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Chairman’s Forward

Having joined the Trust as Chairman midway through this financial year, I have been very impressed with the work of all the members of staff and, in those that I have met and talked with, I have been struck by their dedication to serving our patients. This has been a busy and challenging year for everyone as we continue to provide good quality care for our patients against a backdrop of national financial pressures felt across the whole of the NHS. Our staff have worked incredibly hard to make sure that patient care is at the heart of everything that we do and I am pleased to report that our performance and achievements during 2011-12 reflect this.

The 2011 Dr Foster Good Hospital Guide highlighted the Hospital as having one of the lowest and most improved ‘Hospital Standardised Mortality Ratios’ across the country; in a comprehensive Care Quality Commission inspection undertaken in November 2011, the Hospital met all 17 key standards. In addition to this, Kingston Hospital has been named in the CHKS Top 40 Hospital’s list for the eleventh year running which demonstrates our commitment to providing high quality treatment and safe care for those who come to us.

Our vision for the Hospital is to be the ‘Hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff’. The Trust is focusing on delivering five strategic objectives over the next 5 years, which will enable us to fulfil this vision.

These are:

- Delivering quality, patient centred healthcare services with an excellent reputation;
- Delivering care by competent and caring staff working in effective and supportive teams who feel valued by the Trust;
- Working with partners to consolidate and strengthen the healthcare we deliver to our local community;
- Working with GPs and other providers to support the delivery of more care in primary and community settings; and,
- Delivering well managed quality services which are value for money for the taxpayer.

We have moved closer to our goal of becoming a Foundation Trust in the last year. As well as progressing with our business plan and application, we have undertaken a three month public consultation and now have a public membership of approximately 4,800, with the expectation of having 5,000 members by summer 2012.

We still have some work to do as part of our Foundation Trust application which includes the recruitment of local people to stand in our Council of Governors elections taking place in the summer. If all goes to plan, then the Hospital will be a Foundation Trust by the end of this year.

Being a Foundation Trust will be of great benefit to our patients as it will give local people more say on the services that we offer to our community and further develop the Hospital in line with local needs to provide the best care, treatment and facilities for them. Equally, there are benefits of being a Foundation Trust for the Trust, as it will give us more control over our own affairs and decision making and enable us to make appropriate
changes to the Hospital for the local population more easily, with the support of the Council of Governors.

Our staff, partners, members, volunteers and fundraisers all make a huge contribution in helping make sure that patient care is at the forefront of everything we do, and I would like to record our thanks to all of them for their continued commitment and hard work. I would also like to extend my personal thanks to the Chief Executive, Executive Directors and other members of the Trust Board for helping me to settle in to my new role while continuing to provide strong leadership of the Trust.

Ian Reynolds

Chairman
Chief Executive’s Introduction

I would like to warmly welcome our new Chairman, Ian Reynolds, to the Trust, who joined us at a very busy time, in November 2011. Ian settled into the role of Chairman quickly and easily, which has helped the Executive Team continue with their drive and determination to deliver the Trust’s strategy and vision; it has been a pleasure working with him over the past few months.

Throughout the past year our key focus has been on improving quality and safety for our patients by building on the good work we have already done in these areas. We have also been focusing on delivering the key performance targets, such as reducing the length of time our patients wait in Accident & Emergency and how long they wait for their outpatient appointment or operation. We have also been progressing with our Foundation Trust application and we hope to become licenced as a Foundation Trust towards the end of 2012.

During the summer of 2011 and on the heels of our national patient safety award win in March last year, we carried out an extensive piece of work with our staff to define the kind of culture we wanted to have at Kingston Hospital. We spent some time talking about the kind of culture we thought we wanted to see here and through discussions with staff came up with a culture, as one which is ‘patient centred, which puts safety first and where staff take responsibility, are valued and value each other.’

We then spent a number of weeks refining a set of shared values and behaviours – to be caring, safe and responsible, and to value each other. Over the latter half of the year, these values and associated behaviours were then adopted into the Trust so they are reflected in our policies, such as our recruitment and staff appraisal framework, making them what we do. It is about us all helping each other to deliver great patient experience more consistently – involving people who use our services, their families, carers, staff and partners in continuing to improve the experience people have using and delivering our services.

Already we are seeing how this is having an impact on the work we do, as there have been a number of achievements this year that I am especially proud of. We passed an unannounced full inspection by the Care Quality Commission with flying colours and received fantastic feedback from them on the care we are providing to our patients. We were also named in the national Dr Foster Good Hospitals’ Guide as having one of the lowest and improved ‘Hospital Standardised Mortality Ratios’ of NHS Trusts across the country. This means that less people die at Kingston Hospital than at any average Hospital. The Good Hospital Guide showed that the Trust is one of the best performing Hospitals in the country for patients who break their hip, with operations carried out quickly and patients stay in Hospital well below the national average, which means our patients are back at home sooner than most other patients across the country.

Finally I’d like to thank all the staff and volunteers at Kingston Hospital; the team of people who day to day make this Hospital the success it is. Without their support and hard work we would not have achieved what we have. We are looking forward to the future and what will be another very busy year ahead for us.

Kate Grimes
Chief Executive
Directors’ Report

The Trust continues to deliver excellent patient care to the communities it serves, whilst seeking to maintain a strong financial position that will allow it to drive forward quality and service improvements in future years.

Striking a balance between quality and service delivery and a healthy financial position, with surpluses to reinvest, is proving increasingly challenging in the ever tightening financial environment.

The Trust has worked hard to achieve against the CQUIN (Commissioning for Quality and Innovation) targets agreed with our commissioners for the financial year, and will continue to work hard to achieve against the targets set for 2012-13.

In addition, the Trust is preparing for the wider changes the Health and Social Care Bill will introduce, and have been building strong and productive relationships with the new Clinical Commissioning Groups in the communities we serve.

Performance and Inspection

Sustaining operational performance against a wide range of national and local targets and measures, as well as ensuring the delivery of high quality and clinically safe care to hundreds of thousands of patient contacts a year remains an enormous challenge. It has required sustained effort from all of the Trust’s staff, and the Trust works hard to support them, for example through successful Frontline Focus Fridays and the Releasing Time to Care programme.

The Trust continues to have considerable success in reducing hospital acquired infections and retains a constant focus on quality, safety, clinical effectiveness and patient experience through the priorities agreed with local stakeholders for the Quality Account.

The Trust performed well in the 2011 Patient Environment Action Team inspection, being rated as good in environment, excellent in food and good in privacy and dignity.

However, the Trust is aware there is more that can be done to improve the quality of the care for patients. The Trust’s Risk Management Strategy focuses on a fair blame approach, seeking to identify improvements and learning from lessons highlighted through risk assessment, adverse events, near misses and patient and public feedback.

Under the Care Quality Commission’s system for regulating health and social care organisations the Trust was granted its licence to provide services with no conditions or improvement notices, having complied with all sixteen essential standards for quality and safety.

In November 2011 the Trust met 100% of the standards in a full unannounced inspection. The report on the inspection demonstrates that the Trust is continuously striving to deliver high quality services and that patients treated at the Trust receive safe and appropriate care that meets their needs.

An inspection of dignity and nutrition in October 2011 put the Trust as one of only 45 out of the 100 Trusts inspected that were fully compliant and met these two key standards.

Working with our Partners

Our long working relationship with St George’s Healthcare NHS Trust has continued, with over 20 consultants with either joint appointments or clinical commitments at both hospitals.

Last year the Trust Board’s of both Trusts agreed a Strategic Alliance Partnership to understand what opportunities there may be for even closer working to develop clinical
services and improve clinical pathways for our patients.

Our partnership with The Royal Marsden Hospital NHS Foundation Trust and Macmillan Cancer Support continues to deliver benefits to our patients, both in terms of the delivery of treatment close to home and in the provision of high quality information and advice, all out of the dedicated Sir William Rous Unit on the Trust site.

Business Review
The Trust performed well in the year, despite the increasingly challenging financial environment.

The Trust has declared a surplus of £2.066 million for the financial year, slightly above the surplus planned for, after accounting for an impairment of £615 thousand due to the revaluation of the Trust's buildings. This year's surplus will add to those achieved in previous years.

As part of the Trust's Foundation Trust application, a review of the most prudent level of investment in service development and capital schemes in support of the Trust's strategic vision has been undertaken. The Trust is committed to funding future service development and capital out of generated cash flow, wherever possible.

The Trust has identified a number of drivers of change that it believes present both challenges and opportunities. These are:

- Changing health policy and legislation;
- The challenging economic environment;
- Changes to commissioning arrangements for clinical services;
- The drive to deliver more care closer to home, particularly in community settings;
- The need to continue to focus on improving productivity to make savings;
- The changing regulatory environment and powers available to the Trust associated with a move to Foundation Trust status; and,
- Commercial opportunities.

The Trust continues to focus on managing the risks associated with the drivers of change which are potential challenges, and on ensuring that it is in a strong position to take advantage of any potential opportunities.

The Trust has a well established financial and performance reporting model that includes detailed monthly scorecard reporting of national and Trust performance targets to the Trust Board. In addition, local performance indicators are well developed throughout the Trust. During the past year, we have made considerable progress in delivering patient level costing across the Trust, and this will be further developed and embedded in 2012-13.

The Board has paid close attention to the areas where performance has proved challenging, particularly the 18 week referral to treatment target following problems identified in the first quarter of 2011. Since October 2011 the Trust has been achieving all targets in this area.

Corporate Social Responsibility
The Trust has a strong track record of acting responsibly in terms of the environment, staff, the local community and wider population.

Our investment in a modern combined heat and power plant is showing reductions in both power costs and carbon production. Taken with other carbon management initiatives this means the Trust is on target to deliver a 10% reduction in its CO2 emissions by 2014-15.

The Trust is committed to buying goods and services responsibly, and wherever possible locally.

Board of Directors
The Board of Directors brings a wide range of experience and expertise to the stewardship of the Trust and continues to demonstrate the
vision, oversight and encouragement required to enable it to thrive.

On 31 October 2011 Christopher Smallwood (Trust Board Chairman) left to take up the post of Chairman at St George’s Healthcare NHS Trust, and the Trust welcomed Ian Reynolds as its new Chairman (from 1 November 2011).

In addition, during the year Trust Board membership consisted of five Non Executive Directors: Candace Imison; Michael Jennings; Joan Mulcahy; Cherill Scott; and, Jacqueline Unsworth.

And five Executive Directors: Kate Grimes, Chief Executive; Lance McCarthy, Chief Operating Officer to 16 May 2011; Sarah Tedford, Chief Operating Officer from 1 June 2011; Simon Milligan, Director of Finance; Jane Wilson, Medical Director; and, Jenny Parr, Director of Nursing & Patient Experience.

The Board of Directors is not aware of any relevant audit information that has been withheld from the Trust’s auditors, and members of the Trust Board take all the necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

Looking Ahead
The Trust, in common with the rest of the health service, and public sector as a whole, is operating in a changing and demanding environment.

The Trust recognises the need to significantly increase efficiency whilst maintaining high quality care at a time when budgets are getting tighter. The Trust will continue to use its solid financial track record and dedicated workforce to respond to these challenges.

The Trust’s application to become a Foundation Trust has progressed well during the year, and has the support of local commissioners and NHS London. The Trust hopes to be licenced by the end of 2012.

The Trust strongly believes the greater freedoms afforded upon licencing as a Foundation Trust will allow it to thrive and set its own strategic direction for the benefit of the patients and communities it serves, as well as its staff.

In conclusion the Board of Directors would like to thank the people who have helped the Trust to achieve so much in 2011-12, including our staff, our membership, the partner organisations we work with, the charities and volunteers that support our work and our many external stakeholders and supporters, in particular our commissioning primary care trusts and other NHS organisations with whom we work.

Kate Grimes
Chief Executive
On behalf of the Board of Directors
30 May 2012
Operating & Financial Review

Who We Are
Kingston Hospital is a single site, medium sized district general hospital, located within Kingston-upon-Thames. The Trust provides a full range of diagnostic and treatment services to approximately 320,000 people locally on behalf of commissioners within South West London and North Surrey.

For centuries, the town of Kingston-upon-Thames has served as the regional centre for the surrounding population. Residents from areas such as Wimbledon, Richmond, Epsom and Esher have historically travelled to Kingston for business, shopping, legal affairs at the courts and for their hospital care. Kingston also has a university and college drawing people in from further afield and a vibrant night time economy. There are excellent travel links and most importantly, historic flows mean that people from the surrounding area look at Kingston as their regional centre.

Although generally the catchment is fairly affluent, the Trust does serve more disadvantaged populations. The Trust also serves a mix of ethnic groups including large Korean and Tamil communities around Kingston and has therefore developed services to be responsive to the needs of a diverse population.

What We Do
Kingston is a popular local hospital and its services have a very good reputation. The Trust’s flagship services include:

- **Maternity Services** which are recognised locally, nationally and internationally as offering a very high standard of care. The Trust has the largest unit in south west London and is the second biggest single site unit in London, delivering around 5,900 babies a year;

- **Accident & Emergency Department** which is in the top 5% in the country seeing over 110,000 attendances per year. The Trust has relatively low admission rates and 95% of patients attending the Accident & Emergency Department spend less than 3 hours and 59 minutes in the Department;

- **Paediatric Services** which support the maternity and accident & emergency services. The Trust runs shared care cancer services with The Royal Marsden Hospital NHS Foundation Trust and Great Ormond Street Hospital for Children NHS Foundation Trust. The Trust is increasingly being asked to increase its’ shared care capacity for patients from other local areas;

- **Day Surgery Services** are provided from a purpose built unit, which was opened in 1996. The Trust started performing day surgery in 1978 and in 2004 was the first day surgery unit in Europe to be accredited by the Health Quality Service. The Trust regularly hosts hospitals from around the world who want to see how the Trust has designed and used its purpose built facility; and,

- **Cancer Services** are provided from a dedicated facility built in 2008, and in partnership with the The Royal Marsden Hospital NHS Foundation Trust and Macmillan Cancer Support.

The Trust has demonstrated consistently strong performance in operational delivery, clinical quality and financial management. The Trust has low levels of Health Care Acquired Infections, such as Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C.Diff), compared with other local hospitals and mortality rates are extremely low.
The Trust works closely with, and responds to the needs of the local community, by delivering care closer to home. The Trust’s clinicians provide and/or support care in outpatient and day surgery facilities at a number of community locations including Queen Mary’s Hospital Roehampton, Teddington Memorial Hospital, Molesey Hospital, Cobham Day Surgery Unit and Emberbrook Community Centre. The Trust has strong links with tertiary and specialist hospitals, particularly St George’s Healthcare NHS Trust and The Royal Marsden Hospital NHS Foundation Trust. The Trust also has close links with Kingston University and St George’s Medical School, and is a partner in the Elective Orthopaedic Centre based at Epsom Hospital.

Our Performance
During 2011-12:

- 113,021 people attended the Trust’s Accident & Emergency Department (including attendances to the Royal Eye Unit Casualty and GP admissions) with 17,441 needing emergency admission to the hospital;
- There were 340,007 attendances to the Outpatient Department.
- There were a further 21,256 outpatient attendances at the Wolverton Centre, including attendances at our Genito-Urinary, Family Planning and Alpha clinics;
- 22,180 patients were able to go home on the same day as their planned treatment or operation;
- 4,142 planned procedures requiring patients to stay in hospital were carried out; and,
- Our maternity unit delivered 5,914 babies.

Accident & Emergency
The Trust has consistently demonstrated good performance against the Operating Framework target of 95% in relation to the 4 hour target, whilst treating more patients than in previous years:

A number of new indicators have been introduced around patient care/experience in Accident & Emergency.

The median wait for patients for definitive treatment is 40 minutes against a target of one hour:
Only 3% of patients leave the department without being seen against a target of no more than 5%:

Work continues with GPs to address the 8.7% of patients who regularly re-attend Accident & Emergency.

During 2011-12 the Trust developed and implemented a number of ambulatory pathways which for some conditions has reduced the need to admit patients in to hospital. Patients can be treated and discharged home then followed up by an appropriate health professional if necessary.

Access and Waiting Times

In Quarter 4 of 2010-11, the Trust 18 week Referral to Treatment target fell significantly as a result of a problem with the administrative processes regarding the booking of patients. Since October 2011 the Trust has been achieving all performance standards relating to the 18 week Referral to Treatment target:

A thorough review of all the issues was undertaken and corrective action taken as follows:

- A review of waiting list processes. Administration teams are being devolved to work closely with the operational teams to improve the patient experience by providing a more responsive service and improving patient choice;

- The operational divisions have undertaken a review of demand and capacity in all specialities to support sustained delivery of waiting times. Capacity has been increased in Ophthalmology and work is underway in Trauma and Orthopaedics to finalise a business case to increase capacity; and,

- The Directory of Services has been reviewed and expanded in conjunction with consultants to support GPs in making effective referrals. This has also resulted in greater slot availability and clarity of specialist clinics.
Genito-urinary Medicine Access
We are consistently delivering 100% compliance with 48 hour access to genito-urinary medicine (GUM) clinics.
Since October 2011 we have been providing an integrated sexual health service. This is good news for patients who can now sort out their sexual health and contraceptive needs at the same time.

Did Not Attend Rates

The Trust Did Not Attend rate in March 2012 was 9.6%, below the local target of 10%.
Whilst this has improved on previous years the Trust is reviewing options to introduce text alerts for patients to remind them of their appointments and ensure a more sustainable solution to reducing Did Not Attend rates.

Cancelled Operations
Work has been undertaken to improve the Trust performance for patients cancelled on the day of operation for non clinical reasons.
Theatre scheduling meetings take place weekly to ensure resources are appropriately allocated for all planned theatre lists.

Delayed Transfers of Care
Significant work has taken place to maintain the rate of delayed transfer of care at 2.6%. This has included increased collaboration with community providers and local authorities to ensure that transfers to community hospitals, support in the home and residential/nursing home placements are organised promptly.

Cancer
Year to date performance (February 2012) for all cancer targets is above plan. Performance has however fluctuated in both the 62 day referral to treatment target and 31 day diagnosis to treatment target.

The numbers of patients in these two standards are very low which impacts on performance. Poor performance has mainly been as a result of delays in patient pathways created between organisations. The Trust is working closely with other hospitals to improve pathways and remove any unnecessary delays.
The Trust has invested in an information system to help track patients on their cancer pathway. This is currently being installed and will be fully operational by May 2012.

Stroke
We were successful in meeting the A2 and B Stroke Unit standards and have therefore maintained Stroke Unit Accreditation.
Our performance in relation to the time spent on the stroke unit and treatment of Transient Ischemic Attack (TIA) patients within 24 hours has improved as recognised by the South London Stroke and Cardiac Network.

Venous Thromboembolism (VTE)
We are focused on ensuring all appropriate patients receive their VTE assessments and have achieved the 90% standard.

A key challenge within this process remains the timely collection and recording of the clinical activity within our patient administration system. This is being improved through increased awareness and training.

Infection Control
The Trust has worked hard to reduce infection rates over recent years. Infection prevention and control remains a top priority for the Trust and significant progress has continued to be made in maintaining low levels of healthcare associated infections.

During 2011-12 the Trust reported a total of two Trust apportioned cases of MRSA bacteraemia against a ceiling target of three.

The Trust reported a total of 33 Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemias during the past year, of which six were Trust apportioned. There are no ceiling targets for MSSA bacteraemias.

During 2011-12 the Trust reported a total of 18 Trust apportioned C.Diff cases against a ceiling target of 17.

Reports on infection prevention and control are routinely presented at divisional governance meetings. Aspects of infection prevention and control feature in the Nursing Scorecard. The Director of Nursing & Patient Experience is also the Director of Infection & Prevention Control (DIPC) and reports to all Trust Board meetings.

The Trust has also worked with the Department of Health Saving Lives programme to ensure compliance in a number of high impact areas including hand hygiene, bare below the elbow, urinary catheter care, management of peripheral lines and isolation procedures.

Mortality
The Trust has one of the lowest and most improved mortality rates across the country. Compared to other acute hospitals in the country, the Trust has performed well in terms of its Hospital Standardised Mortality Ratio. The Trust’s ratio of actual number of deaths to the expected number of deaths (where 100 is the national average) is 82.

The Trust’s performance in relation to mortality is presented to the Trust Board on a monthly basis within the Clinical Quality and Patient Safety Report.

Commissioning for Quality and Innovation (CQUIN)
In agreeing the 2011-12 contract the Trust agreed a number of clinical quality targets associated with the CQUIN process. These
included: improved patient experience; VTE assessments; end of life care; chronic obstructive pulmonary disease discharge bundles; health promotion; the timeliness and quality of discharge summaries; and, improved medicines management.

The Trust has made good progress against each of the standards and latest forecasts suggest an achievement of c90% of the full financial value of the CQUINs.

Our Achievements: Highlights of the Year

Inspections by the Care Quality Commission (CQC)
The Trust met 100% of the standards set out by the Care Quality Commission in a full unannounced inspection of the Trust undertaken in November 2011.

The full Care Quality Commission report highlighted the Trust as being compliant across all 16 standards that the government says patients have the right to expect. After speaking with patients, staff and stakeholders and observing the running of the Trust for two days, 14 inspectors agreed that the Trust met all essential standards including:

- Treating people with respect and involving them in their care;
- Providing care, treatment and support that meets people’s needs;
- Caring for people safely and protecting them from harm;
- Quality and suitability of management; and,
- Staffing.

Patients echoed this when interviewed by the Care Quality Commission during their inspection. The report includes quotes from these satisfied patients including; “they treat you as a person here,” and “the care has been exemplary, I can’t fault them”. Many patients even said that they preferred Kingston Hospital to other Hospitals that they could have gone to, and one patient remarked; “we made a deliberate and positive choice to use this Hospital because of the standard of service provided”.

The report demonstrates that the Trust is continuously striving to deliver high quality services and that patients treated at the Trust receive safe and appropriate care that meets their needs.

Following an inspection on elderly care in October 2011, the Trust was named as one of only 45 Trusts out of 100 that were inspected that were deemed fully compliant and that met two key standards relating to elderly care:

- Standard one: privacy and dignity – respecting and involving people who use services; and,
- Standard five: nutrition – respecting and involving people who use services and meeting the nutritional needs of patients.

During their spot check, the Care Quality Commission inspected two of the Trust’s medical wards and found that the patients were treated with kindness, respect and that their privacy was maintained. During their visit they found that the patients were able to make informed choices and were involved in planning their care and treatment.

The inspectors also found that patients were able to make informed choices about their meals and drinks. Patients were aware that the Trust caters for special diets and that each individual patient’s nutritional needs were assessed and monitored. The report highlighted that people were given the support they require by staff to make sure they have a balanced diet and enjoy their meals.

The Trust was also commended on the interaction with patients during mealtimes, the assistance offered to patients who were unable to eat their meals themselves and the quality of the food they were given.

In March 2012, the Trust had an unannounced visit from the Care Quality Commission to
investigate if the Trust was compliant with Termination of Pregnancy regulations.

The inspector reviewed a sample of patient notes and spoke to staff about the Trust's processes.

Verbal feedback was received by the Chief Executive, Medical Director and Director of Nursing & Patient Experience on the day of the visit and the Trust was found to be fully compliant with the standards required.

The Trust is awaiting a full report from the Care Quality Commission.

Dr Foster 2011 Good Hospital Guide
In the 2011 Dr Foster Good Hospital Guide the Trust excelled in certain areas such as mortality rates, which show us as having one of the lowest and most improved ‘Hospital Standardised Mortality Ratios’ of NHS Trusts across the country. This means that less people die at The Trust than at any average Hospital and that the Trust has a downward trend in mortality rates.

The Guide also incorrectly reported that the Trust had unusually low levels of staffing in at weekends, which had some reputational impact for us. After discussions with Dr Foster they acknowledged that they had used incomplete data to calculate our staffing ratios, hence the error. Dr Foster sent us a written apology, removed the incorrect data from their website and added a correction.

Excellent Hip Fracture Care
The Doctor Foster 2011 Good Hospital Guide also showed that the Trust is one of the best performing Hospitals in the country for patients who break their hip, with operations carried out quickly and patient stay in Hospital well below the national average.

The Trust’s Orthopaedic Unit also continues to achieve 80% compliance with the ‘Best Practice Tariff’ for patients admitted to Hospital following a hip fracture. The Orthopaedic Unit at the Trust has used this initiative to improve and develop the service provision for hip fracture. By using this approach, the Trust has seen an improvement in standards of care for patients with hip fracture.

In the last year, we have continued to make improvements in standards of care for patients with fractured hips. This includes:

- Average time to operation of 23.71 hours – compared to the London average of 34.19 hours and national average of 34.55 hours;
- Average length of stay ranging from 14.5 to 15 days – compared to the London average of 20.39 days and national average of 19.77 days;
- Pre-operative assessments by specialist geriatricians in 100% of patients – compared to London levels of 87% and national levels of 69%;
- Bone protection and prevention of further fractures in 98% of patients – compared to London levels of 91% and national levels of 86%; and,
- Falls assessments performed in 98% of patients – compared to London levels of 91% and national levels of 86%.

Our results are recorded and reported using the National Hip Fracture Database which shows that the unit has demonstrated steady improvement in key areas of care.

One of the Hospital’s Matrons and Orthogeriatrician has been selected to join the expert panel for hip fractures at NHS London. This panel has been charged with standardising the care across London to ensure all hospital delivery a quality service by achieving the ‘Best Practice Tariff’ for this patient group.

CHKS ‘Top 40’ Hospital
The Trust has been named in the CHKS Top 40 Hospital’s list for the eleventh year running. The Top Hospital category is based on 21 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and
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quality of care and demonstrates the Hospital’s commitment to provide high quality, safe care to its patients.

Defining our Values
In March 2011 the Board agreed an Organisational Development Plan including key objectives to achieve in 2011-12. These were:

- Defining the organisational culture and developing with staff and patients a clear set of future values for the organisation;
- Setting out the behaviours that support our values and embedding these within the Trust;
- Supporting managers and staff with training and development;
- Setting expectations for individuals and teams that are balanced (use a balanced scorecard) at all levels; and,
- Making progress on better aligning expectations with incentives and performance measures.

We have made good progress with this plan and over the Summer of 2011 undertook a comprehensive engagement and consultation exercise with our staff to define with them the desired culture of the Trust, as one which is ‘patient centred, which puts safety first and where staff take responsibility, are valued and value each other’.

The values that support this, developed by our staff, are that we are ‘caring, safe, responsible and value each other’.

For each value we have worked with staff to describe the behaviours that will evidence living those values every day. As well as the four values and associated behaviours, we now have a set of 14 commitments and service standards that our patients can expect us to provide. These are also included in the new appraisal paperwork that the Trust launched in March 2012.

Nursery Receives Outstanding OFSTED Report
The Trust’s Honey Bees Staff Day Nursery has scored “Outstanding” in all categories after OFSTED inspected the team and their facilities in Summer 2011.

OFSTED reported that: “Overall quality in the early years provision is outstanding. The staff team are highly effective and nurturing, which helps children settle and feel safe. Overall children flourish and enjoy being part of an exciting and child-led environment. The exceptional partnership with parents and carers is a key strength of the nursery”.

The nursery provides on-site childcare for Hospital staff whose children are aged between one and five years and the Trust has recently expanded the nursery into a new building to accommodate more children and provide a new atmosphere in which the children can develop further.

Maternity Unit Improvements
There have been a number of changes and improvements in the Hospital’s Maternity Unit to deliver better care for mothers and their babies. A new Consultant Midwife joined the Maternity Unit in November 2011. Although many units across London have a consultant midwife, this is a first for Kingston and is the only consultant midwife in hospitals across South West London. The consultant’s main roles will be focusing on the promotion of normal birth, both clinically and through staff training, and supporting those women who have a complex medical history to achieve a normal birth.

In addition to this, a dedicated vaginal birth after caesarean (VBAC) clinic has been set up within maternity to support women who previously delivered by caesarean section to have a normal birth with support and advice.
This year, the Maternity Unit has invested in a training mannequin for simulation. This will complement the existing training programme for staff working in the Unit and ensure they are well prepared for and practiced in rare emergency situations.

**Advanced Training for Maternity Support Staff**

The Maternity department has supported 17 support staff on a foundation degree programme over 2 years at Kingston University and South Bank University. At the end of the programme the Midwifery Support Workers will be able to practice at an advanced level to support the role of the midwife and improve the quality of care for women and their family.

**Diagnostics**

The Radiology Department at the Trust continue to deliver same day Computed Tomography (CT) scanning for inpatients contributing to the improved patient flow that is evidenced in the Trust’s reduction in average length of stay. In addition, the Department has opened up a number of pathways that GP’s can have direct access to. This enables patients to receive diagnostic tests early in their treatment and may prevent non-essential attendance in Outpatients.

The Pathology laboratory has maintained its accreditation status with Clinical Pathology Accreditation and demonstrated compliance with Medicines and Healthcare products Regulatory Agency (MHRA) and the Human Tissue Authority (HTA). The availability of order communications for GP’s has also increased as part of a planned roll out of this information technology function that allows desk top ordering of tests for GPs.

**New Acute Assessment Unit**

In July 2011 the Medical Assessment Centre became the Acute Assessment Unit (AAU) and moved from Roehampton Wing to a new area on Level 3 within the Kingston Surgical Centre. The increased closeness to Accident & Emergency has led to easier patient flow and has also enabled the Trust to improve discharge planning and have senior clinical input from all medical specialities teams from across the Trust. Overall, the new environment and facilities, including more space between beds, has enhanced patient and staff satisfaction.

**Momentum Viewing Room**

At the end of 2011, The Trust’s Paediatric Accident & Emergency Department worked with the charity Momentum to provide a special place where families could spend time with their loved one, if their child was to die suddenly. Momentum commissioned local artist Amanda Leggatt to design a space which was beautiful and peaceful for this difficult time.

The Accident & Emergency Department is a very busy environment and the dedicated room enables parents to spend as much time as possible with their child, allowing them time to bathe, dress and generally be with their loved one without feeling like they have to leave the department in a hurry. Staff working within Paediatric Accident & Emergency have already had positive feedback about the new room.

**Introduction of Rapid Assessment in Accident & Emergency**

In line with the new Department of Health Quality Indicators for Emergency Care, new rapid assessment processes have been introduced into the working of the Accident & Emergency Department to ensure that the sickest patients in need of clinical input, receive an initial assessment and start of treatment within the shortest space of time.

**Increase in Accident & Emergency Consultants**

An expansion in the number of consultants in the Accident & Emergency Department is currently taking place and will mean double the number of consultants working in the Department, bringing the total to ten. This will
bring the Trust closer into line with College of Emergency Medicine and Department of Health recommendations and will allow more senior presence and consultant-led working within the Department. It will also mean consultant presence in Accident & Emergency for over sixteen hours each day, seven days a week.

**New Cardiac Catheterisation Laboratory**
In 2011, the Trust opened a new Cardiac Catheterisation Laboratory to provide on-site diagnostic service for patients. The laboratory has been very beneficial in reducing the length of stay from and in improving the time to diagnosis and treatment for patients who previously had to wait to be transferred to a tertiary centre.

**Improved Patient Pathways**
The Acute Medicine & Emergency Care division at the Trust has launched an intensive programme of work aimed at delivering quality care for the right patient in the right setting at the right time.

The work streams developed to support this look at improving the flow of patients from the ‘front door’ to effective, timely discharge into the community and include a focus on ambulatory care pathways, complex discharge for care of elderly patients and emergency assessment. Significant changes have already been made including a reduction in length of stay, introduction of additional ambulatory pathways to avoid inpatient admission, improved communication with patients and carers regarding the expected day of discharge and increased provision of community in reach services. A similar programme of work is planned to be launched in surgery and critical care.

**Breast Services**
A new Consultant Breast Surgeon joined the Trust in February 2012 from Barts and The London NHS Trust. The appointment has increased the Departments’ capacity to offer patients requiring breast cancer surgery the choice of immediate reconstruction. The additional clinic capacity for the breast surgery department will also provide more availability and choice for patients.

**Acute Oncology Service Launched**
In September 2011 the Trust introduced a new Acute Oncology (cancer) Service at the Trust.

As part of a national initiative, and developed in partnership with Consultant Oncologists from the Royal Marsden Hospital, the service brings their oncological expertise to the bedside of Kingston Hospital inpatients and integrates the existing outpatient and chemotherapy support already in place. Patients are seen and assessed on site by a Consultant Oncologist or Clinical Nurse Specialist from the Acute Oncology Service team within 24 hours of being referred. Those who need to be treated locally continue to do so while less common cancers are fast-tracked to specialist services.

**New Domestic Violence Service**
Following a successful pilot project the Trust now has a domestic violence service run by Victim Support, which provides confidential, independent support to victims of domestic abuse (both patients and staff).

The new service also provides tailored in-house training to staff to help raise awareness of domestic violence and to give them the confidence in identifying, supporting and referring patients to the service. It is hoped that the specialist service in the Trust will help increase the safety of those patients and staff affected by domestic violence and help to reduce both the short term and long term impact of violence and abuse on their health.

Since the service was launched in October 2011 the Service has had 88 people referred for advice and support and 90 members of staff have received training.
Outpatient Kiosks
The Trust is currently trialling the use of 'self check-in kiosks' in the main Outpatients Department.

Using the electronic screen, patients are now able to check themselves in for their appointments. These are similar to the airport check-in screens and those in some GP surgeries.

This is a great step forward for the Trust, not just in terms of technological advances, but also for patient experience as it will reduce the queues at the Outpatient’s reception desk. So far, the trial has gone very well and the feedback received from patients has been very positive.

The plan is to introduce the kiosks to other Outpatient areas if all continues to go well.

Sexual Health Integrated Service
In September 2011, the Wolverton Centre officially launched the Kingston Integrated Sexual Health (known as KISH), a multi-agency partnership group made up of local provider organisations responsible for delivering local sexual health services.

As a result of this new service, the Wolverton Centre commenced a service redesign and as from October 2011, is now a sexual and reproductive healthcare service providing a one stop clinic for the sexual health and contraceptive needs of patients.

In addition, the Centre also provides training for local health professionals enabling GPs and Family Planning Nurses to be able to offer LARCs (Long Acting Reversible Contraception) at their practices.

Our Finances
The Economic Environment
The tough economic climate means that the NHS must prepare for very low growth and give rising demand the equivalent of real-terms cuts in funding from 2011 onwards.

Revised forecasts for public spending, in the budget, mean the NHS is now under pressure to make significant savings. In his annual report the NHS Chief Executive states that the NHS will have to make efficiency savings of £15-£20 billion between 2010-11 and 2014-15.

2012-13 Financial Outlook
The assumptions provided by NHS London, which require around 5% a year improvement in efficiency, are included in the Trust’s Integrated Business Plan, as are reductions in the tariff (the amount the trust get paid for treatments) of 1.5% per annum based on recent Department of Health indications.

The South West London Primary Care Trusts (PCT) Cluster needs to save £125m up to 2014-15 to deal with financial and demographic pressures, and NHS Surrey also faces considerable financial challenge. The Trust’s plans allow for Quality Innovation, Productivity, Prevention (QIPP) savings of (£5.3m) for South West London and (£2.4m) for Surrey up to 2016-17 based on discussion with commissioners.

The Trust has developed a detailed financial plan for 2012-13 recognising the required reductions in public spending. This is a significant change from the previous environment of above inflation increases granted to the NHS, which made the planning cycle a challenging process for both providers and commissioners.

Whilst recognising the financial challenges ahead, the Trust has developed a plan showing a £2.1m (1%) surplus. It is important that this funding is saved for future years to ensure the estate and equipment can be maintained and updated as well as investing in service development.

The level of savings required to attain this surplus whilst continuing to invest in quality of care is £9.2m in 2012-13. This is a challenging target and developing schemes to deliver the savings has been a key part of the planning process. Efficiency targets have
been developed using service line reporting information for each department. This has enabled clinical engagement and appropriate levels of savings to be identified in all services. For 2012-13 back office functions have been set a higher percentage savings target than the clinical divisions, to ensure that the maximum funding is direct towards front line services.

2012-13 will see continued use of the clinical quality indicators (CQUINs). Achievement of the agreed quality standards will enable the Trust to earn £4.0m of clinical income. This is a key priority for the Trust and processes are being developed to ensure delivery of the indicators and receipt of the funds.

During 2012-13 the Trust will continue to work with commissioners to develop patient pathways which will ensure patients are seen by the right person, at the right time, in the right place.

Financial Performance in 2011-12
The Trust planned to deliver a £2.1m surplus in 2011-12, which it achieved.

During the year the Trust incurred additional costs relating to increased activity levels which were offset by additional income from over-performance payments.

Financial Targets
Each year the financial performance of the Trust is judged externally against a range of financial duties and targets.

A summary of the Trust’s duties is as follows:

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Rate of return on capital employed (Capital Cost Absorption)

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<td>Rate of return on capital employed</td>
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A full set of financial statements can be found later in this document.

Revenue
In 2011-12 the Trust received income of £204.5m. This was an overall increase of 2.2% on the income received in 2010-11.

The graph below shows the income received excluding any non recurrent funds to support projects in year:

Income can be split as following:

- Direct patient treatment; 90%
- Training and education; and, 4%
- Other income. 6%

Trust income relating to direct patient care activities increased by £3.1m in 2011-12, with other operating revenue increasing by £0.8m.

The PCT income increase is spread across most specialties. Two additional, one-off, funding streams were for activity relating to the clearance of the backlog on 18 week Referral to Treatment and the Department of Health winter access initiative.
During 2011-12 the Trust continued to work in partnership with other providers (e.g. St George’s Healthcare NHS Trust at Queen Mary’s Roehampton) to deliver patient care on their sites. This activity and its associated tariff income are not included within the Trust’s financial position.

The Trust’s patient care income of £178m was commissioned by five main PCTs:

- Wandsworth 19%
- Richmond & Twickenham 22%
- Sutton & Merton 6%
- Surrey 15%
- Kingston 42%
- Others 5%

**Expenditure**

Total costs incurred in 2011-12 were £202.5m, split as follows:

- £129.5m Staff costs
- £67.1m Running costs (excluding staff)
- £3.3m Finance costs (PFI)
- £2.5m Public dividend payable to HM Treasury
- £0.1m Write down on disposals

The graph below shows the costs incurred excluding any non recurrent expenditure to support projects in year:

Staff costs increased by £1.3m (1%) in the year.

This can be attributed to: pay awards and increments of £2.4m (2.0%); increased staffing to deliver increased levels of activity of £6.7m; partially negated by staff savings of £7.8m in the year.

Staff costs were split by staff group as follows:

The Trust’s running costs (excluding staff) showed a net increase of £2.3m (3.6%).

The main changes were due to:

- Clinical insurance premiums increased across the NHS in 2011-12 and the impact on the Trust was £1.1m;
- The Trust decreased expenditure on premises costs by £2m due to a combination of realignment between capital repayments and interest payments following a review of the PFI model and reductions on rental costs;
- Expenditure on clinical supplies and services increased by £1.3m as a result of increases in activity;
- Drug spend rose by £0.9m as a result of price and volume increases; and,
- Impairments on the Trust’s assets as a result of a revaluation were £0.5m higher.
The finance costs incurred by the Trust were £1.0m higher than those for 2010-11 and relate to the lease contracts now reported on the Statement of Financial Position (e.g. PFI). The increase is due to the realignment of the PFI payments as noted above.

**Capital Investment**

The Trust had an approved capital expenditure limit of £8.3m for 2011-12 (after taking asset disposals and donations into account). This is known as the Capital Resource Limit (CRL). The expenditure programme can be divided into three areas:

- Estates;
- Medical Equipment; and,
- IM&T.

Gross capital expenditure in 2011-12 was £9.1m, split:

- £4.6m (50%) maintaining and updating the estate;
- £1.8m (20%) replacing clinical equipment; and,
- £2.7m (30%) invested in IT infrastructure and systems.

Expenditure included improving the ward environment and investing in additional equipment to support clinical services such as the new fluoroscopy suite, together with IT developments such as the introduction of eRostering and a patient level costing system.

A donation from the Trust's Charitable Fund enabled a £0.5m development of the Maple Nursery during the year.

The Trust re-valued its land and buildings as at 31 March 2012. This has resulted in a reduction in the value of some assets, which is in part due to the current economic climate. The asset values have decreased by £2.6m, all of which relates to buildings, with land values unchanged. Where allowed, the fall in value has been funded using the revaluation reserve. The remaining cost of £0.6m has been charged to the Statement of Comprehensive Income as an impairment.

Planned capital expenditure for 2012-13 is £7.6m of which 41% relates to estates, 47% to IM&T and 12% to clinical equipment.

**Capital Cost Absorption Rate**

NHS Trusts must plan to achieve a rate of return on capital employed of 3.5%, known as the Capital Cost Absorption Rate. This reflects the Trust Debt Remuneration (dividends) as a percentage of net assets.

This charge recognises that there is a financing cost associated with the capital base which the Trust is required to absorb in full through the public dividend payable to HM Treasury.

This target was achieved by the Trust.

**External Financing Limit**

The External Financing Limit (EFL) is a control on net cash flows of NHS Trusts. It sets a limit on the level of cash that an NHS Trust may draw from external sources or its own cash reserves (which would be a positive EFL) or increase cash reserves (a negative EFL).

The Trust ended the year with an increase in cash reserves (marginally undershooting its EFL by £37k and therefore achieving the target) and has consistently met this target.

**Productivity and Efficiency**

The Trust successfully managed to deliver £10.1m of efficiency savings in year (2010-11:...
£11.1m) and looks to build on this position in 2012-13.

The Trust continues to work in partnership to deliver effective and efficient services to the local health economy. This is demonstrated through a below average national reference cost index of 89 in 2010-11 (100 being the average).

Recognising the future slowdown in public sector spending the Trust continues to develop its service line reporting system. This has enabled the examination of efficiencies, informed service strategies and played a key role in identifying savings programmes for 2012-13

Financial Standards

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

In 2011-12 the Trust paid 93% by value and 93% by number of non-NHS trade invoices and 93% by value and 91% by number of NHS invoices within the required timescale.

The Prompt Payment Code
On the 1 March 2010 the Trust became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:
- Pay suppliers on time;
- Give clear guidance to suppliers and resolve disputes as quickly as possible; and,
- Encourage suppliers and customers to sign up to the code.

External Auditors
The Trust’s external auditors for the financial year 2011-12 were the Audit Commission. Their fees amounted to £145k (2010-11: £165k), which was for services provided to conduct the statutory audit and related services.

Late Payment of Commercial Debts
There were no claims for interest payable under the late payment of Commercial Debts (Interest) Act 1999.

Pension Liabilities
The treatment of pension liabilities is detailed in the notes to the accounts.

Directors and Directors’ Interests
During the year none of the Trust’s Directors or senior management staff, or parties related to them, has undertaken any material transactions with Kingston Hospital NHS Trust.

Changes in Accounting Policies
The annual accounts are presented under International Financial Reporting Standards (IFRS), introduced in the NHS in 2009-10 to bring the NHS in line with private sector reporting.

There have been two changes to accounting policies in 2011-12, as directed by HM Treasury.
Accounting for donated assets: A donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as for purchased assets. Gains and losses on revaluations, impairments and sales are as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

Accounting for government granted assets: A government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

Our Future Plans

Mission and Vision
The Trust’s mission, which sets out our fundamental purpose, is:

- ‘To improve the health and well being of our community through the provision of high quality, patient focussed healthcare’.

The Trust’s vision, which sets out our goals for the next five years (following public consultation), is:

- ‘To be the Hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff’.

The vision is visually represented and described further, in the diagram below:

Core Services:
At the heart of the Trust’s vision is the provision of high quality hospital services for patients who need immediate care.

To deliver this the Trust needs to provide accident & emergency, maternity and intensive treatment unit (ITU) services together with beds into which we can admit emergency patients. These high acuity services will be consultant delivered with effective community and outreach.

The Trust believes that it should provide these services locally so that people don’t have to travel too far and women can give birth close to where they live as well as in the way they would like.

Planned Services:
The Trust plans to provide care for those patients whose illnesses need more intervention than can be available from their GP. Where appropriate the Trust will provide surgery and medical treatments locally so that local people have timely access to consultants, clinics and operations, and will only need to
travel further afield for specialist care. The Hospital’s planned core services will be high throughput, with low complexity and variability.

Integrated Community Services:
We will work in partnership with primary and community care to shift work out of the Hospital where clinically appropriate, supporting GPs in prevention, specialist advice and outreach services. Partnership working across primary, community and secondary care is much easier and more successful when this involves clinicians from a local Hospital such as Kingston.

The Trust has five strategic objectives to achieve by 2015-16 to achieve our mission and vision. These objectives and supporting strategies have been guided by the government White Paper “Equity and Excellence: Liberating the NHS and are summarised below:

- Delivering quality, patient centred healthcare services with an excellent reputation;
- Delivering care by competent and caring staff working in effective and supportive teams who feel valued by the Trust;
- Working with partners to consolidate and strengthen the healthcare we deliver to our local community;
- Working with GPs and other providers to support the delivery of more care in primary and community settings; and,
- Delivering well managed quality services which are value for money for the taxpayer.

In 2011-12 the following progress has been made towards delivery of the strategic objectives:

- We implemented a series of measures to maintain quality and safety as well as improving the efficiency and functioning of maternity services pending a new build development to expand capacity;
- The Acute Medicine and Emergency Care Division commenced a programme of work across five work streams, Emergency Assessment, Ambulatory and Short Stay, Improving Discharge, Health Care for Older People and Endoscopy. A workforce review is already underway and will also be integrated into this programme. The Acute Assessment Unit, formerly MAC has now moved from Roehampton Wing to the 3rd floor of Kingston Surgical Centre as part of this programme of work;
- Our 18 week waiting times performance has improved as a result of considerable work that has taken place over the last year and progress has been made to embed new processes to ensure sustained achievement of the standards;
- Progress has been made on the development of mechanisms for pathway redesign (the arrangements for diagnosis and treatment) with local GPs, including the establishment of a System and Sustainability Board. This brings together local clinical commissioners and other partners and provides a strong platform for the development of local services;
- Through the Strategic Alliance Partnership with St George’s Hospital we are exploring the potential to increase productivity at Queen Mary’s Hospital;
- The Trust has defined a set of values – caring, safe, responsible and valuing each other as well as associated behaviours. A monthly awards programme was launched in October 2011 for staff who demonstrate the values in their work;
- Improved the experience of our patients and GPs, through delivery of our patient experience and public involvement strategy which will include the introduction of a patient assembly, patient stories at the Trust Board, customer care training for frontline staff and the embedding of patient
experience key performance indicators (KPIs) in performance monitoring systems;

- Our governance arrangements within the Divisions were strengthened and management re-structures in Surgery and Critical Care and Medicine and A&E were implemented;

- We have strengthened our Board and committee structures to increase the focus on quality (patient safety, experience and outcomes); and,

- Patient level costing was introduced across the Trust by Autumn 2011, which helps to support the drive for more efficient use of resources.

To support delivery of the strategic objectives in 2012-13, the Trust will:

- Increase our services delivered by our most senior doctors (consultants) to improve patient outcomes;

- Work with the new Clinical Commissioning Groups (CCGs) to create a shared vision for healthcare locally. The Trust will work together to further develop urgent care services and take a more collaborative approach to medicines management and continue to develop joint pathways to reduce follow up rates as well as developing virtual clinics;

- Look at a wide range of initiatives and further developments to improve the service user experience;

- Continue to make improvements to the infrastructure and non-clinical processes, including improvements to Choose and Book, integrate digital dictation and voice recognition into Care Records Service, commission a document management system to strengthen our communication process with GPs and improve the format of electronic discharge summaries;

- Strengthen relationships with GPs through the System and Sustainability Board, working with individual CCGs, and an ongoing programme of GP practice visits and further development of the Kingston Hospital GP Forum;

- Continue to develop plans with GPs in Merton to provide Kingston outpatient services at the new Raynes Park Health Centre from Autumn 2012;

- Continue to work with BMI Healthcare to expand the provision of private patient services on the Kingston Hospital site; and,

- Implement the revised appraisal system.

Foundation Trust Application

The Trust has made good progress during 2011-12 with its Foundation Trust application and continues to deliver against the key milestones within the Tripartite Formal Agreement between the Trust, the Department of Health, NHS London and the South West London Cluster.

Since September 2010 we have had well over 70 meetings with GPs, PCTs, patients, patient groups, staff and local authorities and the plans within our five year Integrated Business Plan have been built around their priorities. Letters of support for our application have been received from key commissioners including South West London and NHS Surrey. An updated version of our Integrated Business Plan and Long Term Financial Model was submitted to NHS London in March 2012.

Having successfully navigated through two formal stages of Historical Due Diligence, completed the formal Strategic Health Authority Assurance Process culminating in the Board to Board Meeting with NHS London in February 2012, the Trust is currently progressing through separate external reviews of our Board Governance Assurance Framework, Quality Governance and Working Capital and Financial Reporting Procedures.

Moving forward with our Foundation Trust application is a major target for the Trust in 2012-13 and we are confidently expecting to
become a Foundation Trust in the coming financial year. We will be publishing the final version of our Integrated Business Plan and supporting Long Term Financial Model with a new base year of 2012-13. This has involved extending all our plans for a further financial year to 2017-18 and specifically the Cost Improvement Plans (CIPs) will be developed in detail for 2014-15.

Before moving to the Monitor (the health regulator) stage we will be completing a Board Statement and supporting Memoranda on clinical quality, service performance, risk management processes and Board roles, structure and capacity. Work will also be completed on addressing Commissioner caveats and agreeing with our Commissioners the Schedule of Mandatory Services and Schedule of Protected Assets. We will continue to implement our membership strategy and preparation for Governor Elections is underway with elections due to take place during September 2012.

A formal three-month public consultation on the Hospital’s Foundation Trust plans took place between April and July 2011. The consultation asked for views on the Trust’s vision, strategy, governance and management arrangements. During the consultation process the Trust’s plans were circulated and promoted widely. There were three public meetings, Trust Directors attended a number of formal council, commissioning and GP meetings and presented to the local Health Overview and Scrutiny Committees as well as Kingston’s Health and Wellbeing Board.

