacement of calorifiers with plate heat exchangers
- New energy efficient lighting
- Energy monitoring software and metering
- Increased insulation on roofing renewal projects

Governance Process

A Sustainable Development Group (SDG) is being formed with the aim of developing further work looking specifically at energy; waste; procurement; and transport.

This Group will report to Trust Executive Committee bi-annually and the Trust Board annually and will develop the work previously undertaken by the 10:10 Group.

Key achievements

Key achievements during the year include:

- Trust wide buildings survey, undertaken by consulting energy engineer, with support from the Carbon Trust (cost-free)
- Ventilation controls, particularly reducing use of fans when areas (e.g. theatres) not in use
- Use of low energy equipment in capital schemes
- Engineered replacement schemes for light fittings, using new high efficiency lighting, including daylight saving and motion sensors
- Developing a scheme for Buildings Management and energy monitoring of our existing buildings at St Peter's Hospital

- Upgraded departmental block heating controls.
- Replaced boilers at Ashford with more energy efficient boilers.
- Replacement windows and increased insulation to Kingfisher ward external fabric
- Use of gas powered air conditioning systems in Juniper and Aspen ward to comply with the requirements of the heat wave plan (i.e. keeping wards cool in the hot weather) and the use of a more efficient form of energy
- Semi waterless urinal flush controllers on urinals
- Continued eradication of bottled water coolers and replacement by mains water supply type; reducing use of plastic and travel to replace water bottles.
- Transport – developing a travel plan, improving facilities for cyclists, participating in local cycle and walk to work schemes, use of diesel fuel in all transport vehicles
- Waste management – recycling of plastics, cans and glass, battery recycling, segregating all waste electrical equipment from waste stream and removing for recycling/recovery, recycling of used fluorescent light tubes.

Fig. 49: Sustainability information

Area	Type	Non-financial information	Financial information
Greenhouse gas emissions	Emissions from sources owned or controlled by the Trust	Electricity – 15,193,000 kWh, 8,200 tonne Co2 Gas – 12,490,000 kWh, 2,293 Tonne Co2 Transport (fleet vehicles*) – 87,239 tonnes Co2	Electricity - £1,326,940 Gas - £800,000 Fleet vehicles - £100,000 (diesel cost)
	Emissions relating to official business travel	Total number of miles paid was 444,896	Total payments made for mileage claimed - £153,632.41
Waste minimisation and management		Total waste – 1098.2 tonnes Waste sent to landfill 453.66 tonnes Waste Recycled 324.6 tonnes Waste Incinerated (including EFW) 319.94 tonnes	Total Waste £294,245 Waste sent to landfill £142,561 Waste Recycled £38,023 Waste Incinerated £103,377
Finite resources		Water – 80,565m3	Water £113,230

* Figure excludes emissions from 6 minibuses and 1 truck as no carbon emission data is available on these older vehicles.

6. Financial Report and Accounts

Financial review

As a result of the Trust becoming a Foundation Trust on 1st December 2010 the accounts in this Annual Report cover the four month period to 31st March 2011. These four month accounts have been prepared using the NHS Foundation Trust Annual Reporting Manual 2010-11 issued by Monitor.

For the four month period to 31st March 2011 the Trust achieved a surplus of £0.1m against a plan of £0.5m. This was mainly as a result of the Trust agreeing a cap on its income with its main commissioner, NHS Surrey, and higher winter pressure costs incurred during the period. An analysis is set out below: -

	Plan £m	Actual £m	Var £m
Income			
Clinical Income	67.8	70.0	2.2
Non-Clinical Income	5.0	5.0	-
Total Income	72.8	75.0	2.2
Expenses			
Pay Costs	-45.2	-47.2	-2.0
Non-Pay Costs	-22.0	-22.6	-0.6
Total Expenses	-67.2	-69.8	-2.6
EBITDA	5.6	5.2	-0.4
Depreciation & Amortisation	-3.4	-2.5	0.9
Non-operating expenses	-	-1.0	-1.0
Interest (net)	-0.1	-0.1	-
Dividend on PDC	-1.6	-1.5	0.1
Net surplus	0.5	0.1	-0.4

Key variances from plan are set out below: -

- NHS clinical income was £2.2m above plan due to activity over-performance across most specialties. As stated above income with the Trust's main commissioner was capped for the period.
- Pay costs were £2.0m higher than plan, primarily due to an increase in clinical activity which was in excess of plan, resulting in short-term staffing solutions and increased spend on temporary staffing.
- Non-pay costs were £0.6m higher than plan because of increased use of drugs, pacemakers and prosthesis related to increased activity.
- Depreciation and dividend costs were underspent by £0.9m and £0.1m respectively due to a revaluation in property resulting in lower depreciation and non-current assets.
- Non-operating expenses are in respect of a provision for the restructuring of pathology services.
- Net interest received was in line with plan.
- 100% of the planned cost improvement programme was delivered during the period.