A total of 180 formal responses were received from members of the public and key stakeholders. The vast majority of those who responded were largely positive about the Trust’s plans with over 71% broadly in favour, 23% broadly neutral and only 6% broadly opposed to the proposed plans. The main issues and critical comments raised were around the Trust’s proposed governance arrangements. This was focussed on the makeup of the Council of Governors and the organisations represented and whether this was proportional. In response, the Trust Board agreed to separate Sutton and Merton so that they have one public seat each, and provide Kingston with a further seat, increasing the Council of Governors to 33.

Kingston Hospital Membership
Anyone over the age of 14 who lives in the Trust’s catchment area can become a public member of the Trust. All staff meeting the eligibility criteria will automatically become members of the Trust unless they opt out. Membership gives staff and the local population a greater say in the development of our future plans and the services that we provide to the community. Members will be able to hold the Board of Directors to account and have a say in the future strategic direction of the Trust, through the election of Governors.

The membership strategy seeks to build a membership that is representative of the local population through active engagement with patients, the public in general and key multi-faith and voluntary groups. Some members will wish to be more active than others in their involvement with the Trust. With this in mind, the membership strategy offers different tiers of membership to allow members to choose the appropriate level of involvement for them.

The Trust currently has a public membership of approximately 4,800 and a staff membership of 2,721. The Trust is working towards having a public membership of 5,000 by June 2012. The public membership is expected to increase to 8,000 within two years of the Trust becoming a Foundation Trust.

All members receive regular communications including a quarterly newsletter (Insight) and have the opportunity to find out more about the operation of the Trust and its services.

We have established a Patient Experience and Public Involvement Delivery Board, which will ensure a coordinated and planned approach to the delivery of our Patient Experience and
Public Involvement Strategy. Members are also invited to join a Readers' Panel and will have the opportunity to input into the Trust’s service developments and future plans and themed events such as a winter warmer information event. A programme of events has been planned for 2012. We also hold regular events which are open to members including ‘in your shoes’ listening events as well as ‘medicine for members’ events.

Council of Governors
As part of our Foundation Trust application we will be holding governor elections in the summer of 2012 and will be holding ‘Governor Awareness’ sessions for members and staff prior to the elections. The Council of Governors are all members of the Hospital. They comprise of:
- 17 elected public Governors;
- 4 elected staff Governors; and,
- 12 partnership appointed Governors.

The Trust has been meeting with and contacting different local charities and community groups to encourage them to become members and to stand as governors. The Trust is also actively working to ensure that we have a diverse group of candidates standing in the public and staff elections to represent the local population.

The Council of Governors is a voice for members and partners in a Foundation Trust’s governance structure. Foundation Trusts are required to be more responsive and accountable to the communities which they serve, and the Council of Governors is a way in which this can be formally monitored and achieved. The Council will be led by the Chairman of the Trust with the support of the Senior Independent Director, the Head of Corporate Affairs and the Communications and Membership Manager. The Council of Governors will establish a work programme for its first year, adopting the current membership strategy and deciding how to take it forward, identifying how the Council of Governors will deliver its statutory duties and the other priorities that the Council would like to address.

Better Services, Better Value
The NHS across South West London, like other parts of the NHS, is facing significant financial challenges. The South West London cluster has launched the Better Services, Better Value review to look at how Hospitals can work more efficiently and achieve better value for money for local people. Local doctors, nurses and therapists from across South West London, as well as patient representatives, have been working together since last summer to carry out the review.

There are five clinical working groups looking at the following areas:
- Planned care and end of life care;
- Urgent, unscheduled and emergency care;
- Maternity and newborn care;
- Children’s services; and,
- Long term conditions.

In March 2012, the South West London Cluster of PCTs published the recommendations from the final clinical reports that recommended:
- Three emergency departments in South West London rather than the current four, each with an integrated urgent care centre. A fourth stand-alone urgent care centre which could treat up to 70% of patients currently seen at A&E, is also proposed;
- Three obstetric units in South West London rather than the current four, though clinicians do not rule out the possibility of a stand-alone midwife-led unit. The three units would be co-located with emergency departments;
- A world class, state-of-the-art planned care centre for elective surgery, kept separate from emergency care, so that
emergencies do not disrupt planned operations; and,

- Increasing services in the community – more services delivered in GP surgeries, community settings and people’s homes, including support for people with long term conditions.

The Trust has been working collaboratively with the cluster and stands ready to help with any potential solutions proposed as part of the review. Whilst the Trust remains flexible in responding to emergent changes in demand as a result of the work to reconfigure unviable services elsewhere, at present our strategy is based on providing for the needs of our own catchment population.

There will be a formal public consultation taking place in the summer of 2012 on the different options to provide safe and high quality services across the hospitals in South West London.

**NHS South West London Joint Pathology Programme**

Following recommendations from NHS London Modernising Pathology Report and Carter 2 Report which demonstrated a case for the reconfiguration of pathology services across London, a review of Pathology Services is currently being carried out across the NHS in South West London.

The review will recommend a preferred set of options for Pathology Services across South West London that will deliver a sustainable and high quality service, whilst generating ongoing cost savings and supporting GP needs and Trust’s service strategies.

The Trust’s Chief Executive is leading this project and a steering group and Programme Board has been set up to oversee the project. This consists of the Chief Executives or their delegated representatives of the five Trusts in the cluster (Kingston Hospital NHS Trust, St George’s Healthcare NHS Trust, Epsom and St Helier University Hospitals NHS Trust, Croydon Health Services NHS Trust, and The Royal Marsden Hospital NHS Foundation Trust), the Clinical Directors for Pathology of the Trusts and a finance and communications lead for South West London.

Significant work has been undertaken with a broad cross-section of pathology staff across the cluster and work streams have been established in the four pathology disciplines as set out below, each consisting of a clinical and a laboratory lead from each of the five Trusts in the cluster:

- Blood sciences, including laboratory haematology, chemical pathology and transfusion services;
- Cellular pathology, including surgical pathology, diagnostic cytology, cervical screening cytology and autopsy services;
- Microbiology, including bacteriology, virology, mycology and parasitology; and,
- Immunology.

The work streams have developed and presented their vision of a future service model for their specialty across South West London. The clinical aspects of these models were then tested at an away day held in January 2012 which was attended by over 90 staff working in pathology services across the cluster. The result of this work is a clear preference for a single hub and spokes across the cluster, with immunology and microbiology work being focussed at the hub, along with some elements of cellular pathology and all “cold” blood sciences. Spokes would then be required on all acute Trust sites, to process urgent blood science work (predominantly Accident & Emergency and inpatient work) alongside some cellular pathology cutting up and reporting of samples.

A preferred option will be selected from a range of short listed options in May 2012. These will then be written up as an Outline Business Case for submission to the five Trust Boards in May/June 2012 and a full business case and implementation plan developed thereafter.
**Commercial Strategy**

In July 2011 the Trust Board approved a refreshed commercial strategy for 2011-12 to 2015-16 and supporting implementation plan to protect and where possible, increase the Trust's market share and income, so that the Trust can continue to provide the services that GPs and their patients want.

Much of the focus over the last six months has been on strengthening the service offering including reducing waiting times and putting processes in place to enable improvements in Choose and Book performance which are expected to have taken effect by April 2012. This work should enable the Trust to attract more referrals and in due course could create opportunities to pull work in from other providers who are unable to meet waiting times targets.

The four clinical divisions within the Hospital (Acute Medicine & Emergency Care, Surgery & Critical Care, Women & Child Health and Ambulatory Care) have continued to work up specialty level marketing plans which has created a better understanding of the costs of each specialty by point of delivery and highlighted some areas where further work is required.

Good progress has also been made on a number of key strategic projects supporting the commercial strategy, including the development of plans for the provision of outreach services to Merton residents at the new Raynes Park Health Centre at Lambton Road. The Trust is also working with BMI Healthcare (the private healthcare provider based on the Hospital site) to develop options for a new private patients facility on site.

**Estates Strategy**

The Trust has an estates strategy to provide a framework for all future site developments and to ensure their proper integration into the Trust’s overall business plans.

The strategy takes into consideration how the current estate is performing, how space is utilised, the functional suitability of buildings, costs of running the estate, and will help inform any future decision making about how buildings can be made suitable for key clinical developments.

The strategy seeks to support the Trust’s overall business plans and key service developments. It will ensure provision for new service developments and that existing buildings are well maintained and provide fit-for-purpose patient environments, as well as being a good neighbour to those living or working close by.

**Refurbishment and Improvement Works**

The Trust is the largest single site District General Hospital in South West London and over the years significant investment has been made to ensure the Trust has a high quality estate. As part of the on-going estates programme, the Trust has invested a total of £8.6 million this year for maintenance and refurbishments across the Hospital to help improve the patient experience. This includes a major refurbishment of one of the Paediatric wards, modification of toilets and showers in five of the Hospital’s wards and new layout and corridors in the Trust’s Day Surgery Unit to ensure single sex use and compliance.

The Trust’s Esher building and Accident & Emergency plant room have also had new roofing and the refrigerators in the mortuary have been replaced and the public waiting area and viewing room have been refurbished. In addition to this, the old Maple Children’s Centre has been converted into a staff nursery.

Smaller works include replacement of theatre doors and improvements to general electrical services.

**Information Technology and Care Records Service (CRS) Update**

At the end of 2011, the Trust Board approved a refreshed Information Technology Strategy to guide future developments over the next few years.
At the heart of our strategy is making best use of the Care Records Service and using this to develop an Electronic Patient Record for the Trust. The other major components of our Electronic Patient Record will be an Electronic Document Management system and an underpinning Wireless Network. An Electronic Patient Record effectively means all patient data, digitally stored, accessible immediately from anywhere on site. This means information should be more easily readable, accurate, safe, secure, and available when and wherever required.

During 2011, the Trust’s Information Technology Department delivered a number of changes to the Care Records Service to make it easier to use and to enhance functionality. This included more convenient label printing for pathology specimens, changes to improve data quality, automated import of patient results from testing requested by GPs, incorporating Venous Thrombo-embolism (VTE) assessment and supporting smoking cessation, adding more ‘alerts’ to help our staff, wristband printing for neonates and paediatrics, and fixing a number of issues so that extra work to safeguard income was no longer needed.

In addition to this, the Department has been involved in the pilot of self check-in kiosks in Main Outpatients. There has also been a major system upgrade which will conclude around the end of 2011-12, which will allow the Trust to configure the system over the remainder of next year and introduce new functions, including more clinical documentation and electronic prescribing.

Other Information Technology developments include procurement of the new Wireless Network, which will be installed in 2012, and installation of new clinical systems and upgrades. A successful pilot has been undertaken to enable GPs to order diagnostic tests electronically and to see results of tests ordered by Hospital Consultants on their patients. In addition to this, the Trust is upgrading the system to deliver correspondence electronically to GPs so that it is more convenient for them.

The Information Technology Department has provided remote access to a number of groups including midwives working in the community and to the Children’s Services at Moor Lane in Kingston. An electronic staff e-rostering system has also been purchased to manage the allocation of staff shifts.

Alongside all of this, the Trust has maintained the usual maintenance programme to ensure that it’s Information Technology network and associated equipment and systems remain robust and fit for purpose.

Security
The Trust is required to have a security management plan, overseen by a Non Executive Director (Michael Jennings), a Security Management Director (Sarah Tedford, Chief Operating Officer), and a Local Security Management Specialist (Jonathan Gladwin).

The plan highlights the key areas which the Trust is focussing on in the coming year; these include creating a pro-security culture, prevention and deterrence of crime as well as detection and investigation, liaison and reporting.

A large part of the plan centres on the prevention of crime through the existence of robust polices, accurate and appropriate risk assessments and focussing on staff groups at a greater risk such as lone workers and community workers. The Local Security Management Specialist also acts as a liaison with NHS Protect and other agencies to assist with Olympic preparedness and to help ensure the Trust has robust plans in place to prevent, or manage, security risks.

The security management plan also allows for the Local Security Management Specialist (under direction from the Security Management Director) to investigate serious security related incidents and ensure the Trust responds to such incidents in a timely and
appropriate manner which may include police involvement or written warnings. The plan also ensures the Trust reports appropriate statistics to central bodies and that regular liaison takes place between the Trust, local authorities, assets and larger bodies such as NHS Protect.

Emergency Planning and Preparedness
The Trust is required to meet a number of statutory duties in relation to Emergency and Business Continuity Planning as detailed within the following documents;

- The Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005;
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010; and,
- Care Quality Commission Essential Standards of Quality and Safety 2010.

In addition to meeting legislative duties, the Trust is also required to adopt and align to guidance and framework documents, including but not limited to:

- Department of Health Emergency Planning Guidance 2005;
- Department of Health NHS Resilience and Business Continuity Management Guidance 2008; and,
- NHS Operating Framework 2011/12.

Over the past year the Trust has delivered the following Testing and Exercising, producing formal exercise reports including:

- Four communication exercises testing the major incident activation and call out procedure;
- Exercise Albion, a table top exercise testing the Major Incident Plan; and,
- Exercise Bellona, a live exercise testing the Major Incident Plan, Rapid Discharge Plan and Patient Pathways.

In addition to this, the Trust has undertaken formal debriefs and produced formal incident reports for two internal major incidents to capture areas identified for the improvement of Trust arrangements. The Trust has also implemented a new training schedule, launching a Major Incident Loggist Training Session which has been completed by ten Trust staff.

The Trust has undertaken review and maintenance of Emergency Plans with completed reviews of the Pandemic Influenza Plan and Major Incident Plan. The Trust Business Continuity Plan is undergoing major review, whilst an additional three new plans have been written.

The Trust has established the Fire Action Safety Group to act upon recommendations and increase the Trust’s response to incidents of fire.

In preparation for the 2012 Olympics, the Trust has established an Operations Working Group, chaired by the Emergency Planning Manager, with monthly meetings attended by representatives from across the Trust to form operational plans and strategies for the Olympic period in line with the Cabinet Office London Olympic Resilience Planning Assumptions (LORPA).

The Trust was fully involved in the multi-agency planning for the Olympic trial event the London to Surrey Road Race which took place in August 2011 and have contributed lessons identified and good practice for the formal debrief. The plan written for this event will be revised and implemented for the road races taking place in July 2012.
Major incident plan compliance

I certify that Kingston Hospital has major incident plans in place, which are fully compliant with the Department of Health’s ‘Handling Major Incidents’ operational doctrine and accompanying NHS guidance on major incident preparedness and planning. Kingston Hospital regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported at Board level.

Kate Grimes
Chief Executive
Our Patients, Partners, Staff & Local Charity Support

Listening to our Patients: The Patient Experience

The Trust is committed to involving patients and the public in the development and improvement of the Trust’s services. As part of this, the Trust approved a new Patient Experience & Public Involvement Strategy in March 2011. The Strategy has been developed to enhance organisational values so that the patient’s perspective drives delivery of care, governance and the decision making of the Trust, and so that hospital teams deliver a caring, respectful, safe and high quality experience all of the time.

As part of the Strategy, and to ensure the patient’s perspective drives delivery of care, the Trust has set up a Patient Assembly. Patient Assembly members are invited to sit on Trust committees and forums to represent patients’ views on matters raised by the Trust. Those who sit on the Patient Assembly also have the opportunity to participate in activities to improve the patient environment and receive presentations and updates from the Trust and other stakeholders.

The main roles of the Patient Assembly are to:
- Represent the views of patients and members;
- Ensure that the Trust is responsive to any relevant views raised by the Patients Assembly;
- Assist the Trust to seek views from traditionally hard to reach groups and enable feedback to those groups;
- Establish an annual work plan;
- Participate in activities to improve the patient environment and ensure feedback;
- Consider feedback on patient experience and proposed actions for improvements; and,
- Receive presentations and updates from the Trust and other stakeholders.

The Patient Assembly met for the first time in February 2012. The Patient Assembly is continuing to recruit its membership and aims to have approximately twenty members to support the Trust in its work.

The Patient Assembly will meet quarterly, and the meeting is attended by the Director of Nursing & Patient Experience or the Deputy Director of Nursing.

Patient Experience Trackers

There are 29 Patient Experience Tracker handsets used throughout the Trust. The trackers have enabled the Trust to continue encouraging patient engagement in feeding back their experiences. The patient usage of the trackers is reported weekly and the responses are analysed every month.

Net Promoter Score Pilot

As part of the Trust’s Patient Experience & Public Involvement Strategy, the Trust is also piloting the Net Promoter Score. This is a simple patient experience measure, which allows the Trust to obtain real-time, rapid feedback from every patient using Trust services.

Patients are given a card at the end of their care episode which can be completed and left in card return boxes, or returned by post. The card asks the question ‘how likely are you to recommend the service that you received today to a friend or family member?’ The patient is asked to score between ‘0’ and ‘10’ by checking a box. The patient is then invited to write a comment on the main reason for their score in a box.

The data from these cards will be analysed for each ward and outpatient department on a monthly basis and reports will be produced to
provide detailed feedback for staff that can be used to drive improvements.

Listening Events
The Trust held a series of successful listening events called ‘In Your Shoes’ in November 2011, where patients were invited to share their experiences of using Trust services. Around 70 patients attended and discussed their experiences on a one to one basis with a member of staff. Themes were then discussed in small groups. The information provided by patients was carefully documented and analysed to produce valuable learning.

The information from these events has been used to develop “patient commitments”, which are statements about the care and treatment the Trust commits to deliver. The learning has also further clarified the Trust's values and staff behavioural standards, and will be cascaded through the Trust in staff training, team development sessions, and staff performance appraisals.

Listening sessions were also held for staff to listen to each other’s experience of working at the Trust, and the learning from these sessions has also been used to improve patient experience.

Inpatients’ Survey
The Trust received the results of the 2010 inpatient survey in May 2011.

The survey highlighted that the Trust was in the top 20% of hospitals for providing single sex wash facilities, staff keeping noise to a minimum at night and for providing clear written information to patients about what to do once they are discharged from hospital.

The Trust had also improved in a number of areas compared to the previous year’s survey, including reducing waiting times before being admitted to a bed, asking patients about the quality of the care they are receiving and providing information about what to do if they are concerned about their condition.

Although the Trust did not perform as well as it would have liked in some areas, a survey carried out subsequently showed that the Trust was making improvements in some of these areas.

Since the survey took place, the Trust has put in place a Patient Experience & Public Involvement Strategy to ensure the patient perspective drives delivery of care and that they receive a high quality service all of the time. In addition to this, the Trust is using patient experience trackers to help identify any issues and take action to make improvements. The Trust is also reviewing its discharge process to reduce delays and to involve patients and their families more in the process.

The Trust now has two hourly nurse rounds to ensure all patients are visited on a regular basis, giving them an opportunity to ask any questions, as well as have their needs assessed and responded to.

The results for the 2011 Inpatient Survey were published in April 2012.

These showed that the Trust was performing about the same as most other Trusts on most questions in the survey, but compared to the 2010 survey the Trust showed significant improvement on four questions:

- Experience of sleeping accommodation, that was not shared by members of the opposite sex;
- Experience of bathroom and toilet facilities that were not shared by members of the opposite sex;
- Communication with doctors if patients had an important question to ask; and,
- Receiving copies of discharge letters sent from the hospital doctor to their GPs.

The Trust is striving to continually improve all areas of inpatients experience, particularly those areas in which the Trust did not perform to the high quality standards it aims to provide.
Outpatients’ Survey
The national Outpatient Department survey, took place in June 2011. A total of 850 patients were surveyed with 406 completed questionnaires returned, being a response rate of 48%.

Since the last Care Quality Commission survey took place in 2009 the Trust has significantly improved in some areas. This includes reducing how long patients have to wait to receive an appointment date as well as the length of time they spend waiting to be seen in the Outpatients Department.

There were some areas in which the Trust did not perform as well as expected. These included the Hospital environment and facilities (cleanliness of the department); tests and treatment (effective provision of information to patients about tests); seeing a doctor and other professional (information provided by the doctor, and time to communicate problem with the doctor); and, overall impression of the department (the management of the problem patients sought help for, the care received, and whether patients were treated with respect and dignity).

The Trust already has a number of initiatives in place to make improvements to the patient experience in Outpatients. This included holding ‘listening events’ in autumn 2011 for patients so that they could feedback any concerns they may have, setting up a new Outpatient’s Improvement Group to look at patient feedback, make any changes and the kiosks pilot in Outpatients.

The Outpatient Improvement Group is developing an action plan which will address and monitor patient experience closely.

Patient Environment Action Team (PEAT) survey
The Trust performed well in the 2011 Patient Environment Action Team (PEAT) survey result published in September 2011. This is a voluntary programme, yet 100% of the eligible NHS organisations covering 1,222 Hospitals took part in 2011. PEAT assessments aim to provide a snapshot of standards across a range of non-clinical activities that impact on the patient in Hospital, from cleanliness to signage to assistance with eating and drinking.

Hospitals are scored in each of three categories ranging from “excellent” to “unacceptable”. The Trust scored:
- Good (90.67%) in Environment;
- Excellent (95.65%) in Food; and,
- Good (94.98%) in Privacy and Dignity.

Patient Advice & Liaison Service (PALS)
The Trust welcomes and encourages feedback on its services and the Patient Advice & Liaison Service are happy to receive such comments.

The Patient Advice & Liaison Service provide information and help to resolve concerns that a patient or their family may have. The team aims to sort out problems and concerns quickly in order to avoid them escalating into a complaint.

Staff work hard to ensure that any investigations are thorough and that the outcomes reflect the seriousness of the issues that patients and their relatives or carers have raised. Concerns received from or on behalf of patients in no way prejudice how they are treated and are seen as a valuable way of improving services for patients and carers.

The top five concerns raised through the Patient Advice & Liaison Service this year were:
- Communication problems: such as difficulties patients experience not being able to contact a department by telephone, or being unable to leave a message;
- Treatment issues: such as delays in commencing treatment, or patients unhappy with the outcome of treatment;
- Administration issues: such as letters for cancelled clinics not being printed, and delays in referral letters processed;
• Waiting times: for example delays in being given a follow up appointment, and delays in clinics due to overbooking of appointment slots; and,
• Staff attitude problems: such as staff not responding to requests for assistance, or staff being dismissive of patients’ concerns.

The percentage of patients who had a concern and then proceeded to a formal complaint (i.e. they were not happy either with the way the Patient Advice & Liaison Service managed their concern, or felt that the issue needed to be raised again through the formal process) was just under 4%.

This reflects the comprehensive way that concerns brought to the Patient Advice & Liaison Service are responded to. It is encouraging that the majority of concerns are dealt with promptly and conclusively without escalation.

Complaints
Over the course of 2011-12, the Trust received 433 formal complaints, an 8% reduction on the 469 complaints received in 2010-11.

The top five issues complained about were:
• Communication with patients and relatives;
• Medical treatment;
• Appointment problems;
• Delays and failures in diagnoses; and,
• Discharge errors.

The Trust’s complaints performance and response times are monitored by the Risk Management Committee, which reports to the Trust Board via the Quality Assurance Committee. The response rate for the year was 72% completed within 25 working days. There has been considerable focus on improving the timeliness of complaint responses.

Next Stage of Complaints
Once local resolution has been exhausted, complainants can refer any outstanding issues to the Health Service Ombudsman, where an assessor will review the complaint investigation and the subject of the complaint.

There have been three referrals to the Ombudsman in 2011-12. To date, the Ombudsman has declined to take on two of the cases, and is considering the third. This is a positive reflection of the robustness of our complaints process.

Learning from Comments & Compliments
Through close working between the Patient Advice & Liaison Service and complaints team and the clinical divisions, the Trust aims to resolve issues at an early stage whenever possible and also to learn from the feedback we receive.

Some examples of actions taken as a result of complaints are:
• Review of pain relief given to patients in the Hysteroscopy clinic. All patients are asked to give routine feedback of pain relief given for each procedure;
• New telephone triage proforma introduced in the Maternity Unit. The form is then updated each time the patient contacts the Unit in early labour;
• Expansion of the Consultant team in the Royal Eye Unit in order to increase the availability of clinic appointments; and,
• All patients over 65 years and all patients with a learning disability attending the Accident & Emergency Department undergo a falls risk assessment using the established screening tool.

Patient Stories
This year, the Trust launched a new initiative to improve the patient experience and help the Trust learn from complaints. Each month the Director of Nursing & Patient Experience presents a ‘patient story’ to the Trust Board.
The stories are chosen to reflect issues highlighted in the recently published outpatient survey results. Senior members of staff from the area concerned also attend to answer any questions, discuss actions that have been taken and to show how improvements are being made.

The purpose of presenting patient stories to the Trust Board is to:

- Connect better with patients, relatives and frontline staff on an emotional level;
- Understand the impact of the experience on the patient and their perspective on why it happened, and how it could be avoided in future;
- Appreciate the human aspects of harm and errors and develop an open culture to learn from errors; and,
- Make the experience of the patient personal to the Trust at all levels, recognising that ‘this experience happened here’.

**Freedom of Information (FOI)**

In 2011-12 the Trust received 360 Freedom of Information requests. However, the complexity of some of these requests, as well as the volume, has increased and overall 65% have been answered within the 20 working days limit (estimated 69% as we still have requests within the 20 working day limit). This compares with 69% of the 246 requests in 2010-11. The additional resource allocated to the Freedom of Information process ceased during the year.

The main areas for requests were around staffing information, service performance, policies & procedures, incidents, structure and financial information.

The Trust has published a list of frequently asked Freedom of Information questions on the Trust’s website. Overall since the Act came fully into force in January 2005, the Trust has received 1,378 requests and over 75% of these have received all of the information, or the nearest alternative held.

**Confidentiality & Data Protection**

Protecting the confidentiality of our patients, including their personal data, is something the Trust takes extremely seriously. Significant instances involving breaches of confidentiality or loss of data are reported as Serious Incidents (SIs) and thoroughly investigated. During 2011-12 there have been four such instances.

**Patient Safety**

The Trust has a strong patient safety culture and continues to strive to be a safer Hospital, working towards avoiding deaths and minimising preventable harm.

The Trust regularly receives national alerts on patient safety issues and performance of medical equipment. During 2011-12 121 alerts were issued, of which 37 were relevant to the services provided or equipment used by the Trust.

Of these 121 alerts, 1 alert was issued in 2010 and should have been completed by November 2011. Although most of the action required in the alert was completed in time, a Medication Treatment Guideline is still outstanding.

The Trust completed all the actions recommended, or relevant to the trust, for 118 alerts within the required timescales. There are 2 alerts that have just been received and we are in the process of assessing the relevance to the Trust.

**Two Hourly Ward Rounds**

Nursing Rounds is a proactive intervention where nurses (or a combination of nurses and other healthcare workers) do bedside rounding with patients at regularly scheduled intervals.

There have been a number of studies both in the UK and abroad which have shown that nursing rounds are associated with significant increases in patient satisfaction and with
equally significant reductions in the use of call bells and in the frequency of falls, pressure ulcers and complaints.

As part of our suite of strategies to improve patient experience and quality of care, the Medical and Surgical Divisions introduced two hourly rounds for patients on the inpatient wards to ensure that we promptly address care, comfort needs and monitor privacy and dignity issues.

During these rounds the nurses ask the patients if they require repositioning, have any pain, require the use of the toilet, need a drink or want anything explained. In addition to this, the nurses explain to the patient and relatives the plan for the next two hours, ensure that the call bell, personal items and drinks are close at hand as well as take the opportunity to review infusions, oxygen, drains, catheters and update relevant charts.

Patient rounding brings improvements to patient care, patient experience and improves patient safety.

New Supervisory Ward Sister Role
In the changing landscape of health and social care, quality and patient outcomes are key to ensuring sustainable models of care. This makes the ward sister and team leader role pivotal.

The Royal College of Nursing (RCN) report “Breaking down Barriers, Driving up Standards”, (2009), discussed the importance of the ward sister role and highlighted the urgent need for work to be done to strengthen and support this role for the delivery of high-quality nursing and care. The Royal College of Nursing recommended that all ward sisters and team leaders become supervisory to clinical practice.

During 2011, the Trust undertook a nursing skill mix review, led by Director of Nursing & Patient Experience, to provide the Trust with a clear understanding of the current nursing establishment in relation to patient activity/volumes and staffing levels.

As part of the outcomes of the review, the Medical Division has introduced the role of the supervisory ward sister (matching the system already in place in the Surgery Division). This means that the ward sister is now in a supervisory role rather than delivering direct patient care on the ward which has had a very positive effect for patients and the ward team as a whole. The new role has enabled better coordination of the nursing team, support and supervision and direction of care delivered by less experienced nurses, as well as supporting reductions in length of stay in hospital.

Nursing & Midwifery Quality Scorecards
Quality indicators facilitate an understanding of a system and how it can be improved, thereby monitoring performance against agreed standards or benchmarks. They provide a mechanism whereby care providers can be accountable for the quality of their nursing services.

The report State of the Art Metrics for Nursing: A Rapid Appraisal (Kings College, London, 2008), reviewed the status of the evidence base on nursing metrics. The recommendations within this report helped frame the development of the Trust’s Nursing Quality Ward Scorecard.

During the course of the year, the nursing leadership team have adapted the Nursing Quality Ward Scorecards and these now serve as a very useful “heat map” of the Trust. They allow senior nurses to, at a glance, see how they compare to other wards, their previous performance and most importantly support the development of local action plans to address issues identified.

The scorecards are reviewed at the Divisional level meetings, the Nursing and Midwifery Advisory Committee and the Trust Risk Management Committee.

Eliminating Mixed Sex Accommodation
In January 2009, the Secretary of State for Health announced an intensive drive to
eliminate mixed sex accommodation within the NHS.

The NHS Operating Framework for 2010-11 required all providers of NHS funded care to confirm whether they are complaint with the national definition 'to eliminate mixed sex accommodation except where it is in the overall best interest of the patient, or reflects their patient choice'.

The Trust has a zero tolerance approach to patients being placed in mixed sex accommodation for any reason other than one that is clinically justified and the Trust has a number of measures to support local delivery of this commitment.

Matrons report, measure and analyse any mixed sex breaches monthly. These are then investigated and integrated into Trust and Divisional scorecards which are reviewed at the Trust Board in the Clinical Quality and Patient Safety report and the monthly Risk Management Committee. We highlight the number of complaints relating to mixed sex accommodation at our Patient Experience Committee.

In 2011-12 we created two single sex wards and undertaken building works in five wards in the Hospital's Esher Wing to improve the proximity to toilets and showers for some side rooms. In addition to this, the Day Surgery Unit has completed building works to improve the privacy and dignity of patients.

**Releasing Time to Care (Productive Ward)**
The Division of Acute Medicine & Emergency Care has been implementing the releasing time to care programme since 2010-11. Over this time, ward teams have addressed a variety of issues including the ward environment, management of resources and capturing ‘bright ideas’ from front line staff, who have both the knowledge base and close contact with our patients. The Trust is harnessing these in-house skills for the benefit of both staff and patients so that those who work in the ward will be empowered to shape their environment and maximise effective patient care.

Feedback to date has shown that the programme is well received and is now being rolled out across other areas of the Trust.

**Frontline Focus Fridays**
Over the last 18 months the Trust has embedded an approach to strengthen nursing and midwifery visibility and leadership through frontline focus.

Every Friday, the Director of Nursing & Patient Experience and other senior nurses now dedicate time to monitor direct clinical care leadership at ward level and meet to discuss the environment, area of focus, Trust policies as well as results of audit clinical professional standards. The approach provides opportunities to learn from clinical audit undertaken by local leaders and translate this learning into practice improvements quickly.

Over the past year, the nursing and midwifery professions have used this approach to provide evidence for Care Quality Commission inspections, environmental checklists, development of ward scorecards and the nursing assurance framework. The group provides a regular update to the Executive Management Committee and is now a key vehicle for driving performance and change at a local level.

Attendance to the meetings has been encouraging, with approximately 18 staff attending the hour long sessions, including representatives from Heads of Nursing and Midwifery, Ward Sisters, Infection Control, Practice Development, Midwifery, Estates and ISS (our cleaning and catering contractor).

The topics vary from week to week and are identified through either a rolling programme planned in advance or, on occasion, covering matters arising from day to day activity.

The forum serves not only to deliver focused sessions on topics (for example falls/pressure ulcer care/infection control) but have also
raised awareness of some areas which require attention (such as nutrition/screening programmes and health promotion). A key strategy has been the inclusion of the wider team in the Trust to address areas which require a more collaborative approach, such as environmental standards of cleaning.

**Working with our Partners**

The Trust has close working relationship with many partner organisations and is working to strengthen these further. The Trust continues to work closely with our partners in primary care and other healthcare organisations to improve patient care and enable significant efficiency gains for both GPs and the Hospital.

**St George’s Healthcare NHS Trust**

We have a long history of working with St George’s Healthcare NHS Trust. There are over 20 consultants with either joint appointments or clinical commitments in both hospitals, covering upper Gastro Intestinal (GI), vascular, plastics, orthopaedics, urology, oral surgery, paediatric surgery, ophthalmology, ENT, cardiology, respiratory, dermatology and neurology. These shared posts deliver excellent clinical links and improve partnership working across the specialties. They also help to make sure that patients are provided better care across the two hospitals and are ‘seen in the ‘right place, at the right time, by the right person’.

Both Trusts participate in wider South West London clinical networks and recently collaborated on the development of trauma and stroke services for the sector. Our Trust now provides dedicated trauma and stroke units for our local patients, and these units work closely with a larger centre for patients with complex needs, at St George’s Hospital.

Last year, the Board agreed a new Strategic Alliance Partnership with St George’s to understand what opportunities there may be for even closer working to develop clinical services and improve clinical pathways for our patients. The Strategic Alliance Partnership Board now meets bi-monthly to steer and oversee this work. Through this joint working, patients will benefit from shared clinical knowledge, shared clinical, technical and managerial skills and the expertise of both trusts.

This work has involved staff across both Trusts in discussions about how our services can work more closely together for the benefit of our patients. The areas where we are currently working together are: Pathology; Radiology; Pharmacy; Medical Engineering; Cardiology; IM&T; and, Queen Mary’s Hospital, Roehampton.

An example of why this work helps local patients is in Cardiology. Patients will now be able to have a diagnostic procedure and an interventional procedure both undertaken at Kingston Hospital, whereas previously, a proportion of our local patients would need to transfer to St George’s Hospital for the intervention to be carried out. This improves our patient pathway, saves time and saves money. It also ensures that patients are seen in the ‘right place, at the right time, by the right person’.

Pathology and Radiology services are now part of a sector-wide partnership, which commenced at the end of summer 2011.

**Queen Mary’s Hospital (QMH)**

For several years the Trust has provided a range of services at Queen Mary’s Hospital on a recharge basis. A Memorandum of Understanding has been signed between the Trust, Community Services Wandsworth (now taken over by St George’s Healthcare NHS Trust) and NHS Wandsworth covering the provision of services provided at Queen Mary’s Hospital.

The Memorandum of Understanding involves a subcontract with Community Services Wandsworth for the provision of services for Anticoagulation, Audiology, Breast Surgery, Clinical Haematology, Diabetes, ENT, Elderly Care, General Surgery, Gynaecology, Health
Records, Information Management and Technology (IM&T), Minor Injuries, Neurology, Ophthalmology, Orthopaedics, Paediatric Medicine, Pain, Pathology, Pharmacy, Phlebotomy, Rheumatology, Stoma Care, Urology and Radiology.

**Teddington Hospital**
The Trust provides outpatient clinics at Teddington Memorial Hospital for Rheumatology, Neurology, Gynaecology, Dermatology, Colorectal, Orthopaedics and Gastroenterology.

**The Royal Marsden and Macmillan Cancer Support**
We have an established partnership with The Royal Marsden Hospital NHS Foundation Trust for the delivery of care to our cancer patients. Working in partnership with The Royal Marsden and Macmillan Cancer Support, the Trust’s Sir William Rous Unit provides patients who have cancer with the best medical facilities locally, as well as being the source of high quality information and advice.

Within the Sir William Rous Unit, The Royal Marsden provides chemotherapy services, the Trust provides outpatient and diagnostic services and Macmillan Cancer Support provides information and support.

**Working with GPs**
The Trust has historically had strong links with GPs in Kingston, Richmond and Surrey with a significant proportion of our outpatient activity undertaken in community venues in conjunction with GPs. Over the past two years the Trust has worked closely with GPs in Kingston and Richmond to redesign services and shift them out of the Hospital. We have established a number of innovative models and will continue to build on these.

Examples of current and planned initiatives include:

- Ensuring all tier 1-3 diabetic patients are treated in the community following the redesign of diabetes services during 2010-11;
- The development of a Kingston Sexual Health Managed Clinical Network during 2010-11 to shift care into the community and enhance care for hard to reach groups;
- A new model of service in maternity implemented in 2010-11 where midwifery teams can deliver care for low risk women from preconception, through antenatal, then into hospital for delivery in a midwifery led unit, followed by postnatal care, resulting in an increase in home deliveries and reduced admissions;
- Development of an integrated urgent care service within our Accident & Emergency Department during 2010-11, with GPs, Emergency Care Practitioners and primary care nurses working alongside Accident & Emergency staff;
- A new model implemented within endoscopy where results are now sent straight to GPs and patients are followed up in primary care rather than in hospital;
- A new service for stable glaucoma in the community for Kingston patients with local GPs, optometrists and New Medica, commencing in 2010-11;
- Joint pathway working with primary care for seven specialties where follow up rates are out of line with the national average, from 2010-11 onwards; and,
- The development of virtual clinics and clinical assessment units, from 2010-11 onwards.

The focus of the Trust’s work has mainly been with NHS Kingston, although some of the initiatives have also involved NHS Richmond.

For East Elmbridge we have worked closely with the Medics Gateway to develop community clinics in gynaecology, paediatrics, ophthalmology, dermatology, upper GI, urology, orthopaedics, cardiology and
gastroenterology and the shift of a significant proportion of day case activity to a community setting. Settings include Emberbrook Community Centre, Molesey Hospital and Cobham Day Surgery Unit.

We will need to develop mechanisms which suit each of our main Clinical Commissioning Groups to progress this work which will need to grow and strengthen rapidly over the next few years. For Kingston, Richmond, East Elmbridge and Merton, it is expected that much of this work will be processed through the System Sustainability Board and its subgroups. This is a joint planning mechanism established in December 2011, including the Trust and its key commissioners.

The addition of Surbiton Hospital as a new community facility for Kingston residents is key to shifting work into the community. We also have advanced plans for Trust services to be an integral part of the New Raynes Park Medical Centre which will combine primary care with outpatient clinics. Plans currently allow for us to rent space so that we can deliver outpatient clinics in this new facility closer to where people live and in conjunction with GPs.

BMI Healthcare Limited (BMI) Coombe Wing
In October 2009, the Trust entered into a series of agreements with BMI Healthcare Limited (BMI) via their holding company General Healthcare Group Limited. These agreements relate to BMI providing the private patient services on the Hospital site. There are two main phases to the contract.

Phase 1, which involves the provision of private patient services, largely through the use of Coombe Wing but also including private patient activity taking place outside of Coombe Wing, e.g. in the Day Surgery Unit, Royal Eye Unit and Maternity Unit.

Phase 2, which relates to the option of building a new private hospital facility on the old nurses’ home site and adjoining land, which BMI will lease from the Trust for 25 years from the date of occupation. The contract states that by September 2012 BMI must provide detailed plans to the Trust for approval regarding the new build. Once built, the new hospital reverts to NHS use after 25 years.

South West London Elective Orthopaedic Centre (SWLEOC)
The Centre is the UK’s largest dedicated hip and knee service providing world class orthopaedic care.

The Centre was established by the four South West London acute Trusts, St George’s, Croydon, Kingston and Epsom & St Helier to deliver a strategic change in the delivery of planned orthopaedic care. It provides orthopaedic services to the patients of the four Trusts.

The 11,000 hip and knee replacements carried out each year also provides a vast amount of clinical outcomes data, which allows clinical leaders to refine clinical pathways in the pursuit of providing a high quality efficient service. The benefits are many and include patients having a knee replacement at the Centre spending on average just 4.78 days as an inpatient. This compares with the London average of 8.05 days for a knee replacement.

Prime/ISS
Prime Healthcare Solutions (Kingston) Ltd (Prime) was created solely to finance and manage the Private Finance Initiative building with the Hospital grounds. It is a consortium of private companies who provided the capital to finance the build of the Kingston Surgical Centre which opened in 2007. Members of the consortium (and their responsibilities) are John Laing Construction and Costain Construction (construction of Kingston Surgical Centre), ISS Mediclean (soft facilities management services, such as cleaning, portering and catering, across the whole Hospital site) and Parsons Brinckerhoff (hard FM services, such as building repairs for the Surgical Centre).
Prime provides the hard facility management services (i.e. building repairs) for the Trust’s Surgical Centre only and the soft facility management services (i.e. cleaning, portering and catering) for the whole of the hospital site.

Dalkia
The Trust is aware of the need to take an environmentally sensitive approach to running the Hospital and is committed to reducing its carbon footprint. To achieve this, the Trust has entered into a partnership agreement with Dalkia, the leading European provider of energy services.

Dalkia designed, built and financed a new energy centre on the Hospital site which went into service in November 2007. This modern, energy efficient engineering plant provides heating and cooling and generates electricity. The contract runs for 15 years (ending 2022) during which time Dalkia will provide energy and energy management services through the operation and maintenance of the systems on a mobile remote basis, supply all fuel and set up the electricity export agreement contract to optimise export revenue and reduce electricity import costs.

Richmond and Kingston LiNKs
The Trust has consolidated its relationship with Kingston Health Watch Pathfinder and Richmond LiNKs during 2011. Monthly meetings are held between the Chairs of both organisations and the Director of Nursing & Patient Experience. The organisations have worked closely with the Trust in the development of the Patient Experience & Public Involvement Strategy. This Strategy is delivered through the Patient Experience Committee and the Chairs of both Richmond LiNKs and Kingston Health Watch Pathfinder are members of the committee.

The Trust has also been represented at meetings of Kingston Health Watch and Richmond LiNKs.

Kingston Health Watch members were provided with an information session, to support their understanding of Trust services. A number of presentations were provided for the group including clinical audit, complaints, information, and the Patient Experience & Public Involvement Strategy.

The Trust has additionally worked closely and consulted with the two organisations in the following areas:
- Quality Accounts;
- Patient Environment Action Team Audits; and,
- Nutrition Committee.

Police
The Trust continues to work closely with the local police to reduce crime and the fear of crime in the Hospital’s community. The Safer Neighbourhoods Team visits and patrols the Hospital site on a regular basis offering advice and support as well as proactive security tips to staff, visitors and patients.

The Trust is involved in the Kingston Town Centre radio scheme alerting the Trust’s security officers to any issues occurring in the town centre which may affect the day to day running of the Hospital.

Valuing our Staff
As at 31 March 2012, the Trust employed 2,718 substantive staff across all groups including nursing and midwifery, medical and dental, administrative and clerical, ancillary and management. Staff work together to provide the best possible services for patients.

Our workforce and staff employed by our contractors are key to our future success as a Foundation Trust and delivery of our vision. Only the right workforce, motivated, inspired, flexible, innovative and committed to the values of the Trust and the NHS can deliver the high quality and excellence in personalised care that the public expects.

The Trust Board approved a workforce strategy in 2010 that set out our ambition to be a great employer – involving, supporting,
developing and valuing our staff. Achieving this will support us in realising our plans, improving the experience of both patients and staff and helping us to become a ‘best in class’ performing organisation.

This workforce strategy is informed by key areas for improvement identified in staff surveys and a thorough analysis of future workforce needs. It is focussed on action in the following areas:

- Improved workforce planning;
- Recruitment and retention of a competent and capable workforce;
- Increasing workforce productivity;
- Reducing reliance on temporary staffing;
- Valuing equality and diversity;
- Developing our education and training;
- Good leadership and talent management;
- Excellence in people management;
- Supporting managers;
- Staff engagement; and,
- Pay policy and recognition arrangements.

**Annual Staff Survey**

The 2011 annual staff survey was conducted by Quality Health and went to a random selection of staff across the Trust. The survey closed in December 2011 and the response rate was 51%, which is slightly lower than in 2010.

The national NHS staff survey allows the Trust to understand how staff are feeling at a point in time. It also allows the Trust to compare itself with other NHS organisations on issues concerning staff welfare, motivation and performance.

Within the NHS good employment practice and staff engagement can improve staff satisfaction and with that organisational performance in terms of the quality of the patient experience and outcomes. The staff survey provides a measurement of satisfaction, and in highlighting the feelings of staff can help identify areas to address and for improvement.

The results for 2011 were announced on 20 March 2012. The Trust’s results were disappointing, putting the Trust in the bottom 20% of Trusts nationally in a number of areas.

The main areas of challenge identified by staff included:

- A high perception of staff being bullied or harassed;
- Staff feeling under pressure;
- Staff engagement and influence was not thought to be good enough;
- That there was a lack of support for work-life balance and wellbeing;
- Staff reporting lack of hand washing facilities always readily available; and,
- Staff not believing there is equality of opportunity.

The Trust wants to be regarded as one of the highest performing organisations by its staff. In light of the staff survey findings the Trust Board has agreed a number of actions. These include investment in a management and leadership development plan, reviewing staffing establishments, improving awareness and training on staff wellbeing, flexible working and work-life balance, embedding the Trust’s values, particularly ‘value each other’ and being clear on standards of behaviour at work to make clear what is and is not bullying.

The Trust has been going through a period of considerable change and the staff survey emphasises that it is important that staff are involved in designing and delivering change, supported to do so and kept well informed throughout. Changes have also been made to improve communications with staff and to encourage feedback.

There were some successes too. There has been a noticeable increase in the number of staff agreeing that care of patients is the
Trust’s top priority, reflecting the Trust’s activity on quality, culture and values. The Trust has also maintained a high performance in areas where it has been taking focussed action, particularly appraisal, mandatory training and support for personal development.

The full results for all Trusts are available at: http://www.nhsstaffsurveys.com/cms/

Healthcare Assistants Survey
In January 2012 the Trust Board received a report on why the rates of turnover, vacancies and sickness for Health Care Assistants (HCAs) working at the Trust were particularly high. The report looked at trends over the last three years and involved a survey of Health Care Assistants working in the Trust. A ‘valuing our Health Care Assistants’ workshops also took place.

The key themes identified were that Health Care Assistants felt their work was undervalued by colleagues, that there was a lack of opportunity for career progression and there was inadequate banding for the role.

The recommendations being taken forward following the survey are to:

• Review the scope and practice of Health Care Assistants across the Trust;
• Provide core training for Health Care Assistants relevant to their role;
• Develop a clear Health Care Assistants career structure; and,
• Monitor information from Health Care Assistants on turnover, vacancy rate and sickness to understand where issues may be arising.

Policies and Procedures
Policies and procedures affecting the working lives of staff across the Trust are important in ensuring good staff management. The Human Resources team have worked in conjunction with managers and trade union representatives across the organisation to ensure these are up to date and provide a clear framework that is fair and consistent in managing staff and ensures NHSLA and Care Quality Commission compliance.

Long Service Awards
The Trust has a six monthly Long Service award scheme to celebrate and give recognition to staff who have worked 25 or more years service with the NHS or at the Trust. A ceremony is held for all staff that are eligible and on the day, they are presented with a certificate, engraved photo frame and a badge as a token of appreciation.

Monthly Staff Awards
The Trust has performed well this year, due to the tremendous commitment and contributions from its entire staff. In October 2011 and as part of our Organisational Development Plan, the Trust launched a new Monthly Staff Excellence Award scheme to recognise staff that go above and beyond the call of duty and live the Trust’s new values. Patients and staff members can nominate someone they feel deserves the award under the Trust’s four main values which are caring, safe, responsible or value each other. Once all the nominations have been received, they are reviewed by the Directors and a winner in each category is agreed. Each month the winners receive a £25 Amazon gift card, a certificate and a mug for their achievement.

Annual Staff Excellence Awards
The Trust also holds Annual Staff Excellence Awards which are presented at the Annual General Meeting. This is an opportunity for teams or individuals who have excelled during the year, under the heading of one of the four new values, to be nominated by colleagues or managers. There were four individual winners at the September 2011 Annual General Meeting, along with a two outstanding contribution awards.

Learning and Development
The Trust provides training and professional development for staff through its Education
The Education Centre keeps staff updated about professional development courses on offer, as well as the knowledge and practical skills training required to meet mandatory and statutory obligations.

A broad range of practical skills training is provided by the clinical skills team, working in conjunction with the Professional Development Coordinator. A major initiative to improve the induction training of new Health Care Assistants has proved successful, and this has led to improved retention over the last six months. With the aid of funding through the Joint Investment Fund, the Trust has sponsored experienced Health Care Assistants to achieve NVQ levels two and three in Health and Social Care and to provide courses for first line supervisory and management diplomas, delivered on-site by Kingston College of Further Education. The Trust has also made improvements in training on medical devices, appointing a new coordinator role.

One of the Trust’s values is be ‘safe’ - making the safety of patients and staff a primary concern. The Trust therefore monitors key Mandatory Training undertaken by all employees. Reports on employees’ compliance are recorded on the intranet and data by division and staff category are published in the Monthly Trust Board Report, Monthly Divisional Boards and through the Weekly Executive Management Committee Performance Summary.

The Trust continues to play an important role in medical training. It has 600 medical students’ placements a year with up to 95 students in the trust at any one time as well as 36 Foundation Year One and 30 full time Foundation Level Two doctors. Our medical students are from St George’s Hospital and Imperial College Healthcare. We also train Nurses and Allied Health Professionals who access undergraduate and post graduate programmes across a wide range of specialities. We provide pre-registration placements for approximately 100 nursing, midwifery and Allied Health Professional students at any one time. These students are primarily from Kingston University and St George’s University of London, however Allied Health Professional student placements are also provided for a number of Higher Education Institutes across London.

Additionally staff engage with learning opportunities across the Higher Education Institutes and other specialist provision contracted to NHS London through Non Medical Education and Training funding streams. There are 12 staff undertaking MSc programmes in a range of areas which include Maternal and Child Health, Healthcare Education, Clinical Leadership and Advanced Practice.

In February 2012, the Trust’s Stenhouse Library, as part of a group of 5 acute Trusts (Kingston, Epsom & St Helier, Croydon, Lewisham and South London Healthcare), were commended for best practice during the judging of the Sally Hernando Award for Organisational Innovation.

The award recognises introducing a new or improved way of organising or managing the library service, including working in partnership with other services, to increase overall performance and productivity.

The Trust currently chairs the South West London Continuous Personal Professional Development forum and collaborates with partner Trusts in developing learning opportunities for staff generating innovative projects. We are currently involved in the development of:

- E-learning packages for mandatory mentorship update and infection control;
- Cross-sector development of preceptorship support programmes;
- A foundation degree for assistant practitioners;
A leadership and management programme delivered through action learning for bands 5 to 7;

Knowledge transfer partnership major trauma pathway; and,

Bespoke programmes to support and develop the knowledge and skills of maternity assistants and maternity support workers.

The Trust contributes to the Academic Health and Social Care Network which provides a collaborative platform to initiate and support research and education in practice. The Trust is a part of the South London Comprehensive Research Network, which includes St George’s, Kings College, Guy’s & St Thomas’, Epsom & St Helier and The Royal Marsden. Our lead clinicians participate in NHS research by running studies and being local investigators for national studies.

Staff Benefits and Work Life Balance
The Honey Bee’s staff nursery has expanded and relocated to provide 80 places. The refurbishment of the old Children’s Maple Centre has been undertaken by the Kingston Hospital NHS Trust General Charitable Fund and involved the children in the design and decoration of this wonderful new learning environment.

In summer 2011 the nursery achieved an ‘outstanding’ OFSTED report, which is one of only eight childcare provisions within the borough to do so. The staff in the day nursery worked extremely well as a team and this was recognised when they were nominated and achieved the staff excellence award.

Staff benefits and discounts continue to be promoted throughout the Trust on both the intranet and via the NHS Discounts website. The Human Resources Department are working together to improve the quality, the range and accessibility of the intranet Human Resources web pages. This will be ready to be launched later in 2012.

E-Rostering
The Trust has been introducing e-rostering to improve the way in which shifts are allocated for clinical staff and make sourcing temporary staff easier. The new system not only speeds up the rostering process but ensures that rostering is fair, supports flexible working and enables staff to be released for training when required.

E-rostering also means that the Trust can be sure it is operating safely, with our clinical areas being able to better monitor staffing levels and therefore having the right skill mix. Also, there is no longer a need for paper rosters or leave request books and it is easier for staff to book shifts and view rosters, either from home or via the Intranet. The roll out of e-rostering across the Trust will be complete in 2012.

Occupational Health and Well Being
The Occupational Health and Wellbeing Team provided various health promotion events for staff throughout 2011-12, which were well received. These included blood pressure measuring for ‘Know your Numbers Week’, National Walk to Work Week, awareness days for bowel cancer prevention, migraine, stress and mental health. In addition to this, the Annual Health & Wellbeing Day was held on 1 February 2012 offering free cholesterol and blood pressure checks. Over 200 staff took advantage of the advice and information provided on stress management, healthy eating and physical activity. Attendance exceeded all previous years and the feedback received was very positive.

The Trust has signed up to ‘Shift into Sport’, an initiative by the Fitness Industry Association and the Mayor of London, which offers reduced membership to gyms and other sports clubs at off peak times, with the aim of encouraging shift workers to increase their physical activity, and many staff have registered with them. A lunchtime walking club has been established at the Trust and the onsite chair massages are now well
established and fortnightly Zumba dance classes have also commenced.

The Counselling Service is now accredited with the British Association of Counselling Psychotherapists, one of the few NHS counselling services to be accredited.

We had a successful staff flu vaccination campaign. As in previous years the team visited wards and departments to offer the vaccine to staff, with a good take up of 42.5%.

Sickness Absence Rate
Having a healthy workforce is important to the Trust and the support provided by the Trust’s Occupational Health & Well Being Service is therefore vitally important.

This is reflected in the Trust’s relatively low sickness absence rate. For 2011-12 the sickness absence rate was an average of 2.98%, compared to an average for Acute London Medium Trusts of 3.51%.

Volunteering
The Trust has a well established team of volunteers who devote much spare time to carrying out voluntary work within the Hospital. They are valued and appreciated for the help given and are an important part of the Hospital.

Many volunteers come in the first place because they wish to give something back in return for the service received when relatives or friends have been patients. Others are getting experience that may help them develop a career in healthcare.

A walk around the Hospital will reveal volunteers undertaking a wide range of tasks including taking people to Hospital departments or pointing them in the right direction, visiting patients, operating tea trolleys, doing administrative and reception work, contributing to the Hospital radio and helping in many other vital areas of Hospital life. Jackie Purrett, is the Volunteer Service Manager who has worked tirelessly to support the volunteers to deliver services that are meaningful to staff and patients. Jackie confirmed at the Christmas Tea Party that she would be retiring from the Trust after leading the service for nearly ten years, so we would like to thank her for her services. Our membership function will be taking over from Jackie and will continue to support our volunteers.

Relationship with Unions
We are fully committed to the process of staff participation and involvement in decision making. If managers, employees and trade unions work together, organisations can effectively utilise staff knowledge and experience to solve problems.

Trade union engagement can give employees the assurance that changes are for the benefit of the service and the workforce. Unions also give employees a voice that can contribute to bringing about the cultural changes essential to service improvement.

We have a formal agreement with the Trade Unions about managing employee relations and will continue to review this regularly.

Outside of this formal relationship and processes it is important that there is regular contact and communication with Trade Union representatives and staff to develop joint ownership of issues and approaches to them. To foster these relationships there is increasing joint working on programmes, particularly in matters such as diversity, equal opportunities, dignity and respect and we expect to develop these further in the future.

In September 2011 we concluded agreement in the difficult area of negotiating new payment arrangements for on-call work now national agreements have ended.

Future Workforce
In common with other NHS organisations we plan significant workforce changes driven by the need to improve the quality and efficiency of our services, manage within NHS financial
constraints and meet the expectations of commissioners and patients for high quality care.

We are investing significant time and resources in pursuing productivity through lean process re-design, shared clinical and non-clinical support functions and general workforce efficiencies such as skill mix changes. For example, using Midwifery Support Workers to take on some of the workload previously undertaken by Midwives, hence freeing Midwives to undertake the roles requiring clinical knowledge and experience.

Our investment in information technology is also yielding opportunities to reduce administrative and clerical roles. For example, making use of digital dictation for consultant letters and reports, reducing the requirement for typists, whilst at the same time improving turnaround times.

All of these changes are designed to deliver a sustainable modern, safe and efficient Hospital as outlined in our vision.

Support from Local Charities

Momentum
Momentum was established as an independent charity in 2004 and supports children with cancer and life-limiting conditions in Surrey and South West London.

Last year Momentum raised funds for a new clinical area in the Dolphin Ward, to ensure the safe and efficient administration of chemotherapy and blood transfusions in a child-friendly environment. The unit was completed in spring 2011 and consists of a two-bedded oncology room, with an outside reception and waiting area.

At the end of 2011 Momentum worked with Paediatric Accident & Emergency to refurbish a special viewing room used by parents who have just lost a child. The Consultants in the department are convinced that the serene and special room will be a great help to grieving families.

Momentum continues to use donations to support families in a number of ways, particularly to provide treats and outings which they might otherwise not be able to afford. The charity also runs two holiday homes in Dorset for family respite breaks. At Christmas 2011, Momentum created a wonderful Santa’s Grotto in the Paediatric Department, which all the oncology and other seriously ill children were invited to visit and receive a gift.

Friends of Kingston Hospital
The Friends of Kingston Hospital continue to support the Trust by raising funds in a number of ways. In the past twelve months over £50,000 has been contributed to a variety of different areas affecting and improving the lives of patients, staff, and visitors.

Together with Hospital Radio, which provides an invaluable service to patients in the Trust, the Friends have almost 100 unpaid volunteers, holding raffles, tombolas, and book sales throughout the year.

Since 2000, the Friends have raised over £500,000 for the Trust. Recent purchases include, a special lay flat chair for ITU, a number of wheelchairs dedicated to Accident & Emergency, specialist couches for both the Wolverton Centre and the Pain Clinic, and comfortable recliners for the Haematology Day Care Unit, where patients can receive treatment for 6 to 8 hours, including chemotherapy. The Friends have also funded privacy and dignity signs, falls equipment and sensors for wards.

For the coming year, the charity has also agreed to fund a new birthing pool for the Maternity Unit, patient story films to feedback patient experience from ward level to the Trust Board, and a number of smaller projects which will help make a difference to the day to day lives of patients, staff and visitors.

Kingston Hospital NHS Trust General Charitable Fund
The Fund is set up to benefit the patients, families and staff of Kingston Hospital.
Expenditure is structured to ensure that the money raised is used to best effect to support the Trust’s work and is in line with donor’s wishes and the Fund’s objective.

The Fund does not provide facilities or equipment direct to the public but provides facilities and equipment for the Trust and, in so doing, for the patients, their families and staff of the Trust.

Grants made to the Trust do not focus on the income of patients or their families but provide a benefit to any patient requiring the service of the Trust, which are available to all entitled to NHS treatment based on need.

During the year the Fund continued to support a range of areas within the Trust via the purchase of small items of equipment as well as welfare payments for both staff and patients.

The two major items of expenditure during the year where:

- The Fund agreed to pay for the first year’s cost for the new Domestic Violence Service run by Victim Support; and,

- The Fund contributed £530,000 towards the refurbishment and kit out of the old Maple Centre as a Staff Nursery. The enlarged Nursery provides a significant expansion in capacity and should help more mothers to return to work after pregnancy, meaning essential skills are not lost to the NHS.

In addition the Fund has two well known sub-funds, which raise funds for specific sections of the Trust, as follows:

**Kingston Can**

Kingston Can was set up to raise funds to build the Trust’s Sir William Rous Unit. Although the major fundraising effort for Kingston Can is complete and the Unit has been open for some time, donations continue to be received on a regular basis from the Trust’s supporters, to help fund equipment used for the treatment of cancer.

During the past financial year these donations have purchased a specialist piece of equipment for the Unit called a Perometer, used to help in the measurement and assessment of Lymphoedema.

**Born Too Soon**

Born Too Soon was established in 1985 to offer information and support to parents with premature or unwell babies being cared for on the Hospital’s Neonatal Unit. The Unit cares for up to 20 special babies at a time.

Born Too Soon offers invaluable advice and support to those families whose babies are being cared for on the Neonatal Unit. Pauline Woods, Born Too Soon’s Co-ordinator is on the unit daily. Support for families could be anything from help registering the baby’s birth, or sadly if the baby dies, to register his or her death, and helping to arrange a funeral.

Born Too Soon also helps provide funding towards a weekly parents support group ‘Welcare’ for families, and a twice-yearly memorial service organised in conjunction with the Chaplaincy and the Maternity Unit.

During the year the funds raised purchased 73 pulse oximeters for use across the Paediatric Unit, Neonatal Unit and Paediatric Accident & Emergency. Pulse oximetry enables the clinical team to closely monitor a patient’s arterial blood oxygen saturation level. Oxygen saturation provides an indication of how effectively the respiratory system is delivering oxygen to the body. In addition pulse oximeters provide a continuous monitoring facility of heart rate which can quickly alert the clinical team to high risk issues such as low oxygen levels or heart slow heart rates which other devices are unable to detect. The existing units that the Trust was using gave a relatively high number of false alarms, which increased noise on the Units, and could be distressing to families. The new units have reduced noise from false alarms, and improved the environment for both staff and families.
Introduction
The equality agenda is an important one for the Trust, impacting on staff, patients and their carers/families alike. The Trust is committed to ensuring that equality is at the heart of everything we do.

The NHS has developed the Equality Delivery System as a tool to help NHS organisations improve equality performance and embed equality into mainstream NHS business. Using the System has led to internal discussions about how to foster or improve equality across various parts of the Trust taking account of patients, staff and services in line with the nine protected characteristics within the Equality Act 2010.

The Equality Duty requires organisations to consider all individuals when carrying out its day to day work, in developing policy and in delivering services. Therefore the Trust undertakes an equality impact assessment (EQiA) whenever it produces or updates policies and/or procedures or re-designs a service.

To support the Trust in meeting its obligations and commitment to equality an Equality & Diversity Committee has been established. The purpose of the Committee is to provide leadership and strategic direction on equality, diversity and human rights issues and to ensure implementation of the Equality Delivery System within the Trust.

The Trust has also considerably strengthened its links to a range of community partners, including the Kingston Centre for Independent Living, the Kingston Racial Equality Council and the Patient and Public Involvement Forum as well as other partners who continue to play a vital role in quality assuring, challenging and supporting the Trust to continuously improve services for patients, visitors and carers.

Background
The Equality Act 2010 (the Act) brought together all previous equality legislation and introduced a new public sector equality duty (the equality duty) to replace the previous duties in relation to race, disability and gender. The equality duty is made up of a general equality duty, supported by specific duties.

The general equality duty requires public authorities, in the exercise of their functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act;
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it; and,
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

These are often referred to as the three aims of the general equality duty.
The nine protected characteristics under the Act are:
- Gender;
- Ethnicity;
- Age;
- Disability;
- Sexual Orientation;
- Religious Belief;
- Marital Status;
- Maternity/Pregnancy; and,
- Gender Reassignment.

As a public authority covered by the specific duties the Trust must:
- Consider what information it wants to collect, use and publish in the future;
- Consider at what intervals it will publish information;
- Think about how it will use the information (and other sources e.g. national data) to identify the most significant equality challenges;
- Consider benchmarking its equality performance against other relevant public authorities, or national information;
- Consider what steps it may need to take to fill in information gaps, including engagement that it may want to undertake to do this; and,
- Consider how it will use the information to develop and monitor its equality objectives.

Two reports have been prepared, one dealing with the Trust’s workforce and the other with the users of our services. Both provide data covering the 2011-12 financial year and/or as at 31 March 2012.

The workforce report analyses the workforce against the nine protected characteristics, where possible, in the following categories: staff in post, recruitment activity & new starters, promotions, leavers, completed performance development reviews and employee relations cases.

The service user report is more limited in scope, as the Trust has traditionally only collected data on age and gender, for all service users, and ethnicity for admitted patients. The Trust is, however, looking at how it can collect a wider data set, to allow monitoring and reporting in the future.
Staff Equality & Diversity Report

Executive Summary

Characteristic 1: Gender
- The Trust employed a predominately female workforce (79%).
- Women & Child Health employed the highest percentage of female staff (96%).
- The Trust employed more male staff in the higher pay bands.
- 66% of initial applicants to the Trust were female.
- 73% of new starters were female.
- 81% of promotions were for female employees.
- 70% of leavers were female.
- For performance development reviews both male and female staff had a completion rate over 90%.
- 80% of employee relations cases were for female staff.

Characteristic 2: Ethnicity
- The Trust employed a more ethnically diverse workforce than the population in the borough of Kingston-upon-Thames.
- Surgery & Critical Care recorded the highest percentage of staff declaring themselves to be from a Black & Minority Ethnic background (37%).
- Healthcare Assistants recorded the highest percentage of staff declaring themselves to be from a Black & Minority Ethnic background (43%).
- 33% of initial applicants categorised themselves as from a Black & Minority Ethnic background.
- 18% of new starters categorised themselves as from a Black & Minority Ethnic background.
- 21% of staff promoted in the year categorised themselves as from a Black & Minority Ethnic background.
- 33% of leavers categorised themselves as from a Black & Minority Ethnic background and 64% categorised themselves as White.
- Staff categorising them self as White or from a Black & Minority Ethnic background had a performance development review completion rate of over 90%.
- 34% of employee relations cases were for staff declaring themselves to be from a Black & Minority Ethnic background.

Characteristic 3: Age
- 47% of the workforce, as at 31 March 2012, were under the age of 40 and 7% were over the age of 60.
- Acute Medicine & Emergency Care had the youngest workforce, as at 31 March 2012, with 57% being under 40.
• 77% of initial applicants to the Trust were under the age of 40.
• 81% of new starters were under the age of 40.
• 64% of staff promoted were under the age of 40.
• 73% of leavers were under the age of 40.
• Only employees in their 20s recorded under the target of 80% completion for performance development reviews (79%).
• 43% of employee relations cases were for staff under the age of 40.

Characteristic 4: Disability
• 2% of the workforce declared themselves to have a disability and 80% declared they had no disability.
• 3% of initial applicants to the Trust had declared themselves to have a disability.
• 1% of new starters had declared themselves to have a disability.
• 3% of staff promoted had declared themselves to have a disability.
• 1% of leavers had declared themselves to have a disability.
• All disability categories recorded above the completion target for performance development reviews.
• 2% of employee relations cases were for staff who had declared they had a disability.

Characteristic 5: Sexual Orientation
• 27% of the workforce had chosen not to declare their sexual orientation.
• The category to which the highest percentage of staff attribute themselves, as at 31 March 2012, is heterosexual (71%).
• 89% of initial applicants to the Trust declared themselves to be heterosexual.
• 87% of new starters declared themselves to be heterosexual.
• There were no staff promoted in the year who had declared their sexual orientation as bi sexual, gay or lesbian.
• 77% of leavers had declared themselves to be heterosexual and 21% had chosen not to declare their sexual orientation.
• All sexual orientation categories recorded over the completion target for performance development reviews.
• 60% of employee relations cases were for employees declaring themselves to be heterosexual.

Characteristic 6: Religious Belief
• 26% of the workforce had chosen not to declare their religious belief.
• The category to which the highest percentage of staff attribute themselves, as at 31 March 2012, is Christianity (51%).
• 52% of initial applicants to the Trust declared themselves to have a religious belief of Christianity.
• 51% of new starters declared themselves to have a religious belief of Christianity.
• 49% of staff promoted in the year had declared themselves to have a religious belief of Christianity.

• 48% of leavers had declared themselves to have a religious belief of Christianity.

• Only Judaism record under the 80% target for completed performance development reviews (however this religion only record very small numbers and therefore each individual has a disproportionate effect on the percentage).

• 43% of employee relations cases were for staff declaring themselves to have a religious belief of Christianity.

**Characteristic 7: Martial Status**

• At 31 March 2012 50% of the workforce had a declared marital status of married and 40% had a declared marital status of single.

• 64% of new starters had a declared marital status of single.

• There were no staff promoted in the year who had a declared marital status of civil partnership or widowed.

• 52% of leavers had a declared marital status of single.

• All marital status’ categories recorded over the completion target for performance development reviews.

• 46% of employee relations cases were for staff with a declared marital status of married.

**Characteristic 8: Maternity/Pregnancy**

• 4% of the female workforce are on maternity leave as at 31 March 2012.

• 85% of employees taking maternity leave during 2010-11 returned to work.

• 3% of leavers left as a result of pregnancy.

**Characteristic 9: Gender Reassignment**

• None of the current systems within the Trust allow for recording data in this characteristic, however the Trust promotes an open culture that recognises the differing needs of a diverse workforce and encourage staff to express any concerns with regards to treatment.

**Staff in Post: Summary**

The Trust employed 2,718 substantive staff (headcount) as at 31 March 2012, representing a whole time equivalent workforce of 2,391.66. The majority of staff (89%) worked across the four clinical divisions: Acute Medicine & Emergency Care (716 staff); Ambulatory Care (459 staff); Surgery & Critical Care (678 staff); and, Women & Child Health (558 staff). The Corporate Directorates consisted of six areas: Corporate Affairs & Commercial; Finance & IM&T; Human Resources; Medical Director; Nursing & Quality; and, Operations.

The group with the highest proportion of staff was Qualified Nursing at 32% and the lowest Technicians at 3%.

20% of staff were employed at pay band 5 and 54% were in the pay bracket £20,000 to £39,999.
31% of staff worked part time. Many full time staff worked in a flexible manner, however these work patterns were not recorded centrally so further analysis cannot be given.

Characteristic 1: Gender Profile of Staff in Post Summary

The Trust employed a predominately female workforce (79%). 2010-11 Equality and Diversity Reports for a selection of other Trusts show similar results:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Female</th>
<th>Hospital</th>
<th>Female</th>
<th>Hospital</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George's Healthcare</td>
<td>74%</td>
<td>Whips Cross</td>
<td>76%</td>
<td>Kingston</td>
<td>79%</td>
</tr>
<tr>
<td>Croydon Healthcare</td>
<td>80%</td>
<td>Lewisham Hospital</td>
<td>80%</td>
<td>Epsom &amp; St Helier</td>
<td>86%</td>
</tr>
</tbody>
</table>

The Population Census 2001 recorded Kingston-upon-Thames as having 49% of its residents with a male gender. Although the workforce was not representative of the people living in the area it is well known that traditionally the NHS employs a more female weighted workforce.

Characteristic 1: Gender Profile of Staff in Post by Division

The division with the highest percentage of female staff was Women & Child Health at 96% and the lowest was Surgery & Critical Care at 73%.

This is not unusual as these areas are traditionally dominated by females and the data supports this trend.

The Central Directorates employed 64% female staff, but this is not unexpected as these areas included job roles that are more male dominated. For example, there was a lower than Trust average percentage of females within the Operations Directorate, which included Estates staff (22% were female), and within the Finance and IM&T Directorate (59% were female).

Characteristic 1: Gender Profile of Staff in Post by Staff Group

The staff group with the highest percentage of female staff was Qualified Nursing at 93% and the lowest was Medical & Dental at 55%.

These statistics support intelligence that it is usually women who are attracted to nursing roles and that a mixture of female and male staff choose to become doctors.

Other staff groups with a higher than Trust average percentage of male staff were Clinical Support, at 32%, and Admin & Estates, at 23%.
Characteristic 1: Gender Profile of Staff in Post by Pay Band (excluding Doctors)

The lower pay bands (band 1 and band 2) and higher pay bands (band 8b, band 8c, band 9 and VSM) had the highest percentages of male staff.

The Very Senior Managers (VSM) pay band had the lowest percentage of female staff, at 57%, although this represented a very small number of staff, so the percentage is easily moved.

Band 5 showed the highest percentage of female staff, at 89%.

Characteristic 1: Gender Profile of Staff in Post by Basic Salary

When analysing basic salaries the trend shows the percentage of females drops from 78% in the £1,000 to £19,999 bracket to 42% in the £80,000+ bracket.

Some of this can be explained by more female staff working part time hours (92% of part time staff are female).

However, as the pay band analysis above shows the percentage of male staff increases in the higher pay bands.

Characteristic 2: Ethnic Profile of Staff in Post Summary

69% of staff in the Trust classified themselves as White. This compares to 84% in the borough of Kingston-upon-Thames, 75% within Outer London (Population Census 2001) and 86% of the population of England as a whole (Population Census 2011).

Conversely 30% of staff declared themselves to be from a Black & Minority Ethnic background, which means that the staff employed by the Trust were more ethnically diverse than the local population. The percentage of staff declaring themselves to be from a Black & Minority Ethnic background rose by 2% between March 2011 and March 2012.

The Trust recorded one of the lowest percentages of staff declaring themselves to be from a Black & Minority Ethnic background compared to surrounding hospitals (2010-11: St George’s Healthcare 46%, Epsom & St Helier 31%). However given the geographically position of the Trust and the local population mix this is not a concern.

The largest Black & Minority Ethnic group at the Trust was Asian/Asian British, at 14%, and the smallest Chinese, at 1%.

All staff had categorised their ethnicity although 42 have chosen not to state their ethnicity (1%). This is less than as at 31 March 2011 when 72 staff (3%) had chosen not disclose their ethnicity.
Characteristic 2: Ethnic Profile of Staff in Post by Division

The most ethnically diverse division was Surgery & Critical Care with 36% of staff categorising themselves with a Black & Minority Ethnic background. The Black & Minority Ethnic category reporting the largest percentage for this division was Asian, at 18%.

Acute Medicine & Emergency Care recorded the highest percentage of staff categorising themselves as Black at 14%.

Women & Child Health and the Central Directorates had the lowest percentages of staff declaring themselves to be from a Black & Minority Ethnic background, with 20% and 21% respectively. Within the Central Directorates Corporate Affairs & Commercial and Medical Director registered the lowest percentages of staff declaring themselves to be from a Black & Minority Ethnic background, both at 14%.

Ambulatory Care had the highest percentage of staff that have chosen not to declare their ethnicity, at 3%.

Characteristic 2: Ethnic Profile of Staff in Post by Staff Group

The most ethnically diverse staff group was Healthcare Assistants, with 43% of staff declaring themselves to be from a Black & Minority Ethnic background, followed by Medical & Dental, at 40%.

24% of staff within Medical & Dental and 20% within Qualified Scientific & Technical had classified themselves as Asian. 21% of Healthcare Assistants had classified themselves as Black.

The lowest percentages of staff declaring themselves to be from a Black & Minority Ethnic background were Technicians and Admin & Estates, with 14% and 17% respectively.

Technicians had the highest percentage of staff choosing to not declare their ethnicity, at 5%.
Characteristic 2: Ethnic Profile of Staff in Post by Pay Band (excluding Doctors)

Band 5 staff were the most ethnically diverse with 36% of staff declaring themselves to be from a Black & Minority Ethnic background, followed by band 2 at 34% and band 6 at 33%.

Within band 8d, band 9 and VSM there were no staff declaring themselves to be from a Black & Minority Ethnic background, but these bands have very small numbers of staff.

Band 1 had a low percentage of staff declaring themselves to be from a Black & Minority Ethnic background at 12%.

Band 6 had the highest percentage of staff classifying themselves as Asian, at 18%, and band 5 the highest number of staff classifying themselves as Black, at 16%.

Band 2, band 3 and band 4 had the highest percentage of staff that had chosen to not declare their ethnicity, all at 2%.

Characteristic 2: Ethnic Profile of Staff in Post by Basic Salary

Staff whose basic salary is above £60,000 were the most ethnically diverse with 33% of staff in both the £60,000 to £79,999 and £80,000+ brackets declaring themselves to be from a Black & Minority Ethnic background.

The £40,000 to £59,999 bracket recorded the lowest percentage of staff declaring themselves to be from a Black & Minority Ethnic background, at 23%.

Characteristic 3: Age Profile of Staff in Post Summary

47% of staff at the Trust are under the age of 40 and 7% over the age of 60. The youngest employee in the Trust is 18 and the oldest 75.

This is not unusual given the NHS has a mixture of professional, skilled and unskilled roles. In order to occupy some of the roles available it requires years of study and practical application of learning in some professions.

In April 2011 the default retirement age was abolished and this, coupled with the reduction of staff with “special class” status for their NHS pension, may result in the age profile of our workforce increase over the coming years.
Characteristic 3: Age Profile of Staff in Post by Division

The divisions with the youngest mix of workforce were Acute Medicine & Emergency Care and Women & Child Health with 57% and 53% of staff respectively being under the age of 40.

These were also the two divisions with the highest turnover, which would make sense as traditionally younger employees are more likely to move on as a career opportunity arises.

The oldest workforce mix was in Ambulatory Care and the Central Directorates, with 35% of staff over the age of 50 in each. Within the Central Directorates it was Operations that had the highest percentage of over 50s, at 47%.

Surgery & Critical Care had the highest number of staff over the age of 60 (59 employees).

Characteristic 3: Age Profile of Staff in Post by Staff Group

Medical & Dental was the youngest staff group with 60% being under the age of 40. Qualified Allied Health Professions also recorded a high percentage of under 40s, at 59%.

Admin & Estates was the oldest staff group with 44% being over the age of 50. They also had the most staff over the age of 60 (78 employees) and the highest percentage of staff in their 50s, at 31%.

Characteristic 3: Age Profile of Staff in Post by Pay Band (excluding Doctors)

Band 5 staff were the youngest with 66% being under the age of 40.

Staff on band 8b were the oldest with 56% being over the age of 50.

All staff on the VSM pay band were in their 40s, and all staff from band 8a upwards were over the age of 30.

Progression from band 5 to band 8c showed a gradually decrease of staff under the age of 40, but this is an expected trend as it demonstrates normal career progression.
Characteristic 3: Age Profile of Staff in Post by Basic Salary

58% of staff in the £20,000 to £39,999 salary bracket were under the age of 40 compared to only 6% in the £80,000+ bracket.

This is very much as would be expected given normal career progression.

Characteristic 4: Disability Profile of Staff in Post Summary

Only 2% of the workforce had declared themselves to have a disability (43 employees).

80% of the workforce had declared they have no disability, and 18% had chosen not to declare their disability status.

There were 9 undefined records and information had been requested from these members of staff.

Characteristic 4: Disability Profile of Staff in Post by Division

All divisions had some staff who considered them self to have a disability.

The Central Directorates had the highest percentage of staff declaring them self to have a disability, at 3%. Within this Human Resources had the highest percentage of staff declaring them self to have a disability at 5%, but this only related to 4 staff.

Acute Medicine & Emergency Care recorded the highest number of staff with a disability, 12 employees.

Surgery & Critical Care had the highest percentage of staff who have chosen not to declare their disability status, at 23%.

Women & Child Health and the Central Directorates recorded no undefined records.
**Characteristic 4: Disability Profile of Staff in Post by Staff Group**

All staff groups recorded some staff with a declared disability.

Admin & Estates along with Clinical Support had the highest percentage of staff with a declared disability, 3% for each staff group.

Qualified Scientific & Technical had the highest percentage of staff declaring themselves to have no disability, at 90%.

Healthcare Assistants had the highest percentage of staff who had chosen not to declare their disability status, at 28%.

**Characteristic 4: Disability Profile of Staff in Post by Pay Band (excluding Doctors)**

Band 2 had the highest percentage of staff with a declared disability, at 3% (14 employees).

No member of staff had declared a disability in each of band 8b, band 9 and VSM.

Band 3 had the highest percentage of staff that had chosen not to declare their disability status, at 23%.

Band 1 had the highest percentage of staff with undefined records, at 4%.

**Characteristic 4: Disability Profile of Staff in Post by Basic Salary**

All salary brackets employed staff with a declared disability.

It is the salary bracket up to £19,999 that recorded the highest percentage of staff declaring a disability, at 3%.

Salary bracket £40,000 to £59,999 had the highest percentage of staff with no declared disability, at 84%

The salary bracket with the highest percentage of staff that had chosen not to declare their disability status was £60,000 to £79,999, at 22%.

Undefined records were all for staff who earn under £40,000.
Characteristic 5: Sexual Orientation Profile of Staff in Post Summary

The Trust has been collecting data on sexual orientation since October 2008.

For the past three years an annual validation exercise has taken place to try and improve the number of staff declaring information on this characteristic. As at 31 March 2012 27% of staff had chosen not to disclose their sexual orientation, a 10% decrease on the 31 March 2011 data.

The category recording the most declarations was heterosexual, at 71%.

Characteristic 5: Sexual Orientation Profile of Staff in Post by Division

78% of staff in the Central Directorates had categorised themselves as heterosexual, which was the highest percentage of heterosexual records. Within the Central Directorates Operations had the highest percentage of non-disclosed records at 35%.

All sexual orientations, other than heterosexual, had very small percentages declared (between 1% and 3%). Acute Medicine & Emergency Care and the Central Directorates had the highest percentage of sexual orientations other than heterosexual at 3% each.

Proportionately Surgery & Critical Care had the highest number of staff who do not wish to disclose their sexual orientation, at 35%, and the Central Directorates the lowest at 20%.

Characteristic 5: Sexual Orientation Profile of Staff in Post by Staff Group

Medical & Dental was the most sexually diverse with 3% of staff declaring a sexual orientation other than heterosexual.

Technicians were the only staff group that record no gay, lesbian or bi-sexual staff, however 33% of staff declined to declare their sexual orientation.

Clinical Support had the highest percentage of staff not wishing to disclose their sexual orientation, at 36%.
Characteristic 5: Sexual Orientation Profile of Staff in Post by Pay Band (excluding Doctors)

The VSM pay band showed the most diverse mix of sexual orientations (29% declaring a sexual orientation other than heterosexual). However this group was small in number and therefore each individual had a disproportionate effect on the percentage, compared to other staff groups.

Band 8d and 9 recorded the highest percentage of staff declaring their sexual orientation to be heterosexual at 92% and 100% respectively.

Band 3 had the highest percentage of staff that had chosen not to declare their sexual orientation, at 35%.

Characteristic 5: Sexual Orientation Profile of Staff in Post by Basic Salary

The highest percentage of staff declaring their sexual orientation as heterosexual was recorded in the £60,000 to £79,999 salary bracket, at 79%. This was also the salary bracket with the highest percentage of sexual orientations other than heterosexual, at 6%

36% of staff in the £80,000+ pay bracket had chosen not to disclose their sexual orientation, the highest percentage of non-disclosures.

Characteristic 6: Religious Belief Profile of Staff in Post Summary

As with sexual orientation the Trust have been collecting data on religious belief since October 2008.

For the past three years an annual validation exercise has taken place to try and improve the number of staff declaring information on this characteristic. As at 31 March 2012 26% of staff had chosen not to disclose their religious belief, a 10% decrease on the 31 March 2011 data.

The category recording the most declarations was Christianity at 51% followed by Atheism at 8%.
Characteristic 6: Religious Belief Profile of Staff in Post by Division

The Central Directorates recorded the highest percentage of staff with a declared religious belief other than Christianity, at 27%. Within the Central Directorates Human Resources recorded the highest percentage of staff with a declared religious belief other than Christianity, at 36%.

Women & Child Health had the highest percentage of staff with a declared religious belief of Christianity, at 55%, followed by Acute Medicine & Emergency Care at 53%.

Proportionately Surgery & Critical Care had the highest percentage of staff not wishing to disclose their religious belief, at 31%, and Acute Medicine & Emergency Care the lowest at 22%.

Characteristic 6: Religious Belief Profile of Staff in Post by Staff Group

Medical & Dental was the most religiously diverse staff group with 42% of staff recording a religion other than Christianity.

Qualified Nursing recorded the highest percentage of staff with a declared religious belief of Christianity, at 59%.

Clinical Staff had the highest percentage of staff who did not wish to disclose their religious belief, at 32%.

Characteristic 6: Religious Belief Profile of Staff in Post by Pay Band (excluding Doctors)

VSM was the most religiously diverse with 43% of staff recording a religion other than Christianity, followed by band 1 at 36%.

Band 8b staff recorded the highest percentage of staff with a declared religious belief of Christianity, at 69%.

Band 3 at 34% and band 9 at 67% were the bands with the highest percentage of staff choosing not to disclose their religious belief.
Characteristic 6: Religious Belief Profile of Staff in Post by Basic Salary

Staff earning over £80,000 were the most religiously diverse with 30% of staff recording a religion other than Christianity.

Salary bracket up to £19,999 recorded the highest percentage of staff not wishing to disclose their religious belief, at 28%.

Characteristic 7: Marital Status Profile of Staff in Post Summary

The category recording the most staff is married at 50% followed by single at 40%.

There are currently only 4 members of staff where their marital status is not declared.

Characteristic 7: Marital Status Profile of Staff in Post by Division

All divisions recorded staff in all marital status categories.

Ambulatory Care and Surgery & Critical Care recorded the highest percentage of staff with a declared marital status of married, at 54%.

The Central Directorates recorded the highest percentage of staff with a declared marital status of widowed at 2% and Acute Medicine & Emergency Care recorded the highest percentage of staff with a declared marital status of single, at 46%.

Characteristic 7: Marital Status Profile of Staff in Post by Staff Group

Technicians recorded the highest percentage of staff with a declared marital status of divorced, at 13%.

Qualified Allied Health Professions recorded the highest percentage of staff with a declared marital status of single, at 50%.

The highest percentage of staff with a declared marital status of married was for Qualified Scientific & Technical, at 60%.
Characteristic 7: Marital Status Profile of Staff in Post by Pay Band (excluding Doctors)

All the staff that had a declared marital status of separated were at or below band 8a.

Band 8c had the highest percentage of staff with a declared marital status of married, at 75%.

Band 1 had the highest percentage of staff with a declared marital status of single, at 56%.

The VSM pay band had the highest percentage of staff with a declared marital status of civil partnerships, at 29%, however this group was small in number and therefore each individual had a disproportionate effect on the percentage, compared to other staff groups.

Characteristic 7: Marital Status Profile of Staff in Post by Basic Salary

Salary bracket £20,000 - £39,999 recorded the highest percentage of staff with a declared marital status of single, at 46%.

82% of staff in the £80,000+ bracket had a declared marital status of married. This was the highest bracket proportionately for married employees.

Characteristic 8: Maternity/Pregnancy Profile of Staff in Post Summary

As at 31 March 2012 there were 80 employees on maternity leave, 4% of the female workforce.

85% of females that took Maternity leave in 2010-11 returned to work.

Characteristic 8: Maternity/Pregnancy Profile of Staff in Post by Division

All divisions recorded some maternity leave at 31 March 2012.

Women & Child Health recorded the highest percentage of staff on maternity leave at 6%.
All staff groups recorded some maternity leave at 31 March 2012.

The staff group with the highest percentage of maternity leave was Qualified Allied Health Professions, at 9%.

Staff in band 8d had the highest percentage on maternity leave, at 10%, followed by band 6 at 5%.

There were several bands where there was no maternity leave being taken at 31 March 2012.

The salary bracket £60,000 to £79,999 had the highest percentage of staff on maternity leave, at 7%.

In terms of actual numbers of employees on maternity leave the salary bracket £20,000 to £39,999 had the highest, at 55 employees.
Recruitment Activity & New Starters: Summary
During 2011-12 there were 15,329 applicants for jobs within the Trust, an increase of 1,640 applicants compared to 2010-11 (note: these figures only relate to applications processed through NHS Jobs. Applicants recruited from Trust Open Days or through the London Deanery are not included in the following analysis). Only 128 applications were not received from the online application process (0.8%).

3,748 of applicants were shortlisted, representing 24% of applications. 336 applicants were appointed, representing 2% of original applicants and 9% of shortlisted applicants.

There were 579 new starters to the Trust in 2011-12.

The Trust runs an internal recruitment and selection course and at least one member of the appointing panel must have attended this course before interviewing can take place. One of the key course objectives is to highlight the importance of equality legislation and equal opportunities. It is worth noting that at applicant and short-listing stage the panel have no equality data on candidates, only having relevant information to be able to shortlist without discrimination.

Characteristic 1: Gender Profile through the Recruitment Process
66% of initial applications to the Trust were from female candidates.
At short-listing stage 73% of candidates were female and 80% of appointed candidates were female.
However, if all recruitment to the Trust is included 73% of new starters were female.

Characteristic 1: Gender Profile of New Starters compared to Staff in Post by Division
The division with the highest percentage of female new starters was Women & Child Health, at 95%, and the lowest was Surgery & Critical Care, at 58%.
In all four clinical divisions the Trust appointed more male new starters proportionately than the staff in post profile.
Characteristic 1: Gender Profile of New Starters by Staff Group

Healthcare Assistants was the only staff group to recruit entirely females.

97% of Qualified Nursing new starters were female.

Admin & Estates and Technicians recorded the highest percentage of male new starters, at 44% and 43% respectively.

Characteristic 1: Gender Profile of New Starters by Pay Band (excluding Doctors)

Band 4 and band 9 were the only bands that employed all female new starters.

There were also high percentages of female new starters in band 3, at 88%, and band 5, at 93%.

Band 8b and band 8c have a 50:50 split between male and female new starters.

Generally the higher bands had proportionately more male staff recruits, which was in line with the overall staff profile.

Characteristic 2: Ethnic Profile through the Recruitment Process

35% of applicants classified themselves as White and 63% classified themselves to be from a Black & Minority Ethnic background.

The percentage of White applicants shortlisted rises by 8% to 43% and then rises again for appointed candidates by 26% to 69%.

Conversely, the proportion of Black & Minority Ethnic applicants reduced from 63% at application to 55% at short-listing, to 30% at appointment.

Taking all new recruitment into account, the percentage of new starters classifying themselves as White was 61% and those classifying themselves to be from a Black & Minority Ethnic background was 36%.

A sample of rejected applicants against successful shortlisted applicants may need to be reviewed in order to assess further whether there
is any bias or discrepancies. However all short-listing panels have no access to equality data when completing the short-listing process.

Characteristic 2: Ethnic Profile of New Starters compared to Staff in Post by Division

For all the divisions, apart from Acute Medicine & Emergency Care, there was a greater percentage of new starters declaring themselves to be from a Black & Minority Ethnic background than the staff in post profile.

Women & Child Health employed the highest percentage of White new starters, at 70%, and Ambulatory Care employed the highest percentage of new starters declaring themselves to be from a Black & Minority Ethnic background, at 49%.

Characteristic 2: Ethnic Profile of New Starters by Staff Group

The highest percentage of White new starters was in Qualified Allied Health Professions, at 92%, followed by Technicians at 86%.

Qualified Scientific & Technical employed the highest percentage of new starters declaring themselves to be from a Black & Minority Ethnic background, at 55%.

Characteristic 2: Ethnic Profile of New Starters by Pay Band (excluding Doctors)

Band 8a and band 2 were the most ethnically diverse with 44% and 39% respectively of new starters declaring themselves to be from a Black & Minority Ethnic background.

The band with the highest percentage of new starters classifying themselves as Asian was band 6, at 22%.

The band with the highest percentage of new starters classifying themselves as Black was band 8b, at 25%.

For band 8c and above all the new starters declared themselves to have a White background.
Characteristic 3: Age Profile through the Recruitment Process

77% of initial applicants were under the age of 40.
73% of under 40s were shortlisted and the same percentage subsequently appointed.
Taking all new recruitment into account, 83% of new starters were under the age of 40, with only 2% over the age of 60.

Characteristic 3: Age Profile of New Starters compared to Staff in Post by Division

All the clinical divisions employed a higher percentage of new staff in their 20s than their staff in post profile. The most significant was Acute Medicine & Emergency Care were 63% of new starters were in their 20s, compared to 25% of staff in post, a 38% differential. The next highest was Ambulatory Care with a 35% differential (49% of new starters compared with 14% of staff in post).
The Central Directorates employed the highest percentage of new starters in the higher age brackets, with 42% being over the age of 40.

Characteristic 3: Age Profile of New Starters by Staff Group

Qualified Allied Health Professions had the highest percentage of new starters in their 20s, at 67%.
Technicians had the highest percentage of new starters over the age of 40, at 57%.
Admin & Estates had the most even split of new starters over the age brackets.
Healthcare Assistants, Qualified Allied Health Professions and Qualified Scientific & Technical didn’t employee any new starters over the age of 50.
Characteristic 3: Age Profile of New Starters by Pay Band (excluding Doctors)

New starters from band 8b upwards were all over the age of 30.

The percentage of new starters in the higher age brackets increased as you moved up the pay bands, which is as would be expected given career progression.

Band 2 was the only band to have new starters from every age bracket.

73% of the new starters in band 5 were in their 20s, and 91% in this band were under the age of 40.

Characteristic 4: Disability Profile through the Recruitment Process

3% of initial applicants declared themselves to have a disability, rising to 4% of shortlisted candidates, reducing to 3% of appointed staff.

Taking all new recruitment into account, 1% of new starters classified themselves as having a disability. These employees continue to be given support by the Trust to be able to do their job.

All the data collected is dependent on the individual’s perception of disability and so remains subjective.

The percentage of undisclosed records for all new starters was 5% compared with 1% of new starters from the NHS Jobs route. Further work needs to be undertaken to ensure that all new starters not appointed via NHS Jobs have every opportunity to complete an equal opportunities form and that the data is then accurately recorded within the Human Resources system.
Characteristic 4: Disability Profile of New Starters compared to Staff in Post by Division

All division employed new starters with a declared disability.

Ambulatory Care recorded the highest percentage of new starters with no declared disability, at 97%.

When comparing the staff in post profile to new starters the percentage of new starters choosing not to declare a disability was less across all the divisions.

Characteristic 4: Disability Profile of New Starters by Staff Group

100% of Qualified Scientific & Technical and Technicians new starters declared themselves as having no disability.

Clinical Support and Healthcare Assistants had the highest percentages of new starters with a declared disability, at 5% and 3% respectively.

Admin & Estates and Medical & Dental had new starters with undefined records. This will be addressed in the sign on process in future.

Characteristic 4: Disability Profile of New Starters by Pay Band (excluding Doctors)

100% of the new starters in band 4, band 8b, band 8c and band 9 had no declared disability.

Band 8d had the highest percentage of new starters choosing not to declare their disability status, at 33%, and VSM the highest percentage of undefined records, at 50%. However, both of these bands had small numbers of new starters and so there was a disproportionate effect on the percentages.
Characteristic 5: Sexual Orientation Profile through the Recruitment Process

89% of initial applicants classified themselves as heterosexual and 8% chose not to disclose their sexual orientation. Therefore at initial application stage there was a very small number of staff with a declared sexual orientation other than heterosexual.

92% of appointed candidates declared themselves to be heterosexual.

Taking all new recruitment into account, 89% of new starters declared themselves to be heterosexual.

All sexual orientations were represented by new starters.

Characteristic 5: Sexual Orientation Profile of New Starters compared to Staff in Post by Division

95% of new starters in Women & Child Health declared themselves as heterosexual, the division with the highest percentage in this category.

9% of new starters in Ambulatory Care chose not to disclose their sexual orientation.

The percentage of new starters choosing not to declare their sexual orientation was lower than the percentage for staff in post, in every division.

Characteristic 5: Sexual Orientation Profile of New Starters by Staff Group

100% of Technicians new starters declared themselves as heterosexual, with 97% of new starters in Healthcare Assistants and Qualified Scientific & Technical also declaring themselves as heterosexual.

Admin & Estates had new starters in all the sexual orientation categories.

Medical & Dental had the highest percentage of new starters with undefined records, at 3%.
Characteristic 5: Sexual Orientation Profile of New Starters by Pay Band (excluding Doctors)

100% of new starters in band 1, band 8a, band 8b, band 8c, band 9 & VSM declared themselves as heterosexual.

The highest percentage of undeclared records was in band 8d, at 33%, however this related to a small number of new starters and so there was a disproportionate effect on the percentages.

Characteristic 6: Religious Belief Profile through the Recruitment Process

A declared religious belief of Christianity represented the highest percentage of initial applicants, at 57%, rising to 61% for shortlisted candidates and to 68% for appointed candidates.

Those choosing not to declare their religious belief held steady at 8% all the way through the recruitment process. However, taking all new recruitment into account, 12% of new starters chose not to disclose their religion.

Taking all new recruitment into account, the number of new starters declaring their religious belief as Christianity was 50%. This indicates that a higher percentage of new starters not appointed through NHS Jobs classified themselves with religious beliefs other than Christianity than those appointed through NHS Jobs.

Characteristic 6: Religious Belief Profile of New Starters compared to Staff in Post by Division

62% of new starters in Women & Child Health declared their religious belief as Christianity, the division with the highest percentage in this religious belief. This compares to 55% of staff in post.

The highest percentage of new starters for a religious belief other than Christian is in Ambulatory Care, where 22% of new starters declaring their religious belief as Islam.
Characteristic 6: Religious Belief Profile of New Starters by Staff Group

86% of Technicians new starters declared a religious belief of Christianity, the highest percentage for this religious belief.

Qualified Allied Health Professions recorded the highest percentage of new starters who declare themselves to be Atheist, at 17%.

Medical & Dental had the highest percentage of not declared, at 17%.

Characteristic 6: Religious Belief Profile of New Starters by Pay Band (excluding Doctors)

Band 2 and band 3 have the most diverse range of declared religious beliefs for new starters.

The highest percentages of new starters with a declared religious belief of Christianity were in band 8b at 100%, band 8c at 75% and band 4 at 70%.

The highest percentage of undeclared records was in band 9, at 100%, however this related to a small number of new starters and so there was a disproportionate effect on the percentages.

Characteristic 7: Marital Status Profile through the Recruitment Process

NHS Jobs does not allow reporting on candidates’ marital status.

Overall 64% of new starters declared their marital status to be single and 31% declared their marital status to be married.

Characteristic 7: Marital Status Profile of New Starters compared to Staff in Post by Division

Across all of the divisions new starters with a declared marital status of single were a higher percentage than the staff in post profile. The largest difference was in Surgery & Critical Care where 65% of new starters declared themselves as single compared to 36% of the staff in post, a difference of 29%.

Ambulatory Care was the only division with new starters with a declared marital status of widowed.

Surgery & Critical Care and Women & Child Health didn’t appoint any new starters with a declared marital status of civil partnership.
Characteristic 7: Marital Status Profile of New Starters by Staff Group

45% of new starters in Admin & Estates had a declared marital status of single and 45% a declared marital status of married.

The highest percentage of new starters with a declared marital status of single were Healthcare Assistants, at 83%.

Characteristic 7: Marital Status Profile of New Starters by Pay Band (excluding Doctors)

All starters at band 8b and above declared a marital status of either married or single.

The percentage of new starters declaring a marital status of married increased as you progressed up the pay bands.

Band 9 registered the most new starters with a declared marital status of single, at 100%, however this related to a small number of new starters and so there was a disproportionate effect on the percentages. The next highest was band 5 with 78% of new starters declaring a marital status of single.

Characteristic 8: Maternity/Pregnancy

Female applicants are not asked whether they are pregnant at any stage of the recruitment process, as we have a duty not to discriminate against these candidates.

Promotions: Summary

73 members of staff were promoted internally in 2011-12. Some of these may have been due to posts being re-graded but unfortunately reasons for change on the human resources system are not completely accurate, something that needs to be tackled for next year.

27% of the members of staff promoted worked part time, 6% higher than in 2010-11.

The highest proportion of promotions occurred from band 5 to band 6 (40% of promotions), but some of this can be attributed to the automatic progression arrangements for band 5 midwives.

25% of the promotions were for staff with under 2 years’ service with the Trust and the member of staff with the longest service gaining promotion was 15 years.

Surgery & Critical Care recorded the lowest number of internally promoted staff.
Characteristic 1: Gender Profile of Promotions Summary

81% of staff promoted were female, which was comparable with the staff in post profile of 79% of the workforce being female.

Characteristic 1: Gender Profile of Promotions compared to Staff in Post by Division

Ambulatory Care had a higher percentage of male staff promoted, at 38%, compared to the staff in post profile, at 23%.

All other divisions show roughly the same profile of promotions as staff in post.

Women & Child Health had the highest percentage of female promotions, at 96%, but this is inline with the staff in post profile.

Characteristic 1: Gender Profile of Promotions by Staff Group

Qualified Scientific & Technical only promoted male staff and Technicians only promoted females, however the numbers here were extremely small and so not of great concern.