The Trust spent £5.9m on purchased capital during the period and ended the financial year with a cash balance of £18.7m.

Over the whole of the financial year the Trust met its planned surplus of £3.3m.

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.

Accounting policies for pensions and other retirement benefits are set out in note 9 to the accounts and the details of senior employees' remuneration can be found on page 90 in the remuneration report.

Monitor

The reporting to Monitor, on which the Financial Risk Rating is based, is based on a different period covering the whole of the financial year 2010/11.The Trust's financial performance for the whole of the financial year was given a Financial Risk Rating of 4 out of 5 by Monitor, where 5 is 'low risk'. The metrics making up this rating are set out in the table below: -

	Metric	Score
EBITDA margin (%)	7.4%	3
EBITDA against plan (%)	89.8%	4
Return on assets employed (%)	5.8%	4
I&E surplus margin (%)	1.9%	3
Liquidity ratio (days)	26.3	4
Weighted score		4

2011/12 Plan

The 2011/12 financial year will provide additional 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 £2.1m on planned income of £219.2m 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 the Non-Executive Directors of the Trust Board chaired by Senior Independent Director, Peter Taylor and meets as a minimum once a year. It met once during this reporting period, attended by Peter Taylor, Aileen McLeish and Sue Ells.

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

Salary and pension entitlements of senior managers for the 4 month period to 31 March 2011

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

A) Remuneration

	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)**
Executive Team	£000	£000	£00
Andrew Liles Chief Executive	55-60	-	10
John Headley Director of Finance	35-40	-	14
Dr Mike Baxter Medical Director	15-20	50-55	16
Valerie Bartlett Deputy Chief Executive	40-45	-	-
Raj Bhamber Director of Workforce and Organisational Development	35-40	-	-
Susan Osborne Interim Chief Nurse (to 22 December 2010)	10-15		
Suzanne Rankin Chief Nurse (from 20 December 2010)	25-30	-	-
Chairman and Non-Executives			
Aileen McLeish Chairman	5-10	-	-
Peter Taylor Non-Executive Director	0-5	-	-
Philip Beesley Non-Executive Director	0-5	-	-
Terry Price Non-Executive Director	0-5	-	-
Sue Ells Non-Executive Director	0-5	-	-
Nadeem Aziz Non-Executive Director (to 31 December 2010)	0-5	-	-

Notes

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

B) Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011	Cash Equivalent Transfer Value at 30 November 2010	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension (to nearest £100)
Executive Team	£000	£000	£000	£000	£000	£000	£000	£00
Andrew Liles Chief Executive	0.0-2.5	0.0-2.5	25-30	80-85	369	359	7	-
John Headley Director of Finance & Information	0.0-2.5	-	0-5	-	45	37	6	-
Dr Mike Baxter Medical Director	0.0-2.5	0.0-2.5	60-65	190-195	1,357	1,306	36	-
Valerie Bartlett Deputy Chief Executive	0.0-2.5	2.5-5.0	35-40	105-110	548	550	(2)	-
Raj Bhamber Director of Workforce and Organisational Development	0.0-2.5	0.0-2.5	15-20	45-50	238	232	4	-
Suzanne Rankin Chief Nurse (from 31 December 2010)	0.0-2.5	-	0-5	-	27	n/a	2	-

Note:

a) As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
b) The real increase in Cash Equivalent Transfer Value (CETV) for Suzanne Rankin for the 4 month period to 31 March 2011 has been calculated using the opening CETV as at 31 March 2010 due to the CETV at 30 November 2010 being unavailable.

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

John Headley
Acting Accounting Officer
2 June 2011

Statement of Accounting Officers 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.

John Headley
Acting Accounting Officer
2 June 2011

Statement on Internal Control 2010/11

Scope of responsibility

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

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 the Trust for the period ended 31 March 2011 and up to the date of approval of the Annual Report and accounts.