No Healthcare Assistants promoted were male, however 84% of the staff in post were female, so again this is not of great concern.

Clinical Support promotions were split 50:50 male to female.

35% of promotions in Admin & Estates were male, compared to only 23% of staff in post being male.

Characteristic 1: Gender Profile of Promotions by Pay Band (excluding Doctors)

Only female staff were promoted from band 1 and band 7 during the year, but the numbers were relatively small so not of concern.

The percentage of male staff promoted reduced the higher the band.
Characteristic 2: Ethnic Profile of Promotions Summary

75% of promoted members of staff classified themselves as White and 21% of promoted members of staff classified themselves as from a Black & Minority Ethnic background, 2% more than last year.

Characteristic 2: Ethnic Profile of Promotions compared to Staff in Post by Division

Ambulatory Care promoted a higher percentage of staff classifying themselves as from a Black & Minority Ethnic background, at 38%, than their staff in post profile of 29%.

Conversely, Acute Medicine & Emergency Care promoted a very high percentage of staff classifying themselves as White, at 82%, which did not compare to the staff in post profile in that division of 64% of staff classifying themselves as White. Some investigation to ensure interviewing and selection processes in this division are fair will be undertaken.

Characteristic 2: Ethnic Profile of Promotions by Staff Group

Clinical Support shows the most ethnically diverse promoted staff.

The highest proportion of Black & Minority Ethnic staff promoted was in Qualified Scientific & Technical, at 100%. However, this only related to a very small number of appointments.

The percentage of White staff promoted in each of Healthcare Assistants and Qualified Nursing, at 80% and 81% respectively, were higher than the staff in post profiles of 56% and 67% respectively.

Characteristic 2: Ethnic Profile of Promotions by Pay Band (excluding Doctors)

Band 2 was the most ethnically diverse band for promotions, with 38% of staff promoted classifying themselves in a Black & Minority Ethnic category.

Only staff declaring themselves to be White have been promoted in band 1 and band 7.

Generally the percentage of staff declaring themselves to be White being promoted increased the higher the band.
Characteristics 3: Age Profile of Promotions Summary

64% of staff promoted were under the age of 40.

3% of staff promoted were in their 60's.

Characteristics 3: Age Profile of Promotions compared to Staff in Post by Division

Across all the divisions a higher percentage of staff in their 20s were promoted than the staff in post profile. This is as would be expected given career progression.

Acute Medicine & Emergency Care recorded the highest percentage of promoted staff under 40, at 82%, but this was comparable to the staff in post profile for the division.

Ambulatory Care was the only division that promoted staff in their 60's.

Characteristics 3: Age Profile of Promotions by Staff Group

Admin & Estates promoted the highest percentage proportionately of staff in their 50's, at 30%.

They were also the only staff group who promoted employees in their 60's.

100% of the staff promoted in Clinical Support and Qualified Scientific & Technical were under the age of 40.

All the Qualified Nurses promoted were under the age of 50.

Characteristics 3: Age Profile of Promotions by Pay Band (excluding Doctors)

All the staff promoted from band 1 were over the age of 50. Band 1 was also the only band that promoted staff over the age of 60.

Staff promoted from band 2 were across all the age ranges except 60s.

79% of staff promoted from band 5 were under the age of 40.

All the staff promoted from band 6 and band 7 were over the age of 30, but again this is unsurprising given career progression.
Characteristic 4: Disability Profile of Promotions Summary

3% of staff promoted had declared themselves to have a disability.

21% of promotions were for staff that had declined to disclose their disability status.

Characteristic 4: Disability Profile of Promotions compared to Staff in Post by Division

The only divisions promoting staff with a declared disability were Ambulatory Care and the Central Directorates.

Characteristic 4: Disability Profile of Promotions by Staff Group

Promotions for staff declaring a disability occurred in Admin & Estates and Clinical Support.

Four of the seven staff groups promoted staff who had declined to disclose their disability status.

Characteristic 4: Disability Profile of Promotions by Pay Band (excluding Doctors)

Band 2 and band 6 were the only bands that promoted staff with a declared disability.

75% of staff promoted in band 4 had declined to disclose their disability status.
Characteristic 5: Sexual Orientation Profile of Promotions Summary

77% of the staff promoted had declared themselves to be heterosexual.

No employees declaring themselves to be bi-sexual, gay or lesbian were promoted this year, although this pertains to very small numbers of staff overall so is not an unusual occurrence.

Characteristic 5: Sexual Orientation Profile of Promotions compared to Staff in Post by Division

Ambulatory Care had the highest percentage of promotions from staff declaring themselves to be heterosexual, at 88%.

Women & Child Health had the highest percentage of promotions from staff who had chosen not to declare their sexual orientation, at 29%. This was comparable with their staff in post profile of 28% of staff declining to state their sexual orientation.

Characteristic 5: Sexual Orientation Profile of Promotions by Staff Group

100% of staff promoted in Clinical Support and Qualified Scientific & Technical declared themselves to be heterosexual.

100% of Technicians promoted had chosen not to declare their sexual orientation, followed by Healthcare Assistants at 30%.

Characteristic 5: Sexual Orientation Profile of Promotions by Pay Band (excluding Doctors)

100% of the staff promoted from band 3 and band 7 had declared themselves to be heterosexual.

75% of staff promoted from band 4 had chosen not to declare their sexual orientation.
Characteristic 6: Religious Belief Profile of Promotions Summary

49% of staff promoted had declared themselves to have a religious belief of Christianity.

There are several religious beliefs that were not represented amongst staff promoted in the year.

Characteristic 6: Religious Belief Profile of Promotions compared to Staff in Post by Division

Acute Medicine & Emergency Care and Women & Child Health both promoted significantly higher percentages of staff with a religious belief declared as Atheism compared to the staff in post profile, 27% versus 9% and 19% versus 8% respectively.

Ambulatory Care and Surgery & Critical Care promoted higher percentages of staff with a declared religious belief of Christianity than their staff in post profile, 56% versus 49% and 80% versus 47% respectively.

Women & Child Health promoted the highest percentage of staff proportionally who chose not to disclose their religious belief, at 37%.

Characteristic 6: Religious Belief Profile of Promotions by Staff Group

Admin & Estates and Qualified Nursing had the most religiously diverse set of promoted staff.

100% of Technicians promotions had declined to declare their religious belief. The next highest group was Healthcare Assistants, at 50%.

Qualified Allied Health Professions and Clinical Support promoted the highest percentage proportionately of staff who declared their religious belief to be Christianity, both at 75%.

Characteristic 6: Religious Belief Profile of Promotions by Pay Band (excluding Doctors)

Promotions from band 2 and band 5 were the most religiously diverse set of promotions.

All pay bands promoted staff with a declared religious belief of Christianity, with 100% of promotions from band 7 having a declared religious belief of Christianity.

Promotions from band 4 had the highest percentage of staff who did not wish to disclose their religious belief, at 75%.
Characteristic 7: Marital Status Profile of Promotions Summary

52% of promoted staff had a declared marital status of single and 37% had a declared marital status of married.

There were no staff promoted who had a declared marital status of civil partnership or widowed in the year.

Characteristic 7: Marital Status Profile of Promotions compared to Staff in Post by Division

73% of staff promoted in Acute Medicine & Emergency Care had a declared marital status of single, compared to the staff in post profile of 46%.

Ambulatory Care was the only division to promote staff who had a declared marital status of separated.

75% of staff promoted in Surgery & Critical Care had a declared marital status of married, compared to the staff in post profile of 54%.

Characteristic 7: Marital Status Profile of Promotions by Staff Group

Admin & Estates promoted staff from the widest mix of marital statuses.

50% of Healthcare Assistants promoted had a declared marital status of married, the highest percentage amongst all the staff groups.

100% of promoted Qualified Scientific & Technical had a declared marital status of single.

Qualified Allied Health Professions and Clinical Support both had 75% of promoted staff with a declared marital status of single.

Characteristic 7: Marital Status Profile of Promotions by Pay Band (excluding Doctors)

75% of promotions from band 4 were for staff with a declared marital status of married.

All the promotions from band 7 and 72% from band 5 were for staff with a declared marital status of single.

All the staff with a declared marital status of separated promoted were promoted from band 1.
Characteristic 8: Maternity/Pregnancy Summary
Current systems do not allow for easy reporting either on staff that have returned from maternity leave and then subsequently been promoted or staff who are pregnant and get promoted. At present any analysis on this is a manual exercise.

Further investigations into how we may be able to provide this data in the future will be considered.

Leavers: Summary
There were 647 leavers from the Trust during the financial year, 230 of which were junior doctors in training who left as part of their normal rotation programme with the Deanery.

58% of the leavers left to work in other NHS organisations; unfortunately we were only able to record 18% of future NHS destinations. Of the 18% recorded the majority left to work at St. George’s Healthcare NHS Trust.

3% of leavers were dismissed (18 people), 0.77% were made redundant (5 people) and 10% retired (66 people).

Characteristic 1: Gender Profile of Leavers Summary
71% of leavers were female, which was a lower percentage than either the staff in post profile, at 79%, or new starter profile, at 73%. The trend over the year was therefore for more men to leave the Trust than would have been expected or who joined.

Characteristic 1: Gender Profile of Leavers compared to Staff in Post by Division
Ambulatory Care was the only division where the percentage of male leavers was lower than the staff in post profile, 15% leavers compared to 24% staff in post.

In all other division the percentage of male leavers was higher than the staff in post profile.

The division with the highest percentage of female leavers was Women & Child Health, at 90%. However this was still lower than their staff in post profile of 96% female.

Characteristic 1: Gender Profile of Leavers compared to New Starters by Division
The Central Directorates recorded a significantly higher percentage of male leavers than new starters, 46% versus 33%.

Ambulatory Care had 85% female leavers versus 69% staff in post.

In all the other divisions the percentage split between the genders for leavers was comparable to the new starters split.
Characteristic 1: Gender Profile of Leavers by Staff Group

The highest percentage of male leavers was in Medical & Dental, at 45%, which was exactly the same as the staff in post profile.

Admin & Estates also had a high percentage of male leavers, at 36%, which was significantly higher than the staff in post profile of 23%.

The highest percentages of female leavers were in Qualified Nursing and Qualified Allied Health Professions, at 94% and 95% respectively.

Characteristic 1: Gender Profile of Leavers by Pay Band (excluding Doctors)

From band 8a upwards the percentage of male leavers steadily increased, which is a similar trend to the staff in post profile.

Band 1 had 100% of leavers being female, followed by band 4 at 93% female and band 5 at 90% female.

Characteristic 2: Ethnic Profile of Leavers Summary

64% of leavers classified themselves as White and 33% as from a Black & Minority Ethnic background. This correlates closely with the staff in post profile of 69% of staff classifying themselves as White and 30% declaring them self to be from a Black & Minority Ethnic background.

Characteristic 2: Ethnic Profile of Leavers compared to Staff in Post by Division

Surgery & Critical Care recorded the highest percentage of leavers declaring themselves to be from a Black & Minority Ethnic background, at 39%, and the Central Directorates recorded the highest percentage of leavers classifying themselves as White, at 79%.

The percentage of leavers in each ethnic category was broadly in line with the staff in post profile, except for Asian leavers in Women & Child Health, where the percentage of leavers at 18% was well above the staff in post percentage of 7%.
Characteristic 2: Ethnic Profile of Leavers compared to New Starters by Division

Ambulatory Care and the Central Directorates both had higher percentages of White leavers and lower percentages of Asian leavers than their new starter profile.

Conversely Women & Child Health had a higher percentage of Asian leavers and lower percentage of White leavers than their new starter profile.

All other leaver and new starter profiles were comparable.

Characteristic 2: Ethnic Profile of Leavers by Staff Group

Qualified Allied Health Professions recorded the highest percentage of White leavers, at 95%.

Medical & Dental and Qualified Scientific & Technical had the highest percentage of leavers classifying themselves to be from a Black & Minority Ethnic background, at 45% and 46% respectively.

For Medical & Dental this was comparable with the staff in post profile of 40% of staff classifying themselves to be from a Black & Minority Ethnic background. However, for Qualified Scientific & Technical the staff in post profile was only 34%, a 12% gap.

Characteristic 2: Ethnic Profile of Leavers by Pay Band (excluding Doctors)

Leavers from band 6 were the most ethnically diverse, followed by band 5.

All the leavers from band 1, band 8b, band 8d, band 9 and VSM classified themselves as White.

The highest percentage of leavers classifying themselves as Black was in band 8c, at 50%.

20% of the leavers in band 6 classified themselves as Asian, and 20% in band 2 classified themselves as Black.

Characteristic 3: Age Profile of Leavers Summary

69% of leavers were under the age of 40, with 36% in their 20s. This was a much higher percentage than the staff in post profile of 47% of staff under 40, however this is to be expected given career progression, particularly for staff of this age range.
Characteristic 3: Age Profile of Leavers compared to Staff in Post by Division

Acute Medicine & Emergency Care and Women & Child Health both had 77% of leavers under the age of 40.

The Central Directorates recorded the highest percentage of leavers over the age of 50, at 46%.

In the four clinical divisions the percentage of leavers in their 20s was greater than the staff in post profile, as would be expected given career progression.

Characteristic 3: Age Profile of Leavers compared to New Starters by Division

Across all of the divisions the percentage of new starters in their 20s was greater than the percentage of leavers, which means the Trust is employing a younger workforce. This is to be expected as people leave to progress their careers.

Characteristic 3: Age Profile of Leavers by Staff Group

The highest percentages of leavers under the age of 40 were Medical & Dental, which is as expected as this staff group contains junior doctors who leave on training rotation.

The highest percentage of over 40s leaving was for Technicians, which also had the highest percentage of staff in their 40s leave, at 39%.
Characteristic 3: Age Profile of Leavers by Pay Band (excluding Doctors)

Leavers in band 5 recorded the highest percentage of staff in their 20’s, at 57%.

After VSM, which had 100% of leavers in their 30s, band 5 had the highest percentage of leavers under the age of 40, at 76%.

The higher bands recorded higher percentages of leavers from the higher age brackets, but this is as expected given the staff in post profile.

Characteristic 4: Disability Profile of Leavers Summary

1% of the leavers had declared themselves to have a disability and 67% had declared themselves to have no disability.

20% of leavers had declined to declare their disability status. The data quality programme with Human Resources aims to ensure new starters provide data on this characteristic, even if they chose not to disclose their status, and statistics show a decrease in the number of undefined records as a result.

Characteristic 4: Disability Profile of Leavers compared to Staff in Post by Division

There were no leavers within Ambulatory Care or Women & Child Health who had declared themselves to have a disability.

Surgery & Critical Care recorded the highest percentage of leavers with an undefined disability status, at 29%.

Characteristic 4: Disability Profile of Leavers compared to New Starters by Division

The success of the data quality programme can be seen in the lower percentages of undefined records for new starters compared to leavers.
Characteristic 4: Disability Profile of Leavers by Staff Group

Medical & Dental had the highest percentage of leavers with undeclared records, at 30%, but again the data quality programme should help to reduce this going forward.

Characteristic 4: Disability Profile of Leavers by Pay Band (excluding Doctors)

Leavers who declared them self to have a disability were all in band 7 and below.

Characteristic 5: Sexual Orientation Profile of Leavers Summary

77% of leavers had classified their sexual orientation as heterosexual and 22% had chosen not to declare their sexual orientation.

Characteristic 5: Sexual Orientation Profile of Leavers compared to Staff in Post by Division

Generally the percentage of leavers in each sexual orientation category correlated with the staff in post percentage profile.

Acute Medicine & Emergency Care had the highest percentage of leavers classifying themselves as heterosexual, at 80%.

Ambulatory Care had the highest percentage of leavers who had chosen not to declare their sexual orientation, at 33%.
Characteristic 5: Sexual Orientation Profile of Leavers compared to New Starters by Division

There was a lower percentage of heterosexual leavers than starters in all divisions.

The percentage of new starters not declaring their sexual orientation was lower in every division compared to those leaving.

Characteristic 5: Sexual Orientation Profile of Leavers by Staff Group

Medical & Dental had the highest percentage of leavers who had declared their sexual orientation as heterosexual, at 85%.

Clinical Support had the highest percentage of leavers who had chosen not to disclose their sexual orientation, at 35%.

Qualified Allied Health Professions had the only leavers who had categorised themselves as lesbian.

Characteristic 5: Sexual Orientation Profile of Leavers by Pay Band (excluding Doctors)

Band 1, band 8c, band 8d and VSM all recorded 100% of leavers as having classified themselves as heterosexual.

Bands 3 had the highest percentage of leavers who had chosen not to disclose their sexual orientation, at 42%, followed by band 6 at 41%.

Characteristic 6: Religious Belief Profile of Leavers Summary

48% of the leavers had declared themselves to have a religious belief of Christianity.

22% of the leavers had chosen not to declare their religious belief.
Characteristic 6: Religious Belief Profile of Leavers compared to Staff in Post by Division

The percentage split between religious beliefs was broadly comparable between leavers and staff in post.

The division that records the highest percentage of leavers declaring Christianity as their religious belief was Acute Medicine & Emergency Care, at 51%.

Women & Child Health recorded the highest percentage of leavers that record a religion other than Christianity, at 34%.

The Central Directorates recorded the highest percentage of leavers that had chosen not to declare their religious belief, at 33%.

Characteristic 6: Religious Belief Profile of Leavers compared to New Starters by Division

The percentage split between religious beliefs was broadly comparable between leavers and new starters, except for Islam in Ambulatory Care (7% leavers versus 22% new starters) and Christianity in Women & Child Health (45% leavers versus 62% new starters).

Characteristic 6: Religious Belief Profile of Leavers by Staff Group

73% of Qualified Allied Health Professions leavers had declared their religious belief as Christianity, the highest percentage of all staff groups.

Medical & Dental had the highest percentages of staff declaring their religious belief to be Hinduism, at 14%, and Atheist, at 11%.

Qualified Nursing had the highest percentage of leavers who had declined to declare their religious beliefs, at 31%.
Characteristic 6: Religious Belief Profile of Leavers by Pay Band (excluding Doctors)

Band 8c and band 9 had 100% of leavers with a declared religious belief of Christianity, followed by 69% in band 8a.

40% of leavers in band 1 had declared themselves to be atheist.

100% of leavers in band 9 had declined to disclose their religious belief, followed by 36% in band 6 and 35% in each of band 3 and band 7.

Characteristic 7: Marital Status Profile of Leavers Summary

51% of leavers classified themselves as having a marital status of single and 41% as having a marital status of married.

Characteristic 7: Marital Status Profile of Leavers compared to Staff in Post by Division

The profile of leavers was broadly comparable to the profile of staff in post.

Ambulatory Care had the highest percentage of leavers with a declared marital status of married, at 49%, followed by Surgery & Critical Care at 48%.

Acute Medicine & Emergency Care had the highest percentage of leavers with a declared marital status of single, at 60%.

The Central Directorates recorded the highest percentages for leavers with a declared marital status of divorced or widowed, at 14% and 4% respectively.

Characteristic 7: Marital Status Profile of Leavers compared to New Starters by Division

The four clinical divisions all recorded higher percentages for leavers with a declared marital status of married than new starters with a declared marital status of married, with those with a declared marital status of single having the opposite profile.
Characteristic 7: Marital Status Profile of Leavers by Staff Group

56% of Qualified Nursing leavers had a declared marital status of single, followed by 55% of both Medical & Dental and Healthcare Assistants.

52% of Clinical Support leavers had a declared marital status of married, followed by 50% of Qualified Allied Health Professions.

17% of Technicians and 15% of Admin & Estates leavers had a declared marital status of divorced.

Characteristic 7: Marital Status Profile of Leavers by Pay Band (excluding Doctors)

Band 8c, band 9 and VSM all recorded 100% of leavers with a declared marital status of married.

The percentage of leavers with a declared marital status of single generally decreased the higher the pay band, with the highest percentage for leavers with a declared marital status of single recorded in band 3 and band 5, both at 65%.

Band 2 recorded the only leavers with a declared marital status of civil partnership.

Characteristic 8: Maternity/Pregnancy Summary

3% of leavers left as a result of pregnancy.

Only 15% of the staff that were on maternity leave and due to return to work in 2011-12 subsequently left the Trust. The majority of these were Doctors in training, who would have left the Trust anyway as part of their rotation programme with the Deanery.

Completed Performance Development Reviews: Summary

At the beginning of each financial year the Trust issues a timetable for completion of performance development reviews, by pay band, which runs over the first quarter of the next financial year. During that time period a report is sent weekly to the Trust’s Executive Management Committee on progress, until the cycle is complete.

For the financial year 2011-12 the target for completion was 80% by the end of July 2011. This target was exceeded with an actual completion rate of 91% by the end of July 2011.

The following data does not include medical staff.

A large proportion of this staff group are junior doctors who rotate in and out of the Trust regularly. They are required to complete various assessments throughout their placement with the Trust but it is the London Deanery that has overall responsibility for the trainees and would be required to ensure appraisal compliance.
Consultants and non-career grade Doctors performance development reviews are undertaken in the Trust but are not recorded centrally, therefore it is not possible to include them in the analysis. Consideration will need to be given in the future as to how this data can be recorded centrally to enable us to be able to report on all staff groups.

**Characteristic 1: Gender Profile of Completed Performance Development Reviews Summary**

83% of staff with a completed performance development review were female, which correlates with the staff in post profile of 79% of staff being female.

91% of male staff had a performance development review and 92% of female staff.

**Characteristic 1: Gender Profile of Completed Performance Development Reviews by Division**

Surgery & Critical Care reported the highest percentage of female staff with a completed performance development review at 96% and the Central Directorates the highest percentage of male staff at 95%.

Ambulatory Care had the lowest overall percentage of completed performance development reviews, although they were still above target, with 88% completed.

Women & Child Health had the largest gap between the percentage of completed performance development reviews for the genders (89% of females and 80% of males).

**Characteristic 1: Gender Profile of Completed Performance Development Reviews by Staff Group**

All staff groups had a completion total over the 80% target.

Qualified Allied Health Professions reported the highest percentage of females with a completed performance development review, at 95%, and Qualified Nursing the highest percentage of male staff, at 97%.

Clinical Support had the lowest overall percentage, at 84%.

Qualified Scientific & Technical had the biggest percentage gap between completed performance development reviews for the genders (90% of females and 81% of males).
The only pay bands with a completion percentage under the target were males in Band 8d, at 67%, and females in VSM, at 75%.

The shortfalls on these percentages relate to one person in each case, each of whom was a new starter to the Trust. Trust policy is to complete a performance development review for a new starter within the first three months of their start date. It may be, therefore, that the individuals who were non-compliant at the point of measurement went on to have their performance development review within the required three month timeframe.

There were several bands that showed 100% completion for both female and male staff.

The lower pay bands generally had a lower completion rate and this should be tackled in 2012-13 with the next round of performance development reviews.

Acute Medicine & Emergency Care and Surgery & Critical Care recorded all ethnic groups over the target completion rate of 80%.

Ambulatory Care recorded staff who declared themselves as from a Black & Minority Ethnic background as under target, at 79%, Women & Child Health recorded staff who declared themselves to be of mixed ethnic origin under target, at 75%, and the Central Directorates recorded staff who declared themselves to be of Chinese ethnic origin under target, at 50%.
Characteristic 2: Ethnic Profile of Completed Performance Development Reviews by Staff Group

The only staff groups with all ethnicities recorded over target were Technicians and Qualified Nursing.

Clinical Support had three ethnic categories under target; Asian, Black and Other.

For Admin & Estates it was staff choosing not to declare their ethnicity that was under target, at 75%.

Characteristic 2: Ethnic Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)

The majority of ethnic groups for each pay band achieved above target completion rates.

Band 1, band 2, band 4 and band 8a all recorded at least one ethnic group as under target.

Characteristic 3: Age Profile of Completed Performance Development Reviews Summary

Staff in their 20's were the only age bracket not to achieve the 80% target, achieving 79%.

All other age brackets achieved a completed percentage above 90% and the Over 70's were 100% complete.

Characteristic 3: Age Profile of Completed Performance Development Reviews by Division

Ambulatory Care recorded the lowest percentage of completed performance development reviews of staff in their 20's, at 72%.

The only other division recording under target was Women & Child Health with 78% of the staff in their 20’s having a completed performance development review.
Characteristic 3: Age Profile of Completed Performance Development Reviews by Staff Group

Staff in their 20’s were under target for completed performance development review in Clinical Support, at 68%, Healthcare Assistants, at 74% and Qualified Scientific & Technical at 63%.

All other age and staff groups were over target.

Characteristic 3: Age Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)

Bands 8a and above all had a higher than target completion percentage.

Band 1, band 2, band 6 and band 7 were all under target for staff in their 20’s.

Band 1 also recorded staff in their 40’s as under target.

Characteristic 4: Disability Profile of Completed Performance Development Reviews Summary

All disability categories reported over the 80% target.

Staff with an undefined disability record had the highest percentage of completed performance development reviews, at 95%, and those who declared themselves to have a disability the lowest percentage, at 87%.

Characteristic 4: Disability Profile of Completed Performance Development Reviews by Division

Ambulatory Care was the only division that recorded a disability category under target, and that was for staff with a disability, at 50%. However this group was small in number and therefore each individual had a disproportionate effect on the percentage. This percentage is, therefore, not of immediate concern.
Characteristic 4: Disability Profile of Completed Performance Development Reviews by Staff Group

The majority of categories across the staff groups achieved above target completion rates.

Staff who declare themselves to have a disability were under the target for Qualified Scientific & Technical and Technicians. This only referred to one person in each case so the small numbers had a disproportionate effect on the percentages.

Staff who had chosen not to declare their disability were under target for Qualified Allied Health Professions.

Characteristic 4: Disability Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)

The majority of categories across the pay bands achieved above target completion rates.

Band 3, band 6 and band 7 all reported staff with a disability as under the target. However these were small numbers in each case, which had a disproportionate effect on the percentages.

Characteristic 5: Sexual Orientation Profile of Completed Performance Development Reviews

Summary

All sexual orientation categories reported over the 80% target completion rate.

Staff who chose not to declare their sexual orientation recorded the highest percentage of completed performance development reviews, at 95%, and those who categorise themselves as lesbian the lowest percentage, at 80%.
Characteristic 5: Sexual Orientation Profile of Completed Performance Development Reviews by Division

Staff in the Central Directorates and Ambulatory Care were the only areas where some sexual orientation categories were under target.

Ambulatory Care reported bi sexual and lesbian at 50% each, but this only referred to one member of staff in each case and so the small numbers in these areas had a disproportionate effect on the percentages.

The Central Directorates reported gay at 67% and lesbian at 75%, but again small numbers in each category had a disproportionate effect on the percentages.

Characteristic 5: Sexual Orientation Profile of Completed Performance Development Reviews by Staff Group

Admin & Estates reported staff declaring themselves to be lesbian as under target, at 60%.

Healthcare Assistants and Qualified Nursing reported staff declaring themselves to be bi sexual under target, at 50% and 75% respectively.

Characteristic 5: Sexual Orientation Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)

All sexual orientation categories recorded some performance development review completions under target.

Bi sexual was under target in band 2 at 67% and band 7 at 50%, gay at 60% in Band 7, heterosexual at 75% in VSM, not declared in band 1 in 71% and band 8d at 67% and lesbian in band 3 at 67% and band 4 at 0%.

All of the areas referred to small numbers of staff and so there was a disproportionate effect on the percentages.
Characteristic 6: Religious Belief Profile of Completed Performance Development Reviews Summary

Judaism was the only religious belief that recorded under target, at 75%, however there were only 4 members of staff in the Trust who declare this belief and therefore each individual had a disproportionate effect on the percentage.

Staff who had declared Buddhism and Jainism as their religion had 100% of performance development reviews completed.

Characteristic 6: Religious Belief Profile of Completed Performance Development Reviews by Division

Ambulatory Care recorded two religions under target: Islam at 65%; and, Other at 75%.

Acute Medicine & Emergency Care also recorded staff declaring their religious belief as Islam under target, at 78%.

All other divisions and religions were over target, with many recording 100%.

Characteristic 6: Religious Belief Profile of Completed Performance Development Reviews by Staff Group

Clinical Support recorded staff declaring their religious belief as Hinduism under target, at 67%.

Qualified Scientific & Technical recorded under target for staff declaring their religious belief as Islam, at 33%, Judaism, at 0%, and Other, at 75%.

Qualified Allied Health Professions recorded under target for staff declaring their religious belief as Sikhism, at 0%, and Other, at 75%.

Characteristic 6: Religious Belief Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)

Band 4, band 5, band 7, band 8b, band 8c and band 9 all recorded all staff for all religions over the 80% target.
Characteristic 7: Marital Status Profile of Completed Performance Development Reviews Summary
All marital status categories reported over the 80% target.

Staff in a civil partnership recorded the highest percentage of completed performance development reviews at 100% and those who categorise themselves as single the lowest percentage at 88%.

Characteristic 7: Marital Status Profile of Completed Performance Development Reviews by Division
Acute Medicine & Emergency Care and Women & Child Health were the only divisions with categories under target. In both cases this is for staff who categorise themselves as separated, at 75% and 78% respectively.

Characteristic 7: Marital Status Profile of Completed Performance Development Reviews by Staff Group
Clinical Support reported under target for marital statuses of separated, at 50%, and single, at 78%.

Healthcare Assistants reported under target for marital status of widowed, at 60%, and Technicians for marital status of separated, at 50%.

Characteristic 7: Marital Status Profile of Completed Performance Development Reviews by Pay Band (excluding Doctors)
Band 1 reported under target for marital statuses of single, at 79%, and separated, at 50%.

Band 2 reported under target for marital status of widowed, at 60%, band 6 for marital status of separated, at 50%, band 8d for marital status single, at 67% and VSM for marital status married, at 50%.
Characteristic 8: Maternity/Pregnancy
Staff who are on maternity leave during the performance development review cycle are exempt from receiving a performance development review as they are taking their entitled period of time off.

The Trust would expect maternity leave returners to have a performance development review within three months of their return to work.

Employee Relations Cases: Summary
All employee relations cases are recorded centrally within Human Resources and for the first time this year we have extended the recording to include informal sickness cases. There were 321 employee relations cases during the financial year, 151 of which were for these informal cases, 47% of the case load. Excluding the informal cases it was cases pertaining to formal sickness capability that record the highest number of cases, at 59%.

The Trust only recorded 3 grievance cases during the year. These cases reflected a mixture of gender, ethnicity and age categories.

For disciplinary cases the Trust recorded 36 cases. Again these didn’t show any patterns of discrimination in any of the nine characteristics

Characteristic 1: Gender Profile of Employee Relations Cases Summary
80% of employee relations cases related to female employees which was comparable with the staff in post profile of 79% of the workforce being female.

Characteristic 1: Gender Profile of Employee Relations Cases compared to Staff in Post by Division

The highest female case load was in Women & Child Health, at 92%, but this comparable to the gender split of staff in post in the division (96% of staff in post were female).

The male case load was higher than the staff in post profile in Acute Medicine & Emergency Care (23% case load versus 20% staff in post) and Women & Child Health (8% case load versus 4% staff in post). In all other divisions the female case load was higher than the staff in post profile.
Characteristic 1: Gender Profile of Employee Relations Cases by Staff Group

Qualified Allied Health Professions showed the highest percentage of cases for female staff, at 95%. This is the only staff group where employee relations cases for female staff are higher than the staff in post profile.

Medical & Dental had the largest percentage difference between staff in post and cases, with male cases 15% higher (and therefore female cases 15% lower) than the staff in post profile.

Characteristic 1: Gender Profile of Employee Relations Cases by Pay Band (excluding Doctors)

Band 1, band 4 and band 6 all showed a higher percentage of female cases compared to their staff in post profile.

Band 4 recorded no male cases in the year.

The percentage of male cases increases significantly in the higher bands, but this is comparable with the staff in post profiles.

Characteristic 2: Ethnic Profile of Employee Relations Cases Summary

35% of cases were for staff declaring themselves as from a Black & Minority Ethnic background, which was higher than the staff in post profile of 30%. The percentage of cases for staff declaring themselves as from a Black & Minority Ethnic background was also higher in 2010-11, but the differential has decreased by 2% in 2011-12, which is a positive change.

Characteristic 2: Ethnic Profile of Employee Relations Cases compared to Staff in Post by Division

The percentage of cases for staff categorising themselves as White were higher than the staff in post profile, in Ambulatory Care and Women & Child Health.

The percentage of cases for staff declaring themselves as from a Black & Minority Ethnic background were highest in Acute Medicine & Emergency Care, at 46%, followed by Surgery & Critical Care, at 45%.
Characteristic 2: Ethnic Profile of Employee Relations Cases by Staff Group

The percentage of cases was higher than the staff in post profile for employees categorising them self as White in Medical & Dental and Technicians.

The difference between the percentage of cases for staff declaring them self as from a Black & Minority Ethnic background and the staff in post profile was widest for Clinical Support, at 13% (41% of cases versus 28% of staff in post).

Healthcare Assistants registered the highest percentage of cases for staff declaring themselves as from a Black & Minority Ethnic background, at 50%, however this is less of a concern as 43% of the staff in post classify them self in a Black & Minority Ethnic category.

Characteristic 2: Ethnic Profile of Employee Relations Cases by Pay Band (excluding Doctors)

Band 4 had 100% of cases pertaining to staff categorising themselves as White, however the staff in post profile is 83% of staff categorising them self as White, so this is not of great concern.

Band 8a and band 8c had the highest percentage of staff who declared themselves as from a Black & Minority Ethnic background undergoing a case, both at 50%, followed by band 2 at 40%.

Band1, band 8a and band 8c only record cases for staff classify them self as White or Black.

Characteristic 3: Age Profile of Employee Relations Cases Summary

42% of cases were for staff under the age of 40, whereas 47% of the workforce are within this age bracket.

There has been an increase in the percentage of cases for staff in the older age brackets.
Characteristic 3: Age Profile of Employee Relations Cases compared to Staff in Post by Division

The Central Directorates have the largest differences between the age profile of cases and the age profile of staff in post (13% less cases for the 30s age bracket than the staff in post profile, 17% more for the 40s age bracket and 10% less for the 50s age bracket).

Other significant swings between age brackets compared to the staff in post profile are: in Acute Medicine & Emergency Care cases for 20s 7% lower than the staff in post profile, with 50s 7% higher; and, Women & Child Health cases 8% higher for 40s and 8% lower for 50s.

Characteristic 3: Age Profile of Employee Relations Cases by Staff Group

Qualified Allied Health Professions had 77% of cases for staff under the age of 40, much higher than the staff in post profile of 59% of staff under 40.

Admin & Estates have a high percentage of cases for staff over 40, at 72%, but this is reflective of the staff in post profile.

Characteristic 3: Age Profile of Employee Relations Cases by Pay Band (excluding Doctors)

66% of band 5 staff were under the age of 40 but only 54% of case were for staff under 40.

For band 1 all cases were for staff aged 40 or over, compared to a staff in post profile of 60%, and for band 4 96% of cases were for staff aged 40 or over, compared to a staff in post profile of 78%.

Band 7 upwards had no cases recorded for staff in their 20s.

Characteristic 4: Disability Profile of Employee Relations Cases Summary

2% of cases were for staff who had declared them self to have a disability, in line with the staff in post profile.
Characteristic 4: Disability Profile of Employee Relations Cases compared to Staff in Post by Division

26% of the cases in Surgery & Critical Care were for staff with an undefined disability record. Indeed across all of the division the undefined disability records were higher than the staff in post figures.

Ambulatory Care recorded the highest percentage of cases for employees with no disability, at 88%.

Characteristic 4: Disability Profile of Employee Relations Cases by Staff Group

Qualified Nursing and Medical & Dental recorded the highest percentage of cases with an undefined disability, both at 20%.

All of the cases for Qualified Allied Health Professions were for staff declaring no disability.

Admin & Estates, Clinical Support and Qualified Scientific & Technical all recorded cases for staff who had declared a disability, with percentages not out of step with the staff in post profiles.

Characteristic 4: Disability Profile of Employee Relations Cases by Pay Band (excluding Doctors)

16% of cases for band 2 and band 5 staff were for undefined disability records, the highest percentages across the pay bands.

Band 2, band 3, band 4 and band 7 all recorded cases for staff who had declared a disability, but percentages are not out of step with the staff in post profiles.

Characteristic 5: Sexual Orientation Profile of Employee Relations Cases Summary

60% of cases were for staff who had declared themselves to be heterosexual, lower than the staff in post profile of 71%.

A higher proportion of cases were for staff who had declined to disclose their sexual orientation than the staff in post profile (37% of cases versus 28% of staff in post).
Characteristic 5: Sexual Orientation Profile of Employee Relations Cases compared to Staff in Post by Division

Surgery & Critical Care had the highest percentage of cases for staff that had chosen not to disclose their sexual orientation, at 45%, followed by the Central Directorates at 43%.

Ambulatory Care had the highest percentage of cases for staff declaring themselves as heterosexual, at 68%.

Surgery & Critical Care, Women & Child Health and the Central Directorates only had cases for staff either disclosing their sexual orientation as heterosexual or declining to disclose their sexual orientation.

Characteristic 5: Sexual Orientation Profile of Employee Relations Cases by Staff Group

Healthcare Assistants had the highest percentage of cases for staff not wishing to disclose their sexual orientation, at 50% of cases, followed by Qualified Scientific & Technical at 47%.

A relatively high percentage of cases in Clinical Support related to staff who had declared their sexual orientation as gay, but these were very small numbers and therefore had a disproportionate effect on the percentages.

Characteristic 5: Sexual Orientation Profile of Employee Relations Cases by Pay Band (excluding Doctors)

All cases for band 8a and band 8c were for staff who have declared them self to be heterosexual, followed by 90% in band 4.

Band 6 had the highest percentage for staff not wishing to disclose their sexuality, at 44%.

Band 2 had cases for most of the sexual orientations.
Characteristic 6: Religious Belief Profile of Employee Relations Cases Employee Relations Cases Summary

43% of cases were for staff whose religious belief was declared to be Christianity, compared to 51% of staff in post with a declared religion of Christianity.

38% of cases were for staff who had chosen not to declare their religious belief, which was a higher percentage than the staff in post profile of 26%.

Characteristic 6: Religious Belief Profile of Employee Relations Cases compared to Staff in Post by Division

The Central Directorates had the highest percentage of cases for staff who had declined to disclose their religious belief, at 54%, followed by Surgery & Critical Care at 41%.

Ambulatory Care had the highest percentage of cases for staff who have declared their religious belief to be Christianity, at 52%. This was comparable with the staff in post profile, at 49%.

Ambulatory Care was the only division to record cases for staff disclosing their religious belief to be Buddhism.

Characteristic 6: Religious Belief Profile of Employee Relations Cases by Staff Group

Qualified Allied Health Professions recorded the highest percentage of cases for staff declaring their religious belief to be Christianity, at 55%, followed by Admin & Estates at 50%.

60% of the Medical & Dental cases were for staff who had chosen not to declare their religious belief.

21% of the cases for Qualified Scientific & Technical were for staff who had declared their religious belief as Atheists.
Characteristic 6: Religious Belief Profile of Employee Relations Cases by Pay Band (excluding Doctors)

Band 2 had cases in all religious belief categories.

Band 5 and band 6 also had cases in the majority of religious belief categories.

All the cases in band 8c were for staff with a declared their religious belief as Christianity, followed by band 1 at 86% of cases.

Band 4 recorded the highest percentage of cases for staff choosing not to disclose their religious belief, at 45%, followed by band 5 at 42%.

Characteristic 7: Marital Status Profile of Employee Relations Cases Summary

46% of cases related to staff with a declared marital status of married, which is comparable to the staff in post figure of 51% of staff with a declared marital status of married.

Characteristic 7: Marital Status Profile of Employee Relations Cases compared to Staff in Post by Division

Acute Medicine & Emergency Care recorded a significantly higher percentage of cases for staff with a declared marital status of divorced compared to the staff in post profile (12% compared to 6%).

Within Ambulatory Care and Women & Child Health percentages were the highest for staff with a declared marital status of single, at 52% and 47% respectively.

For Surgery & Critical Care and Acute Medicine & Emergency Care the highest percentages were for staff with a declared marital status of married, at 55% and 47% respectively.

Ambulatory Care was the only division to have cases for staff with a declared marital status of civil partnership.

Surgery & Critical Care was the only division to have cases for staff with a declared marital status of widowed.
Characteristic 7: Marital Status Profile of Employee Relations Cases by Staff Group

All the cases in Medical & Dental were for staff with a declared marital status of married.

The highest percentage of cases for staff with a declared marital status of single occurred in Qualified Allied Health Professions, at 68%, followed by Healthcare Assistants at 52%.

Characteristic 7: Marital Status Profile of Employee Relations Cases by Pay Band (excluding Doctors)

There were no cases for staff in Band 1 who had a declared marital status of single.

100% of the cases in Band 8c were for staff with a declared marital status of married.

Cases within Band 6 spanned all of the marital status categories.

Band 4 recorded the highest percentage of cases for staff with a declared marital status of single, at 58%.

Characteristic 8: Maternity/Pregnancy Summary

Employee relations cases will always register a nil return for staff on maternity leave as these staff are not at work to be able to be subject to a case.

Employees that are pregnant and take time off sick with a pregnancy related illness will not count towards the Trust triggers for monitoring sickness absence and will therefore not have to undergo any employee relations cases in relation to this absence. This ensures they are not discriminated against, in this respect, for being pregnant. Pregnancy, however, does not exempt females from any other form of employee relations case and if necessary these staff will be investigated under the relevant policy the same as any other employee. Such cases have not been specifically monitored to date.

Action Plan

New Starters

• Ensure that data is entered for all 8 characteristics on the human resources system;
• Focus on employees that are not migrated from NHS Jobs as this is where the most undeclared records are showing; and,
• Review the Equality & Diversity Form given to new starters.

Promotions

• Ensure that the human resources system input records correct reason for change as promotion;
Further look at analysing maternity leave staff and whether they are promoted; and,

Ensure Acute Medicine & Emergency Care are following recruitment practice, to ensure no discrimination to Black & Minority Ethnic staff.

Leavers

- Improve data on the NHS organisation that employees move to.

Performance Development Reviews

- Start to record Consultant and Non Career Grade Doctors on the Human Resources system;
- Target new starters to ensure Performance Development Reviews are completed within 3 months of joining;
- Ensure that Black & Minority Ethnic staff receive Performance Development Reviews;
- Ensure the lower pay bands receive Performance Development Reviews; and,
- Ensure Maternity Leave returners receive Performance Development Reviews.

Employee Relations Cases

- Ensure record whether any of the employee relations cases are for employees on maternity leave.

Gender Re-assignment

- Consider ways of collecting data on this characteristic.

General

- Ensure the analysis for each characteristic is looked at in detail and target any areas of concern by division, by staff group and by band, taking into account any soft intelligence there may be in these areas and asking questions to answer (e.g. Why was there a high percentage of male leavers in the Admin & Estates staff group?).

Conclusion

This report gives a comprehensive look at all aspects of the workforce at the Trust in relation to equality and diversity and the nine protected characteristics. Data collection on all strands of diversity will continue to be monitored with a view to improving the data quality of information held so that the Trust can actively promote equality and diversity within its workforce.
Service User Diversity Report

Executive Summary
The Trust has traditionally not collected information that would allow for reporting against some of the nine protected characteristics (disability, sexual orientation, religious belief, marital status, maternity/pregnancy and gender reassignment) as these are not relevant to treating patients. In addition the Trust has not historically collected ethnicity information for outpatient and accident & emergency users.

For the characteristics the Trust does collect information on, the profile of users of the Trust’s services is broadly in-line with the profile of the local population, with variations, particularly in age profiles, as you would expect.

The Trust is looking at how best to collect additional information, so that a fuller analysis against the nine protected characteristics can be provided in future years.

The Local Population
Kingston Hospital is located in south west London serving a diverse local community, including Kingston University, and people from across the country who attend Accident & Emergency.

The Trust’s primary commissioner is Kingston Primary Care Trust, though significant activity is also generated from bordering areas, for example Wandsworth and Surrey.

Census 2001 recorded 49% of the local population as male, which is broadly comparable to the London profile.

The local population has a significantly higher profile of people classifying themselves as white, compared to London overall, 11% difference (ONS mid 2010 estimates).

All other ethnic categories are lower in Kingston compared to the London profile.
Review of Activity
Equitable access to services based on need is a primary driver behind the Trusts delivery of clinical services. Data is available through internal reports and external services such the NHS Information Centre and Dr Fosters International.

The following sections look at the profile of service users for each of accident & emergency, outpatients and admitted patients.

Accident & Emergency
During the calendar year 2011 just over 110,000 patients attended accident & emergency at the Trust.

The gender profile of accident & emergency attendances matched that of the local population.

As would be expected the under 14s and over 65s are higher users of accident & emergency services than the population profile of either Kingston or London.
Outpatients
During the calendar year 2011 just over 330,000 outpatient attendances occurred at the Trust and its outlying centres.

A significantly higher percentage of outpatient appointments were for females than the local population profile.

This is to be expected given the large maternity department within the Trust.

As would be expected the over 65s represent a higher proportion of outpatient users than the local population.

The 15 to 44 age bracket also shows significant use of outpatient services, which makes sense with expectant mothers using the Trust maternity service.

Admitted Patients
During the calendar year 2011 they were just over 67,500 admissions to the Trust, with around 40% of patients being treated as day cases.

The gender profile of admitted patients is very similar to that for outpatients, however given the large maternity department at the Trust this is not unexpected.
The age profile of admitted patients is similar to that of outpatients, but with a slightly higher proportion of admissions for the under 15s. This would be expected given the large maternity department at the Trust and consequent baby and early years admissions.

The profile of admitted patients shows a higher proportion of Other (including not declared) than either the Kingston or London profiles, with lower profiles in all other categories. It is not clear whether this reflects a truly higher proportion from other ethnic categories, or reluctance on the part of some individuals to declare their ethnic background. Further analysis is required in this area.

**Action Plan**

The Trust is committed to further developing its monitoring of equality of access to services and during 2012-13 there will be three key focus areas:

- Review and ensure that the formal monitoring of equality of access is enhanced with the appropriate organisational governance groups receiving regular information;
- Develop reports that specifically monitor access and clinical outcomes, for example waiting times, mortality, etc.; and,
- Review, and where practical start to collect, a broader range of equality information regarding our patients, including disability information.

**Conclusion**

This report provides an overview of the profile of the users of the Trust's services in relation to three of the nine protected characteristics (gender, age and ethnic profile).

Data collected on all strands of diversity will continue to be monitored with a view to improving the data available for reporting and quality of data held, so that the Trust can actively promote equality amongst the users of its services.
Sustainability Report
Executive Summary
The Trust recognises the importance of managing the environmental impact from its operations. Moving towards a low carbon future will help reduce the Trust’s contribution to global warming.

Emissions over the Carbon Management Plan period to-date, and the emissions target for each year are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Emissions SCOPE 1-3</th>
<th>Emissions Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09*</td>
<td>8,923.8</td>
<td>9,470.3</td>
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<tr>
<td>2009-10*</td>
<td>8,910.1</td>
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<tr>
<td>2014-15</td>
<td>2014-15</td>
<td>8,750.8</td>
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</table>

* There are limitations to the accuracy of non-financial data for 2008-09 and 2009-10, as this was collected retrospectively. The Trust continues to improve the quality of its data capture, and this has ensured later periods are accurately recorded.

Total CO2 emitted ('000 tonnes) over the Carbon Management Plan period

The Trust is on course to achieve its target of a 10% reduction in its CO2 emissions by 2014-15 as set out in the Carbon Management Plan.

Reductions have been achieved by a combination of the energy efficiency projects, staff behavioural changes and awareness campaigns.

The Trust will be embarking on the following projects to further decrease its CO2 emissions:

- Full implementation of mixed recycling;
- Smart metering for energy monitoring and targeting;
- Energy efficient lighting; and,
- Food waste recycling.

The Trust's Low Carbon Vision
The Trust recognises that global climate change is currently the greatest challenge facing humanity and commits itself to systematically reducing its greenhouse gas emissions.

It is committed to developing and embedding a sustainable and carbon conscious culture throughout the Trust and all its activities, by integrating carbon management within corporate strategies, policies and operational procedures.

As a large employer in the local area the Trust will use its position to engage, inform and influence patients, visitors, staff and other local external organisations to encourage them to reduce their carbon emissions.
Introduction

The Trust has made significant progress in ensuring carbon emissions from its operational activities are well managed and mitigated, in order to fulfil its commitment to continuous environmental improvement in a low carbon future.

Since 2007, the Trust has contributed to the Government target of reducing CO₂ emissions by operating its own combined heat and power plant, together with a refurbished boiler house, which continue to bring savings to annual energy consumption costs and reduce CO₂ emissions from operations. The Trust makes uses of the waste heat from the combined heat and power plant to provide cooling, through the use of energy efficient absorption chillers which have low CO₂ emissions and use ozone friendly refrigerants.

The Trust has developed a Carbon Management Plan covering the period 2010 to 2015 and a Sustainable Waste Action Plan covering 2010 to 2012. Together these plans set out the Trusts’ ambitions and how it plans to deliver CO₂ emissions reductions from energy usage and waste management operations.

Since the development of these plans, the Trust has:

- Introduced the orange clinical waste stream for infectious waste which is disposed of via an alternative treatment technology, a more environmentally friendly process of disposing of waste to replace incineration. This has saved the Trust around £28,000 since September 2010;
- Installed roof insulation on Esher wing;
- Improved heating controllability through the review of the building management system;
- Implemented HTM 07-01 approved colour coding system for effective waste segregation and waste storage facilities;
- Run its first Environmental awareness day, on 1 February 2012, covering energy usage and waste reduction;
- Carried out several waste reduction awareness campaigns;
- Provided an additional 250 internal clinical and domestic waste bins as part of the drive to ensure correct waste segregation and to reduce waste disposal costs; and,
- Started a mixed recycling trial, with the provision of twenty green mixed recycling bins to help divert recyclable materials which otherwise would have ended up in landfill. The scheme will be implemented across the Trust site upon successful completion of the trial. This is expected to increase the Trust recycling rate by a further 5% and save around £6,000 annually from waste disposal cost.

Gas and fuel oil data from the Trust’s energy consumption is used for reporting CO₂ emissions annually in the European Union Emissions Trading Scheme (EU ETS). In addition, the Trust is an Information Declarer in the Carbon Reduction Commitment (CRC) Energy Efficiency Scheme.

The Trust ensures that Display Energy Certificates are updated annually to indicate the amount of energy being used in each individual building and demonstrate the energy efficient of each building.

The data below covers all areas of the Trust site where employees consume energy, produce waste and use water and the Trust is directly responsible for paying the associated utility bill.
## Energy Consumption

<table>
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<tr>
<th>Non-Financial Indicators (Tonnes of CO₂)</th>
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<th>2009-10</th>
<th>2010-11</th>
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<tr>
<td>SCOPE 1: Direct Emissions</td>
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<tr>
<td>Natural Gas</td>
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<td>Total Net Emissions</td>
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<td>1,208.2</td>
<td>1,798.1</td>
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<td>Total Gross Emissions</td>
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<table>
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<th>Related Energy Consumption (MWh)</th>
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<td>CHP Generated Electricity</td>
<td>10,862.0</td>
<td>10,457.3</td>
<td>9,189.6</td>
<td>8,700.3</td>
</tr>
<tr>
<td>Total Energy Consumption</td>
<td>53,303.8</td>
<td>52,567.3</td>
<td>50,353.0</td>
<td>46,096.6</td>
</tr>
</tbody>
</table>

Financial Indicators: Expenditure on Energy (£’000) | 1,809 | 1,182 | 1,612 | 1,413 |

* There are limitations to the accuracy of non-financial data for 2008-09 and 2009-10, as this was collected retrospectively. The Trust continues to improve the quality of its data capture, and this has ensured later periods are accurately recorded.

The Trust continues to reduce its CO₂ emissions from activities in Scope 1: Direct Emissions, with a 15.1% decrease in CO₂ emissions between 2008-09 and 2011-12.

There was an increase in Scope 2: Indirect Emissions over the period 2008-09 to 2010-11, due to weather related issues and maintenance work on the combined heat and power plant, particularly in...
2009-10, requiring the use of increased amounts of purchased electricity. This trend has been reversed in 2011-12, and the trust will be looking to maintain this improvement going forward.

Total consumption of electricity has fallen steadily over the period from 2008-09, however the increased amount of purchased electricity, compared with 2008-09, pushes total emissions higher than they would otherwise be, as the emissions benefits of electricity generated by the combined heat and power plant are not realised.

### Waste Production

<table>
<thead>
<tr>
<th>Non-Financial Indicators (Tonnes of CO₂)</th>
<th>SCOPE 3: Un-quantified Emissions</th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Waste</td>
<td></td>
<td>104.9</td>
<td>113.5</td>
<td>99.2</td>
<td>97.0</td>
</tr>
<tr>
<td>Domestic Waste</td>
<td></td>
<td>273.0</td>
<td>250.7</td>
<td>245.5</td>
<td>236.6</td>
</tr>
<tr>
<td>Reused/Recycled</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bulky Waste</td>
<td></td>
<td>24.8</td>
<td>29.1</td>
<td>18.7</td>
<td>20.9</td>
</tr>
<tr>
<td><strong>Total Gross Emissions</strong></td>
<td></td>
<td>402.7</td>
<td>393.3</td>
<td>363.4</td>
<td>354.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waste Tonnages (Tonnes)</th>
<th>SCOPE 3: Un-quantified Emissions</th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Waste</td>
<td></td>
<td>460.3</td>
<td>497.6</td>
<td>435.1</td>
<td>425.6</td>
</tr>
<tr>
<td>Domestic Waste</td>
<td></td>
<td>498.2</td>
<td>457.5</td>
<td>448.1</td>
<td>431.7</td>
</tr>
<tr>
<td>Reused/Recycled</td>
<td></td>
<td>65.5</td>
<td>78.2</td>
<td>74.1</td>
<td>86.6</td>
</tr>
<tr>
<td>Bulky Waste</td>
<td></td>
<td>45.3</td>
<td>53.2</td>
<td>34.1</td>
<td>38.2</td>
</tr>
<tr>
<td><strong>Total Tonnage</strong></td>
<td></td>
<td>1,069.3</td>
<td>1,086.6</td>
<td>991.4</td>
<td>982.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Indicators: Expenditure on Waste (£’000)</th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>292</td>
<td>274</td>
<td>261</td>
<td>260</td>
</tr>
</tbody>
</table>

* There are limitations to the accuracy of non-financial data for 2008-09 and 2009-10, as this was collected retrospectively. The Trust continues to improve the quality of its data capture, and this has ensured later periods are accurately recorded.

The Trust continues to reduce its CO₂ emissions from waste, with a 12.0% decrease in CO₂ emissions between 2008-09 and 2011-12.

The decrease in emissions has been influenced by a number of initiatives, including: the introduction of alternate treatment technology for infectious clinical waste; improved recycling rates for cardboard;
waste reduction awareness campaigns; and, improvements in waste management systems through purchases of internal waste bins.

There has been an increase in the tonnage reused/recycling from 65.5 tonnes (6.1% of total waste) in 2008-09 to 86.6 tonnes (8.8% of total waste) in 2011-12.

It is expected that further reductions in CO2 emissions will be achieved with the recent introduction of mixed recycling and toner cartridge recycling.

Water Supply & Waste Water

<table>
<thead>
<tr>
<th>Non-Financial Indicators</th>
<th>SCOPE 3: Un-quantified Emissions</th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Tonnes of CO2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Supply</td>
<td></td>
<td>17.1</td>
<td>21.6</td>
<td>17.0</td>
<td>14.9</td>
</tr>
<tr>
<td>Waste Water</td>
<td></td>
<td>35.3</td>
<td>44.4</td>
<td>35.9</td>
<td>30.6</td>
</tr>
<tr>
<td>Total Gross Emissions</td>
<td></td>
<td>52.4</td>
<td>66.0</td>
<td>52.9</td>
<td>45.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Water Volumes (m³)</th>
<th>SCOPE 3: Un-quantified Emissions</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Water Supply</td>
<td></td>
<td>50,386.5</td>
<td>63,450.0</td>
<td>49,945.0</td>
<td>43,766.0</td>
</tr>
<tr>
<td>Waste Water</td>
<td></td>
<td>50,386.5</td>
<td>63,450.0</td>
<td>49,945.0</td>
<td>43,766.0</td>
</tr>
<tr>
<td>Total Volume</td>
<td></td>
<td>100,773</td>
<td>126,900</td>
<td>99,890</td>
<td>87,532</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Indicators: Expenditure on Water (£'000)</th>
<th>2008-09*</th>
<th>2009-10*</th>
<th>2010-11</th>
<th>2011-12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>147</td>
<td>155</td>
<td>92</td>
<td>74</td>
</tr>
</tbody>
</table>

* There are limitations to the accuracy of non-financial data for 2008-09 and 2009-10, as this was collected retrospectively. The Trust continues to improve the quality of its data capture, and this has ensured later periods are accurately recorded.

With about 3,000 staff and over 300,000 visitors annually, the Trust has to ensure an adequate and clean water supply for consumption by clinical wards, offices and restaurants. Through regular maintenance and using poster campaigns to raise staff and patient awareness of the need to conserve water the Trust has achieved significant reductions in water consumption and costs since 2009-10.

As a consequence, since 2008-09 the Trust has reduced both its water consumption and CO2 emissions from water supply & waste water by 13.1%.
Priority for Patient Safety Improvements in 2012-13: Recognise when a patient’s condition is deteriorating and taking swift clinical action

Lead: Jane Wilson, Medical Director
Monitoring: Patient Safety Committee

Why we chose this
Every day more than a million people are treated safely and successfully in the NHS, but the evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff. And when things go wrong, patients are at risk of harm.

Analysis of 576 deaths reported to the National Patient Safety Agency’s (NPSA) National Reporting and Learning System (NRLS) over a one year period (2005) identified that 11% were as a result of deterioration not recognised or acted upon (66 cases). (National Patient Safety Agency)

Overall the Trust’s patient outcomes are excellent with a Hospital Standardised Mortality Ratio (HSMR) well below the expected rate nationally, but the Trust knows it could do better in the areas of recording patient’s observations and escalating the care needed.

The audits undertaken in the Trust show that the completeness of patient’s vital signs observations and the timeliness of their recording can be improved. Delays arising from not recognising early signs of deterioration and not responding to these appropriately can also be improved. This means that currently some patients could become more unwell and need admission to intensive care, when earlier intervention could have prevented this from happening.

Hospitals that have good systems in place to recognise deterioration in patient’s vital signs increase the chances of survival following cardiac arrest, when appropriate steps are taken to deal with the emergency. Prompt recognition of cardiorespiratory arrest and prompt instigation of resuscitation techniques can double the chance of survival (Resuscitation Council (UK) 2005).

How we have performed to-date:
The Trust performs extremely well in many of the patient safety measures and the HSMR mortality measure is at 82.2 for 2011, representing 172 less deaths than expected for the year (770 versus 942).

The Trust uses observation charts to help to track a patient’s condition. The results of these Early Warning Score (EWS) audits show that the Trust has improved performance in some months, but not on a consistent basis.

EWS – Full sets of observations:
Nurses and doctors should be measuring all of the patients observations all of the time where required. The charts help staff to identify when a patient’s condition is not improving or needs to have higher levels of treatment provided. The audit also shows that there are times when abnormalities are recorded but staff don’t act on the information.
The results of this audit are shown in the graph below.

EWS – Episodes not escalated:

<table>
<thead>
<tr>
<th>Year</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-12</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010-11</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What are we going to do?**

**Aim:** To increase the early recognition and treatment of deteriorating patients.

- During the first quarter of the year, we will collect, analyse and review data on the patients who are admitted to the intensive care unit, and initiate root cause analysis of any incidents where failure to take appropriate action resulted in an admission to ITU. Audits of cardiac arrest and peri-cardiac arrest calls will be undertaken. The information generated from this will identify the improvement actions to be taken and an action plan will be developed.

- In the second quarter of the year the issues identified will be used to develop a series of actions and measures to identify the ways we can improve our performance and begin measuring and reporting performance.

- During the third quarter of the year we will embed the changes that we have planned and continue measuring the improvements we expect to find.

- During the last three months of the year we expect to show that the number of incidents that have occurred, where patient’s observations were not acted upon, will reduce (compared to our baseline data).

**How will we measure progress?**

The Trust, through the Acute Response Group, will monitor the action plan and measures of success which include:

- The Standardised Hospital Mortality Indicator (SHMI);
- Relevant Patient Safety Indicators;
- The number of episodes when a patient has deteriorated and appropriate action was not taken evidenced through the and the EWS audits; and,
- Results of the audit of admissions to Intensive Care.

**Why we chose these measures**

Methods of collection are established and their patterns of data collection are consistent over time and will demonstrate performance, and any improvement.

Benchmarking against other hospitals may not be a valid approach because of differences in patient population, resource availability and/ or severity of illness. Therefore benchmarking based on improvement within the Trust is considered most appropriate.
Priority for Effectiveness of Care Improvements in 2012-13: Reduce variations in care out of hours

Lead: Jane Wilson, Medical Director
Monitoring: Clinical Effectiveness Committee

Why we chose this
The Trust needs to deliver a safe and consistently high quality service for patients seven days a week.

In London, data shows that the probability of dying as a result of many emergency conditions is significantly higher if the admission is at the weekend, compared to a weekday. Outcomes for patients in London vary considerably across different hospitals. A variety of outcome measures, such as mortality rates, length of stay and re-admission rates provide an indication of the quality of a service and enable comparisons between services across London.

The Trust has introduced a number of projects which have improved the ways of working together: to improve access to diagnostic tests; increase the number of consultant ward rounds; and, the scheduling of emergency operations.

The result of this is an improvement in the overall mortality rate, length of stay and emergency readmissions, however the difficulty in delivering good continuity of care across all hours is recognised and effective handover is crucial to the quality and safety of patient care.

The Trust operates a “Hospital at Night” team and the team co-ordinates handover and clinical tasks required for all patients out of hours. The Trust has not fully encompassed all of the principles of a comprehensive team, by making sure that the right skill mix and numbers of staff are in place in the hospital at night time.

In particular, the role of the team and the leadership of the team could support more co-ordinated multi-disciplinary handover.

How we have performed to-date:
Throughout the last year the Trust has been working to improve care in the hospital 24/7.

The Medical Assessment Centre has been relocated and this has led to improvements in length of stay and patient flow through the hospital. Senior clinical staff are now more involved in patient pathways at an early stage, with access to the necessary diagnostics to ensure that length of stay, complication rates and readmissions are within best practice guidelines.

The Trust will continue to introduce changes that will see consultant led patient care in emergency situations and during an extended working day and the work the Trust has done so far has helped with inpatient reviews and discharge planning.

The weekend has traditionally seen a reduction in services to support care delivery. In order to improve care delivery the Trust has made good progress in:

- Reviewing consultant job plans to include weekend ward rounds; and,
- Increasing accessibility to diagnostics and therapies.

The latest mortality figures, length of stay and readmissions rates for weekend and weekdays show that there is no significant variation between patient's outcomes for weekday and weekend admissions. In many areas, the Trust is significantly better than the level that could be expected.
What are we going to do?

**Aim:** To improve clinical leadership and handover processes out of hours so as to improve the effectiveness of the care that patients receive.

- In the first quarter of the year, we will collect, analyse and review data on the patients who are cared for out of hours, including the outcomes for these patients compared to those who are admitted or discharged during week days and at night.
- In the second quarter of the year the issues identified will be used to develop a series of actions and identify the ways we can improve our performance.
- During the third quarter of the year we will embed the changes that we have planned and begin measuring the improvements we expect to find.
- During the last three months of the year we expect to show that the care for patients across the 24 hour 7 day period has come closer together and that there are reductions in the variability of outcomes for these patients.

**How will we measure progress?**

The Trust will continue to review mortality rates, length of stay and emergency readmission rates and compare weekend to weekday variations to ensure that the good performance is sustained.

The handover completeness (communication of patient demographics/diagnosis/tasks required) along with the perception of staff regarding usefulness of the handover will help to identify areas for improvement.

Through quarter one the Trust will seek to identify more sensitive measures of quality regarding leadership of the hospital at night team.

**Why we chose these measures**

Although the Trust performs very well in terms of variations in outcomes for patients (mortality, length of stay and readmissions) and whilst these are very useful in identifying areas of local focus, the Trust currently don't collect data which is sensitive enough to identify the subtle variations in handover and completeness of tasks allocated

The leadership of the team and the skills of the staff within the team are key components of effective working.
Priority for Patient Experience Improvements in 2012-13:
Improving communication with our patients

Lead: Jenny Parr, Director of Nursing & Patient Experience

Monitoring: Patient Experience Committee

**Why we chose this**
Health care is provided in partnership with patients, their carer’s and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Medicines management plays an important role in preparing patients, and their carers, for transfer/discharge, and has an impact on the recovery and/or maintenance of their condition(s) following discharge. The use of medication is increasing and many patients will be taking a number of different medicines, quite appropriately, to manage their condition. The risk of drug interactions increases with additional medication. A high proportion of hospital admissions and readmissions, quoted as between 5% and 17% (Source: Macmillan Cancer Support, 2010, Office for National Statistics, 2009), are due to adverse reactions to medicines or incorrect medicine taking.

Engaging patients and carers in discussions about care and ensuring that decisions about treatment are shared can improve the management of the condition and improve a patients’ experience of care. Patients benefit from having information about their condition and treatment options and from having support to understand, interpret and translate that information. The results of national patient surveys for inpatients and outpatients have not shown improvement in this area over recent years.

Specific areas where patients report areas for improvement include: involvement in decisions about treatment and discharge; being informed of who to contact if worried; understanding the purpose and side effects of medicines; and, being kept informed of delays.

Despite reductions in the absolute number of complaints regarding attitude and communication the Trust wishes to continue to further improvement. Results of the Patient Experience Tracker used during the past 12 months have not demonstrated improvement in the involvement of patients in decisions about treatment or discharge.

**How we have performed to-date:**
The Trust has been successful in obtaining feedback from large numbers of patients, and in developing and delivering improvement actions. The Trust held a number of listening events for approximately 70 patients. These events provided the Trust with important information from patients which it has used to re-define the Trust’s values, make new commitments to patients, and develop new standards.

Patients views have been collected routinely by using feedback tablets, available in wards and outpatient settings, for patients to comment on their experience. A number of local surveys of patients have been conducted across a number of services, and developed quality improvement initiatives as a result.

A Patient Assembly has been implemented to provide a patient and community perspective on the Trust’s plans and strategies. Some Patient Assembly members are also representatives on Trust committees.

A new patient feedback system called the Net Promoter Score is being implemented. This allows patients in all service areas to take a minute to complete a comment card, on the service they have just received.
What are we going to do?

Aim: We aim to improve the perception of patients that they have had more personalised care.

- In the first quarter of the year, we will collect, analyse and review data on the patients using a variety of systems including Net Promoter Score.
- In the second quarter of the year the issues identified will be used to develop a series of actions and identify the ways we can improve our performance. This will include areas such as making information about waiting times visible and updated, developing patient leaflets and piloting the checkout sheet from the outpatients clinic.
- During the third quarter of the year we will embed the changes that we have planned and begin measuring the improvements we expect to find.
- During the last three months of the year we expect to show that patient reports of how effective communication is has improved through our net promoter scores in outpatient and inpatient areas and results of national inpatient and local outpatient surveys.

How will we measure progress?

As part of the national inpatient survey there are a number of questions each of which describes a different element of the overarching patient experience theme “responsiveness of personal needs of patients.

We will conduct local audits to establish how we are improving based on these questions:

Q1: Were you involved as much as you wanted to be in decisions about your care and treatment?
Q2: Did you find someone on the hospital staff to talk to about your worries and fears?
Q3: Were you given enough privacy when discussing your condition or treatment?
Q4: Did a member of staff tell you about medication side effects to watch for when you went home?
Q5: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

We will analyse the responses we get from patients to check that we are improving the performance and use the scores to track our performance.

Net Promoter Scores will be gathered at ward and department level.

The Trust will undertake a local survey of outpatients.

Why we chose these measures

The benefits of effective communication for patients are that patients believe they have been supported and have made the right decisions about their future care, and importantly, patients feel part of the care process, an active partner and not disempowered.

The nationally recognised benchmarking arising from the patient survey is a one off annual event and we will conduct in year surveys.

The Net Promoter Score system allows a more localised assessment, based on the different wards and services we provide and also offers us a quicker and more timely way to identify local improvement drivers.
Quality Strategy Targets

In March 2012 the Trust Board approved an overarching Quality Strategy, which brings together a number of previous documents that dealt with aspects of quality into one cohesive Strategy.

Quality underpins the Trust’s vision which is that local people choose Kingston Hospital because they recognise it for delivering excellent care services. The Quality Strategy describes how the safety and effectiveness of care will be enhanced whilst continuing to improve patient experience over the next five years against a backdrop of financial constraint. The Trust has placed quality as the primary Trust corporate objective and all staff have this as a key personal objective so that patients receive safe and high quality care.

The Trust has been working to deliver quality care at Kingston for some time. The Trust has a demonstrable track record of continuous improvement and good results while continuing to ensure that the finances are well managed. In 2012 it is vital to have a strategy to ensure that quality is protected in the challenging environment of change and financial efficiency. The Quality Strategy draws together the key elements from the core individual strategies (Patient Safety and Patient Experience), and brings them together and updates them to produce a cohesive approach to delivering high quality care.

Quality relies upon having the right culture throughout the Trust to enable staff to deliver quality care. The famous quotation “culture eats strategy for breakfast” (Drucker) recognises the need to build a culture that supports strategy implementation. The Trust has recently engaged staff in developing the core values of caring, safe, responsible and value each other. Put simply, the quality vision is to create the right environment for all staff so that they, in turn, can deliver the appropriate care for patients.

The Strategy details a range of actions that the Trust will take to deliver the Quality Strategy.

Capabilities & Culture
The culture puts quality first throughout the Trust from the Wards to the Board and in all the Trust’s supporting and administrative areas.

The action plan will aim to improve the visibility of the leadership by the whole Trust Board with respect to quality improvement. Quality KPIs will improve and the staff survey will demonstrate improvements in key questions related to incident reporting and quality of care being seen as a top priority.

The workforce will be fit for purpose and all staff will demonstrate behaviour which is consistent with the Trust’s values all of the time to deliver compassionate care consistently.

The action plan will aim to embed the values throughout the employee lifecycle, reinforcing expectations of how staff should interact with each other and patients and equip staff with the skills to “live the values everyday”. Improvement will be seen in the numbers of staff who undertake training in these areas, the staff survey will demonstrate improvement in questions relating to appraisal and management feedback, and the Net Promoter Score will demonstrate improvement.

Processes & Structures
A robust systematic approach to governance and risk management, which permeates right through the Trust and creates and maintains reliable processes and continuous learning.

Evidence of challenge regarding quality will be visible in the minutes of meetings throughout the Trust. WHO and Internal Audit results will improve. Escalation of risks and awareness of gaps in control will be visible from ward to Trust Board. A range of assurance
mechanisms will be used including internal and external audit.

Communication systems must be effective and accurate and maximise the capacity of information technology to share information efficiently within and outside of the Trust.

The action plan will aim to ensure the risk of incidents relating to the handover of care between organisations and individuals is reduced. Incidents will be monitored and learning shared.

Patients and the public will be involved, heard from and are responded to.

The numbers of patients or public involved on committees will increase. The patient and public contribution will be visible at all levels of the Trust.

Mechanisms will be developed to enable the Trust to place itself at the forefront of publishing accessible and useful information on the quality and outcomes of the services delivered for patients.

Outcomes will be available on the Trust website for patients to see. The contribution of patients and the public to the development of the Quality Account, its priorities and the publication of outcomes will be evident in the work plan of the Patient Assembly and the stakeholder commentary of the Quality Account.

Services will be fit for purpose having captured patients’ ideas on improving efficiency and redesign of services.

The Patient Assembly work plan will identify programmes of work and demonstrate increased involvement. Patient feedback will improve in those services where patients have been involved in redesign.

Innovative solutions will be used to ensure that delivering efficient services enhances quality.

Actions will improve staff satisfaction and reduce sickness. The Patient’s experience will be improved as length of stay and harm events (pressure ulcers and falls) will reduce. Resources will be used more efficiently. Project evaluations will monitor the quality impact and measures of improvement.

The impact of any service development or service change is assessed to ensure that the quality and equality of the service or care delivered is not compromised.

Post implementation reviews will be scheduled and learning will be built into future plans. Patient and staff experience and quality KPIs will be maintained or improved. The quality impact and measures of improvement will be monitored.

Measurement
Systematic flows of information are used from frontline staff to the organisational leaders and back, to achieve high reliability and enhance quality.

Performance relating to national standards will improve, exception reporting and forecasting will be used and lead to evidence of actions at all levels. Quality KPIs will improve.

Quality standards are set, monitored and published to drive quality improvement.

The performance of the Trust with respect to national standards will be visible within and externally to the Trust. Action plans will be developed at the right level to address areas for improvement.

Continuous Improvement
The Trust seeks to continuously improve by setting challenging goals, build on successes and evaluating achievements and taking lessons and implementing best practice from world-wide exemplars.

Clinical audit results will demonstrate improvement year on year. Lessons will be shared at the annual Clinical Audit Seminar, and departmental governance meetings.
Looking back at 2011-12: Summary

Performance against our Quality Account priorities for 2011-12 can be summarised as follows:

<table>
<thead>
<tr>
<th>PATIENT SAFETY</th>
<th>Achievement</th>
</tr>
</thead>
</table>
| Priority One   | • 43% reduction in inpatient falls (871 to 497)  
                 • Average of 3.4 falls per 1,000 bed days over 2011-12 |
| Priority Two   | • 39% reduction in grade 2 ulcers (142 to 86) |
| Priority Three | • 63% reduction in grade 3 and grade 4 ulcers (30 to 11) |
| Priority Four  | • Now >80% of patients assessed  
                 • Standardisation of documentation  
                 • Pain Link Nurse programme introduced  
                 • Groups were invited to trial new forms |
| Priority Five  | • Emergency post elective readmissions reduced to 1.8% from 2.2% |
| Priority Six   | • Increased education of junior doctors  
                 • 81% of patients aged 65 and over had memory assessment |

By putting information about the quality of the Trust’s services into the public domain, the Trust is offering its approach to quality up for scrutiny, debate and reflection.
We have used the following symbols to indicate how well we have done against the various priorities and targets we report on:

✓ Met the target

= Good progress but more to do

✗ We did not meet the target

**Review of the 2010-11 Quality Account by the Audit Commission**

The Audit Commission undertook a ‘dry run’ audit of the 2010-11 Quality Account and made recommendations to help the Trust be in a better position for the requirement for a formal audit, which commences from 2011-12.

Guidance from the Department of Health required the Audit Commission to:

- Review the Trust’s arrangements for satisfying itself the Quality Account was fairly stated and followed relevant requirements; and,
- Test two performance indicators included in the Quality Account.

In reviewing the management arrangements the Trust was found to have clear governance arrangements with good systems and processes for producing the Quality Account. On reporting arrangements the Audit Commission recommended that the Trust provide an earlier draft of the Quality Account to stakeholders, to further improve engagement in identifying and agreeing priorities.

Stakeholders have been involved in the process of selecting the priorities for 2012-13 and received a first draft of the Quality Account for comment before the end of April 2012.

In testing indicators on clostridium difficile and numbers of patients with pressure ulcers the Audit Commission made two recommendations with regards to pressure ulcers, both of which the Trust has taken action to address.

**Internal Audit**

Internal Audit also reviewed the arrangements for producing the 2010-11 Quality Account. The audit opinion was Substantial Assurance with no issues found with the adequacy of controls and only one recommendation made around the effectiveness of controls.

The recommendation, regarding including an explanation of how performance indicators for each priority were selected, has been addressed in Section 2a of this Quality Account.

**Feedback to the Trust Board**

Combined with monitoring reports, this year has seen a new initiative at the Trust Board, where a patient story is read alongside any actions taken as a result. The following is an example to illustrate how we value and learn from you:

*A child was due to undergo an investigation that required them to stay all day. The child was accompanied to hospital by a parent, who had to make special arrangements; taking a day off work and arranging childcare for siblings. The family travelled by car and paid for the parking.*

*On admission to the children’s ward it was discovered that the equipment required for the investigation in X-ray had broken down. The ward staff thought the X-ray Department had informed the patient, however this had not occurred. The parent of the child complained.*

*The Trust has apologised and the family has been offered free parking for the rescheduled investigation. The Radiology Supervisor has now written a protocol for contacting patients in the event of equipment breakdown to ensure this event is not repeated.*
Progress against 2011-12 Patient Safety Priorities

PRIORITY ONE: Reduce Falls

Aim: To reduce patient falls to less than the 4.8 falls per 1,000 bed days National Patient Safety Agency benchmark, by March 2012.

Why we chose this
Patient falls are among the most common occurrences reported in hospitals and are a leading cause of death in people aged 65 years or older. Of those who fall, as many as half may suffer moderate to severe injuries that reduce mobility and independence, and increase the risk of premature death.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure risk assessments are completed on all patients and take steps to identify causes and actions.</td>
<td>Audited regularly to check compliance.</td>
</tr>
<tr>
<td>Implement the falls action plan. If performance drops we will take remedial actions.</td>
<td>Action plan implemented.</td>
</tr>
<tr>
<td>Implement ward score card to provide transparency of levels of performance and strengthen accountability.</td>
<td>Ward score cards are produced monthly.</td>
</tr>
<tr>
<td>Implement hourly rounding.</td>
<td>Two hourly rounds implemented on all wards.</td>
</tr>
<tr>
<td>Benchmark internally, developing local action plans to achieve local target reductions.</td>
<td>Benchmarking undertaken and action plans developed and implemented.</td>
</tr>
</tbody>
</table>

How did we measure progress?
Regular reporting of the number of falls to ward, divisional and Trust Board meetings.

Monthly reporting to NHS London High Impact Actions, a London benchmarking exercise that enables a comparison to be made of the Trust’s performance against other London Trust.

Monthly reporting of statistics to the local LINks and HealthWatch.

The Falls High Impact Actions action plan is monitored at the Patient Safety Committee.
How did we do?

We achieved our target for this priority.

The number of patient safety incident falls has fallen from 871 in 2010-11 to 497 in 2011-12, a reduction of 43%.

Since May 2011, the Trust has remained below the national benchmark of 4.8 falls per 1,000 bed days, averaging 3.4 falls per 1,000 bed days over 2011-12.

A number of initiatives were implemented over the year. Raising awareness and implementing an educational strategy proved to be very effective. Alongside this, two hourly rounding, consistent, regular monitoring of falls, and the purchase of innovative equipment designed to provide a mechanism to alert staff of potential risk, have all been successful. The nursing assessment documentation now incorporates a falls risk assessment and, where indicated, nurses should be using a variety of strategies to reduce the risk. Despite the progress made, in 2011-12 there have been five falls in which the patients sustained head injuries and subsequently died.

Since then, the Medical and Nursing Directors led a review of each case to establish if there were any common issues or events related to these episodes and to consider what actions should be put in place to minimise the likelihood of recurrence. A task and finish group has since been established led by the Medical and Nursing Directors until these actions are completed.

PRIORITY TWO: Reduce Pressure Ulcers

Aim: To reduce the number of hospital acquired grade 2 pressure ulcers from the baseline 2010-11 figure by 30% (a reduction of 43 incidents) by March 2012.

Aim: To reduce the number of hospital acquired grade 3 and 4 pressure ulcers by 70% (a reduction of 16 incidents) by 30 March 2012.

Why we chose this

Pressure ulcers can cause serious pain and severe harm to patients. The cost of treating all hospital acquired pressure ulcers in the UK is estimated to be between £1.4 billion and £2.1 billion each year, comprising of approximately 4% of total NHS expenditure. In the majority of cases pressure ulcers can be prevented if we follow simple measures.
**ANNUAL REPORT**

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure risk assessments are completed on all patients and take steps to identify causes and actions.</td>
<td>Audited regularly to check compliance.</td>
</tr>
<tr>
<td>Reinforce the pressure ulcer care plan across all wards.</td>
<td>Regular focus with senior nursing staff.</td>
</tr>
<tr>
<td>Ward Sisters will investigate the cause of serious pressure ulcers, develop action plans to drive improvement, and present these to Director of Nursing &amp; Patient Experience.</td>
<td>Now occurring. Action plans are signed off by the Director of Nursing &amp; Patient Experience.</td>
</tr>
<tr>
<td>Implement ward score card to provide transparency of levels of performance and strengthen accountability.</td>
<td>Produced monthly.</td>
</tr>
<tr>
<td>Strengthen the High Impact Action Skin group.</td>
<td>Patient Safety Committee monitors outputs.</td>
</tr>
<tr>
<td>Develop a patient information leaflet.</td>
<td>Done.</td>
</tr>
<tr>
<td>Develop and implement a skin care bundle.</td>
<td>Now in use.</td>
</tr>
<tr>
<td>Benchmark internally, developing local action plans to achieve local target reductions.</td>
<td>Benchmarking undertaken and action plans developed and implemented.</td>
</tr>
</tbody>
</table>

**How did we measure progress?**

Regular reporting of the number of pressure ulcers to ward, divisional and Trust Board meetings.

Monthly reporting to NHS London High Impact Actions, a London benchmarking exercise that enables a comparison to be made of the Trust’s performance against other London Trust.

Monthly reporting of statistics to the local LINks and HealthWatch.

The Skin High Impact Actions action plan is monitored at the Patient Safety Committee.

**How did we do?**

We achieved our target for reducing grade 2 pressure ulcers, but whilst making significant progress did not hit the reduction target we had set ourselves for grade 3 & 4 pressure ulcers.

The number of patients with hospital acquired grade 2 pressure ulcers has decreased by 39% against a target of 30% and is now running below the 2011-12 target.

There was a total of 86 grade 2 pressure ulcers in 2011-12, down from 142 in 2010-11.
All grade 3 or 4 pressure ulcers are investigated and the findings are presented to the Director of Nursing & Patient Experience and reported at the Executive Management Team meeting.

The learning from investigations has raised awareness across the Trust and seen an increased focus in education and prevention strategies for staff within the Emergency Department.

The nursing assessment documentation follows this through and a care bundle has been developed to assist staff in planning patient centred care. A patient information leaflet has been developed to raise awareness of risks and preventative strategies targeted at patients and carers.

The High Impact Action Group has been strengthened and meets monthly with the Matrons, tissue viability specialised Nurse and risk managers.

**PRIORITY THREE: Increase VTE Assessment**

**Aim:** To meet the 95% risk assessment target set last year.

**Why we chose this**

Venous Thromboembolism (VTE) is one of the commonest causes of death in this country. Safe and effective methods of prevention of VTE have been known for many years but the importance and scale of VTE as a public health and patient safety issue has remained largely unrecognised. VTE risk assessment is about saving lives and avoiding long term ill health.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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<tbody>
<tr>
<td>Ensure that all relevant staff are trained to and record all risk assessments on the Care Records Service.</td>
<td>We trained all our doctors to be able to undertake a VTE risk assessment.</td>
</tr>
<tr>
<td></td>
<td>All completed risk assessments are now recorded on the Care Records Service.</td>
</tr>
<tr>
<td>Report any in-patient VTE and undertake a root cause analysis of why this happened.</td>
<td>All patients who experience a VTE are now investigated to understand why.</td>
</tr>
<tr>
<td>Develop an action plan to drive improvement.</td>
<td>An action plan was developed and implemented.</td>
</tr>
</tbody>
</table>

The number of patients with hospital acquired grade 3 and 4 pressure ulcers has decrease from 30 in 2010-11 to 11 in 2011-12, a reduction of 63%.

There were no grade 4 pressure ulcers between August 2010 and February 2012.
How did we measure progress?
Reports from the Care Records Service are reviewed on a weekly basis, by ward and Consultant, together with records of training undertaken.

The action plan was monitored and VTE incident reports were analysed at the Patient Safety Committee.

How did we do?
We achieved our CQUIN and contractual target of at least 90% of patients receiving a VTE assessment upon admission to the hospital, however we did not achieve the stretch target of 95% that we set as a Quality Account priority last year.

The Trust has made a concerted effort to ensure that all patients who are admitted to hospital have a VTE assessment. All assessments are recorded on the Care Record Service.

In March 2012 91.9% of patients (4,556 patients) received a VTE assessment upon admission.
Progress against 2011-12 Clinical Effectiveness Priorities

PRIORITY FOUR: Better Pain Control

Aim: To reduce the pain patients feel after operations.

Why we chose this
In November 2010, the Department of Health (DH) identified that the National Confidential Enquiry Patient Outcome and Death (NCEPOD) report claimed hospitals were failing to address pain issues adequately particularly in elderly patients.

Pain is counterproductive in the restrictions it has on our ability to perform normal activities. In hospital particularly following surgery, pain can contribute to the development of complications such as chest infections and VTE. The stresses it places on the body can also increase the risk of heart attack and delay wound healing. The human cost of this is not measurable but impacts on patient’s recovery and increases length of stay.

Our patients identified pain management in the Inpatient Survey as something we needed to focus on.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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</thead>
<tbody>
<tr>
<td>We are aiming to improve the assessment and management of pain through a series of interventions which include:</td>
<td>The Campaign Against Pain task group was set up to implement better pain control for patients.</td>
</tr>
<tr>
<td>• An analysis of the opportunities and barriers to effective pain management;</td>
<td>An average of 87% of all patients now have their pain assessed every day (end of March 2012 audit).</td>
</tr>
<tr>
<td>• Establishment of a designated group;</td>
<td>A standardised assessment tool has been developed and the vital signs chart incorporates pain as the 5th vital sign.</td>
</tr>
<tr>
<td>• Routine monitoring of pain as the 5th vital sign alongside temperature, pulse, blood pressure and respiration;</td>
<td>An audit cycle has been developed to monitor the effectiveness of this newly developed assessment strategy and resultant care plans.</td>
</tr>
<tr>
<td>• Ensure that pain is included in the review of nursing documentation and included as a question within hourly rounding;</td>
<td>A patient information booklet is being developed alongside a network of Pain Link Nurses, who will act as a ward level resource.</td>
</tr>
<tr>
<td>• Develop a Pain Link Nurse on medical and surgical wards alongside a supporting educational development programme;</td>
<td>The Campaign Against Pain task group is researching available benchmarking information and tools.</td>
</tr>
<tr>
<td>• Production/re-launch of prescribing guidelines;</td>
<td></td>
</tr>
<tr>
<td>• Develop a patient information leaflet; and,</td>
<td></td>
</tr>
<tr>
<td>• Identify means to benchmark ourselves against other trusts and undertake this.</td>
<td></td>
</tr>
</tbody>
</table>

How did we measure progress?
We audited the effectiveness of planned interventions to address pain, as recorded in the nursing documentation, as well as undertaking an annual audit of nursing documentation.
We measured and analysed what patients said on our inpatient survey. Delivery against actions detailed in our action plan was monitored by the Patient Experience Delivery Board.

How did we do?
We achieved our target, as demonstrated by an improved score in the national patient survey:

<table>
<thead>
<tr>
<th>Question: Staff did everything they could to control pain (response: yes definitely)</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>68%</td>
<td>64%</td>
<td>68%</td>
</tr>
</tbody>
</table>

A local audit undertaken in March 2012 (102 respondents) shows that when comparing with the standards, 87% of patients had been asked whether they had experienced pain in the previous 24 hours by either a doctor or nurse, an improvement of 4% compared to the last audit, and 70% of patients were reassessed by a nurse after taking analgesia to see if it had worked, a 10% increase from the previous audit.

PRIORITY FIVE: Reduce Readmission Rates

Aim: To eliminate emergency readmissions occurring within 30 days of discharge following an elective admission. ✗

Aim: To reduce all other readmissions within 30 days of discharge. ✓

Why we chose this
Feedback says that patients only want to be in hospital when it is absolutely necessary. Patients also say that if they can be treated at home or within the community they would prefer this to a hospital environment. Wherever possible, the Trust wants to ensure that it has good discharge arrangements in place to avoid readmissions.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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<tbody>
<tr>
<td>Continue to ensure Consultant job plans in the Emergency Department facilitate cover for the department through extended hours service until 22.00 during the week and for 6 hours at the weekend.</td>
<td>We have increased the number of Consultants in the Emergency Department. Job plans have been reviewed as part of the 2012-13 job planning round.</td>
</tr>
<tr>
<td>Ensure that every patient potentially requiring readmission is discussed with a Registrar before being referred to a specialty or sent home.</td>
<td>A Registrar or Consultant reviews all referrals.</td>
</tr>
<tr>
<td>Ensure that every patient is sufficiently recovered to enable recovery to continue safely at home or in the community.</td>
<td>The Trust continues to work towards no patient transfers or discharges after 22.00.</td>
</tr>
</tbody>
</table>
What were we going to do?
Ensure that every patient has a robust discharge plan that it is communicated and understood by patient and family member/carer. Discharge planning will include senior level supervision from both nursing and medical staff.
Ensure discharge summaries are completed and sent to GPs.

What did we do?
Additional focus will be placed on this as part of the 2012-13 priorities.
Audited to ensure compliance with the requirement to complete and send.

How did we measure progress?
Conversions (the number of people seen in Accident & Emergency and subsequently admitted) were monitored on a daily basis by Emergency Department Consultants.
Readmissions were monitored and reported to the Contract Monitoring Group.
The patient experience of discharge was monitored via the results on the National Inpatient Survey.
Involvement in discharge was audited via an audit of ward sister’s documentation and discharge summaries were audited on an annual basis.

How did we do?
The Trust did not eliminate emergency post elective readmissions, but did significantly reduce the percentage from 2.2% in April 2011 to 1.8% in March 2012.
The Trust also reduced emergency post emergency readmissions from 10.6% in April 2011 to 9.9% in March 2012.

Emergency post elective readmissions have reduced from 2.2% of all elective admissions in April 2011 (33 patients out of 1,500 patients admitted) to 1.8% of all elective admissions in March 2012 (38 patients out of 2,064 patients).
The Accident & Emergency Department at the Trust has an excellent track record of managing admissions and has one of the lowest conversion rates in the country. The reductions in readmission rates have helped to maintain that record and the Trust will be looking to maintain and, hopefully, build on the improvements in readmission rates in future years.

**PRIORITY SIX: Improve Care for Dementia Patients**

**Aim:** To improve the care to our patients who suffer from dementia.

**Why we chose this**
People with dementia deteriorate physically and psychologically when they are in hospital. The Alzheimer’s Society estimates that better care for patients with dementia who are admitted to hospital could improve outcomes, reduce complications, reduce complaints, and reduce the average length of stay of these patients by a week. The National Dementia Strategy recommends good quality early diagnosis and intervention, ‘person-centred care’, and an emphasis on staff training. A national audit of people with dementia being cared for in acute general hospitals was undertaken in 2010. The aim of the audit was to establish a baseline of service provision and to act as a driver for service improvement.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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</thead>
<tbody>
<tr>
<td>Develop an action plan that includes:</td>
<td>We put a training programme in place, led by the Dementia Lead for the Trust</td>
</tr>
<tr>
<td>• Early brief cognitive assessment of all patients aged 65 and over admitted to Kingston</td>
<td>Training has been provided to Nurses on all wards, including the Acute Assessment Unit, so that they can conduct minimal test score</td>
</tr>
<tr>
<td>Hospital, in order to identify those who have memory loss, confusion, and dementia;</td>
<td>A care plan is now in place, developed by a Consultant in elderly care</td>
</tr>
<tr>
<td>• Increase staff education and training to include all newly qualified staff, all trained</td>
<td></td>
</tr>
<tr>
<td>nurses and healthcare practitioners, and junior medical staff and maintain record of</td>
<td></td>
</tr>
<tr>
<td>training programmes;</td>
<td></td>
</tr>
<tr>
<td>• Develop a care plan for patients with delirium which</td>
<td></td>
</tr>
</tbody>
</table>
## What were we going to do?

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enables individualised care to be identified, delivered and evaluated; and,</td>
<td></td>
</tr>
<tr>
<td>- Ensure person-centred care including help with eating and drinking is delivered to patients with dementia focussing on the areas highlighted in the Healthcare for London Dementia Plan.</td>
<td></td>
</tr>
</tbody>
</table>

### How did we measure progress?

The Trust undertook local audits, training records audits and a record keeping audit, with the outcomes of all audits reviewed by the Audit & Clinical Effectiveness Committee.

As part of Frontline Focus Fridays the Essentials of Nursing Care are audited.

### How did we do?

The Trust is aware that it has not fully achieved its ambitions in improving the care of patients with dementia.

The care for patients with dementia now has a raised profile throughout the Trust. The new nursing assessment documentation highlights the mini memory assessment and follows this through with a section that focuses on cognition. The Trust is currently developing a care bundle to implement alongside this to assist staff in planning person centred care.

In 2012-13 the Trust has a CQUIN target around the care of patients with dementia which will be reported on quarterly to Commissioners.
Progress against 2011-12 Patient Experience Priority

**PRIORITY SEVEN: To Listen and Communicate Better with our Patients**

**Aim:** To ensure that we listen to you and address your concerns and improve the way we communicate with you.

Why we chose this

The “Patient Experience” lies at the heart of our business. At the Trust we want to create a culture where we engage with you to improve communication to influence and subsequently deliver the highest quality patient-centred care. Staff at the Trust aim to ensure all patients are treated with dignity, compassion, courtesy and respect. Our complaints, the National Inpatient Survey and our local survey show us we need to improve in this area.

<table>
<thead>
<tr>
<th>What were we going to do?</th>
<th>What did we do?</th>
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</thead>
<tbody>
<tr>
<td>Implement our Patient Experience Strategy year one action plan which includes:</td>
<td>Output some from the “listening events”, held with Trust patients and stakeholders, have been used to re-define Trust values, standards and patient commitments. These values promote compassionate, dignified and respectful care.</td>
</tr>
<tr>
<td>• Defining with you a set of expected behaviours so that we deal with you in a compassionate and respectful way;</td>
<td>“Listening events” have been completed, for patients, carers and visitors and staff. The Net Promoter Score pilot will be implemented across the Trust between March and June 2012.</td>
</tr>
<tr>
<td>• Introduce new ways in which we engage with patients, carers and visitors and identify area for improvement. This will include “listening events”;</td>
<td>Patient stories have been introduced at Board meetings.</td>
</tr>
<tr>
<td>• Introduce “patient story” to Board meetings;</td>
<td>The outcomes of the “listening events” have been fed back to staff at the Patient Experience Delivery Board meeting and the Patient Experience Committee. A human resources organisational development plan has identified plans to implement this learning in staff training and appraisal plans.</td>
</tr>
<tr>
<td>• Feedback patient experience to staff and identify and implement training needs; and,</td>
<td>A team development session has been developed as part of the Living Our Values Everyday project. The course has been piloted with approximately 60 staff, and will be formally launched in quarter four of 2011-12. This course will be delivered to all frontline staff.</td>
</tr>
<tr>
<td>• Establish a customer service skills course for all frontline staff.</td>
<td></td>
</tr>
</tbody>
</table>
How did we measure progress?
The Trust has continued to implement a range of interventions to respond to the needs of patients using our services, particularly those needs for information, respecting privacy and dignity, and to be involved in care decisions.

The Trust used the Patient Experience Tracker in 2011 to provide a rapid, patient feedback system at the point of care, in clinical settings. Clinical staff received regular reports on patient feedback, and developed action plans to make improvements based directly on patient feedback.

In 2012, the Trust started to pilot the Net Promoter Score. This provides patients in both ward and outpatient clinic settings the opportunity to provide feedback using a brief postcard survey to score and comment on the service they received. Following analysis of this data, staff will develop improvement action plans in order to be able to demonstrate improvement in care delivery and patient experience.

How did we do?
The results of the Care Quality Commission National Inpatient Survey 2010 demonstrate that the Trust has improved its performance on the five survey questions that relate to this indicator.

In 2009 the Trust obtained an average survey score of 63.6 for these questions, and improved this in 2010 with a score of 64.4.

Over 2011-12, the total number of complaints about communication decreased to 256, from 287 in 2010-11.
# National Priorities & Core Standard Metrics for 2011-12

## Outcomes and Effectiveness

### Relative Risk of Mortality (taken from Dr Foster)

<table>
<thead>
<tr>
<th>RAG rating</th>
<th>Green Achieve</th>
<th>Amber Underachieve</th>
<th>Red Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>101-105</td>
<td>&gt;105</td>
<td>102.3</td>
</tr>
<tr>
<td>Overall Performance to Date</td>
<td>85.9</td>
<td>97.3</td>
<td>85.9</td>
</tr>
</tbody>
</table>

### Relative Risk of Mortality (taken from Dr Foster)

- **Outcomes and Effectiveness**
  - **Relative Risk of Mortality (taken from Dr Foster)**
    - <=100: 73.02
    - 101-105: 86.5
    - >105: 95.0
    - <=100: 77.9
    - 101-105: 67.5
    - >105: 84.9

<table>
<thead>
<tr>
<th>Date</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Overall</th>
</tr>
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<tbody>
<tr>
<td>2011/12</td>
<td>102.3</td>
<td>102.3</td>
<td>102.3</td>
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<td>102.3</td>
<td>102.3</td>
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</tbody>
</table>

### Average Length of Stay (taken from Dr Foster)

- **Average Length of Stay**
  - **Actual**
    - 6.7
    - 3.8
    - 3.7
  - **Expected**
    - 6.7
    - 4.1
    - 4.1
  - **<1 day compared to average LOS**
    - 3.4
    - 3.4
    - 3.4

### 30 Day Readmission Rate

- **Number of Emergency Readmissions within 30 days of Elective**
  - 0: 2.2%
  - 1: 1.3%
  - 5: 1.9%
  - 10: 1.5%

### Patient Safety

- **Hospital Acquired Pressure Ulcers (Grade 1-4)**
  - <=30: 12
  - >30 to <=35: 18
  - >35: 24

### Other

- **A&E - Percentage of A&E Attendances for Cellulitis + DVT that end in Adm**
  - 25.6%: 28.2%
  - 26.1%: 28.3%
  - 21.7%: 28.4%
  - 25.4%: 21.6%
  - 24.1%: 24.5%
  - 25.6%: 24.8%
  - 21.20%: 10.5%

- **A&E - Patients presenting in High Risk Groups**
  - Reduce the number of Intensive Care Unit patients who are readmitted into ICU after transfer
  - 0: 1
  - 1: 0
  - 2: 0

- **PSI Patient Falls per 1000 G&A beddays**
  - <=4.8: 123.29
  - >4.8: 13930

- **Nutrition - compliance with MUST assessment**
  - >=85%: 88.0%
  - >=70% to <85%: 88.0%
  - <70%: 88.0%
The table above is presented to the Trust Board on a monthly basis, as part of the Trust's commitment to quality at the heart of everything we do.

Additional narrative around clinical quality and safety is provided in an accompanying written report, prepared by the Medical Director and Director of Nursing & Patient Experience.

Copies of the full report are available on the Trust website as part of Trust Board papers.
Core Quality Indicators

The National Quality Board, which has steered the policy underpinning Quality Accounts since their introduction, has recently considered how to foster readers’ understanding of comparative performance whilst maintaining local ownership.

They have recommended the introduction of mandatory reporting against a small, core set of quality indicators. Ministers have accepted this advice and are likely to introduce this new requirement by amending the Quality Accounts regulations for the 2012-13 reporting period.

In accordance with best practice the Trust has decided to incorporate reporting against the proposed core set of indicators in its current Quality Account.

We have used the following symbols to indicate how well we have done in 2011-12:

- **Met the target**
- **Good progress but more to do**
- **We did not meet the target**

**NHS OUTCOMES FRAMEWORK DOMAIN 1: Preventing people from dying prematurely**

**Indicator: Summary Hospital-level Mortality Indicator (SHMI)**

SHMI is a hospital-level indicator which measures whether mortality associated with hospitalisation was in line with expectations.

The SHMI value is the ratio of observed deaths in a trust over a period of time divided by the expected number given the characteristics of patients treated by the trust (where 1.0 represents the national average). Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts.