Capacity to handle risk

Risk Management is a corporate responsibility and the Trust Board has ultimate responsibility for ensuring that effective processes are in place. The Board is committed to the continuous development of a framework to manage risks in a structured and focused way in order to protect patients, staff and the public from harm and to protect the Trust from losses or damage to its reputation.

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

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

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

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

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

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

Training is provided on an ongoing basis in order to equip staff to carry out their designated responsibilities according to their roles. In addition, risk management awareness is featured in the induction process for all new staff and all staff have access to information on risk, safety and relevant Trust policies. All such policies are available on the Trust's intranet.

The risk and control framework

The Integrated Governance and Risk Management Strategy was reviewed by the Trust Board in December 2010. The strategy sets out the roles of the Board, Directors and key officers, managers and all staff. It describes the governance and risk management structures in place. The strategy sets out the variety of ways in which risks are identified, and puts in place a risk grading matrix based on likelihood and severity.

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

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

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

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

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

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

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

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

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

- Key risks: the main risks as identified under the Integrated Governance and Risk Management Strategy which might impede the Trust in achieving its objectives;

- Key Controls / Treatments: mechanisms for controlling the risks that have been identified;

- Board Assurance: the Board gained assurance that the Trust's objectives were being achieved and the risks controlled through a variety of assurance processes, including performance reports with KPIs, audit (internal and external), assessments by regulatory and monitoring agencies and reports from its assurance sub committees.

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

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

- In a large hospital organisation there is a risk that pockets of poor practice and poor patient experience can pass undetected. A variety of controls are in place, but further actions are underway to reinforce the need for staff to report incidents.

- One of the Trust's key objectives is to improve the experience of patients. A real time patient feedback system ("Your feedback") has been put in place and action plans are in place for a major programme of staff engagement around the patient experience.

In respect of the year ahead the 2011/12 operating framework sets a challenging financial environment for acute providers generally. These issues are compounded by the specific financial challenges faced by the Trust's main commissioner, NHS Surrey, and other partner uthorization such as social services. The Trust has a robust set of financial controls and oversight, and has produced cost savings plans to respond to these changes in the trading environment and reduced funding.

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

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

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

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

Members of staff also have an important role to play in identifying and uthorizat risks as part of their every day work within the Trust. Each individual has a responsibility for their own personal safety and

for the safety of their colleagues, patients and all visitors to the Trust. All staff are expected to have an understanding of the Incident Reporting Procedure and knowledge of the corporate categories of incident which must be reported.

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

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

Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

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

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

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

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

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

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

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

Annual Quality Report

The Directors are required under the Health Act 2009 and National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to 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 uthoriza 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 and the Executive managers within the Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee and IGAC and a plan to address weaknesses and ensure continuous improvement of the system is in place. The Trust Board is highly aware of its responsibility for risk management. The role of the Trust Board and its sub-Committees has been thoroughly reviewed and tested as part of the successful Foundation Trust assessment process during the year.

The Audit Committee refreshed its terms of reference during the year, extending its formal responsibilities to cover counter fraud activity and putting in place a coordinated oversight process for the production and sign off of the Annual Report and accounts and the Quality Account.

Significant progress was made in following up internal audit actions. The number of outstanding actions graded as "high" or "medium" fell from 67 to 21 by the end of the year.
The Integrated Governance Assurance Committee (IGAC) raised its profile within the Trust, reviewing the structure of clinical and non clinical risk sub committees. IGAC promoted local ownership of risks by reviewing and challenging local risk registers, and their link to the corporate risk register. IGAC sought detailed reviews in areas where a pattern of risk appeared to be manifested, contributing to a better understanding of the issues and improved action plans from local managers. IGAC has played a key role in shaping the Board Assurance Framework and Corporate Risk Register, ensuring that the risks of Foundation Trust status were promptly reflected upon Authorisation.

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

Conclusion

No significant internal control issues have been identified in the Trust for the period ended 31 March 2011 and up to the date of approval of the Annual Report and accounts.

John Headley
Acting Accounting Officer
2 June 2011

ANNUAL ACCOUNTS

FOUR MONTH PERIOD ENDING 31 MARCH 2011

FOREWORD TO THE ACCOUNTS

These Accounts for the four month period ended 31 March 2011 have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

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

INDEPENDENT AUDITOR'S REPORT TO THE BOARD 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 four month period ended 31 March 2011 on pages 102 to 134. These financial statements have been prepared under applicable law and the accounting policies set out in the Statement of Accounting Policies.

This report is made solely to the Board of 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 Board 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 Board 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 93 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 affairs as at 31 March 2011 and of its income and expenditure for the four month period then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

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

In our opinion the 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 Statement on Internal Control 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 Statement on Internal Control Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts 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

7 June 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE 4 MONTH PERIOD ENDED 31 MARCH 2011

	Note	4 Month Period 2010/11 £'000
INCOME		
Income from patient care activities	3	69,996
Other operating income	4	4,973
Operating expenses	6	(73,255)
OPERATING SURPLUS		1,714
FINANCE COSTS:		
Finance income	12	18
Finance expense	13	(107)
Public dividend capital dividends payable		(1,500)
RETAINED SURPLUS FOR THE PERIOD		125
OTHER COMPREHENSIVE INCOME		
Impairments and reversals		-
Gains on revaluations		-
Receipt of donated assets		206
Reclassification adjustments: - Transfers from donated asset reserve		(115)
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		216

The notes on pages 106 to 134 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	Note	31/03/11 £'000	01/12/10 £'000
NON-CURRENT ASSETS			
Property, plant and equipment	14	148,576	145,118
Intangible assets	15	1,489	1,405
Trade and other receivables	19	1,044	799
TOTAL NON-CURRENT ASSETS		151,109	147,322
CURRENT ASSETS			
Inventories	18	3,788	3,133
Trade and other receivables	19	9,388	18,335
Cash and cash equivalents	20	18,657	13,681
TOTAL CURRENT ASSETS		31,833	35,149
TOTAL ASSETS:		182,942	182,471
CURRENT LIABILITIES			
Trade and other payables	21	(19,096)	(18,070)
Other liabilities	21	(1,864)	(2,394)
Taxes payable		(2,890)	(2,879)
Borrowings	22	(2,450)	(2,450)
Provisions	26	(1,565)	(555)
TOTAL CURRENT LIABILITIES		(27,865)	(26,348)
TOTAL ASSETS LESS CURRENT LIABILITIES		155,077	156,123
NON-CURRENT LIABILITIES			
Borrowings	22	(2,450)	(3,675)
Provisions	26	(628)	(666)
TOTAL ASSETS EMPLOYED		151,999	151,782
FINANCED BY TAXPAYERS' EQUITY:			
Public dividend capital		85,706	85,706
Income and expenditure reserve		5,064	4,745
Revaluation reserve		59,314	59,508
Donated asset reserve		1,915	1,823
TOTAL TAXPAYERS' EQUITY		151,999	151,782

The financial statements on pages 102 - 134 were approved by the Board on 2 June 2011 and signed on its behalf by:

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

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE 4 MONTH PERIOD ENDED 31 MARCH 2011

	Public Dividend Capital (PDC)	Retained Earnings	Revaluation Reserve	Donated Asset Reserve	Total
	£'000	£'000	£'000	£'000	£'000
BALANCE AT 1 DECEMBER 2010	85,706	4,745	59,508	1,823	151,782
CHANGES IN TAXPAYERS EQUITY FOR THE 4 MONTH PERIOD ENDED 31 MARCH 2011					
Retained surplus/(deficit) for the year	-	125	-		125
Transfers between reserves	-	194	(194)	-	-
Impairments and reversals	-	-	-	-	-
Net gain on revaluation of property, plant and equipment	-	-	-	-	-
Receipt of donated assets	-	-	-	206	206
Reclassification adjustments: - transfers from donated asset reserve	-	-	-	(114)	(114)
BALANCE AT 31 MARCH 2011	85,706	5,064	59,314	1,915	151,199

STATEMENT OF CASH FLOWS FOR THE 4 MONTH PERIOD ENDED 31 MARCH 2011

	Note	4 Month Period 2010/11 £'000
CASH FLOWS FROM OPERATING ACTIVITIES		
Operating surplus/(deficit)		1,714
Depreciation and amortisation		2,505
Transfer from donated asset reserve		(114)
(Increase)/decrease in inventories		(655)
(Increase)/decrease in trade and other receivables		8,818
Increase/(decrease) in trade and other payables		1,745
Increase/(decrease) in other current liabilities		(530)
Increase/(decrease) in provisions	26	972
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES		14,455
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest received		18
(Payments) for property, plant and equipment		(5,841)
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES		(5,823)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		8,632
CASH FLOWS FROM FINANCING ACTIVITIES		
Loans repaid to the DH		(1,225)
Interest paid		(164)
Dividends paid		(2,267)
NET CASH INFLOW/(OUTFLOW) FROM FINANCING ACTIVITIES		(3,656)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		4,976
CASH (AND) CASH EQUIVALENTS AT THE BEGINNING OF THE PERIOD		13,681
CASH (AND) CASH EQUIVALENTS AT THE END OF THE PERIOD	20	18,657