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

SHMI was only introduced as a national measure in 2011-12. Historically trusts have monitored the Hospital Standardised Mortality Ratio (HSMR). The main differences between the two measures are that:

- HSMRs reflect only deaths in hospital care where as SHMI also includes deaths occurring outside of hospital care within 30 days of discharge;
- The HSMR focuses on 56 diagnosis groups (about 80% of in hospital deaths) where as SHMI includes all diagnosis groups (100% of deaths); and,
- The HSMR makes allowances for palliative care where as the SHMI does not take palliative care into account.
In 2010-11 the Trust performed better than would be expected for all measures of mortality.

This means less people die in the Trust’s care, or within a month of discharge from the Trust, than the profile of patients would predict.

Looking at the HSMR measure of mortality, the Trust has continued to perform well over the period April 2011 to December 2011, with the ratio of the actual number of deaths to the expected number of deaths, (where 100 is the expected number) below what would be expected for the Trust:

The latest SHMI available is for April 2011 to December 2011 and shows a value of 55.

This data comes from CHKS. Previously the Trust used Dr Foster and were able to show SHMI compared to HSMR. As the Trust no longer has the Dr Foster tool it is not possible to update the HSMR figure for the same time period.
ANNUAL REPORT

NHS OUTCOMES FRAMEWORK DOMAIN 3: Helping people to recover from episodes of ill health or following injury

Indicator: Emergency readmissions to hospital within 28 days of discharge

The Trust reduced emergency post elective readmissions (within 30 days of discharge) from 2.2% in April 2011 to 1.8% in March 2012.

The Trust also reduced emergency post emergency readmissions (within 30 days of discharge) from 10.6% in April 2011 to 9.9% in March 2012.

Readmission rates are a good measure of how well a treatment or procedure went. If it went well (good outcome) then this reduces the risk of having to return to hospital for further treatment.

The Accident & Emergency Department at the Trust has an excellent track record of managing admissions and has one of the lowest conversion rates in the country. The reductions in readmission rates have helped to maintain that record and the Trust will be looking to maintain and, hopefully, build on the improvements in readmission rates in future years.
NHS OUTCOMES FRAMEWORK DOMAIN 4: Ensuring that people have a positive experience of care

Indicator: Responsiveness to inpatients’ personal needs

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

This score is based on the average of answers to five questions in the Care Quality Commission national inpatient survey:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

How did we do?
In 2009 the Trust obtained an average survey score of 63.6 for these questions, and improved this in 2010 with a score of 64.4.

Indicator: Percentage of staff who would recommend the provider to friends or family needing care

How members of staff rate the care that their employing trust provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

The NHS staff survey includes the following statement: “if a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust” and asks staff whether they strongly agree, agree, neither agree nor disagree, disagree or strongly disagree.

How did we do?
In the 2011 survey the Trust scored 3.53, an improvement on the score of 3.45 achieved in the 2010 survey.

The national average for the 2011 survey was a score of 3.5, so the Trust is slightly better than the national average. The assigned RAG rating was Green: Average.
NHS OUTCOMES FRAMEWORK DOMAIN 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Indicator: Percentage of admitted patients risk-assessed for venous thromboembolism (VTE)

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

Meeting the 95% risk assessment target set in 2010-11 was selected as one of our Quality Account priorities for 2011-12 (Priority 3 above).

How did we do?

We achieved our CQUIN target of at least 90% of patients receiving a VTE assessment upon admission to the hospital, however we did not achieve the stretch target of 95% that we set as a Quality Account priority last year. In March 2012 91.9% of patients (4,556 patients) received a VTE assessment upon admission.

The Trust has made a concerted effort to ensure that all patients who are admitted to hospital have a VTE assessment. All assessments are recorded on the Care Record Service.

Indicator: Rate of Clostridium Difficile

Clostridium difficile (C Diff) can cause symptoms including mild to severe diarrhoea and sometimes severe inflammation of the bowel, but hospital-associated clostridium difficile can be preventable.

How did we do?

For 2011-12 the Trust was given a target of no more than 17 hospital acquired cases and reported 18 cases.

For 2012-13 the target has been set at no more than 15 hospital acquired cases.
Indicator: Rate of patient safety incidents and percentages resulting in severe harm or death

An open reporting and learning culture is important to enable the NHS to identify trends in incidents and implement preventative action. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the number of incidents resulting in severe harm or death should reduce.

How did we do?

The latest Organisation Patient Safety Incident Report published by the National Patient Safety Agency shows that from 1 April 2011 to 30 September 2011 the Trust reported 3.0 incidents per 1,000 admissions compared to the median of 6.3 incidents.

Nationally, 68% of incidents are reported as no harm, and just less than 1% as severe harm or death. The Trust reported 40.2% (403 incidents) as no harm and 0.4% (3 incidents) as severe harm or death.

Despite exceeding the target set for 2011-12 Trust performance is still consistently below both all London Trust and all English Trusts.
Remuneration Report
The Remuneration Committee is a standing sub-committee of the Trust Board which determines the contractual terms, conditions and benefits, including salaries, of Trust Executive Directors including the Chief Executive.

The Committee meets at least once a year to determine pay policies and to address other tasks referred to it by the Board.

Membership of the Committee comprises:

- The Trust Chairman; and,
- All Non Executive Directors.

The Chief Executive and the Director of Workforce & Organisational Development attend meetings by invitation only.

The approved terms of reference of the Committee are to:

- Advise the Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:
  - All aspects of salary (including any performance related elements and/or bonuses);
  - Provisions for other benefits, including pensions and cars; and,
  - Arrangements for the termination of employment and other contractual terms
- Make such recommendations to the Board on the remuneration and terms of service of Officer Members of the Board (and other senior Employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust’s circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;
- Monitor and evaluate the performance of individual Officer Members (and other senior Employees);
- Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate; and,
- Report in writing to the Board the basis for its recommendations.

Executive Directors (excluding interims) hold permanent contracts of employment and are subject to three months’ notice. All contracts are made and terminated in accordance with best practice and employment law.

The framework for remuneration of Executive Directors is guided by benchmarking within and outside the NHS to determine appropriate levels. Pay rates for interims are agreed by the Remuneration Committee.

Executive Director posts may be reviewed individually in the light of changes in their responsibilities, in market factors, pay relativities or other relevant circumstances.

In 2011-12 Executive Director pay was subject to a pay freeze, in line with other public sector employees.

Each Executive Director is appraised annually against objectives set at the start of the financial year, which reflect the corporate objectives agreed by the Board. Pay is not performance related.
## Salaries and Allowances

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Salary (bands of £5,000)</th>
<th>Other Remuneration (bands of £5,000)</th>
<th>Bonus Payments (bands of £5,000)</th>
<th>Benefits in Kind (rounded to the nearest £'00)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rachel Benton</strong></td>
<td>Commercial Director</td>
<td>105-110</td>
<td>0</td>
<td>0</td>
<td>105-110</td>
</tr>
<tr>
<td><strong>Charles Cater</strong></td>
<td>Non Executive Director (to 31 May 2010)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>0-5</td>
</tr>
<tr>
<td><strong>John Charlick</strong></td>
<td>Non Executive Director (to 31 December 2010)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>0-5</td>
</tr>
<tr>
<td><strong>Gren Collings</strong></td>
<td>Associate Director (to 31 March 2011)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>5-10</td>
</tr>
<tr>
<td><strong>Jan Grant</strong></td>
<td>Interim Director of Nursing &amp; Patient Experience (from 1 April 2010 to 25 September 2010)</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>40-45</td>
</tr>
<tr>
<td><strong>David Grantham</strong></td>
<td>Director of Workforce &amp; Organisational Development</td>
<td>95-100</td>
<td>0</td>
<td>0</td>
<td>100-105</td>
</tr>
<tr>
<td><strong>Kate Grimes</strong></td>
<td>Chief Executive</td>
<td>145-150</td>
<td>0</td>
<td>0</td>
<td>145-150</td>
</tr>
<tr>
<td><strong>Candace Imison</strong></td>
<td>Non Executive Director</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td><strong>Michael Jennings</strong></td>
<td>Non Executive Director (from 1 June 2010)</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td><strong>Lance McCarthy</strong></td>
<td>Chief Operating Officer (to 16 May 2011)</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>105-110</td>
</tr>
<tr>
<td><strong>Simon Milligan</strong></td>
<td>Director of Finance</td>
<td>110-115</td>
<td>0</td>
<td>0</td>
<td>110-115</td>
</tr>
<tr>
<td>Name</td>
<td>Role and Tenure</td>
<td>2011-12</td>
<td>2010-11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Salary (bands of £5,000)£000</td>
<td>Other Remuneration (bands of £5,000)£000</td>
<td>Bonus Payments (bands of £5,000)£000</td>
<td>Benefits in Kind (rounded to the nearest £’00)£000</td>
<td>Salary (bands of £5,000)£000</td>
</tr>
<tr>
<td>Joan Mulcahy</td>
<td>Non Executive Director</td>
<td>5-10 0 0 0 0-5</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Jenny Parr</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>95-100 0 0 0 45-50</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Ian Reynolds</td>
<td>Chairman</td>
<td>5-10 0 0 0 5-10</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Cherill Scott</td>
<td>Non Executive Director</td>
<td>5-10 0 0 0 5-10</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Christopher Smallwood</td>
<td>Chairman</td>
<td>10-15 0 0 0 20-25</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Sarah Tedford</td>
<td>Chief Operating Officer</td>
<td>90-95 0 0 0 n/a</td>
<td>n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Peter Thomas</td>
<td>Non Executive Director</td>
<td>n/a n/a n/a n/a</td>
<td>0-5 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Jacqueline Unsworth</td>
<td>Non Executive Director</td>
<td>5-10 0 0 0 0-5</td>
<td>0 0 0 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
<tr>
<td>Jane Wilson</td>
<td>Medical Director</td>
<td>25-30 115-120 35-40 0</td>
<td>25-30 105-110 35-40 0</td>
<td>n/a n/a n/a n/a</td>
<td>n/a n/a n/a n/a</td>
</tr>
</tbody>
</table>

No payments are made to third parties for the services of any Director.
No compensation payments have been made to former Directors on termination of contract.
Pension Benefits

<table>
<thead>
<tr>
<th>Name</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2012 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2011 £000</th>
<th>Real increase (decrease) in Cash Equivalent Transfer Value £000</th>
<th>Employer’s contribution to stakeholder pension £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rachel Benton, Commercial Director</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>20-25</td>
<td>70-75</td>
<td>360</td>
<td>285</td>
<td>67</td>
<td>0</td>
</tr>
<tr>
<td>David Grantham, Director of Workforce &amp; Organisational Development</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>10-15</td>
<td>40-45</td>
<td>207</td>
<td>145</td>
<td>57</td>
<td>0</td>
</tr>
<tr>
<td>Kate Grimes, Chief Executive</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>40-45</td>
<td>125-130</td>
<td>709</td>
<td>587</td>
<td>104</td>
<td>0</td>
</tr>
<tr>
<td>Simon Milligan, Director of Finance</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>75-80</td>
<td>440</td>
<td>364</td>
<td>64</td>
<td>0</td>
</tr>
<tr>
<td>Jenny Parr, Director of Nursing &amp; Patient Experience</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>15-20</td>
<td>45-50</td>
<td>250</td>
<td>181</td>
<td>64</td>
<td>0</td>
</tr>
<tr>
<td>Sarah Tedford, Chief Operating Officer (from 1 June 2011)</td>
<td>2.5-5</td>
<td>12.5-15</td>
<td>20-25</td>
<td>70-75</td>
<td>422</td>
<td>266</td>
<td>110</td>
<td>0</td>
</tr>
<tr>
<td>Jane Wilson, Medical Director</td>
<td>2.5-5</td>
<td>10-12.5</td>
<td>60-65</td>
<td>185-190</td>
<td>1,228</td>
<td>1,036</td>
<td>160</td>
<td>0</td>
</tr>
</tbody>
</table>

As Non Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non Executive Directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value 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 Cash Equivalent Transfer Value 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 disclosure applies. The Cash Equivalent Transfer Value figures and the 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. Cash Equivalent Transfer Values are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
Real Increase in Cash Equivalent Transfer Value
This reflects the increase in Cash Equivalent Transfer Value 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.

Pay Multiples
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in the organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid director in the Trust in the financial year was £182,500 (2010-11: £172,500). This was 5.4 times (2010-11: 4.8 times) the median remuneration of the workforce, which was £33,792 (2010-11: £35,795). There are no significant individual factors affecting the movement in the multiple.

In 2011-12 one employee (2010-11: three employees) received remuneration in excess of the highest paid director. Remuneration was in the range £200,000 to £205,000 (2010-11: £180,000 to £210,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

HM Treasury guidance requires organisations to include agency and other temporary staff in the staff used to calculate median pay. Staff employed by the Trust, and paid via its payroll, have been included in arriving at the above calculations. Staff employed by agencies and third party organisations are not employees of the Trust and the trust has no right of access to pay information on those individuals. As such it has not been possible to include such individuals in calculating the median earner.

The relevant tables and narrative within the Remuneration Report have been subject to audit.

Kate Grimes
Chief Executive
30 May 2012
Directors Interests

As at 31 March 2012 the interests declared by members of the Trust Board were as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Board Position</th>
<th>Current Declared Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Reynolds</td>
<td>Chairman</td>
<td>Chairman: City Bond Holdings plc&lt;br&gt;Chairman: Family Holiday Association&lt;br&gt;Director: General Industries plc&lt;br&gt;Daughter: Audit Manager, KPMG LLP</td>
</tr>
<tr>
<td>Candace Imison</td>
<td>Non Executive Director</td>
<td>Deputy Director of Policy at the King’s Fund</td>
</tr>
<tr>
<td>Cherrill Scott</td>
<td>Non Executive Director</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Jacqueline Unsworth</td>
<td>Non Executive Director</td>
<td>Chair: Circus Communications Limited&lt;br&gt;Advisor: Piper Private Equity LLP</td>
</tr>
<tr>
<td>Joan Mulcahy</td>
<td>Non Executive Director</td>
<td>Director: Elmbridge Housing Trust&lt;br&gt;Audit &amp; Treasury Committee member: Paragon Community Housing Group Ltd&lt;br&gt;Chair: AEAT Pensions Trustee Limited</td>
</tr>
<tr>
<td>Michael Jennings</td>
<td>Non Executive Director</td>
<td>Director: Way Ahead Associates Ltd&lt;br&gt;Non Executive Director: Local Government Information House Ltd&lt;br&gt;Consultant Adviser, DHL – runs NHS supply chain&lt;br&gt;Member: Twining Enterprise Ltd&lt;br&gt;Member: Advisory panel on public sector information&lt;br&gt;Wife: Registered with Staff Bank for one off projects</td>
</tr>
<tr>
<td>Kate Grimes</td>
<td>Chief Executive</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Jane Wilson</td>
<td>Medical Director</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Simon Milligan</td>
<td>Director of Finance</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Sarah Tedford</td>
<td>Chief Operating Officer</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Jenny Parr</td>
<td>Director of Nursing &amp; Patient Experience</td>
<td>Honorary Senior Fellow: Kingston University &amp; St. Georges University of London (Faculty of Health &amp; Social Care Sciences)</td>
</tr>
<tr>
<td>David Grantham</td>
<td>Director of Workforce &amp; Organisational Development</td>
<td>Nothing to Declare</td>
</tr>
<tr>
<td>Rachel Benton</td>
<td>Commercial Director</td>
<td>Nothing to Declare</td>
</tr>
</tbody>
</table>
Non Executive Director Profiles

Ian Reynolds  
Chairman  
Ian was appointed as Chairman on 1 November 2011.

Before joining the Trust Ian was Chairman of NHS Wandsworth. He is also a former Non Executive Director of St Mary's Hospital NHS Trust and Trustee of St Mary's Paddington Charitable Trust.

During a 25 year career with IBM UK and IBM Europe, Ian held various posts including Director of Personnel and Corporate Affairs, Vice President of Communications and Director of Marketing and Services. In 1994 Ian retired from IBM to become Chief Executive of ABTA, the Travel Association, a position he held until 2005.

Ian's current Non Executive Directorships include Chairman with Citybond Holdings PLC and the Family Holiday Association.

Ian is a Fellow of the Institute of Directors, the Royal Society for Arts, the Tourism Society and the Institute for Travel and Tourism, a Companion of the Chartered Management Institute and Member of the British Computer Society.

Candace Imison  
Candace was appointed as a Non Executive Director on 1 December 2009.

Candace has held the post of Deputy Director of Policy at The King's Fund since January 2009 and has published work on a wide range of health policy topics. Candace is also on the governance board of the Centre for Workforce Intelligence.

Between 1993 and 1999 Candace worked for the Kingston & Richmond Health Authority where latterly she was Associate Director – Acute Services Development. From 1999 to 2001 Candace was Director of Acute Strategy at Ealing, Hammersmith & Hounslow Health Authority before moving to the Department of Health and holding a range of senior strategy and modernisation roles. In 2006 Candace took up the post of Director of Strategy at Epsom & St. Helier University Hospitals NHS Trust, leaving in 2008 to join The King’s Fund.

Michael Jennings  
Michael was appointed as a Non Executive Director on 1 June 2010.

Michael worked for Surrey County Council from 1984 until his retirement in 2009, in a number of Director level posts (responsible over time for: corporate planning; emergency management; policy; performance, partnerships (including health, police, business and the voluntary sector), external affairs; marketing and communications; and, governance and scrutiny), culminating with his appointment as Deputy Chief Executive.

Between 1971 and 1984 Michael worked for the Greater London Council in various strategy, planning, finance, and management posts roles.

Michael is a member of the Government’s Advisory Panel on Public Sector Information, Non Executive Director of Local Government Information House Limited (a company he founded which trades on behalf of all councils) and runs his own consultancy company.

Michael has acted as a policy adviser on a number of Cabinet Office, Audit Commission and Chartered Institute of Finance & Accountancy advisory groups on issues such as access to services, partnerships, competition, performance management and management accounting and has lectured at the National School of Government.

Michael is a graduate of the University of Leicester, holding a BA (Hons) in English.
Joan Mulcahy  
Joan was appointed as a Non Executive Director on 13 January 2011.  
Joan was formerly a Management Consultant, whose clients included both charities and commercial companies, and is a professionally qualified accountant.

As an experienced Board level Director Joan has significant experience in the banking industry, having previously worked for Allied Irish Bank Group where she held a variety of roles, culminating as Chief Operating Officer and Board Director of AIB Group (UK) plc.

Joan currently undertakes a number of Non Executive Director roles in various strategic bodies and is a Board Director of Elmbridge Housing Trust, an Audit and Treasury Committee Member of Paragon Community Housing Group Ltd and Chair of AEAT Pensions Trustee Limited.

Joan holds an MBA and is a graduate of University College Dublin.

Cherill Scott  
Cherill joined the Trust as a Non Executive Director on 1 August 2005.

Cherill is an Oxford history graduate and a Registered Nurse who has held academic research posts in the Department of Epidemiology, London School of Hygiene and Tropical Medicine (University of London) and the Royal College of Nursing Institute. She is currently Senior Research Fellow in the School of Health and Social Care at the University of Greenwich.


Jacqueline Unsworth  
Jacqueline was appointed as a Non Executive Director on 21 March 2011.

Jacqueline was formally the Vice Chair and a Non Executive Director of Hounslow PCT and has been a Trustee of the charity Family Action for the past eight years.

Jacqueline is a retail strategy specialist with over 20 years experience in market analysis, customer insight and business planning and has worked as a Board level consultant with a range of major retail brands since leaving her position as Strategy and Marketing Director for Liberty plc in 2005.

Prior to this Jacqueline was a Director at specialist retail consultancy Piper Trust Limited for nine years and has worked in strategic planning roles for Storehouse plc and Abbey National. Jacqueline started her career in 1984 as a management consultant in the Strategic Services division of Coopers & Lybrand Associates.

Jacqueline is currently Non Executive Chair of Circus Communications Limited and acts as a Non Executive advisor to Piper Private Equity LLP in addition to running her own management consultancy business.

Jacqueline holds an MBA from the University of Evansville, Indiana, USA and a BSc (Hons) in Economics & Accounting with First Class Honours from the University of Bristol.
Executive Director Profiles

Kate Grimes  
**Chief Executive**  
Kate joined the Trust as Chief Executive on 10 December 2008. 

Prior to starting her career in the NHS, Kate spent a year in the Sudan teaching English after graduating in Biology. Kate’s first job in the NHS was as a porter, followed by various roles managing a range of clinical and non-clinical services in both district general hospitals and teaching hospitals.

After gaining a distinction in her Masters in Health Services Management, Kate specialised in service improvement and redesigning services with patients, managing a major change programme at King’s College Hospital NHS Trust, which pioneered new techniques in service design and delivery.

In 2002, Kate joined the then South East London Strategic Health Authority as Director of Development before being appointed Deputy Chief Executive in 2004. Kate was appointed Chief Executive of Queen Mary’s Sidcup NHS Trust in October 2005 and successfully managed the hospital through a challenging period, working with partners to secure its strategic future.

Sarah Tedford  
**Chief Operating Officer**  
Sarah joined the Trust as Chief Operating Officer on 1 June 2011.

Before joining the Trust Sarah headed up the National NHS Intensive Support Team, going in to Trusts that were struggling to achieve their performance targets and helping them to understand and resolve their operational difficulties.

Sarah has worked in the NHS since 1994, holding a number of senior operational roles in different acute hospitals across London.

Simon Milligan  
**Director of Finance**  
Simon joined the Trust as Director of Finance & Information on 1 February 2010.

Before joining the Trust Simon worked for Commissioning Support for London (formerly Healthcare for London) where he was the senior finance lead working across London’s 31 PCTs to implement Lord Darzi’s report A Framework for Action.

Prior to this Simon was Director of Finance at Winchester & Eastleigh NHS Trust. He previously worked in the finance teams at Hammersmith Hospital NHS Trust, St. Mary’s Hospital NHS Trust and South Durham Health Care NHS Trust, having joining the NHS in 1991, working in the finance team at the then Northern Regional Health Authority.

Simon started his accountancy career at KPMG and is a qualified Chartered Accountant.

Jane Wilson  
**Medical Director**  
Jane was appointed as Medical Director on 3 August 2009.

Jane has previously held a number of leadership roles within the Trust, including Clinical Director in the Women & Child Health Division. As the Trust’s Director of Education from 2002 to 2009, Jane oversaw the introduction of significant changes in Post Graduate Medical Education and merged the Training Departments in the Trust.

Jane continues to have clinical responsibilities alongside her role as Medical Director, as a Consultant Obstetrician and Gynaecologist, a position she was appointed to in August 1993.
Jenny Parr  
**Director of Nursing & Patient Experience**

Jenny joined the Trust as Director of Nursing & Patient Experience on 22 September 2010.

Before joining the Trust Jenny worked as Deputy Director of Nursing at Imperial College Healthcare NHS Trust and previously in a similar role at Hammersmith Hospitals NHS Trust. During her career she has worked at international and regional levels setting up international recruitment mechanisms, has managed clinical services, led nursing initiatives and delivered organisation wide projects. Jenny has worked in the NHS since 1993 and is trained as a nurse and a midwife.

Jenny is a graduate and has an MSc in Healthcare Management.

David Grantham  
**Director of Workforce & Organisational Development**

David joined the Trust as Director of Workforce & Organisational Development on 22 March 2010.

Before joining the Trust David was on secondment to NHS Employers for 2 years, where he led national programmes on the medical workforce, productivity and flexible staffing. He continues to represent NHS Employers on the GMC’s UK revalidation programme board and is co-chair of its Medical Workforce Forum.

Prior to this David was Director of Human Resources and a Board member at Whipps Cross University Hospital NHS Trust in North East London. He previously worked for the British Medical Association as an Industrial Relations Specialist and is a Law and Politics graduate.

Rachel Benton  
**Commercial Director**

Rachel joined the Trust as Commercial Director on 1 March 2010.

Rachel has worked in the NHS since 1990 in a variety of roles covering general management, strategy, planning, business development and marketing. Before joined the Trust Rachel headed up the planning and business development function for Imperial College Healthcare NHS Trust. Prior to this she undertook a similar role at Hammersmith Hospitals NHS Trust, during which time she led the development a number of successful business cases for large capital developments.

Rachel is a graduate with an MSc in Health Services Management.
Statement of the Chief Executive’s Responsibilities as the Accountable Officer of the Trust

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

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

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

Kate Grimes
Chief Executive
30 May 2012
Statement of Directors’ Responsibilities in respect of the Accounts

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

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

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

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

By order of the Board

Kate Grimes           Simon Milligan
Chief Executive       Director of Finance
30 May 2012           30 May 2012
Independent Auditor’s Report to the Directors of Kingston Hospital NHS Trust

I have audited the financial statements of Kingston Hospital NHS Trust for the year ended 31 March 2012 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers’ Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of HM Treasury as relevant to the National Health Service in England. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of Kingston Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective Responsibilities of Directors and Auditors
As explained more fully in the Statement of Directors’ Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My 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 me to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

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

Opinion on Financial Statements
In my opinion the financial statements:

- Give a true and fair view of the financial position of Kingston Hospital NHS Trust as at 31 March 2012 and of its expenditure and income for the year then ended; and,

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

Opinion on Other Matters
In my opinion:

- The part of the Remuneration Report to be audited has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent
of HM Treasury as relevant to the National Health Service in England; and,

- The information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I Report by Exception

I report to you if:

- In my opinion the Governance Statement does not reflect compliance with the Department of Health’s Guidance;
- I refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because I have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or,

I have nothing to report in these respects.

Conclusion on the Trust’s Arrangements for Securing Economy, Efficiency and Effectiveness in the use of Resources

Respective Responsibilities of the Trust and Auditor

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2011, as to whether the Trust has proper arrangements for:

- Securing financial resilience; and,
- Challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2012.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2011, I am
satisfied that, in all significant respects, Kingston Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2012.

**Delay in certification of completion of the audit**
I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust’s annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements or on my value for money conclusion.

Paul Grady
District Auditor
Audit Commission,
1st Floor, Millbank Tower,
Millbank, London, SW1P 4HQ

1 June 2012
Governance Statement

Scope of responsibility
As Accountable 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 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 effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the 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 year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

The governance framework
The Trust Board comprises the Chairman, five Non Executive Directors and five Executive Directors. The five Executive Directors are: the Chief Executive; the Chief Operating Officer; the Medical Director; the Director of Nursing & Patient Experience; and, the Director of Finance.

The constitution also makes provision for other Directors to attend meetings of the Trust Board to provide operational advice and support to the Trust Board in the discharge of their responsibilities. These Directors are not voting members of the Trust Board and do not bear the legal responsibility of a Director. The Director of Workforce and Organisational Development and Commercial Director attend Trust Board meetings but are not voting members of the Trust Board.

The Trust Board has appointed Candace Imison to be Vice-Chairman, Sarah Tedford (Chief Operating Officer) to be Deputy Chief Executive and Michael Jennings to be Senior Independent Director.

Trust Board members bring a range of complementary skills and experience in areas such as finance, commerce and health policy. All Non Executive Director appointments are made through the Appointments Commission taking account of the skill sets already represented on the Trust Board and recognising where gaps could be filled.

The role of the Trust Board is to:

- Set the overall strategic direction of the Trust, within the context of NHS priorities;
- Monitor performance against objectives;
- Provide effective financial stewardship;
- Ensure the Trust provides high quality, effective and patient-centred care;
- Ensure high standards of corporate governance and personal conduct; and,
- Promote effective dialogue between the Trust and the local communities it serves.

As part of the Foundation Trust application process the Trust Board has undergone a rigorous assessment of its effectiveness. Following an initial self assessment, external consultants, as well as NHS London, have
attended Trust Board meetings and reviewed documentation to evaluate the effectiveness of the Trust Board.

The process has largely confirmed the Trust Board is operating effectively, but as would be expected some areas for improvement have been identified and action plans have been established to address these areas. Particular areas for further development include: further development of the Trust Board evaluation process to include input from outside the Trust Board itself; development of succession plans to ensure the Trust Board maintains the correct skill mix to operate effectively, particularly post Foundation Trust authorisation; development of a formal appraisal and personal development plan process for the Chairman and Non Executive Directors; further development of integrated performance reporting to take account of best practice; improvements in the oversight provided by the Trust Board in relation to data quality; and, further development of communication and relationships with commissioners, stakeholders and patients.

The Trust Board undertakes a proportion of its work through sub-committees. Each Committee has a set of terms of reference, which have been formally adopted by the Trust Board. Committee Chairmen present their approved minutes to the Trust Board meeting following their approval, together with a written summary of any meetings that have occurred, but for which approved minutes are not yet available.

A standing item on all Committee agendas is the identification of matters discussed that should specifically be drawn to the attention of the Trust Board. Any identified items are recorded in the Committee Chairman’s written report to the Trust Board.

Audit Committee

The approved terms of reference of the Committee are to:

- Advise the Trust Board on internal and external audit services;
- Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust’s activities (both clinical and non-clinical), that supports the achievement of the Trust’s objectives;
- Monitor compliance with Standing Orders and Standing Financial Instructions;
- Review schedules of losses and special payments; and,
- Review the annual financial statements prior to submission to the Trust Board.

The Committee is composed entirely of Non Executive Directors, as follows:

- Joan Mulcahy (Chair);
- Michael Jennings; and,
- Jacqueline Unsworth.

All the Committee members were in post for the full financial year, and remain in post.

The Committee’s main activities through the year have been:

- Monitoring the financial year end process for 2010-11 and 2011-12, for both the Trust and the Charitable Fund, including reviewing and recommending to the Trust Board for approval the annual report, annual accounts, governance statement, etc;
- Approving the 5 year Strategic Audit Plans and Annual Work Plans for Internal Audit and Counter Fraud and monitoring delivery against both;
- Receiving the Head of Internal Audit Opinion on the system of internal control within the Trust. As in previous years the opinion was Substantial Assurance;
- The re-tender of the Internal Audit and Counter Fraud contracts; and,
• Receiving and considering other reports from Trust management in accordance with its terms of reference.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board, other than the assurances and recommendations as part of the annual report and accounts process.

The Committee undertook an assessment of its operation and effectiveness using the Annual Self Assessment checklist for Audit Committee’s produced by the Healthcare Financial Management Association. This identified some areas for development around ways of working with the Quality Assurance Committee, establishing appropriate working and reporting arrangements for the new Internal Audit and Counter Fraud providers and developing an evaluation process for the External Audit provider. These have been turned into an action plan for the Committee over the next year.

The Committee has established a work plan for the year forward, which is reviewed and updated at each meeting of the Committee.

Finance & Investment Committee
The approved terms of reference of the Committee are to:

• Review the annual budget, before submission to the Trust Board;
• Review the capital budget, before submission to the Trust Board and review progress against it;
• Consider the Trust’s medium term financial strategy, in relation to both revenue and capital;
• Review proposals for major business cases and investment decisions and their respective funding sources and make recommendations to the Trust Board;
• Maintain an oversight of, and obtain assurances on, the robustness of the Trust’s key income sources and contractual safeguards;
• Review key areas of concern in financial performance as requested by the Trust Board;
• Scrutinise the systems and controls around the development and delivery of the Trust’s five year productivity programme, providing assurance to the Trust Board on the effectiveness of those controls; and,
• Commission regular reviews of the Trust’s key contracts with partners including Prime/ISS, Dalkia, BMI Healthcare and The Royal Marsden Hospital NHS Foundation Trust to ensure they continue to deliver benefits for patients.

Membership during the financial year and since the year end has been:

• Christopher Smallwood, Chairman (Chair) (to 31 October 2011);
• Michael Jennings, Non Executive Director (Chair from 1 November 2011);
• Ian Reynolds, Chairman (from 1 November 2011);
• Jacqueline Unsworth, Non Executive Director;
• Kate Grimes, Chief Executive;
• Simon Milligan, Director of Finance;
• Lance McCarthy, Chief Operating Officer (to 16 May 2011);
• Sarah Tedford, Chief Operating Officer (from 1 June 2011);
• Jenny Parr, Director of Nursing & Patient Experience;
• Jane Wilson, Medical Director; and,
• Rachel Benton, Commercial Director.

The Committee’s main activities through the year have been:
Reviewing the monthly finance report, including both revenue and capital outturn year to date and forecast at year end;

Reviewing in year reports on the delivery of the Productivity Programme;

Approving the 2012-13 budget;

Reviewing updates and reports on contracts;

Reviewing and recommending to the Trust Board for approval, major business cases; and,

Reviewing the latest version of the Estates Strategy.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board, other than matters recommended to the Trust Board for approval.

Strategic Risk Committee (to January 2012)
The approved terms of reference of the Committee were to:

- Scrutinise the assessment of risks identified in the Board Assurance Framework and monitor that these risks are managed by the Trust including actions to eliminate gaps in controls;
- Review the performance of the Trust in meeting its relevant statutory and regulatory obligations including compliance with the NHS Act 2006, the Health and Social Care Act 2008 and the CQC (Registration) Regulations 2009;
- Review the draft Trust Quality Account prior to adoption by the Trust Board;
- Review the evidence to support the Trust’s Quality Governance arrangements;
- Monitor and review the Trust’s Quality Performance Indicators in relation to quality and safety;
- Seek assurances from management that lessons are being learnt and relevant changes made following incidents, including SIs, complaints and claims;
- Receive and review on an annual basis the Trust’s Risk Management Strategy and Policy and to make recommendations as appropriate for approval by the Trust Board;
- Review the corporate risk register (in accordance with Risk Policy) seeking assurance that strategic risks are accurately reflected and that appropriate action plans in place to mitigate the risks;
- Monitor the Trust’s compliance with the CQC’s Essential Standards of Quality and Safety; and,
- Receive and consider the Trust’s Annual Risk Management report.

Committee membership whilst the Committee existed was:

- Candace Imison, Non Executive Director (Chair);
- Joan Mulcahy, Non Executive Director;
- Cherill Scott, Non Executive Director;
- Kate Grimes, Chief Executive;
- Lance McCarthy, Chief Operating Officer (to 16 May 2011);
- Sarah Tedford, Chief Operating Officer (from 1 June 2011);
- Jenny Parr, Director of Nursing & Patient Experience; and,
- Jane Wilson, Medical Director.

The role of the Committee and its interaction with the Audit Committee were reviewed at the Trust Board meeting in January 2012. It was decided that the existing Committee should be disbanded and a new Committee should be established, the Quality Assurance Committee.

The Quality Assurance Committee has a narrower focus on Quality and providing assurance to the Audit Committee and Trust Board on clinical systems of integrated governance, risk management and internal control.
The Committee’s main activities whilst it existed were:

- Receiving a detailed presentation on an area of risk. During the year presentations covered: Complaints and PALS; Workforce and Organisational Development; and, Quality Governance;
- Reviewing and approving the Quality Account for 2010-11 and provide input into the priorities for the 2011-12 Account; and,
- Receiving and considering other reports from Trust management and the Risk Management Committee in accordance with its terms of reference.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board.

Quality Assurance Committee (from February 2012)

The approved terms of reference of the Committee are to:

- Scrutinise the assessment of quality risks identified in the Board Assurance Framework and ensure there is sufficient assurance that these risks are managed by the Trust including actions to eliminate gaps in controls, for example, ensuring that audit programmes address the key issues;
- Review the performance of the Trust in meeting its relevant statutory and regulatory obligations including compliance with the NHS Act 2006, the Health and Social Care Act 2008 and the CQC (Registration) Regulations 2009;
- Review the draft Trust Quality Account prior to adoption by the Trust Board;
- Review the evidence to support the Trust’s Quality Governance arrangements;
- Monitor and review the Trust’s Quality Performance Indicators in relation to quality and safety. The Committee will work with the Risk Management Committee to identify the most valuable quality indicators for the Trust Board and maintain oversight of the clinical quality aspects of Risk Management Committee’s work to ensure it has appropriate quality monitoring mechanisms in place for all levels of the Trust;
- Seek assurances from management that lessons are being learnt and relevant changes made following incidents, including SIs, complaints and claims;
- Review the corporate risk register (in accordance with Risk Policy) seeking assurance that clinical quality risks are accurately reflected and that appropriate action plans in place to mitigate the risks;
- Monitor the Trust’s compliance with the CQC’s Essential Standards of Quality and Safety;
- Monitor and make recommendations on the adequacy and effectiveness of any aspects of the Trust’s performance as the Trust Board may request, focusing mainly but not exclusively on outcome measures and liaising with the Finance & Investment and Audit Committees to minimise duplication; and,
- Maintain oversight of quality related strategies.

Committee membership during the part of the financial year that it was established and since the year end has been:

- Candace Imison, Non Executive Director (Chair);
- Joan Mulcahy, Non Executive Director;
- Cherill Scott, Non Executive Director;
- Kate Grimes, Chief Executive;
- Sarah Tedford, Chief Operating Officer;
- Jenny Parr, Director of Nursing & Patient Experience; and,
- Jane Wilson, Medical Director.
The Committee’s main activities since it was establishment have been:

- Considering the Risk Management Committee’s regular report and agreement of escalation protocols where risks change;
- Reviewing the Corporate Risk Register and Board Assurance Framework from a quality perspective; and,
- Approving the 2012-13 Quality Account priorities.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board.

The Committee has established a work plan for the year forward, which will be reviewed and updated at each meeting of the Committee.

Remuneration Committee
The approved terms of reference of the Committee are to:

- Advise the Trust Board about appropriate remuneration and terms of service for the Chief Executive and other Executive Directors including:
  - All aspects of salary (including any performance related elements and/or bonuses);
  - Provisions for other benefits, including pensions and cars; and,
  - Arrangements for the termination of employment and other contractual terms
- Make such recommendations to the Trust Board on the remuneration and terms of service of Officer Members of the Trust Board (and other senior Employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust’s circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;
- Monitor and evaluate the performance of individual Officer Members (and other senior Employees);
- Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate; and,
- Report in writing to the Trust Board the basis for its recommendations

The Committee is comprised of all the Non Executive Directors and the Chairman, who chairs the Committee.

The Committee’s main activities through the year have been:

- Reviewing the performance of the Executive Team, both individually and collectively;
- Approving the terms of service and remuneration offer to the new Chief Operating Officer; and,
- Approving a number of redundancy proposals and severance arrangements.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board.

Trust & Charitable Funds Committee
The approved terms of reference of the Committee are to:

- Act for the Corporate Trustee in all charitable funds’ matters;
- Oversee the performance of all the ring fenced charitable funds, under the umbrella registration with the Charity Commission;
- Set the following policies of the Trust’s Charitable Funds;
The aims and objectives of the funds, including the beneficiaries and the medium/long term strategy;

- The investment policy of surplus funds; and,

- The reserves policy

- Review/agree the Annual Trustee’s Report.

Committee membership over the financial year and since the year end has been:

- Michael Jennings, Non Executive Director (Chair)
- Cherill Scott, Non Executive Director (since October 2011)
- Kate Grimes, Chief Executive
- Simon Milligan, Director of Finance

The Committee’s main activity through the year has been to act on behalf of the Corporate Trustee in the management of the Kingston Hospital NHS Trust General Charitable Fund. Day to day operation of sub-funds is delegated to budget holders within the Trust.

The Committee in exercising oversight has:

- Received reports on income and expenditure by fund, with backing information for transactions above certain thresholds;
- Approved business cases for expenditure of a capital nature, where the planned expenditure was from the general fund and where the planned expenditure was above the delegated threshold for an individual fund;
- Reviewed the Trustee’s Annual Report and Accounts, and associated documentation, and recommended to the Trust Board as Corporate Trustee for approval;
- Reviewed, and recommended to the Trust Board as Corporate Trustee for approval, the Charity Commission Annual Return.

The Committee did not identify any matters that needed specifically drawing to the attention of the Trust Board, other than the assurances and recommendations as part of the annual report and accounts process and Charity Commission Annual Return.

Attendance at Trust Board and sub-committee meetings over the last financial year has been as follows:

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<th>Trust Board</th>
<th>Audit Committee</th>
<th>Trust &amp; Charitable Funds Committee</th>
<th>Finance &amp; Investment Committee</th>
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### The risk and control framework

Risk management is embedded in the activity of the Trust through:

- The Risk Management Strategy and supporting policies and procedures;
- The Committee structures described in this report;
- Management processes (e.g. using a risk-based approach to help prioritise the Capital Programme);
- The Board’s Assurance Framework;

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<td>Joan Mulcahy Non Executive Director</td>
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<tr>
<td>Cherill Scott Non Executive Director</td>
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<tr>
<td>Jacqueline Unsworth Non Executive Director</td>
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<tr>
<td>Kate Grimes Chief Executive</td>
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<tr>
<td>Lance McCarthy Chief Operating Officer (to 16 May 2011)</td>
<td>7</td>
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<td>Simon Milligan Director of Finance</td>
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<tr>
<td>Jenny Parr Director of Nursing &amp; Patient Experience</td>
<td>7</td>
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<tr>
<td>Sarah Tedford Chief Operating Officer (from 1 June 2011)</td>
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<td>Jane Wilson Medical Director</td>
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<tr>
<td>Rachel Benton Commercial Director</td>
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<tr>
<td>David Grantham Director of Workforce &amp; Organisational Development</td>
<td>6</td>
<td>6</td>
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</table>
• Compliance with NHSLA risk management standards – Level 1;
• Compliance with the Essential Standards for Quality and Safety (Care Quality Commission) and the NHS Information Governance Toolkit;
• The Risk and Safety Team working with Divisions;
• Risk management skills training including both clinical risk assessments of various types and the mandatory and statutory training programme; and,
• An active counter fraud culture.

The key elements of the Trust’s Risk Management Strategy are designed to identify and control risks whether strategic, financial, reputational or relating to compliance, health and safety or clinical safety. The Risk Management Strategy is reviewed annually.

The Trust’s Risk Management Strategy focuses on a fair blame approach, seeking to identify improvements and learning from lessons highlighted through risk assessment, adverse events, near misses and patient and public feedback. The Trust employs a standardised methodology for supporting investigations and in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources. As a result risk management is an important element of the Trust’s Business Planning processes and the development of its productivity plans.

The Trust has adopted a bottom up approach to the generation of its risk register with each Division preparing its own risk register that then feeds into the overall Corporate Risk Register. This is supplemented by the identification of strategic risks at Trust level e.g. through the identification of key risks in the Trust’s Integrated Business Plan.

During 2011-12 each of the Divisions and Corporate Departments has continued to undertake regular reviews of their risks. The Risk Management Strategy sets the framework for the escalation of risk. Risks rated as 8 or more on initial assessment must be supported by a time framed action plan and recorded on the Trust’s Corporate Risk Register. These risks and their action plans are reviewed by the Risk Management Committee on a monthly basis and reported to the Quality Assurance Committee (previously the Strategic Risk committee) and Board each time they meet. The process outlined in the Risk Management Strategy requires regular review of individual risk assessments.

The Risk and Safety Team support the Divisions by providing specialist advice on identifying and assessing risks and work with them to facilitate risk mitigation plans through training, education and other individual support.

In addition, the Trust Board agrees the strategic risks that relate to its principle objectives. This forms the Assurance Framework and has been embedded into the Trust since 2004. It is based on the Trust’s corporate objectives as agreed by the Trust Board and is a high level document covering all the Trust’s functions, which is reviewed and, if necessary, updated at each Board meeting. The Assurance Framework is linked to the Care Quality Commission’s Essential Standards of Quality and Safety and the Corporate Risk Register.

The Assurance Framework for 2011-12 covered the following areas:
• Compliance with the Care Quality Commission requirements to maintain license to practice/registration;
• Ensuring sustainable delivery of national standards and targets and CQUIN targets;
• Developing mechanisms to enable the Trust to place itself at the forefront of publishing accessible and useful information on the quality and outcomes of our services for patients and GPs;
ANNUAL ACCOUNTS

- Implementing year two of our patient safety strategy and plan to improve safety and clinical outcomes across the Trust;
- Developing and embedding mechanisms to ensure patients and their perspectives are at the heart of our efforts to monitor, improve and redesign our care and services;
- Improving the patient’s experience of our services based on patient feedback;
- Improving the governance and risk management arrangements in the Clinical Divisions including securing our NHSLA (Acute services) Level and improving our CNST level in Maternity;
- Ensuring all staff have clear objectives, regular appraisals and a personal development plan;
- Ensuring the delivery of our statutory and mandatory training programme that enables the Trust to demonstrate that all staff are trained to protect themselves and our patients;
- Designing and delivering a programme that ensures that staff feel ownership of the services they deliver and are enabled to demonstrably influence the decisions taken over delivery of those services and the Trust as a whole;
- Implementing year two of the Trust’s workforce strategy;
- Clarification and strengthening of the Trust’s alliance with St George’s;
- Ensuring the active monitoring, management and pro-active development of our existing partnerships;
- Development and delivery of a programme of work to improve the GP experience of using services at Kingston Hospital in light of their feedback;
- Developing and pursuing a marketing plan;
- Developing and embedding the full involvement of the members in the running of the hospital in line with the Trust’s agreed membership strategy and providing a training programme for potential Governors;
- Taking costs out of the healthcare system, including delivering care in primary and community settings as set out in the contract, working with GPs and other providers;
- Delivery of the 2011-12 financial plan;
- Delivery of the Trust’s productivity programme that supports the delivery of a balanced long term financial plan for the Trust;
- Development of patient level costing; and,
- Co-ordination and driving the Trust’s Foundation Trust application through the process to ensure that the application is with Monitor within the first half of 2012.

A number of minor gaps in controls and/or assurance were identified in reviewing and agreeing the Assurance Framework. These have been monitored as appropriate within the Committee structure.

Key areas of risk relating to the Assurance Framework in 2011-12 have been:

- Delivery of the 2011-12 financial plan. Additional SLA income to cover over performance has been agreed with our major Commissioners ahead of the year-end. On the expenditure side a rigorous process of outturn review and challenge has fed into the budget setting process for 2012-13 and will be maintained over 2012-13. This has helped to pull early overspends back so that the Trust will deliver to its target outturn for the year;
- Delivery of the Trust’s Productivity Programme. Issues of capacity have been addressed by the recruitment of dedicated additional resource as well as the identification of responsible individuals.
against each scheme. The establishment of a single Programme to bring all productivity activity together under a standard methodology and with Executive leadership has enhanced the Trust’s capability to deliver the more transformational projects, and this is being embedded into budgets for 2012-13, together with key delivery milestones and active tracking; and,

- Achievement of Foundation Trust status. The Trust has made good progress through the Strategic Health Authority assessment stage, completing Historic Due Diligence 1 and 2 and the Board to board with the Strategic Health Authority during 2011-12. It is currently anticipated that the trust will move to the Department of Health stage of the application process in May 2012 with a view to achieving Foundation Trust authorisation by November 2012.

The Trust has been increasing its public membership in anticipation of achieving Foundation Trust Status. Members are key to the Trust’s public and patient engagement and this is being developed further through the Trust’s revised Patient Experience and Public Involvement Strategy. A Patient Assembly has been established, whose members will also sit on Trust Committees and groups.

Public stakeholders have been involved where appropriate in helping the Trust to address risks which impact on them. Examples of such involvement are:

- The Trust’s involvement with the Kingston Learning Disability Parliament and the adoption by the Board of the MENCAP charter. Each ward has identified a link nurse to work with patients with learning disabilities;

- Regular meetings are held between the Director of Nursing & Patient Experience and the Kingston Health Watch pathfinder and Richmond & Twickenham LINk;

- Public involvement in a group set up by the Director of Estates to review the Trust’s compliance with the Disability Discrimination Act;

- Trust members, LINks and members of the public have been involved in the development of priorities for the 2011-12 Quality Accounts; and,

- The low vision group have been working with the Trust to finalise a visual awareness guidance booklet for staff.

Quality is at the heart of the Trust’s strategy as demonstrated by the Trust’s mission to deliver high quality healthcare to our local population.

The Trust’s key strategies are to improve quality through improving patient safety, through improving the patient experience and through efficient delivery of healthcare. The Trust has approved a Quality Strategy which sets out how quality will be improved across the Trust and brings together previously developed key strategies to improve quality through improving Patient Safety (May 2010) and improving the Patient Experience (March 2011). Each of the Workforce and IT strategies and the Organisational Development Plan are fully aligned with and enable delivery of the Quality Strategy.

The Trust Board and Divisional Board agendas are set to address Quality first. Quarterly performance reviews between each Division and the Executive Team focus on quality performance for the first hour, before moving on to look at finance, workforce and strategy. A strong governance structure manages progress and the Performance Management Framework monitors Divisional performance.

Trust Board leadership on quality is evidenced by safety visits throughout the Trust, through monthly Non Executive Director visits and Executive Director Walkabouts. The Trust involves clinicians in all levels of management to ensure the delivery of quality services. The Medical Director has a visible presence in the Trust in a clinical capacity as well as within the
Executive. All clinical Divisions are led by a senior medical Divisional Director, supported by a Head of Nursing and Divisional Manager. Every Friday a ward based quality focussed assessment (Frontline Focus Friday) is led by the Director of Nursing and Patient Experience. The results are discussed with all the ward leaders and the messages disseminated Trust wide.

The Trust Board is aware of the importance of maintaining high standards of information governance and securing the confidentiality of patient’s information. It ensures delivery of this objective via the Senior Information Risk Officer who chairs the Information Governance Committee. The Senior Information Risk Officer is supported by an Information Governance Manager and the Trust has a range of policies, procedures and training material to make sure that information governance principles are well known by all staff and embedded into everyday practice across the Trust. The Trust Board has appointed the Director of Finance as the Senior Information Risk Officer.

The Information Governance Committee oversees completion of the Information Governance Toolkit and also receives information on any information security incidents. The Information Governance Toolkit in 2011 demonstrated compliance with level 3 information governance requirements.

The Trust has a dedicated data and information quality team which produce a comprehensive set of KPI reports to ensure data integrity. They also provide a support function for operational colleagues to support delivery of the required standards. Where activity issues are thought to be data quality related, they are formally logged and reviewed by the information function. A comprehensive Data and Information Quality Strategy has been produced to provide a road map to further enhance the Trust’s performance in this area, with an emphasis on developing operational ownership further.

The Trust is working towards integrating all data into a single source, the Trust data warehouse, based on the Microsoft business intelligence platform, which is updated on a daily basis from the Care Record System.

The Trust has previously been found in the top 5% in the UK for clinical coding and now is not subject to external audit. During 2011-12 the Trust was due to have quarterly audits by Maxwell Stanley auditors commissioned by our PCT commissioners. The first of these was carried out to look at the quality and accuracy of our clinical coding on a pre-determined sample of patients notes selected using criteria designed to discover inaccuracies in coding. The content of the full set of case notes was generally found to be of an excellent standard. The notes were filed in chronological order, and documentation was found within the appropriate section of the case notes. Each specialty used colour-coded paper to denote its input into the patients care and the clinician’s notes were detailed, legible and relevant. The volume of errors was found to be markedly low in comparison to other trusts which led the Commissioners to decide not to carry out this audit again at the Trust.

Clinical coding regularly engages with clinical colleagues to ensure understanding of coding and the resolution of issues that may arise. Representatives from Clinical Coding, information and clinicians have jointly undertaken coding audits as a result of membership of and discussion about coding at the Outcomes Committee.

The Trust is fully compliant with the Care Quality Commission’s Essential Standards of Quality and Safety. Compliance is monitored on a quarterly basis and any areas of potential weakness are addressed through the development of an action plan which is monitored through the Trust’s risk management structures.

The Trust is fully compliant with the registration requirements of 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 Trust’s obligations under equality, diversity and human rights legislation are complied with. The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this Trust’s obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

**Capacity to handle risk**

The Trust is committed to providing high quality services in a safe and secure environment. The Trust offers leadership on risk management through a clear Risk Management Strategy.

As Chief Executive I have overall responsibility for risk. Day to day responsibility for risk management processes is delegated to the Head of Corporate Affairs with Executive Directors taking responsibility for specific risk areas as follows:

- **Medical Director**
  - Audit & Clinical Effectiveness
  - Clinical Outcomes
  - Patient Safety

- **Director of Nursing & Patient Experience**
  - Patient Experience
  - Safeguarding Adults & Children

- **Chief Operating Officer**
  - Infection Prevention & Control

- **Director of Workforce & Organisational Development**
  - Workforce
  - Equality & Diversity

- **Director of Finance**
  - Financial
  - Information Governance

The remit of the Director of Finance includes the formal role of Senior Information Risk Officer as well as being the lead for financial risk management.

The Trust employs a range of specialists to lead on the implementation of risk management strategies covering both clinical and non-clinical risks. These include the Head of Risk and Safety, the Health and Safety Advisor and specialists in information governance, emergency planning, fire, waste, infection control and tissue viability.

The responsibility for risk management is identified across all levels in the Trust; from Trust Board members, through Divisional Directors and Divisional Managers to all managers and staff. As indicated above, named Executive Directors have specific responsibilities and accountability for risk, and these are laid out in the Risk Management Strategy, which was reviewed by the Trust Board in January 2012.

The Risk Management Committee, which I chair, meets monthly. Its membership includes the Executive Directors with specific responsibilities for risk and the Divisional Managers. The Risk Management Committee receives reports and monitors action plans from the subgroups covering the main areas of risk identified above. The Risk Management Committee reports to Quality Assurance Committee (previously the Strategic Risk Committee).
The Strategic Risk Committee met bi-monthly and was a sub-committee of the Trust Board. It took an overview of the Corporate Risk Register and monitored the risks identified in the Board Assurance Framework. It also had a particular focus on quality and safety. Following a review of the Strategic Risk Committee and its interaction with the Audit Committee the Trust Board agreed to reconstitute the Committee as the Quality Assurance Committee and reduce its scope so that it can have sufficient time to focus on clinical quality and risk. It will seek assurance, on behalf of the Trust Board, that there are adequate controls in place to ensure quality care to the Trust’s patients. The Audit Committee continues to have primary responsibility for financial risk and associated controls, corporate governance and for ensuring appropriate governance structures are in place.

Staff and management responsibilities for risk are clearly identified within the Risk Management Strategy, covering both clinical and non-clinical risks. Staff are trained appropriately within that framework, the key elements being the use of root cause analysis techniques for the investigation of serious incidents and the identification, preparation and evaluation of risks for the risk register. The Trust is committed to a robust induction process, and this includes the basic elements of risk management. Training and education of staff in good practice in managing risks of all kinds is provided both in house from the Trust’s specialist advisory team for risk and safety and from external providers, such as fire safety. A range of formal training sessions on matters relating to risk is co-ordinated centrally.

The Trust is committed to learning from good practice, and works closely with its internal auditors and bodies such as the National Patient Safety Agency (NPSA), the Medicines and Healthcare Products Regulatory Agency and Royal Colleges. The Trust regularly submits electronic reports of patient incidents to the NPSA.

Untoward Incidents and near misses are recorded electronically and on a central database, from which trends are analysed and performance reports produced at Trust and Divisional levels. All Serious Incidents at Grade 2 or above are reported to the Trust Board, the Strategic Health Authority and relevant Primary Care Trust, and are subject to a detailed investigation, reporting and action planning process. Learning from serious incidents is shared across the Trust through the Divisional Risk Performance Reports and risk newsletters.

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

The Trust, as with all other publicly funded bodies, faces significant financial challenges over the coming years. The Trust has developed detailed activity and financial models covering the next five years (long term financial model), which are constantly monitored and refreshed as circumstances change.

The long term financial model has been shared with Commissioners and reviewed by the Trust Board as part of the Trust’s Integrated Business Plan, in support of its Foundation Trust application.

To support the successful delivery of cost saving and service reconfiguration schemes the Trust Board appointed a Productivity Director on 1 April 2011 to lead a Trust wide Productivity Programme. The Productivity Programme, supported by a programme management office, co-ordinates and supports the delivery of all cost improvement and service reconfiguration schemes across the Trust.

All areas of the business have financial cost savings targets and were challenged as part of budget setting for 2011-12, and again for 2012-13, to identify specific schemes that would deliver on an ongoing basis the cost
savings being required of them. Where areas were able to make one off savings to meet targets, that are not repeatable in future years, they are required to identify and deliver sustainable cost savings in future years, in addition to their targets for those years.

Throughout 2011-12 progress against the identified schemes, and identification of schemes for future years, has been reported monthly to the Finance & Investment Committee, which is a sub-committee of the Trust Board. In addition delivery of the Productivity Programme has been identified as a key risk for the Trust and has been monitored and reported on at each Trust Board meeting.

The programme management office has established a standardised process for considering cost improvement and service reconfiguration schemes, to ensure schemes are realistic, deliverable, in line with Trust strategy and clinically appropriate. All schemes are considered for the cost of implementation, the savings to be achieved in year one as well as over future years. A process of post-implementation review has been agreed, and quality impacts from the programme will be monitored by the Quality Assurance Committee.

Two major streams of work started in the year, a review with St. George's Healthcare NHS Trust of the potential for sharing services across the two Trusts and a wider review of the potential to share or reconfigure services across the south west of London, involving Commissioners and all the acute providers.

Each of these initiatives has its own governance structure and work streams and is reported on to the Finance & Investment Committee and Trust Board as appropriate. Once schemes are agreed for delivery they will form part of the portfolio of schemes monitored by the Productivity Programme.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. The Department of Health has issued guidance to trust boards on the form and content of the Quality Account which incorporate the above legal requirements.

The Quality Report included in the Annual Report is a summary of the Quality Account for 2011-12 and provides the information the Trust is required under the Regulations to produce and have audited.

Once written the draft Quality Account was shared with stakeholders to get their feedback, and where appropriate comments were incorporated into the final Quality Account.

Performance against the KPIs reported in the Quality Account has been provided to the Trust Board at each of its meetings in the year, together with definitions and tolerances for each measure. National targets are defined consistently within the Trust, in Trust Board reporting, internal reporting and submissions. Data is benchmarked where possible.

The Trust has comprehensive systems in place to assure itself of the quality of the data used in performance reporting.

The Trust has defined quality goals within the three domains of quality; patient safety, clinical effectiveness and patient experience (High Quality Care for All, Department of Health 2008) which reflect national and local priorities. These are to deliver safe care and a consistently high quality patient experience with good outcomes which are value for money.

Board Development sessions were used to shape the Trust's strategies, including the Patient Experience Strategy, the Patient Safety Strategy and productivity plans. Each year the Trust's specific quality goals are developed with stakeholders including
patients, public and clinical commissioners and are described in the Quality Account and CQUIN scheme.

To develop and select the 2012-13 priorities, a multi-faceted approach was adopted to engaging with our stakeholders to get their views. This included 4 stages which included: the establishment of an editorial board and development of a “long list” of priorities based on the national operating framework, local feedback from complaints, best clinical practise developments, Trust priorities and Health Authority projects; this list of priorities was discussed with stakeholders internally and the LINk chairs; the original long list of over 35 suggestions was pared down to a more digestible short list of seven themes; and, this was consulted on with both Kingston’s and Richmond’s LINk, Foundation Trust members and the Patient Assembly and an online survey with staff and patients. Over 200 responses were received through the various feedback routes. Three areas were selected as our priorities for 2012-13, and presented to the Quality Assurance Committee in February 2012 to agree.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report included in 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, the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of internal audit’s work. The Head of Internal Audit Opinion for 2011-12 was substantial assurance.

Managers within the Trust who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the Trust achieving its principle objectives have been reviewed. My review is also informed by the following major sources of external assurance:

- External and internal audit reports;
- Clinical audit reports;
- Assurance Framework (in operation at the beginning of the financial year and reviewed by Internal Audit in March 2012);
- NHS Litigation Authority Acute Services Accreditation Level;
- 100% compliance with CNST Accreditation Level; and,
- Successful achievement of Care Quality Commission registration without compliance conditions with effect from 1 April 2010.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, Quality Assurance Committee (previously the Strategic Risk Committee) and the Trust Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The Trust Board
The Trust Board has reviewed the Assurance Framework and also received regular information from the Audit Committee and the Quality Assurance Committee (previously the Strategic Risk Committee). In addition, the Trust Board receives a Clinical Quality and Patient Safety Report at each meeting, and has reviewed various significant policies including the Risk Management Strategy.

The Audit Committee
The Annual Internal Audit Plan enables the Trust Board to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the Assurance Framework.

The Quality Assurance Committee (previously the Strategic Risk Committee)
The role of the Quality Assurance Committee is to provide assurance to the Trust Board and Audit Committee that there are adequate controls in place to ensure high quality care is provided to the patients using the services provided by the Trust.

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

Internal Audit
During 2011-12 the Trust used Deloitte and Touche Public Sector Internal Audit Ltd as providers of internal audit services. The contract and associated Quality Plan specify that the delivery of the internal audit function will continue to be in compliance with the NHS Internal Audit Standards and those of the Institute of Internal Auditors (UK). The Internal Audit team conducted a review of the Assurance Framework in March 2012. An audit opinion of substantial assurance was given indicating that while there was a basically sound system there were weaknesses which put some of the control objectives at risk.

During the year Internal Audit issued five limited assurance audit reports as follows:

- Consultant Contracts & Job Planning;
- Escrow;
- Fixed Assets & Capital Expenditure; and,
- Waiting List Management (two reviews).

In all cases the issues identified by Internal Audit confirmed areas already identified for improvement by management and did not raise any new issues. Action plans have been put in place to address the issues identified, and follow up reviews will be undertaken in 2012-13 to confirm the improvements have been actioned in full.

Clinical Audit
The Clinical Audit Team develops the clinical audit programme with Speciality Audit Leads who prioritise audits according to risk, effectiveness or efficiency. The Clinical Audit Team also consult with the Risk Team and Executive Directors to ensure that mandatory audits, national clinical audits, audits to provide assurance for NHSLA/CQUIN, peer review, Quality Account or re-audits of areas requiring improvement are included. The programme is mapped against the Risk Register, Assurance Framework, NHSLA standards and CQC outcomes. The programme is finally approved by the Quality Assurance Committee (previously the Strategic Risk Committee) having been considered by governance committees.

Mechanisms used to spread learning from clinical audit include:

- An Annual Audit Seminar;
- Annual Nursing and Midwifery Conference;
• Annual workshop on learning from incidents;
• Annual PICKER Patient Experience Survey workshop;
• Departmental Clinical Governance Meetings;
• Weekly Frontline Focus Friday meetings;
• Annual General Meeting presentations;
• Keyhole; and,
• CEO weekly emails.

Accreditation
The Trust has successfully achieved the A2 in Standards for Stroke Care as defined by Healthcare for London. The Trust achieved 100% compliance at CNST Level 1 and maintained its Level 1 rating for NHSLA general. The Trust had a successful unannounced visit from the Care Quality Commission in November 2011 and was recognised as fully compliant.

Care Quality Commission Registration
The Trust has been registered with the Care Quality Commission without compliance conditions since 1 April 2010.

Conclusion
With the exception of the internal control issues that I have outlined in this statement, my review confirms that Kingston Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Kate Grimes
Chief Executive
30 May 2012
## Statement of Comprehensive Income for the Year Ended 31 March 2012

### Revenue

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
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<tr>
<td>4</td>
<td>Revenue from Patient Care Activities</td>
<td>184,991</td>
<td>177,774</td>
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<tr>
<td>5</td>
<td>Other Operating Revenue</td>
<td>19,534</td>
<td>22,854</td>
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<tr>
<td>7.1</td>
<td>Employee Benefits</td>
<td>(129,555)</td>
<td>(128,967)</td>
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<tr>
<td>7.2</td>
<td>Other Costs</td>
<td>(67,058)</td>
<td>(64,746)</td>
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<td></td>
<td><strong>Operating Surplus</strong></td>
<td>7,912</td>
<td>6,915</td>
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### Finance Costs

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<th>Description</th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
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<tbody>
<tr>
<td>Investment Revenue</td>
<td>18</td>
<td>21</td>
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<tr>
<td>Other Losses</td>
<td>(51)</td>
<td>(520)</td>
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<td>Finance Costs</td>
<td>(3,286)</td>
<td>(2,280)</td>
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<td><strong>Surplus for the Financial Year</strong></td>
<td>4,593</td>
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<td>Public Dividend</td>
<td>(2,527)</td>
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<td>Capital Dividends Payable</td>
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<td><strong>Retained Surplus for the Year</strong></td>
<td>2,066</td>
<td>1,612</td>
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### Other Comprehensive Income

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<tr>
<th>Description</th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
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</thead>
<tbody>
<tr>
<td>Impairments and reversals</td>
<td>(3,104)</td>
<td>(4,115)</td>
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<tr>
<td>Net gain/(loss) on revaluation of property, plant &amp; equipment</td>
<td>922</td>
<td>2,475</td>
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<tr>
<td>Net actuarial gain/(loss) on pensions</td>
<td>(20)</td>
<td>85</td>
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<tr>
<td><strong>Total Comprehensive Income for the Year</strong></td>
<td>(136)</td>
<td>57</td>
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The notes on pages 202 to 251 form part of these accounts.

### Reported NHS Financial Performance Position (adjusted retained earnings)

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<thead>
<tr>
<th>Description</th>
<th>2011-12 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus for the year</td>
<td>2,066</td>
</tr>
<tr>
<td>IFRIC 12 adjustment (including impairments)</td>
<td>1,041</td>
</tr>
<tr>
<td>Impairments (excluding IFRIC 12 impairments included above)</td>
<td>284</td>
</tr>
<tr>
<td>Adjustments in respect of donated asset/government grant reserve elimination</td>
<td>(207)</td>
</tr>
<tr>
<td><strong>Reported NHS Financial Performance Position (adjusted retained earnings)</strong></td>
<td>3,184</td>
</tr>
</tbody>
</table>

A Trust's Reported NHS financial performance position is derived from its retained surplus, adjusted for the following:

- **IFRIC 12 adjustment**: The incremental revenue cost of bringing Private Finance Initiative assets onto the balance sheet (due to the introduction of International Financial Reporting Standards accounting in 2009-10), which has no cash impact and is not chargeable for overall budgeting purposes, is not considered part of the Trust's operating position;

- **Impairments to Fixed Assets**: An impairment charge is not considered part of the Trust's operating position; and,

- **Adjustment in respect of donated asset/government grant reserve elimination**: The HM Treasury Financial Reporting Manual for 2011-12 changed the accounting treatment for the funding elements of capital non-exchange transactions (i.e. government grants, donations and lottery grants). This reflects an interpretation of IAS20 and SIC10 set out in the HM Treasury Financial Reporting Manual. The benefit or additional cost is not considered part of the Trust's operating position.
## Statement of Financial Position as at 31 March 2012

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
<th>31 March 2011 Restated £000</th>
<th>31 March 2010 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant &amp; Equipment</td>
<td>114,345</td>
<td>116,230</td>
<td>117,425</td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>6,387</td>
<td>4,813</td>
<td>4,779</td>
</tr>
<tr>
<td>Trade and Other Receivables</td>
<td>389</td>
<td>277</td>
<td>427</td>
</tr>
<tr>
<td>Other Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Non-current Assets</strong></td>
<td>121,121</td>
<td>121,320</td>
<td>122,631</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>1,261</td>
<td>1,241</td>
<td>1,346</td>
</tr>
<tr>
<td>Trade and Other Receivables</td>
<td>10,420</td>
<td>11,323</td>
<td>11,116</td>
</tr>
<tr>
<td>Other Financial Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>16,958</td>
<td>17,760</td>
<td>17,436</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>138,079</td>
<td>139,080</td>
<td>140,067</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and Other Payables</td>
<td>(18,791)</td>
<td>(20,250)</td>
<td>(21,471)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(895)</td>
<td>(989)</td>
<td>(653)</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Financial Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,298)</td>
<td>(440)</td>
<td>(354)</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>(20,984)</td>
<td>(21,679)</td>
<td>(22,478)</td>
</tr>
<tr>
<td><strong>Total Assets less Current Liabilities</strong></td>
<td>117,095</td>
<td>117,401</td>
<td>117,589</td>
</tr>
<tr>
<td><strong>Non-current Liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and Other Payables</td>
<td>0</td>
<td>0</td>
<td>(108)</td>
</tr>
<tr>
<td>Borrowings</td>
<td>(32,970)</td>
<td>(33,730)</td>
<td>(33,795)</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Financial Liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions</td>
<td>(1,182)</td>
<td>(1,392)</td>
<td>(1,464)</td>
</tr>
<tr>
<td><strong>Total Non-current Liabilities</strong></td>
<td>(34,152)</td>
<td>(35,122)</td>
<td>(35,367)</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>82,943</td>
<td>82,279</td>
<td>(82,222)</td>
</tr>
</tbody>
</table>

### Financed by Taxpayers’ Equity

<table>
<thead>
<tr>
<th></th>
<th>57,911</th>
<th>57,131</th>
<th>57,131</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dividend Capital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retained Earnings</td>
<td>10,196</td>
<td>7,528</td>
<td>5,085</td>
</tr>
<tr>
<td>Revaluation Reserve</td>
<td>14,836</td>
<td>17,620</td>
<td>20,006</td>
</tr>
<tr>
<td>Other Reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Taxpayer’s Equity</strong></td>
<td>82,943</td>
<td>82,279</td>
<td>82,222</td>
</tr>
</tbody>
</table>

The financial statements on pages 197 to 251 were approved by the Board on 30 May 2012 and signed on its behalf by:

Kate Grimes

Chief Executive
Statement of Changes in Taxpayers’ Equity for the Year Ended 31 March 2012

<table>
<thead>
<tr>
<th>2011-12</th>
<th>Public Dividend Capital £000</th>
<th>Retained Earnings £000</th>
<th>Revaluation Reserve £000</th>
<th>Other Reserves £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2011</td>
<td>57,131</td>
<td>7,528</td>
<td>17,620</td>
<td>0</td>
<td>82,279</td>
</tr>
<tr>
<td>Retained surplus for the year</td>
<td>2,066</td>
<td>2,066</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>922</td>
<td>922</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of assets held for sale</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(3,104)</td>
<td>(3,104)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>602</td>
<td>(602)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Income</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New public dividend capital received</td>
<td>800</td>
<td>800</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital repaid in the year</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital written off</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other movements in public dividend capital in year</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pensions</td>
<td>(20)</td>
<td>(20)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net recognised revenue/(expense) for the year</td>
<td>780</td>
<td>2,668</td>
<td>(2,784)</td>
<td>0</td>
<td>664</td>
</tr>
<tr>
<td>Balance at 31 March 2012</td>
<td>57,911</td>
<td>10,196</td>
<td>14,836</td>
<td>0</td>
<td>82,943</td>
</tr>
</tbody>
</table>

Included above:

Transfer from revaluation reserve to retained earnings in respect of impairments | 0 | 0 | 0 |
## ANNUAL ACCOUNTS

### 2010-11 restated

<table>
<thead>
<tr>
<th>Public Dividend Capital £000</th>
<th>Retained Earnings £000</th>
<th>Revaluation Reserve £000</th>
<th>Other Reserves £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2010</strong></td>
<td>57,131</td>
<td>5,085</td>
<td>20,006</td>
<td>82,222</td>
</tr>
<tr>
<td>Retained surplus for the year</td>
<td>1,612</td>
<td></td>
<td></td>
<td>1,612</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>2,475</td>
<td></td>
<td></td>
<td>2,475</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of assets held for sale</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>(4,115)</td>
<td></td>
<td></td>
<td>(4,115)</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>746</td>
<td>(746)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Income</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>New public dividend capital received</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Public dividend capital repaid in the year</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Public dividend capital written off</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Other movements in public dividend capital in year</td>
<td>0</td>
<td></td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pensions</td>
<td>85</td>
<td></td>
<td></td>
<td>85</td>
</tr>
<tr>
<td><strong>Net recognised revenue/(expense) for the year</strong></td>
<td>0</td>
<td>2,443</td>
<td>(2,386)</td>
<td>57</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2011</strong></td>
<td>57,131</td>
<td>7,528</td>
<td>17,620</td>
<td>82,279</td>
</tr>
</tbody>
</table>

**Included above:**

- Transfer from revaluation reserve to retained earnings in respect of impairments | 0 | 0 | 0 | 0 |
## Statement of Cash Flows for the Year Ended 31 March 2012

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash flows from operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating surplus</td>
<td>7,912</td>
<td>6,915</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>6,561</td>
<td>6,488</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>615</td>
<td>113</td>
</tr>
<tr>
<td>Net foreign exchange gains/(losses)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Donated assets received credited to revenue but non-cash</td>
<td>(592)</td>
<td>(53)</td>
</tr>
<tr>
<td>Government granted assets received credited to revenue but non-cash</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest paid</td>
<td>(3,093)</td>
<td>(2,276)</td>
</tr>
<tr>
<td>Dividend paid</td>
<td>(2,594)</td>
<td>(2,407)</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>(20)</td>
<td>105</td>
</tr>
<tr>
<td>(Increase)/decrease in trade and other receivables</td>
<td>756</td>
<td>(4)</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Increase/(decrease) in trade and other payables</td>
<td>(1,958)</td>
<td>(1,854)</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>(346)</td>
<td>(263)</td>
</tr>
<tr>
<td>Increase/(decrease) in non-cash provisions</td>
<td>929</td>
<td>241</td>
</tr>
<tr>
<td><strong>Net cash inflow from operating activities</strong></td>
<td>8,170</td>
<td>7,005</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td>(6,198)</td>
<td>(5,495)</td>
</tr>
<tr>
<td>(Payments) for intangible assets</td>
<td>(2,352)</td>
<td>(710)</td>
</tr>
<tr>
<td>(Payments) for investments with the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Payments) for other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale – property, plant and equipment</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale – intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from disposal of investments with the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Proceeds from disposal of other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revenue rental income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash (outflow) from investing activities</strong></td>
<td>(8,532)</td>
<td>(6,180)</td>
</tr>
<tr>
<td><strong>Net cash inflow before financing</strong></td>
<td>(362)</td>
<td>825</td>
</tr>
<tr>
<td><strong>Cash flows from financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans received from the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other loans received</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans repaid to the Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other loans repaid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Capital grants and other capital receipts</td>
<td>645</td>
<td>0</td>
</tr>
<tr>
<td>Capital element of payments in respect of finance leases and on Statement of Financial Position PFI</td>
<td>(1,002)</td>
<td>(603)</td>
</tr>
<tr>
<td><strong>Net cash (outflow) from financing</strong></td>
<td>443</td>
<td>(603)</td>
</tr>
<tr>
<td><strong>Net increase in cash and cash equivalents</strong></td>
<td>81</td>
<td>222</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at the beginning of the financial year</strong></td>
<td>5,196</td>
<td>4,974</td>
</tr>
<tr>
<td>Effect of exchange rate changes on the balance of cash held in foreign currencies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents at the end of the financial year</strong></td>
<td>23</td>
<td>5,277</td>
</tr>
</tbody>
</table>
Notes to the Accounts

1. **Accounting Policies**

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Accounting convention**

These financial statements 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 **Accounting Standards issued but not yet adopted**

Neither the HM Treasury Financial Reporting Manual nor the 2011-12 NHS Trusts Manual for Accounts, issued by the Department of Health, require the following Standards and Interpretations to be applied in 2011-12:

- IAS 1 Presentation of Financial Statements (Other Comprehensive Income) – subject to consultation;
- IAS 12 Income Taxes (amendment) – subject to consultation;
- IAS 19 Post-employment Benefits (Pensions) – subject to consultation;
- IAS 27 Separate Financial Statements – subject to consultation;
- IAS 28 Investments in Associates and Joint Ventures – subject to consultation;
- IFRS 7 Financial Instruments: Disclosures (Annual Improvements) – effective 2012-13;
- IFRS 9 Financial Instruments – subject to consultation;
- IFRS 10 Consolidated Financial Statements – subject to consultation;
- IFRS 11 Joint Arrangements – subject to consultation;
- IFRS 12 Disclosure of Interests in Other Entities – subject to consultation;
- IFRS 13 Fair Value Measurement – subject to consultation; and,
- IPSAS 32 Service Concession Arrangement - subject to consultation.

The application of the Standards as revised would not have a material impact on the Trust financial statements if they were applied in the year being reported on.

1.3 **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.
1.4 **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.

1.4.1 **Critical judgements in applying accounting policies**

The following are the 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 the most significant effect on the amounts recognised in the financial statements:

- The Trust has undertaken a review of all its leases and agreements and determined that two should be accounted for as a finance lease under International Financial Reporting Standards (A service agreement with Huntleigh Healthcare Limited for Bed Facilities Management and an agreement with Asteral (MES) Limited for the Operation of a Healthcare (CT Scanning) Facility), as the Trust receives significantly all the risks and rewards under the terms of each agreement; and,

- The Trust has two Private Finance Initiative schemes both of which have been accounted for under IFRIC 12 and are on balance sheet under International Financial Reporting Standards.

1.4.2 **Key sources of estimation uncertainty**

The following are the 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:

- NHS Litigation Authority member provisions. These provisions are subject to future outcome of litigation in progress. The probabilities provided by the NHS Litigation Authority have been used to calculate the provision; and,

- Pension provisions for staff and directors. The provision is based on life expectancies of each individual. Life expectancy tables are used and these are obtained from the GAD website (up to 2006) and more recently from the Office of National Statistics.

1.5 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the yearend 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.
ANNUAL ACCOUNTS

1.6 Employee Benefits

1.6.1 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.

1.6.2 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.

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

1.8 Property, plant and equipment

1.8.1 Recognition
Property, plant and equipment is capitalised if:

• It is held for use in delivering services or for administrative purposes; and,
• It is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust; and,
• It is expected to be used for more than one financial year; and,
• 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.

1.8.2 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; and,
- 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 International Accounting Standard 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. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

1.8.3 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.

1.9 Intangible assets

1.9.1 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; and,
• The intention to complete the intangible asset and use it; and,
• The ability to sell or use the intangible asset; and,
• How the intangible asset will generate probable future economic benefits or service potential; and,
• 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.

1.9.2 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.

1.10 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. 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with HM Treasury’s budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by HM Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform HM Treasury if they expect AME spending to rise above forecast. Whilst HM Treasury accepts that in some areas of AME inherent volatility may mean departments do not
have the ability to manage the spending within budgets in that financial year, any expected increases in AME require HM Treasury approval.

1.11 Donated assets
Following the accounting policy change outlined in the HM Treasury Financial Reporting Manual for 2011-12, a donated asset reserve is no longer maintained.

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.12 Government grants
Following the accounting policy change outlined in the HM Treasury Financial Reporting Manual for 2011-12, a government grant reserve is no longer maintained.

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.13 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.

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.

1.14 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.

1.14.1 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.

**1.14.2 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.

**1.15 Private Finance Initiative (PFI) transactions**

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

**1.15.1 Services received**

The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

**1.15.2 PFI asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of International Accounting Standard 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust’s approach for each relevant class of asset in accordance with the principles of International Accounting Standard 16.

**1.15.3 PFI liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with International Accounting Standard 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to ‘Finance Costs’ within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.
An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with International Accounting Standards 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

1.15.4 Lifecycle replacement
Components of the asset replaced by the operator during the contract ("lifecycle replacement") are capitalised where they meet the Trust’s criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator’s planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.15.5 Assets contributed by the Trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust’s Statement of Financial Position.

1.15.6 Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator’s capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

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

1.17 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.

1.18 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 (2010-11: 2.2%) or 2.8% for employee early departure obligations (2010-11: 2.9%).

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 arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs
The NHS Litigation Authority operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority 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 NHS Litigation Authority on behalf of the trust is disclosed at note 33.

1.20 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.

1.21 EU Emissions Trading Scheme
EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

1.22 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.
1.23 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, which is determined by reference to quoted market prices where possible.

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.

1.23.1 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.

Fair value is determined by reference to quoted market prices where possible.

1.23.2 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.

1.23.3 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.

Fair value is determined by reference to quoted market prices where possible.

1.23.4 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.

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.

1.24 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, which is determined by reference to quoted market prices where possible.

1.24.1 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.

Fair value is determined by reference to quoted market prices where possible.

1.24.2 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.

1.25 Value Added Tax (VAT)
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.

1.26 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 spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.27 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 disclosed at note 39.

1.28 Public Dividend Capital (PDC) and Public Dividend Capital 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 Government Banking Service. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.29 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 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 2010-11 and 2011-12 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.

1.31 Associates
Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust’s accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust’s share of the entity’s profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

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

1.32 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. Joint ventures are accounted for by proportional consolidation.

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’.

1.33 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, cash flows.
1.34 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 only has one segment, healthcare.

Income from external customers in the year was £204,525k (2010-11 restated: £200,628).

The following customers contributed more than 10% of total income:

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston PCT</td>
<td>74,717</td>
<td>72,696</td>
</tr>
<tr>
<td>Richmond &amp; Twickenham PCT</td>
<td>39,421</td>
<td>40,792</td>
</tr>
<tr>
<td>Surrey PCT</td>
<td>27,946</td>
<td>27,504</td>
</tr>
</tbody>
</table>

3. Income Generation Activities

The Trust does not undertake any income generation activities that have full costs in excess of £1m.

4. Revenue from Patient Care Activities

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<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Health Authorities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>4,587</td>
<td>140</td>
</tr>
<tr>
<td>Primary Care Trust – tariff</td>
<td>109,186</td>
<td>111,338</td>
</tr>
<tr>
<td>Primary Care Trusts – non-tariff</td>
<td>46,029</td>
<td>42,535</td>
</tr>
<tr>
<td>Primary Care Trusts – market forces factor</td>
<td>22,673</td>
<td>22,277</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>0</td>
<td>98</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>143</td>
<td>142</td>
</tr>
<tr>
<td>Department of Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Private patients</td>
<td>984</td>
<td>604</td>
</tr>
<tr>
<td>- Overseas patients (Non-reciprocal)</td>
<td>137</td>
<td>109</td>
</tr>
<tr>
<td>- Injury cost recovery</td>
<td>561</td>
<td>513</td>
</tr>
<tr>
<td>- Other</td>
<td>691</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>184,991</td>
<td>177,774</td>
</tr>
</tbody>
</table>

Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% (2010-11: 9.6%) to reflect expected rates of collection.
5. **Other Operating Revenue**

<table>
<thead>
<tr>
<th>Description</th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td>1,619</td>
<td>971</td>
</tr>
<tr>
<td>Patient transport services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>8,798</td>
<td>8,150</td>
</tr>
<tr>
<td>Charitable and other contributions to expenditure</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Receipt of donations for capital acquisitions</td>
<td>592</td>
<td>53</td>
</tr>
<tr>
<td>Receipt of government grants for capital acquisitions</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>3,807</td>
<td>8,833</td>
</tr>
<tr>
<td>Income generation</td>
<td>1,667</td>
<td>1,298</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>1,225</td>
<td>1,044</td>
</tr>
<tr>
<td>Other revenue</td>
<td>1,766</td>
<td>2,505</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19,534</strong></td>
<td><strong>22,854</strong></td>
</tr>
</tbody>
</table>

Other revenue includes £260k (2010-11: £313k) for VAT reclaims, £205k (2010-11: £368k) of private finance initiative transitional relief income and £48k (2010-11: £40k) merit award income.

6. **Revenue**

<table>
<thead>
<tr>
<th>Description</th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>From rendering of services</td>
<td>204,403</td>
<td>200,558</td>
</tr>
<tr>
<td>From sale of goods</td>
<td>122</td>
<td>70</td>
</tr>
</tbody>
</table>
### 7. Operating Expenses

#### 7.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee benefits excluding Board members</td>
<td>128,741</td>
<td>128,185</td>
</tr>
<tr>
<td>Board members</td>
<td>814</td>
<td>782</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>129,555</strong></td>
<td><strong>128,967</strong></td>
</tr>
</tbody>
</table>

#### 7.2 Other costs

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 Restated £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from other NHS Trusts</td>
<td>610</td>
<td>119</td>
</tr>
<tr>
<td>Services from Primary Care Trusts</td>
<td>168</td>
<td>747</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Services from Foundation Trusts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purchase of healthcare from non NHS bodies</td>
<td>694</td>
<td>319</td>
</tr>
<tr>
<td>Trust chair and non executive directors</td>
<td>53</td>
<td>58</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>29,332</td>
<td>27,006</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>1,950</td>
<td>1,563</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>855</td>
<td>800</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,589</td>
<td>1,387</td>
</tr>
<tr>
<td>Transport</td>
<td>1,165</td>
<td>1,189</td>
</tr>
<tr>
<td>Premises</td>
<td>15,508</td>
<td>17,581</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>83</td>
<td>(37)</td>
</tr>
<tr>
<td>Inventories written down</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation</td>
<td>5,798</td>
<td>5,821</td>
</tr>
<tr>
<td>Amortisation</td>
<td>763</td>
<td>667</td>
</tr>
<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>615</td>
<td>113</td>
</tr>
<tr>
<td>Impairments and reversals of intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals of financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals of non-current assets held for sale</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments and reversals of investment properties</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees</td>
<td>145</td>
<td>165</td>
</tr>
<tr>
<td>Other auditor’s remuneration</td>
<td>128</td>
<td>94</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>6,778</td>
<td>5,646</td>
</tr>
<tr>
<td>Research and development</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Education and training</td>
<td>621</td>
<td>582</td>
</tr>
<tr>
<td>Other</td>
<td>203</td>
<td>886</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>67,058</strong></td>
<td><strong>64,746</strong></td>
</tr>
</tbody>
</table>

Other auditor’s remuneration includes £45k (2010-11: £35k) for the Local Counter Fraud Service, £54k (2010-11: £59k) for Internal Audit services provided to the Trust and £29k (2010-11: £NIL) for a review of quality processes associated with the Trust’s Foundation Trust application, all provided by an independent firm of accountants.
8. **Operating Leases**

8.1 **As lessee**

Operating lease expenses in the year include rental of buildings £450k (2010-11: £428k), leasing of vehicles £108k (2010-11: £23k), photocopier leases £50k (2010-11: £44k), and equipment leases £10k (2010-11: £19k).

### 8.1.1 Payments recognised as an expense

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>618</td>
<td>514</td>
</tr>
<tr>
<td>Contingent rents</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sub-lease payments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>618</td>
<td>514</td>
</tr>
</tbody>
</table>

### 8.1.2 Total future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Land</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Buildings</strong></td>
<td>215</td>
<td>96</td>
</tr>
<tr>
<td>£000</td>
<td>311</td>
<td>391</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>564</td>
<td>177</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>741</td>
<td>895</td>
</tr>
</tbody>
</table>

8.2 **As lessor**

Rental revenue includes £791k (2010-11: £611k) for the lease of floor space to BMI Healthcare, £321k (2010-11: £311k) for the lease of floor space in the Sir William Rous Unit, £127k (2010-11: £106k) for the lease of roof space for telecoms masts and £16k (2010-11: £16k) for the lease of floor space for the hospital shop.

### 8.2.1 Rental revenue

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent</td>
<td>451</td>
<td>413</td>
</tr>
<tr>
<td>Contingent rent</td>
<td>804</td>
<td>631</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,255</td>
<td>1,044</td>
</tr>
</tbody>
</table>

### 8.2.2 Total future minimum rental revenue

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£000</td>
<td>385</td>
<td>422</td>
</tr>
<tr>
<td><strong>Contingent rent</strong></td>
<td>1,384</td>
<td>1,437</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,289</td>
<td>5,454</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,058</td>
<td>7,313</td>
</tr>
</tbody>
</table>
9. Employee Benefits and Staff Numbers

9.1 Employee benefits

9.1.1 Gross employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanently employed</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>108,653</td>
<td>94,055</td>
</tr>
<tr>
<td>Social security costs</td>
<td>8,803</td>
<td>8,465</td>
</tr>
<tr>
<td>Employer contributions to NHS pension scheme</td>
<td>12,186</td>
<td>11,940</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>861</td>
<td>861</td>
</tr>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td><strong>130,503</strong></td>
<td><strong>115,321</strong></td>
</tr>
</tbody>
</table>

Less: Recoveries in respect of employee benefits (Note 9.1.2)

|                                | 2011-12 | 2010-11 Restated |
|                                | Total   | Permanently employed | Other | Total   | Permanently employed | Other |
|                                | £000    | £000              | £000  | £000    | £000              | £000  |
| Salaries and wages             | 1,330   | 1,330            | 0     | 807     | 807              | 0     |
| Social security costs          | 120     | 120              | 0     | 63      | 63               | 0     |
| Employer contributions to NHS pension scheme | 169   | 169              | 0     | 101     | 101              | 0     |
| Other pension costs            | 0       | 0                | 0     | 0       | 0                | 0     |
| Other post-employment benefits | 0       | 0                | 0     | 0       | 0                | 0     |
| Other employment benefits      | 0       | 0                | 0     | 0       | 0                | 0     |
| Termination benefits           | 0       | 0                | 0     | 0       | 0                | 0     |
| **Total recoveries in respect of employee benefits** | **1,619** | **1,619**      | **0** | **971** | **971**              | **0** |

Net employee benefits including capitalised costs

|                                | 2011-12 | 2010-11 Restated |
|                                | Total   | Permanently employed | Other | Total   | Permanently employed | Other |
|                                | £000    | £000              | £000  | £000    | £000              | £000  |
| Salaries and wages             | 107,184 | 93,994            | 13,182| 107,334 | 93,475            | 13,859|
| Social security costs          | 7,683   | 7,305             | 378   | 7,732   | 7,298             | 434   |
| Employer contributions to NHS pension scheme | 11,317 | 10,901            | 416   | 11,357 | 10,941            | 416   |
| Other pension costs            | 0       | 0                | 0     | 0       | 0                | 0     |
| Other post-employment benefits | 0       | 0                | 0     | 0       | 0                | 0     |
| Other employment benefits      | 0       | 0                | 0     | 0       | 0                | 0     |
| Termination benefits           | 794     | 794              | 0     | 287     | 287              | 0     |
| **Gross employee benefits**    | **125,284** | **111,570**      | **13,744** | **125,599** | **111,719**      | **13,843** |

Less: Employee costs capitalised

|                                | 2011-12 | 2010-11 Restated |
|                                | Total   | Permanently employed | Other | Total   | Permanently employed | Other |
|                                | £000    | £000              | £000  | £000    | £000              | £000  |
| Salaries and wages             | 105,930 | 92,656            | 13,274| 105,758 | 92,470            | 13,288|
| Social security costs          | 7,568   | 7,342             | 226   | 7,677   | 7,345             | 332   |
| Employer contributions to NHS pension scheme | 11,291 | 10,840            | 451   | 11,346 | 10,895            | 451   |
| Other pension costs            | 0       | 0                | 0     | 0       | 0                | 0     |
| Other post-employment benefits | 0       | 0                | 0     | 0       | 0                | 0     |
| Other employment benefits      | 0       | 0                | 0     | 0       | 0                | 0     |
| Termination benefits           | 787     | 787              | 0     | 287     | 287              | 0     |
| **Gross employee benefits**    | **124,588** | **112,288**      | **13,301** | **124,315** | **112,062**      | **13,263** |

Net employee benefits excluding capitalised costs

|                                | 2011-12 | 2010-11 Restated |
|                                | Total   | Permanently employed | Other | Total   | Permanently employed | Other |
|                                | £000    | £000              | £000  | £000    | £000              | £000  |
| Salaries and wages             | 105,142 | 92,370            | 12,772| 105,077 | 92,382            | 12,695|
| Social security costs          | 7,404   | 7,184             | 220   | 7,524   | 7,178             | 346   |
| Employer contributions to NHS pension scheme | 11,240 | 10,800            | 440   | 11,280 | 10,840            | 440   |
| Other pension costs            | 0       | 0                | 0     | 0       | 0                | 0     |
| Other post-employment benefits | 0       | 0                | 0     | 0       | 0                | 0     |
| Other employment benefits      | 0       | 0                | 0     | 0       | 0                | 0     |
| Termination benefits           | 780     | 780              | 0     | 287     | 287              | 0     |
| **Gross employee benefits**    | **122,866** | **112,156**      | **12,392** | **122,377** | **112,129**      | **12,244** |

9.1.2 Recoveries in respect of employee benefits

|                                | 2011-12 | 2010-11 Restated |
|                                | Total   | Permanently employed | Other | Total   | Permanently employed | Other |
|                                | £000    | £000              | £000  | £000    | £000              | £000  |
| Salaries and wages             | 0       | 0                | 0     | 0       | 0                | 0     |
| Social security costs          | 0       | 0                | 0     | 0       | 0                | 0     |
| Employer contributions to NHS pension scheme | 0       | 0                | 0     | 0       | 0                | 0     |
| Other pension costs            | 0       | 0                | 0     | 0       | 0                | 0     |
| Other post-employment benefits | 0       | 0                | 0     | 0       | 0                | 0     |
| Other employment benefits      | 0       | 0                | 0     | 0       | 0                | 0     |
| Termination benefits           | 0       | 0                | 0     | 0       | 0                | 0     |
| **Total recoveries in respect of employee benefits** | **0** | **0**              | **0** | **0**    | **0**              | **0** |
### 9.1.3 Net employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total £000</td>
<td>Permanently employed £000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>107,323</td>
<td>92,725</td>
</tr>
<tr>
<td>Social security costs</td>
<td>8,683</td>
<td>8,345</td>
</tr>
<tr>
<td>Employer contributions to NHS pension scheme</td>
<td>12,017</td>
<td>11,771</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>861</td>
<td>861</td>
</tr>
<tr>
<td><strong>Net employee benefits including capitalised costs</strong></td>
<td><strong>128,884</strong></td>
<td><strong>113,702</strong></td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td><strong>948</strong></td>
<td>948</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>127,936</strong></td>
<td><strong>112,754</strong></td>
</tr>
</tbody>
</table>

### 9.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Permanently employed Number</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>397</td>
<td>367</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>524</td>
<td>450</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>336</td>
<td>234</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>759</td>
<td>693</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>440</td>
<td>426</td>
</tr>
<tr>
<td>Social care staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>154</td>
<td>142</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,628</strong></td>
<td><strong>2,330</strong></td>
</tr>
</tbody>
</table>

Of the above:

Number of whole time equivalent staff engaged on capital projects | 12 | 4 | 8 | 2 | 2 | 0
9.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>16,184</td>
<td>29,025</td>
</tr>
<tr>
<td>Total staff years</td>
<td>2,405</td>
<td>2,419</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>6.7</td>
<td>12.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons retiring on ill health grounds</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Total additional pensions liability accrued in the year

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>54</td>
<td>314</td>
</tr>
</tbody>
</table>

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Where the Trust has agreed early retirements the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included here.

9.4 Exit packages agreed in 2011-12

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compulsory redundancies Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other agreed departures Number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Less than £10,000</th>
<th>£10,001 to £25,000</th>
<th>£25,001 to £50,000</th>
<th>£50,001 to £100,000</th>
<th>£100,001 to £150,000</th>
<th>£150,001 to £200,000</th>
<th>Over £200,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other agreed departures</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Total resource cost £000

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11 Restated</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>258</td>
<td>215</td>
</tr>
</tbody>
</table>

The table above includes the number and total value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous year.

9.5 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 NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

### 9.5.1 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.

### 9.5.2 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.

### 9.5.3 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. **Better Payment Practice Code**

10.1 **Measure of compliance**

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-NHS trade invoices paid in the year</td>
<td>53,095</td>
<td>77,378</td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid within target</td>
<td>49,224</td>
<td>71,904</td>
</tr>
<tr>
<td>Percentage of non-NHS trade invoices paid within target</td>
<td>93%</td>
<td>93%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>6,586</td>
<td>14,180</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>6,001</td>
<td>13,217</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>91%</td>
<td>93%</td>
</tr>
</tbody>
</table>

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.

10.2 **The Late Payment of Commercial Debts (Interest) Act 1998**

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts included in finance costs from claims made under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
11. **Investment Revenue**

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rental income:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PFI finance lease revenue:</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Planned</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Contingent</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other finance lease revenue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total rental income</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Interest income:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Bank interest</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>- Other loans and receivables</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Impaired financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Other financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total interest income</strong></td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>21</td>
</tr>
</tbody>
</table>

12. **Other Losses**

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gain/(losses) on disposal of property, plant and equipment</td>
<td>(36)</td>
<td>(520)</td>
</tr>
<tr>
<td>Gain/(losses) on disposal of intangible assets</td>
<td>(15)</td>
<td>0</td>
</tr>
<tr>
<td>Gain/(losses) on disposal of financial assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gain/(losses) on foreign exchange</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in fair value of financial assets carried at fair value through the Statement of Comprehensive Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in fair value of financial liabilities carried at fair value through the Statement of Comprehensive Income</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(51)</td>
<td>(520)</td>
</tr>
</tbody>
</table>

13. **Finance Costs**

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest on loans and overdrafts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest on obligation under finance leases</td>
<td>48</td>
<td>33</td>
</tr>
<tr>
<td>Provisions – unwinding of discounts</td>
<td>45</td>
<td>36</td>
</tr>
<tr>
<td>Interest on obligations under PFI obligations:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Main finance cost</td>
<td>2,734</td>
<td>1,927</td>
</tr>
<tr>
<td>- Contingent finance cost</td>
<td>459</td>
<td>284</td>
</tr>
<tr>
<td>Interest on late payment of commercial debt</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other interest expense</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total interest expense</strong></td>
<td>3,286</td>
<td>2,280</td>
</tr>
<tr>
<td>Other finance costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,286</td>
<td>2,280</td>
</tr>
</tbody>
</table>
## 14. Property, Plant and Equipment

<table>
<thead>
<tr>
<th>2011-12</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 31 March 2011</td>
<td>26,000</td>
<td>117,548</td>
<td>0</td>
<td>531</td>
<td>22,483</td>
<td>0</td>
<td>7,402</td>
<td>2,422</td>
<td>176,386</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>0</td>
<td>(42,328)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(42,328)</td>
</tr>
<tr>
<td>At 1 April 2011 Restated</td>
<td>26,000</td>
<td>75,220</td>
<td>0</td>
<td>531</td>
<td>22,483</td>
<td>0</td>
<td>7,402</td>
<td>2,422</td>
<td>134,058</td>
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<tr>
<td>Additions purchased</td>
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<td>0</td>
<td>694</td>
<td>1,724</td>
<td>0</td>
<td>307</td>
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<td>6,154</td>
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<tr>
<td>Additions donated</td>
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<td>0</td>
<td>91</td>
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<td>0</td>
<td>0</td>
<td>592</td>
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<td>Additions government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>531</td>
<td>0</td>
<td>(531)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(531)</td>
<td>0</td>
<td>0</td>
<td>(286)</td>
<td>20</td>
<td>(957)</td>
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<tr>
<td>Upward revaluation gains</td>
<td>0</td>
<td>2,020</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,020</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to reserves</td>
<td>0</td>
<td>(3,104)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(3,104)</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments charged to reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cumulative depreciation adjustment following revaluation</td>
<td>0</td>
<td>(4,937)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(4,937)</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2012</td>
<td>26,000</td>
<td>73,660</td>
<td>0</td>
<td>694</td>
<td>23,647</td>
<td>0</td>
<td>7,423</td>
<td>2,402</td>
<td>133,826</td>
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<tr>
<td>Depreciation at 31 March 2011</td>
<td>0</td>
<td>42,328</td>
<td>0</td>
<td>0</td>
<td>12,077</td>
<td>0</td>
<td>4,151</td>
<td>1,600</td>
<td>60,156</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>0</td>
<td>(42,328)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(42,328)</td>
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<tr>
<td>At 1 April 2011 Restated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12,077</td>
<td>0</td>
<td>4,151</td>
<td>1,600</td>
<td>17,828</td>
</tr>
<tr>
<td>Reclassifications</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(620)</td>
<td>0</td>
<td>(283)</td>
<td>18</td>
<td>(921)</td>
</tr>
<tr>
<td>Upward revaluation gains</td>
<td>0</td>
<td>1,098</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,098</td>
</tr>
<tr>
<td>Impairments charged to operating expenses</td>
<td>0</td>
<td>624</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>624</td>
</tr>
</tbody>
</table>
### Annual Report & Accounts 2011-12

#### Assets

<table>
<thead>
<tr>
<th>2011-12</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversal of impairments charged to operating expenses</td>
<td>0</td>
<td>(9)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(9)</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>3,224</td>
<td>0</td>
<td>0</td>
<td>1,572</td>
<td>0</td>
<td>830</td>
<td>172</td>
<td>5,798</td>
</tr>
<tr>
<td>Cumulative depreciation adjustment following revaluation</td>
<td>0</td>
<td>(4,937)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(4,937)</td>
</tr>
<tr>
<td>Depreciation at 31 March 2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13,029</td>
<td>0</td>
<td>4,698</td>
<td>1,754</td>
<td>19,481</td>
</tr>
</tbody>
</table>

#### Net book value at 31 March 2012

<table>
<thead>
<tr>
<th>2011-12</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>26,000</td>
<td>69,553</td>
<td>0</td>
<td>694</td>
<td>10,618</td>
<td>0</td>
<td>2,725</td>
<td>648</td>
<td>114,345</td>
</tr>
<tr>
<td>Donated</td>
<td>0</td>
<td>4,107</td>
<td>0</td>
<td>0</td>
<td>880</td>
<td>0</td>
<td>86</td>
<td>0</td>
<td>5,073</td>
</tr>
<tr>
<td>Government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>321</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>321</td>
</tr>
<tr>
<td>Total at 31 March 2012</td>
<td>26,000</td>
<td>73,660</td>
<td>0</td>
<td>694</td>
<td>10,618</td>
<td>0</td>
<td>2,725</td>
<td>648</td>
<td>114,345</td>
</tr>
</tbody>
</table>

#### Asset financing

<table>
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<tr>
<th>2011-12</th>
<th>Land £000</th>
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<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
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<tbody>
<tr>
<td>Owned</td>
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#### Revaluation reserve balance for property, plant and equipment

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<td>922</td>
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## ANNUAL ACCOUNTS

### 2010-11

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<th>Furniture &amp; fittings £000</th>
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<td>0</td>
<td>3,251</td>
<td>822</td>
<td>116,230</td>
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### ANNUAL ACCOUNTS

#### Annual Report & Accounts 2011-12

<table>
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<tr>
<th>2010-11</th>
<th>Land £000</th>
<th>Buildings excluding dwellings £000</th>
<th>Dwellings £000</th>
<th>Assets under construction £000</th>
<th>Plant and machinery £000</th>
<th>Transport equipment £000</th>
<th>Information technology £000</th>
<th>Furniture &amp; fittings £000</th>
<th>Total £000</th>
</tr>
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<td>75,220</td>
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<td>531</td>
<td>10,406</td>
<td>0</td>
<td>3,251</td>
<td>822</td>
<td>116,230</td>
</tr>
</tbody>
</table>

#### Asset financing

|                      | Owned     | 26,000                            | 53,650         | 0                             | 531                      | 7,305                    | 0                           | 3,251                    | 517        | 91,254    |
|                      | Held on Finance lease | 0     | 0                             | 0                             | 842                      | 0                        | 0                           | 0                        | 305        | 1,147     |
| Private finance initiative | 0     | 21,570                            | 0              | 0                             | 2,259                    | 0                        | 0                           | 0                        | 23,829     |
| **Total at 31 March 2011** | 26,000    | 75,220                            | 0              | 531                           | 10,406                   | 0                        | 3,251                       | 822                      | 116,230    |
14.1 Donated assets
Kingston Hospital NHS Trust General Charitable Fund contributed £91k towards simulation training equipment and £501k towards the redevelopment of the Maple Unit as a Children's Nursery.