NOTES TO THE ACCOUNTS 31 MARCH 2011

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 2010/11 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

Critical judgements in applying accounting policies

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

Key sources of estimation uncertainty

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

1.4 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.

1.5 Employee benefits

Short-term employee benefits

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

Retirement benefit costs

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

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

1.6 Other 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.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Land and buildings used for the Trust's services, or for administrative purposes, are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the Revaluation Reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A

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

Subsequent expenditure

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

1.8 Intangible assets

Recognition

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

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

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

Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value.

Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.9 Depreciation, amortisation and impairments

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

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

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

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

1.10 Donated assets

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

1.11 Non-current assets held for sale

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

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

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

1.12 Leases

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

The Trust as lessee

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

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

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

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

The Trust as lessor

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

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

1.13 Inventories

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

1.14 Cash and cash equivalents

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

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

1.15 Provisions

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

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

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

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

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 26.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims

arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.18 Contingencies

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

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

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

1.19 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

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

Available for sale financial assets

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

Loans and receivables

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

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

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

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

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

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

1.20 Financial liabilities

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

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.

1.21 Value Added Tax

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

1.22 Foreign currencies

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

1.23 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.

1.24 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 31 to the accounts.

1.25 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.

1.26 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.

1.27 Subsidiaries

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

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

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

1.28 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'.

1.29 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

1.30 Research and Development

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

2. Operating Segments

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

	Healthcare 4 months 2010/11 £'000
Income	74,969
Surplus	125
Net assets	151,199

Of the total income £68,717,000 relates to income from Primary Care Trusts.

3. Income from patient care activities

3.1 Income from activities

	4 months 2010/11 £'000
Analysis by activity	
Elective income	14,522
Non-elective income	23,155
Outpatient income	14,687
Other NHS clinical income	13,111
A & E income	3,242
Private Patient income	745
Other non-protected clinical income	534
	69,996
Activity by source	
Primary Care Trusts	68,717
Local Authorities	35
Non- NHS - Private patients	674
- Overseas patients (non reciprocal)	71
- Injury cost recovery	425

- Other	74
	69,996

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

Mandatory/Non-Mandatory Income

	4 months 2010/11 £'000
Mandatory income	68,717
Non-mandatory income	1,279
	69,996

3.2 Private patient income

	4 months 2010/11 £'000	Base Year £'000
Private patient income	745	2,729
Total patient related income	69,996	127,128
Private patient proportion as percentage	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

	4 months 2010/11 £'000
Research and development	116
Education and training	2,655
Transfer from Donated Asset Reserve in respect of depreciation of donated assets	115
Non-patient care services to other bodies	775
Other income:	
Car parking	293
Estates recharges	215
Pharmacy sales	255
Nursery	298
Other	251
	4,973

5. Revenue

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

6. Operating expenses

	4 months 2010/11 £'000
Services from NHS Foundation Trusts	242
Services from NHS Trusts	102
Services from other NHS bodies	641
Purchase of healthcare from non NHS bodies	1,263
Employee benefits – Executive Directors	356
Employee benefits – Non-Executive Directors	16
Employee benefits - staff	46,806
Drugs costs	4,030
Supplies and services – clinical (excluding drugs)	8,877
Supplies and services – general	1,367
Establishment	645
Transport	154
Premises	2,471
Increase/(decrease) in provision for impairment of receivables	279
Depreciation and amortisation	2,505
Auditors remuneration	65
NHS clinical negligence scheme	1,413
Legal fees	10
Consultancy costs	750
Training, courses and conferences	174
Redundancy	991
Insurance	79
Losses, ex gratia and special payments	(78)
Other	97
	73,255

Auditors' remuneration

	4 months 2010/11 £'000
Audit services – statutory audit	57
Audit services – audit related regulatory reporting	8
	65

Audit Liability Cap

The engagement letter signed on 23rd March 2011 states that 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 £1,000,000 in the aggregate in respect of all such services.

7. Operating leases

As lessee:

	4 months 2010/11 £'000
Payments recognised as an expense:	
Minimum lease payments	180
Contingent rents	-
Sub-lease payments	-
	180

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

8. Employee costs and numbers

8.1 Employee costs

	4 months 2010/11 Total £'000	Permanently Employed £'000	Other £'000
Salaries and wages	35,758	35,758	-
Social security costs	2,857	2,857	-
Employer contributions to NHS Pension scheme	3,913	3,913	-
Other pension costs	-	-	-
Termination benefits	991	991	-
Agency/contract staff	4,634	-	4,634
	48,153	43,519	4,634

8.2 Average number of people employed

	4 months 2010/11 Total	Permanently Employed	Other
	Number	Number	Number
Medical and dental	433	433	-
Administration and estates	823	823	-
Healthcare assistants and other support staff	399	399	-
Nursing, midwifery and health visiting staff	950	950	-
Scientific, therapeutic and technical staff	415	415	-
Other	5	5	-
Bank and agency staff	363	-	363
	3,388	3,025	363

3,388 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

	4 months 2010/11 Remuneration	Employer's Pension Contributions	Employer's NI	Benefits in Kind	Total
	£'000	£'000	£'000	£'000	£'000
Executive Directors	287	38	31	4	360
Non Executive Directors	15	-	1	-	16

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

8.4 Staff sickness absence

	4 months 2010/11
Total days lost	7,490
Total staff years worked	1,003
Average working days lost (annualised)	7.5

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

8.5 Management costs

	4 months 2010/11 £'000
Management costs	3,641
Income	74,969

Management costs as a percentage of relevant income	4.86%

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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

(b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation. Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

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

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

(c) Scheme provisions

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

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

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

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

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

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

Members can purchase additional service in the NHS Scheme and contribute to money purchase 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 four month period ended 31 March 2011 there were no early retirements from the Trust agreed on the grounds of ill-health.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	4 months 2010/11	
	Number	£'000
Total Non-NHS trade invoices paid in the period	18,281	27,949
Total Non-NHS trade invoices paid within target	17,172	26,214
Percentage of Non-NHS trade invoices paid within target	93.93%	93.79%
Total NHS trade invoices paid in the period	741	4,532
Total NHS trade invoices paid within target	527	3,327

Percentage of NHS trade invoices paid within target	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 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

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

13. Finance expense

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

14. Property, plant and equipment

2010/11:	Land	Buildings excluding dwellings	Assets under construction and payments on account	Plant & machinery	Transport & equipment	Information technology	Furniture & fittings	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost or valuation at 1 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	-	89
Assets under Construction & POA	-	-
Plant & Machinery	-	12
Transport Equipment	-	1
Information Technology	-	8
Furniture & Fittings	-	8

15. Intangible fixed assets

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

There were no impairments during the period to 31 March 2011.

17. Capital commitments

Contracted capital commitments as at 31 March 2011 were as follows:

	31/03/11 £'000
Property, plant and equipment	4,106
Intangible assets	-
Total	4,106

18. Inventories

	31/03/11 £'000	01/12/10 £'000
Materials	3,017	2,358
Finished goods	771	775
Total	3,788	3,133

19. Trade and other receivables

19.1 Trade and other receivables

	Current		Non-current	
	31/03/11 £'000	01/12/10 £'000	31/03/11 £'000	01/12/10 £'000
NHS receivables – revenue	2,273	2,969	-	-
Provision for the impairment of receivables	(1,051)	(792)	-	-
Prepayments	1,908	2,774	-	-
Accrued income	2,936	10,413	-	-
VAT	365	-	-	-
Other receivables	2,841	2,971	1,044	799
PDC dividend receivable	116	-	-	-
Total	9,388	18,335	1,044	799

19.2 Receivables past their due date but not impaired

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

19.3 Provision for impairment of receivables

	31/03/11 £'000
Balance at 1 December 2010	792
Amount written off during the period	(20)
Amount recovered during the period	-
(Increase)/decrease in receivables impaired	279
Balance at 31 March 2011	1,051

20. Cash and cash equivalents

	31/03/11 £'000	01/12/10 £'000
Cash with Government Banking Service	18,604	13,644
Commercial banks and cash in hand	53	37
Balance at 31 March 2011	18,657	13,681

21. Trade and other payables

	Current		Non-current	
	31/03/11 £'000	01/12/10 £'000	31/03/11 £'000	01/12/10 £'000
Interest payable	11	69	-	-
NHS payables – revenue	477	988	-	-
Non NHS trade payables – revenue	4,334	4,130	-	-
Non NHS trade payables - capital	1,106	418	-	-
Other payables	1,846	1,748	-	-
Accruals	11,322	9,985	-	-
PDC dividend payable	-	651		
VAT	-	81	-	-
Trade and other payables	19,096	18,070	-	-
Deferred income	1,864	2,394	-	-
Other liabilities	1,864	2,394	-	-

22. Borrowings

	Current		Non-current	
	31/03/11 £'000	01/12/10 £'000	31/03/11 £'000	01/12/10 £'000
Department of Health loan	2,450	2,450	2,450	3,675
Finance lease liabilities	-	-	-	-
Total	2,450	2,450	2,450	3,675

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

	31/03/11 £'000
Total long term borrowing limit set by Monitor	25,500
Working capital facility agreed with Monitor	15,000
Total Prudential Borrowing Limit	40,500
Long term borrowing at start of period	6,125
Net actual borrowing/(repayment) during period	(1,225)
Long term borrowing at 31 March 2011	4,900

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

Financial Ratios

	31/03/11	Limit
Minimum Dividend Cover	3.3	>1.0
Minimum Interest Cover	43.8	>3.0
Minimum Debt Service Cover	5.6	>2.0
Maximum Debt Service to Revenue	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 31/03/11 £'000	Present value of minimum lease payments 31/03/11 £'000
Within one year		
Between one and five years	-	-
After five year	-	-
Less future finance charges	-	-
Present value of minimum lease payments	-	-

25. Finance lease commitments

The Trust has not entered into any finance lease whereby the asset will be made available for use and rental payments commence in 2011/12.

26. Provisions for liabilities and charges

	Pensions relating to other staff £'000	Legal claims £'000	Other £'000	Total £'000
At 1 December 2010	516	45	660	1,221
Arising during the year	42	104	1,335	1,481
Used during the year	(27)	(1)	(63)	(91)
Reversed unused	(54)	(38)	(326)	(418)
At 31 March 2011	477	110	1,606	2,193
Expected timing of cashflows:				
In the remainder of the spending Period to 31 March 2012	53	110	1,402	1,565
Between1 April 2012 and 31 March 2016	190	-	69	259
Later than five years	234	-	135	369
As at 31 March 2011				
Current	53	110	1,402	1,565
Non-Current	424	-	204	628

Of the provisions a total of £158,000 is recoverable from PCTs under back to back arrangements.

Clinical negligence provisions

Included in the provisions of the NHS Litigation Authority at 31 March 2011 is £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 2011 include: -

- two injury benefit cases of £116,000 as notified to the Trust by the NHS Business Services Authority - Pensions Division;
- redundancy/restructuring costs of £1,079,500 which includes £1,014,000 for restructuring the pathology service; and
- unpaid salary arrears for medical staff transferring to a new contract of £54,000.

27. Contingent assets/(liabilities)

Other

Other Contingent Liabilities for non-clinical negligence incidents total £(35,000).

28. Financial instruments

28.1 Financial assets

	Loans & Receivables £'000	**Total** £'000
Trade Receivables	9,388	9,388
Cash at bank and in hand	18,657	18,657
Total at 31 March 2011	28,045	28,045

28.2 Financial liabilities

	Other £'000	**Total** £'000
Trade Payables	21,986	21,986
Other borrowings	4,900	4,900
Other financial liabilities	1,864	1,864
Total at 31 March 2011	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 it capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

29. Events after the reporting period

There are no events after the reporting period having a material effect on the accounts.

30. 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:

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

31. Third Party Assets

The Trust held £9,000 cash at bank and in hand at 31 March 2011 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.

32. 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 past 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 57 cases of losses and special payments totalling £(85,000) paid between December 2010 and March 2011. This includes 1 case which was a reimbursement of £106,000 in relation to a payment made in 2009/10. 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.

Ashford and St Peter's Hospitals NHS Foundation Trust
June 2011

This report was produced by the Communications Team, Ashford and St Peter's Hospitals NHS Foundation Trust, Guildford Road, Chertsey, Surrey KT16 0PZ

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