14.2 Property revaluation
The Trust’s freehold properties were valued as at 31 March 2012 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation Standards, Eighth Edition, March 2012, the International Valuation Standards and IFRS. The valuation of these properties were on the basis of Fair Value (MV) primarily derived using the Depreciated Replacement Cost (DRC) method and the valuation is subject to the prospect and viability of the continued occupation and use.

This resulted in the value of land remaining unchanged, some buildings being revalued upwards by £931k, in total, and other buildings being revalued downwards by £3,728k, in total. £922k of the upward valuation was taken to the Revaluation Reserve, with the balance of £9k reversing previous charges to the Statement of Comprehensive Income. £3,104k of the downward valuation was absorbed within the Revaluation Reserve, with a £624k impairment being taken to the Statement of Comprehensive Income.

International Financial Reporting Standards require the Trust to split property, plant and equipment into their constituent significant parts, value each part separately and depreciate each part over an appropriate period. Property is therefore split between structure, fit-out and plant & machinery. On revaluation this can result in one part suffering a revaluation loss, whilst another benefits from a revaluation gain.

<table>
<thead>
<tr>
<th>£000</th>
</tr>
</thead>
</table>

The major constituents of the amount previously charged to the Statement of Comprehensive Income and now reversed are as follows:

- Computer Room: 5
- Esher Wing: 2

The major constituents of the downward revaluation are as follows:

Charged to the Statement of Comprehensive Income:

- Kingston Surgical Centre: 331
- Mortuary: 239
- Esher Wing: 35
- Maternity & Day Surgery Unit: 12

Charged to the revaluation reserve:

- Esher Wing: 2,010
- Maternity & Day Surgery Unit: 321
- Maple Unit: 229
- Kingston Surgical Centre: 169
- Bernard Meade: 96
- Accident & Emergency: 88
- Sir William Rous Unit: 60
- Cataract Theatre: 22
- The Wolverton Centre: 21
- Mortuary: 19
- Princess Dental: 12
- Rowan Bentall: 10

Kingston Surgical Centre is a private finance initiative funded asset. All other assets are owned outright.
## Economic lives

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<thead>
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<th>Minimum Life</th>
<th>Maximum Life</th>
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<tr>
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<td>22</td>
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### Intangible Assets

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<th>Licences and trademarks £000</th>
<th>Patents £000</th>
<th>Development expenditure (internally generated) £000</th>
<th>Total £000</th>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total at 31 March 2012</td>
<td>6,387</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Revaluation reserve balance for intangible assets

<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2011</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revaluation gains</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Release to retained earnings reserve</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balance at 31 March 2012</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Item</td>
<td>2010-11</td>
<td>2010-11</td>
<td>2010-11</td>
<td>2010-11</td>
<td>2010-11</td>
<td>2010-11</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Cost or valuation at 1 April 2010</td>
<td>6,193</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6,193</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>710</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>710</td>
</tr>
<tr>
<td>Additions internally generated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>(222)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(222)</td>
</tr>
<tr>
<td>Upward revaluation gains</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments charged to reserves</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cost or valuation at 31 March 2011</td>
<td>6,681</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6,681</td>
</tr>
<tr>
<td>Amortisation at 1 April 2010</td>
<td>1,414</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,414</td>
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<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassified as held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>(213)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(213)</td>
</tr>
<tr>
<td>Upward revaluation gains</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments charged to operating expenses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments charged to operating expenses</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>667</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>667</td>
</tr>
<tr>
<td>Amortisation at 31 March 2011</td>
<td>1,868</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,868</td>
</tr>
<tr>
<td>Net book value at 31 March 2011</td>
<td>4,813</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4,813</td>
</tr>
</tbody>
</table>
### 2010-11

<table>
<thead>
<tr>
<th></th>
<th>Computer software – purchased £000</th>
<th>Computer software – internally generated £000</th>
<th>Licences and trademarks £000</th>
<th>Patents £000</th>
<th>Development expenditure (internally generated) £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>4,802</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4,802</td>
</tr>
<tr>
<td>Donated</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2011</strong></td>
<td><strong>4,813</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td><strong>4,813</strong></td>
</tr>
</tbody>
</table>

### 15.1 Economic lives

<table>
<thead>
<tr>
<th></th>
<th>Minimum Life Years</th>
<th>Maximum Life Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer software – purchased</td>
<td>5</td>
<td>13</td>
</tr>
</tbody>
</table>
### 16. Analysis of Impairments and Reversals

#### 16.1 Property, plant and equipment

<table>
<thead>
<tr>
<th>Item</th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impairments and reversals charged to the statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss or damage resulting from normal operations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over-specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abandonment of assets in the course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total charged to Departmental Expenditure Limit</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen obsolescence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss as a result of catastrophe</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in market price</td>
<td>615</td>
<td>113</td>
</tr>
<tr>
<td><strong>Total charged to Annually Managed Expenditure</strong></td>
<td>615</td>
<td>113</td>
</tr>
</tbody>
</table>

**Total impairments and reversals charged to the statement of comprehensive income**

<table>
<thead>
<tr>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>615</td>
<td>113</td>
</tr>
</tbody>
</table>

**Impairments and reversals charged to the revaluation reserve**

<table>
<thead>
<tr>
<th>Item</th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss or damage resulting from normal operations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over-specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abandonment of assets in the course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen obsolescence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss as a result of catastrophe</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in market price</td>
<td>3,104</td>
<td>4,115</td>
</tr>
<tr>
<td><strong>Total impairments and reversals charged to the revaluation reserve</strong></td>
<td>3,104</td>
<td>4,115</td>
</tr>
</tbody>
</table>

**Total impairments and reversals of property, plant and equipment**

<table>
<thead>
<tr>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,719</td>
<td>4,228</td>
</tr>
</tbody>
</table>

Details of material impairment losses and reversals can be found in note 14.2.

#### 16.2 Intangible assets

<table>
<thead>
<tr>
<th>Item</th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Impairments and reversals charged to the statement of comprehensive income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss or damage resulting from normal operations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over-specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abandonment of assets in the course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total charged to Departmental Expenditure Limit</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen obsolescence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss as a result of catastrophe</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in market price</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total charged to Annually Managed Expenditure</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
## Total impairments and reversals charged to the statement of comprehensive income

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairments and reversals charged to the revaluation reserve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss or damage resulting from normal operations</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Over-specification of assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abandonment of assets in the course of construction</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unforeseen obsolescence</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loss as a result of catastrophe</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Change in market price</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total impairments and reversals charged to the revaluation reserve</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total impairments and reversals of intangible assets</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### 16.3 Totals

<table>
<thead>
<tr>
<th></th>
<th>2011-12 £000</th>
<th>2010-11 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total impairments and reversals charged to the statement of comprehensive income: Departmental Expenditure Limit</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total impairments and reversals charged to the statement of comprehensive income: Annually Managed Expenditure</td>
<td>615</td>
<td>113</td>
</tr>
<tr>
<td>Total impairments and reversals charged to the statement of comprehensive income</td>
<td>615</td>
<td>113</td>
</tr>
<tr>
<td>Total impairments and reversals charged to the revaluation reserve</td>
<td>3,104</td>
<td>4,115</td>
</tr>
<tr>
<td>Total impairments</td>
<td>3,719</td>
<td>4,228</td>
</tr>
</tbody>
</table>

**Of the above:**

- Impairment on revaluation to “modern equivalent asset” basis | 0            | 0            |

### Donated and government granted assets, included above

#### Donated asset impairments and reversals:

- Charged to the statement of comprehensive income: Departmental Expenditure Limit | 0            | 0            |
- Charged to the statement of comprehensive income: Annually Managed Expenditure | 0            | 0            |
- Charged to the revaluation reserve | 69           | 0            |

**Total donated asset impairments and reversals** | 69           | 0            |

#### Government granted asset impairments and reversals:

- Charged to the statement of comprehensive income: Departmental Expenditure Limit | 0            | 0            |
- Charged to the statement of comprehensive income: Annually Managed Expenditure | 0            | 0            |
- Charged to the revaluation reserve | 0            | 0            |

**Total government granted asset impairments and reversals** | 0            | 0            |

**Total donated and government granted asset impairments and reversals** | 69           | 0            |
17. Commitments

17.1 Capital commitments

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

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

| Property, plant and equipment | 0 | 165 |
| Intangible assets              | 0 | 0   |
| Total                           | 0 | 165 |

17.2 Other financial commitments

The Trust has no non-cancellable contracts (which are not leases of private finance initiative contracts or other service concession arrangements) as at 31 March 2012 (31 March 2011: £NIL).

18. Intra Government and Other Balances

<table>
<thead>
<tr>
<th></th>
<th>Current receivables</th>
<th>Non-current receivables</th>
<th>Current payables</th>
<th>Non-current payables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Balances with Other Central Government Bodies: 6,072 109 4,951 0
Balances with Local Authorities: 88 0 0 0
Balances with NHS Trusts and Foundation Trusts: 1,238 0 995 0
Balances with Public Corporations and Trading Funds: 0 0 0 0
Balances with bodies external to government: 3,022 280 12,845 0

Balance at 31 March 2012: 10,420 389 18,791 0

Balances with Other Central Government Bodies: 6,202 81 4,599 0
Balances with Local Authorities: 122 0 0 0
Balances with NHS Trusts and Foundation Trusts: 1,886 0 967 0
Balances with Public Corporations and Trading Funds: 0 0 0 0
Balances with bodies external to government: 3,113 196 14,684 0

Balance at 31 March 2011: 11,323 277 20,250 0

19. Inventories

Drugs | Consumables | Total
---|-------------|----
£000 | £000        | £000

Balance at 1 April 2011: 942 299 1,241
Additions: 12,407 11,400 23,807
Inventories recognised as an expense in the period: (12,359) (11,428) (23,787)
Write-down of inventories: 0 0 0
Reversal of previous write-down: 0 0 0

Balance at 31 March 2012: 990 271 1,261
### 20. Trade and Other Receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>NHS receivables – revenue</td>
<td>4,079</td>
<td>7,420</td>
<td>109</td>
<td>81</td>
</tr>
<tr>
<td>NHS receivables – capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>2,450</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS receivables – revenue</td>
<td>1,522</td>
<td>2,190</td>
<td>280</td>
<td>196</td>
</tr>
<tr>
<td>Non-NHS receivables – capital</td>
<td>0</td>
<td>53</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>1,626</td>
<td>1,053</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>(277)</td>
<td>(217)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>734</td>
<td>668</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finance lease receivables</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>60</td>
<td>71</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other receivables</td>
<td>226</td>
<td>85</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>10,420</td>
<td>11,323</td>
<td>389</td>
<td>277</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td>10,809</td>
<td>11,600</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Included in NHS receivables at £NIL (2010-11: £NIL) prepaid pension contributions.

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

Other trade receivables include private patients, insurance companies and overseas visitors. All overseas visitors have been included in the provision for impairment of receivables and the Trust expects to receive all other outstanding debts in full.

#### 20.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>By up to three months</td>
<td>881</td>
<td>119</td>
</tr>
<tr>
<td>By three to six months</td>
<td>172</td>
<td>535</td>
</tr>
<tr>
<td>By more than six months</td>
<td>370</td>
<td>436</td>
</tr>
<tr>
<td>Total</td>
<td>1,423</td>
<td>1,090</td>
</tr>
</tbody>
</table>

The Trust does not hold any collateral against receivables outstanding.
## 20.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2011</td>
<td>(217)</td>
<td>(284)</td>
</tr>
<tr>
<td>Amount written off in the year</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Amount recovered in the year</td>
<td>0</td>
<td>105</td>
</tr>
<tr>
<td>(Increase)/decrease in receivables impaired</td>
<td>(83)</td>
<td>(68)</td>
</tr>
<tr>
<td>Balance at 31 March 2012</td>
<td>(277)</td>
<td>(217)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 %</th>
<th>31 March 2011 %</th>
</tr>
</thead>
</table>

Receivables are provided against at the following rates:

<table>
<thead>
<tr>
<th>Category</th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS debt</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Private healthcare covered by an insurance company policy</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Debt with a payment plan in place that is being adhered to</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Injury cost recovery</td>
<td>10.5</td>
<td>9.6</td>
</tr>
<tr>
<td>Overseas visitors</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>All other non-NHS debt between 90 and 120 days old</td>
<td>10.0</td>
<td>10.0</td>
</tr>
<tr>
<td>All other non-NHS debt over 120 days old</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

## 21. Other Financial Assets

The Trust had no other financial assets as at 31 March 2012 (31 March 2011: £NIL).

## 22. Other Current Assets

The Trust had no other current assets as at 31 March 2012 (31 March 2011: £NIL).

## 23. Cash and Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2011</td>
<td>5,196</td>
<td>4,974</td>
</tr>
<tr>
<td>Net change in year</td>
<td>81</td>
<td>222</td>
</tr>
<tr>
<td>Balance at 31 March 2012</td>
<td>5,277</td>
<td>5,196</td>
</tr>
</tbody>
</table>

Made up of:

<table>
<thead>
<tr>
<th>Category</th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash with Government Banking Service</td>
<td>5,261</td>
<td>5,181</td>
</tr>
<tr>
<td>Commercial banks</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Cash in hand</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Current investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents as in statement of financial position</strong></td>
<td>5,277</td>
<td>5,196</td>
</tr>
<tr>
<td>Bank overdraft – Government Banking Service</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bank overdraft – commercial banks</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cash and cash equivalents as in statement of cash flows</strong></td>
<td>5,277</td>
<td>5,196</td>
</tr>
</tbody>
</table>

Patients’ money held by the Trust not included above: 0 £000
## Non-current Assets Held for Sale

<table>
<thead>
<tr>
<th></th>
<th>Plant and machinery £000</th>
<th>Information technology £000</th>
<th>Furniture and fittings £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2011</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus: assets classified as held for sale in the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: assets sold in the year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: impairments of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus: reversal of impairment of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2012</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities associated with assets held for sale at 31 March 2012</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2010</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus: assets classified as held for sale in the year</td>
<td>452</td>
<td>0</td>
<td>0</td>
<td>452</td>
</tr>
<tr>
<td>Less: assets sold in the year</td>
<td>(452)</td>
<td>0</td>
<td>0</td>
<td>(452)</td>
</tr>
<tr>
<td>Less: impairments of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus: reversal of impairment of assets held for sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: assets no longer classified as held for sale, for reasons other than disposal by sale</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2011</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| Liabilities associated with assets held for sale at 31 March 2011 | 0 | 0 | 0 | 0 |

The Trust has not disposed of any non-current assets via sale in the current year. The Trust disposed of two non-current assets via sale in the previous year:

- **CT Scanner.** The Trust has entered an agreement with Asteral (MES) Limited to provide a CT Scanning facility, including provision of new equipment. As part of the agreement the existing equipment was disposed of for £1 to Asteral (MES) Limited, resulting in the Trust recognising a loss on disposal of £251k; and,

- **Anaesthetic Machines.** The Trust replaced 22 machines in the year, realising £4k in disposal proceeds and recognising a loss on disposal of £197k.
### 25. Trade and Other Payables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest payable</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables – revenue</td>
<td>138</td>
<td>777</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS payables – capital</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>1,624</td>
<td>1,032</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables – revenue</td>
<td>673</td>
<td>4,093</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS payables – capital</td>
<td>1,710</td>
<td>1,162</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>10,329</td>
<td>8,669</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>1,220</td>
<td>1,202</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tax</td>
<td>1,417</td>
<td>1,493</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,680</td>
<td>1,822</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18,791</strong></td>
<td><strong>20,250</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total current and non-current**  
18,791 20,250

There are no liabilities for payments due in future years under arrangements to buy out the liability for early retirement over 5 instalments (31 March 2011: £108k for 1 person).

Other payables include £1,547k outstanding pension contributions at 31 March 2012 (31 March 2011: £1,587k).

### 26. Borrowings

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank overdraft – Government Banking Service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bank overdraft – commercial banks</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans from:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Department of Health</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Other entities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PFI liabilities:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Main liability</td>
<td>690</td>
<td>793</td>
<td>32,179</td>
<td>32,734</td>
</tr>
<tr>
<td>- Lifecycle replacement received in advance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finance lease liabilities</td>
<td>205</td>
<td>196</td>
<td>791</td>
<td>996</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>895</strong></td>
<td><strong>989</strong></td>
<td><strong>32,970</strong></td>
<td><strong>33,730</strong></td>
</tr>
</tbody>
</table>

**Total current and non-current**  
33,865 34,719
27. **Other Liabilities**

The Trust had no other liabilities as at 31 March 2012 (31 March 2011: £NIL).

28. **Finance Lease Obligations**

The Trust has two arrangements that are accounted for as finance leases under International Financial Reporting Standards:

- A service agreement with Huntleigh Healthcare Limited for Bed Facilities Management. The agreement is for 10 years and 3 months, commencing in January 2005 and expiring in March 2015. The minimum payments under the lease total £1,020k, payable over 10 years; and,

- An agreement with Asteral (MES) Limited for the Operation of a Healthcare (CT Scanning) Facility. The agreement is for 7 years, commencing in December 2010 and expiring in December 2017. The minimum payments under the agreement total £996k, payable over 7 years.

Future minimum lease payments are calculated by adding the present value of minimum lease payments to the remaining finance lease interest.

### 28.1 Amounts payable under finance leases – other:

<table>
<thead>
<tr>
<th></th>
<th>Minimum lease payments</th>
<th>Present value of minimum lease payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2012 £000</td>
<td>31 March 2011 £000</td>
</tr>
<tr>
<td>Within one year</td>
<td>244</td>
<td>244</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>765</td>
<td>867</td>
</tr>
<tr>
<td>After five years</td>
<td>97</td>
<td>239</td>
</tr>
<tr>
<td>Less: future finance charges</td>
<td>(110)</td>
<td>(158)</td>
</tr>
<tr>
<td><strong>Present value of minimum lease payments</strong></td>
<td>996</td>
<td>1,192</td>
</tr>
</tbody>
</table>

**Included in:**

- Current borrowings 205 196
- Non-current borrowings 791 996

**Total** 996 1,192

The Trust had no future sublease payments expected to be received as at 31 March 2012 (31 March 2011: £NIL).

The Trust had no contingent rents recognised as an expense in the year (2010-11: £NIL).

29. **Finance Lease Receivables**

The Trust had no finance lease receivables as at 31 March 2012 (31 March 2011: £NIL).
30. Private Finance Initiative Contracts

30.1 Private Finance Initiative schemes off-Statement of Financial Position
The Trust did not have any Private Finance Initiative schemes that were excluded from the Statement of Financial Position as at 31 March 2012 (31 March 2011: £NIL).

30.2 Private Finance Initiative schemes on-Statement of Financial Position
The Trust has entered into 2 Private Finance Initiative (PFI) agreements:

- A 29 year agreement for the Development of Phase 5 at Kingston Hospital and Provision of Services with Prime Care Solutions (Kingston) Ltd ("Prime"), expiring in 2036; and,
- A 15 year agreement for the re-provision of Energy and Energy Management Services at Kingston Hospital with Dalkia Utilities Services PLC ("Dalkia"), expiring in 2023.

Under IFRIC 12 the assets of both schemes are treated as assets of the Trust. The substance of both agreements is that the Trust has a finance lease and payments comprise of two elements, imputed finance lease charges and service charges.

There have been no changes to the PFI arrangements during the accounting period.

30.2.1 Development of Phase 5 at Kingston Hospital and Provision of Services
Under the PFI agreement Prime’s obligation was to build the Kingston Surgical Centre building and car parking facilities at the Trust. Under IFRIC 12 the Kingston Surgical Centre building is treated as an asset of the Trust. The Trust has the right to use the building for the purposes specified in the project agreement and to receive the building at the end of the contract period.

The provision of services at the Trust by Prime include a car parking service, a catering service and all other soft facilities management services across the Trust. Prime also provide a hard facilities management service to the Kingston Surgical Centre building.

Significant terms of the agreement include:

- Under clause 44.6 (replacement of non-performing sub-contractor) Prime will put forward proposals for the interim management of the service.
- If Prime fail to provide relevant services to the Trust the Trust may perform such services itself or instruct a third party to do so. If Prime then fail to terminate the relevant service the Trust shall be entitled to its option to exercise its rights in accordance with the provisions of Clause 44.5 (remedy provisions).
- If in the circumstances referred to in Clause 43 (Force Majeure) the parties have failed to reach agreement on any modification to the project agreement within 6 months of the date on which the party affected serves notice on the other party, either party may at any time afterwards terminate the agreement by written notice.
- The Trust shall be entitled to terminate the agreement at any time on 6 months written notice to Prime.

There is a 2.5% RPI increase built into the providers financing model with a base date of 1 April 2002. Actual RPI is calculated on an annual basis.

30.2.2 Energy and Energy Management Services
Dalkia provide and maintain a combined heat and power plant to deliver heat and power to the Trust. Under IFRIC 12 the plant is treated as an asset of the Trust. The Trust has the right to use the combined heat and power plant for the purposes specified in the project agreement.
Dalkia are obligated to provide the plant and machinery for the boiler house. On the expiry date of this contract the funded new equipment shall vest in the Trust provided the Trust has paid Dalkia any payment due to it under the project agreement.

Significant terms of the agreement include:

- The party claiming relief under Force Majeure shall be relieved of its liability under the project agreement to the extent that by reason of the force majeure it is not able to perform its obligations under this Agreement provided that the Trust shall continue to pay the Operating Element to Dalkia notwithstanding the occurrence of an event of Force Majeure.

- On the occurrence of a Dalkia Event of Default referred to in clauses 35.1.2, 35.1.3 (a), 35.1.4, 35.1.5, 35.1.6, 35.1.8 the Trust may terminate the agreement in its entirety by notice in writing having immediate effect.

- On the occurrence of a Dalkia Event of Default referred to in clauses 35.1.3(b), 35.1.3 (c), 35.1.3 (d) and 35.1.7, the Trust may serve notice giving Dalkia the option to remedy the default within 20 business days, or put forward a reasonable plan within 20 business days to remedy the default.

- In the case of any Event of Default referred to in clause 35.1.7, if Dalkia is awarded one or more warning notices in the following contract month, the Trust can issue notice in writing which terminates the agreement with immediate effect.

- The Trust is entitled to terminate the project agreement any time on 6 months written notice to Dalkia.

There is a 2.5% RPI increase built into the scheme with a base date of 1 September 2005. Actual RPI is calculated on an annual basis.

### 30.2.3 Total obligations for on-statement of financial position PFI contracts

<table>
<thead>
<tr>
<th>Due:</th>
<th>31 March 2012 £000</th>
<th>31 March 2011 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one year</td>
<td>3,944</td>
<td>3,071</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>16,822</td>
<td>13,430</td>
</tr>
<tr>
<td>After five years</td>
<td>90,309</td>
<td>78,426</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td><strong>111,075</strong></td>
<td><strong>94,927</strong></td>
</tr>
<tr>
<td>Less: interest element</td>
<td>(78,206)</td>
<td>(61,400)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32,869</strong></td>
<td><strong>33,527</strong></td>
</tr>
</tbody>
</table>

### 30.3 Charges to expenditure

The total charged in the year to expenditure in respect of off-statement of financial position PFI contracts was £NIL (2010-11: £NIL).

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £9,842k (2010-11: £7,979k). Services include: a car parking service; a catering service; all other soft facilities management services across the Trust; and, provision of heat and power to the Trust.
**30.3.1 The Trust is committed to the following charges for services**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within one year</td>
<td>10,292</td>
<td>8,359</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>43,602</td>
<td>35,032</td>
</tr>
<tr>
<td>After five years</td>
<td>278,366</td>
<td>223,003</td>
</tr>
<tr>
<td>Total</td>
<td>332,260</td>
<td>266,394</td>
</tr>
</tbody>
</table>

**31. Other Financial Liabilities**

The Trust had no other financial liabilities as at 31 March 2012 (31 March 2011: £NIL).

**32. Deferred Income**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance at 1 April 2011</td>
<td>697</td>
<td>1,515</td>
</tr>
<tr>
<td>Deferred income addition</td>
<td>999</td>
<td>0</td>
</tr>
<tr>
<td>Transfer of deferred income</td>
<td>(697)</td>
<td>(818)</td>
</tr>
<tr>
<td>Balance at 31 March 2012</td>
<td>999</td>
<td>697</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td>999</td>
<td>697</td>
</tr>
</tbody>
</table>

**33. Provisions**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pensions relating to former directors</td>
<td>14</td>
<td>62</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>136</td>
<td>126</td>
</tr>
<tr>
<td>Legal claims</td>
<td>147</td>
<td>52</td>
</tr>
<tr>
<td>Restructuring</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Redundancy</td>
<td>978</td>
<td>177</td>
</tr>
<tr>
<td>Equal Pay</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,298</td>
<td>440</td>
</tr>
<tr>
<td>Total current and non-current</td>
<td>2,480</td>
<td>1,832</td>
</tr>
</tbody>
</table>

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided.

£38,334k is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011: £31,652k).
### 2011-12:

<table>
<thead>
<tr>
<th></th>
<th>Pensions relating to former directors £000</th>
<th>Pensions relating to other staff £000</th>
<th>Legal claims £000</th>
<th>Restructuring £000</th>
<th>Redundancy £000</th>
<th>Equal pay £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 1 April 2011</strong></td>
<td>144</td>
<td>1,436</td>
<td>52</td>
<td>0</td>
<td>177</td>
<td>23</td>
<td>0</td>
<td>1,832</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>0</td>
<td>0</td>
<td>95</td>
<td>0</td>
<td>1,024</td>
<td>0</td>
<td>0</td>
<td>1,119</td>
</tr>
<tr>
<td>Used during the year</td>
<td>(14)</td>
<td>(135)</td>
<td>0</td>
<td>0</td>
<td>(197)</td>
<td>0</td>
<td>0</td>
<td>(346)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>(164)</td>
<td>0</td>
<td>0</td>
<td>(26)</td>
<td>0</td>
<td>0</td>
<td>(190)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>4</td>
<td>41</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>1</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td><strong>At 31 March 2012</strong></td>
<td>135</td>
<td>1,197</td>
<td>147</td>
<td>0</td>
<td>978</td>
<td>23</td>
<td>0</td>
<td>2,480</td>
</tr>
</tbody>
</table>

#### Expected timing of cash flows:

- **Within one year**: 14 136 147 0 978 23 0 1,298
- **Between one and five years**: 56 544 0 0 0 0 0 600
- **After five years**: 65 517 0 0 0 0 0 582

### 2010-11:

<table>
<thead>
<tr>
<th></th>
<th>Pensions relating to former directors £000</th>
<th>Pensions relating to other staff £000</th>
<th>Legal claims £000</th>
<th>Restructuring £000</th>
<th>Redundancy £000</th>
<th>Equal pay £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 1 April 2010</strong></td>
<td>205</td>
<td>1,461</td>
<td>85</td>
<td>0</td>
<td>177</td>
<td>4</td>
<td>6</td>
<td>1,818</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>0</td>
<td>164</td>
<td>36</td>
<td>0</td>
<td>177</td>
<td>4</td>
<td>6</td>
<td>387</td>
</tr>
<tr>
<td>Used during the year</td>
<td>(64)</td>
<td>(137)</td>
<td>(62)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(263)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>0</td>
<td>(7)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(54)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>5</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>36</td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>(2)</td>
<td>(83)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(85)</td>
</tr>
<tr>
<td><strong>At 31 March 2011</strong></td>
<td>144</td>
<td>1,436</td>
<td>52</td>
<td>0</td>
<td>177</td>
<td>23</td>
<td>0</td>
<td>1,832</td>
</tr>
</tbody>
</table>

#### Expected timing of cash flows:

- **Within one year**: 62 126 52 0 177 23 0 440
- **Between one and five years**: 82 540 0 0 0 0 0 622
- **After five years**: 0 770 0 0 0 0 0 770
34. Contingencies

34.1 Contingent liabilities

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012</th>
<th>31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Equal pay cases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>29</td>
<td>13</td>
</tr>
<tr>
<td>Amounts recoverable against contingent liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>29</strong></td>
<td><strong>13</strong></td>
</tr>
</tbody>
</table>

Other contingent liabilities relate to liabilities under the Liability to Third Parties Schemes (LTPS).

34.2 Contingent assets

The Trust had no contingent assets at 31 March 2012 (31 March 2011: £NIL).

35. Financial Instruments

35.1 Financial assets

<table>
<thead>
<tr>
<th></th>
<th>At fair value through profit and loss £000</th>
<th>Loans and receivables £000</th>
<th>Available for sale £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables – NHS</td>
<td>4,188</td>
<td>4,188</td>
<td></td>
<td>4,188</td>
</tr>
<tr>
<td>Receivables – non-NHS</td>
<td>1,811</td>
<td>1,811</td>
<td></td>
<td>1,811</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>5,277</td>
<td>5,277</td>
<td></td>
<td>5,277</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2012</strong></td>
<td><strong>0</strong></td>
<td><strong>11,276</strong></td>
<td><strong>0</strong></td>
<td><strong>11,276</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>At fair value through profit and loss £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Receivables – NHS</td>
<td>7,501</td>
<td>7,501</td>
<td>7,501</td>
</tr>
<tr>
<td>Receivables – non-NHS</td>
<td>2,378</td>
<td>2,378</td>
<td>2,378</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>5,196</td>
<td>5,196</td>
<td>5,196</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2011 (restated)</strong></td>
<td><strong>0</strong></td>
<td><strong>15,075</strong></td>
<td><strong>15,075</strong></td>
</tr>
</tbody>
</table>

35.2 Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>At fair value through profit and loss £000</th>
<th>Other £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embedded derivatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Payables – NHS</td>
<td>1,253</td>
<td>1,253</td>
<td>1,253</td>
</tr>
<tr>
<td>Payables – non-NHS</td>
<td>13,902</td>
<td>13,902</td>
<td>13,902</td>
</tr>
<tr>
<td>PFI and finance lease obligations</td>
<td>33,865</td>
<td>33,865</td>
<td>33,865</td>
</tr>
<tr>
<td>Other borrowings</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total at 31 March 2012</strong></td>
<td><strong>0</strong></td>
<td><strong>49,020</strong></td>
<td><strong>49,020</strong></td>
</tr>
</tbody>
</table>
35.3 Financial risk management

International Financial Reporting Standard 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 primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. 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 Trust Board. Trust treasury activity is subject to review by the Trust’s internal auditors.

35.3.1 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.

35.3.2 Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the London Strategic Health Authority. The borrowings are for 1 to 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.

35.3.3 Credit risk

Because the majority of the Trust’s income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures at the year end are in receivables from customers, as disclosed in the trade and other receivables note.

35.3.4 Liquidity risk

The Trust’s operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.
36. **Events After the Reporting Period**

There are no post balance sheet events having a material effect on the accounts.

37. **Losses and Special Payments**

There were 52 cases of losses and special payments (2010-11: 122 cases) totalling £176,417 (2010-11: £134,401) accrued during 2011-12.

38. **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 the Trust.

All interests are properly registered in the Trust's Register of Interests.

The Department of Health is regarded as a related party. During the year the 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:

<table>
<thead>
<tr>
<th>Payments to related party £000</th>
<th>Receipts from related party £000</th>
<th>Amounts owed to related party £000</th>
<th>Amounts due from related party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2011-12:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health</td>
<td>2,594</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>0</td>
<td>8,319</td>
<td>273</td>
</tr>
<tr>
<td>Kingston PCT</td>
<td>0</td>
<td>74,717</td>
<td>55</td>
</tr>
<tr>
<td>NHS Business Services Authority</td>
<td>1,461</td>
<td>0</td>
<td>108</td>
</tr>
<tr>
<td>NHS Litigation Authority</td>
<td>6,826</td>
<td>0</td>
<td>48</td>
</tr>
<tr>
<td>Richmond &amp; Twickenham PCT</td>
<td>54</td>
<td>39,421</td>
<td>96</td>
</tr>
<tr>
<td>South West London &amp; St. George’s Mental Health Trust</td>
<td>101</td>
<td>1,569</td>
<td>71</td>
</tr>
<tr>
<td>St. George’s Healthcare NHS Trust</td>
<td>1,876</td>
<td>6,991</td>
<td>577</td>
</tr>
<tr>
<td>Surrey PCT</td>
<td>21</td>
<td>27,946</td>
<td>5</td>
</tr>
<tr>
<td>Sutton &amp; Merton PCT</td>
<td>5</td>
<td>10,957</td>
<td>0</td>
</tr>
<tr>
<td>The Royal Marsden Hospital NHS Foundation Trust</td>
<td>286</td>
<td>663</td>
<td>75</td>
</tr>
<tr>
<td>Wandsworth PCT</td>
<td>79</td>
<td>16,749</td>
<td>221</td>
</tr>
</tbody>
</table>
ANNUAL ACCOUNTS

<table>
<thead>
<tr>
<th>Payments to related party £000</th>
<th>Receipts from related party £000</th>
<th>Amounts owed to related party £000</th>
<th>Amounts due from related party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health</td>
<td>0</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>London Strategic Health Authority</td>
<td>0</td>
<td>8,085</td>
<td>0</td>
</tr>
<tr>
<td>Kingston PCT</td>
<td>78</td>
<td>72,696</td>
<td>0</td>
</tr>
<tr>
<td>NHS Business Services Authority</td>
<td>945</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>NHS Litigation Authority</td>
<td>5,774</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Richmond &amp; Twickenham PCT</td>
<td>59</td>
<td>40,792</td>
<td>22</td>
</tr>
<tr>
<td>South West London &amp; St.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>George’s Mental Health Trust</td>
<td>54</td>
<td>800</td>
<td>9</td>
</tr>
<tr>
<td>St. George’s Healthcare NHS Trust</td>
<td>345</td>
<td>2,255</td>
<td>504</td>
</tr>
<tr>
<td>Surrey PCT</td>
<td>37</td>
<td>27,504</td>
<td>0</td>
</tr>
<tr>
<td>Sutton &amp; Merton PCT</td>
<td>0</td>
<td>11,288</td>
<td>0</td>
</tr>
<tr>
<td>The Royal Marsden Hospital NHS Foundation Trust</td>
<td>69</td>
<td>376</td>
<td>59</td>
</tr>
<tr>
<td>Wandsworth PCT</td>
<td>280</td>
<td>17,092</td>
<td>597</td>
</tr>
</tbody>
</table>

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 HM Revenue & Customs in respect of PAYE, NI contributions and VAT refunds.

The trust received capital contributions from Kingston Hospital NHS Trust General Charitable Fund (Registered Charity Number: 1056510), the corporate trustee for which is the Trust Board. The audited accounts of the Fund are available on the Charity Commission website.

39. Third Party Assets

The Trust held £270 cash and cash equivalents at 31 March 2012 (31 March 2011: £270) which relates to monies held by the Trust on behalf of patients.

40. IFRIC 12 Adjustment

40.1 Revenue consequences of IFRS: Arrangements reported on the statement of financial position under IFRIC 12 (e.g. private finance initiative)

<table>
<thead>
<tr>
<th></th>
<th>31 March 2012 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation charges</td>
<td>604</td>
</tr>
<tr>
<td>Interest expense</td>
<td>3,193</td>
</tr>
<tr>
<td>Impairment charges: Annually Managed Expenditure</td>
<td>331</td>
</tr>
<tr>
<td>Impairment charges: Departmental Expenditure Limit</td>
<td>0</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>9,842</td>
</tr>
<tr>
<td>Revenue receivable from sub-leasing</td>
<td>0</td>
</tr>
<tr>
<td>Impact on public dividend capital dividend payable</td>
<td>816</td>
</tr>
<tr>
<td>Total IFRS expenditure (IFRIC 12)</td>
<td>14,786</td>
</tr>
<tr>
<td>Revenue consequences of PFI schemes under UK GAAP (net of any sub-leasing income)</td>
<td>(13,745)</td>
</tr>
<tr>
<td>Net IFRS change (IFRIC 12)</td>
<td>1,041</td>
</tr>
</tbody>
</table>
40.2 Capital consequences of IFRS: Arrangements reported on the statement of financial position under IFRIC 12
(e.g. private finance initiative)

31 March 2012
£000

| Capital expenditure | 56 |

41. Financial Performance Targets

41.1 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

<table>
<thead>
<tr>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

| External financing limit | (246) | 61 |
| Cash flow financing      | 362   | (825) |
| Finance leases taken out in the year | 0 | 874 |
| Other capital receipts   | (645) | 0 |
| External financing required | (283) | 49 |
| Undershoot               | 37    | 12 |

41.2 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

<table>
<thead>
<tr>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

| Gross capital expenditure | 9,098 | 7,604 |
| Less: book value of assets disposed of | (51) | (524) |
| Plus: loss on disposal of donated assets | 4 | 5 |
| Less: capital grants | (160) | 0 |
| Less: donations towards the acquisition of non-current assets | (592) | (53) |
| **Charge against the capital resource limit** | **8,299** | **7,032** |
| Capital resource limit | 8,300 | 7,200 |
| **Under spend against the capital resource limit** | **1** | **168** |

41.3 Capital cost absorption rate

Until 2008-09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009-10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.
## Breakeven performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Turnover</th>
<th>Retained surplus/(deficit) for the year</th>
<th>Adjustment for:</th>
<th>Break-even in year position</th>
<th>Break-even cumulative position</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>2005-06</td>
<td>161,677</td>
<td>14</td>
<td></td>
<td>14</td>
<td>495</td>
</tr>
<tr>
<td>2006-07</td>
<td>163,728</td>
<td>1,673</td>
<td></td>
<td>1,673</td>
<td>2,168</td>
</tr>
<tr>
<td>2007-08</td>
<td>171,740</td>
<td>2,713</td>
<td></td>
<td>2,713</td>
<td>4,881</td>
</tr>
<tr>
<td>2008-09</td>
<td>183,311</td>
<td>807</td>
<td></td>
<td>807</td>
<td>5,688</td>
</tr>
<tr>
<td>2009-10</td>
<td>195,695</td>
<td>1,166</td>
<td></td>
<td>1,166</td>
<td>8,100</td>
</tr>
<tr>
<td>2010-11</td>
<td>200,066</td>
<td>2,021</td>
<td></td>
<td>2,021</td>
<td>10,824</td>
</tr>
<tr>
<td>2011-12</td>
<td>204,525</td>
<td>2,066</td>
<td></td>
<td>2,066</td>
<td>14,008</td>
</tr>
</tbody>
</table>

**Adjustments for:***

- Use of pre 1 April 1997 surpluses (FDL(97) 24 Agreements)
  - 2005-06: 0
  - 2006-07: 0
  - 2007-08: 0
  - 2008-09: 0

- 2006-07 PPA (relating to 1997-98 to 2005-06)
  - 2005-06: 0
  - 2006-07: 0
  - 2007-08: 0

- 2007-08 PPA (relating to 1997-98 to 2006-07)
  - 2005-06: 0
  - 2006-07: 0
  - 2007-08: 0

- 2008-09 PPA (relating to 1997-98 to 2007-08)
  - 2005-06: 0
  - 2006-07: 0
  - 2007-08: 0

**Adjustments for impairments**

- 2005-06: 0
- 2006-07: 371
- 2007-08: 113
- 2008-09: 615

**Consolidated Budgetary Guidance – Adjustment for dual accounting under IFRIC 12**

- 2005-06: 0
- 2006-07: 0
- 2007-08: 0
- 2008-09: 0

**Adjustment for impact of policy change re: donated/government granted assets**

- 2005-06: 0
- 2006-07: 0
- 2007-08: 0
- 2008-09: 0

**Other agreed adjustments**

- 2005-06: 0
- 2006-07: 0
- 2007-08: 0
- 2008-09: 0

**Break-even in year position**

- 2005-06: 14
- 2006-07: 1,673
- 2007-08: 2,713
- 2008-09: 807
- 2009-10: 2,412
- 2010-11: 2,724
- 2011-12: 3,184

**Break-even cumulative position**

- 2005-06: 495
- 2006-07: 2,168
- 2007-08: 4,881
- 2008-09: 5,688
- 2009-10: 8,100
- 2010-11: 10,824
- 2011-12: 14,008

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust’s financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance.

<table>
<thead>
<tr>
<th>Year</th>
<th>Break-even in-year position as a percentage of turnover</th>
<th>Break-even cumulative position as a percentage of turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.01%</td>
<td>1.02%</td>
</tr>
<tr>
<td></td>
<td>0.31%</td>
<td>1.32%</td>
</tr>
</tbody>
</table>

The amounts in the above tables in respect of financial years 2005-06 to 2008-09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.
GLOSSARY OF TERMS
The following glossary gives an explanation of some of the terms used in the document:

**Agenda for Change (AfC)**  
Agenda for Change is a national pay structure which all NHS Trusts need to use to pay most of their staff, excluding medical staff who are on separate contracts.

**Annual Accounts**  
The annual accounts provide the financial position for the financial year and are made up of:
- The Directors’ Statements of Responsibilities;
- The Auditors’ Report;
- The Governance Statement;
- Four primary statements: Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Taxpayers’ Equity; and, Statement of Cash Flows; and,
- Notes to the Accounts.

**Asset Impairments**  
Land and buildings are held at valuation in the Trust’s financial statements. All land and buildings are re-valued annually, and the values are changed in the financial statements. An impairment occurs where the downward movement in a particular buildings valuation is greater than the previous upward movements, and the excess is charged to the Statement of Comprehensive Income.

**Audit Report**  
A final report by an NHS body’s auditor on the findings from the audit process.

**Average Net Relevant Assets**  
Relevant net assets are calculated as the total capital and reserves of the NHS Trust less the donated asset reserve and cash balances in the Office of the Paymaster General accounts. The average is the average of the opening and closing figures.

**Better Payment Practice Code**  
The target of the Better Payment Practice Code is to pay all NHS and non NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

**Capital**  
Capital expenditure is spending on the acquisition of land and premises, and on the provision, adaptation, renewal, replacement or demolition of buildings, items or groups of equipment and vehicles, etc, where the expenditure exceeds £5,000.

**Capital Charges**  
The revenue costs associated with fixed assets. This includes elements of depreciation and interest.

**Capital Cost Absorption Duty (CCAD)**  
The financial regime of NHS Trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. NHS Trusts are required to absorb the cost of capital at a rate of 3.5 per cent of average net relevant assets.

**Capital Resource Limit (CRL)**  
An expenditure limit set by the Department of Health for each NHS organisation limiting the amount that may be spent on capital purchases.
<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Records Service (CRS)</td>
<td>Also known as NHS Care Records Service. This will be an electronic store of over 50 million health and care records which can be accessed by health professionals where and when they are needed. It will also give patients secure Internet access to their own health record.</td>
</tr>
<tr>
<td>Care Quality Commission (CQC)</td>
<td>CQC is the independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.</td>
</tr>
<tr>
<td>Cash Flow</td>
<td>A summary in a prescribed format of the cash received and paid out by an organisation over a defined time period.</td>
</tr>
<tr>
<td>Clinical Quality Indicators (CQUINs)</td>
<td>National quality indicators, agreed with local commissioners, against which the Trust will be measured. They will cover areas of safety, effectiveness and patient experience.</td>
</tr>
<tr>
<td>Clostridium Difficile (C Diff)</td>
<td>Clostridium Difficile is a bacterium that is present naturally in the gut of around 3% of adults and 66% of children. It does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C Diff bacteria can multiply and cause symptoms such as diarrhoea and fever.</td>
</tr>
<tr>
<td>Combined Heat and Power Unit (CHP)</td>
<td>This is an efficient way to generate electricity and heat simultaneously.</td>
</tr>
<tr>
<td>Cost Improvement Plans (CIPs)</td>
<td>Plans to meet the efficiency savings target levied on NHS bodies by the government.</td>
</tr>
<tr>
<td>Department of Health (DH)</td>
<td>The Department of Health is a government department that exists to improve the health and wellbeing of people in England. It also sets direction for the NHS, for adult social care and public health.</td>
</tr>
<tr>
<td>Depreciation</td>
<td>An accounting adjustment in the statement of comprehensive income to represent the use (or wearing out) of assets. It is a non-cash item designed to reflect the fact that when we buy an asset like equipment or buildings, the cash goes out of the bank account immediately but the use of the asset continues over many years. This spreads the cost over the life of the asset rather than just when it was purchased, and effectively creates a fund for the replacement of the asset.</td>
</tr>
<tr>
<td>Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA)</td>
<td>An accounting term, which represents a measure of the profit from operations, before deducting capital and financing items (depreciation, interest, tax). This is a proxy for the cash generated by operations.</td>
</tr>
<tr>
<td>External Financing Limit (EFL)</td>
<td>The government sets each NHS Hospital Trust a target for the level of cash movement allowed in year.</td>
</tr>
</tbody>
</table>
| European Working Time Directive (EWTD)    | This is a European Union directive designed to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave for all workers and working arrangements for night workers. This has particular relevance for NHS Trusts given the extended transitional
arrangements for Junior Doctor compliance.

**Financial Instruments**
A contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

**Financial Statements**
The main statements in the annual accounts of an NHS body. These include: a statement of comprehensive income, statement of financial position, statement in changes in taxpayers equity and statement of cash flows. The format of these statements is specified in the NHS manual for accounts.

**Forecast Outturn (FOT)**
Estimated year end position.

**Foundation Trust (FT)**
NHS Foundation Trusts in England have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

**Genito-Urinary Medicine (GUM)**
Genito-urinary medicine clinics deal with sexually transmitted infections and many other genital and sexual problems. These clinics are sometimes called ‘GU clinics’ or GUM for short.

**Haemoglobin A1c (HbA1c)**
HbA1c is a test that measures the amount of haemoglobin in your blood. Glycosylated haemoglobin is a substance in red blood cells formed when blood sugar (glucose) attaches to haemoglobin. The more glucose in the blood, the more haemoglobin A1C or HbA1C will be present in the blood.

**Health Care Resource Group (HRG)**
Healthcare Resource Groups (HRGs) provide a means of categorising the treatment of patients in order to monitor and evaluate the use of resources. The National Tariff uses HRGs.

**Health Protection Agency (HPA)**
Established as a non-departmental public body. The functions of the Agency are "to protect the community (or any part of the community) against infectious diseases and other dangers to health" (HPA Act 2004).

**Healthcare Associated Infections (HCAI)**
Healthcare associated infections are infections that are acquired in Hospitals or as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

**Healthcare for London**
Healthcare for London is a 10-year programme to transform healthcare and standards of health in the capital. It is run on behalf of, and funded by, the 31 Primary Care Trusts (PCTs) in London.

**High Quality Care for All**
The outcome of the review of the NHS, led by Lord Darzi, to develop a vision of the NHS fit for the 21st century.

**Human Immunodeficiency Virus (HIV)**
HIV is a virus that is transmitted from person to person through the exchange of body fluids such as blood, semen, breast milk and vaginal secretions. Sexual contact is the most common way to spread HIV, but it can also be transmitted by sharing needles when injecting drugs, or during childbirth and breastfeeding.

**In Year Financial**
Result of income compared with expenditure, ignoring any impact of the
<table>
<thead>
<tr>
<th><strong>Performance</strong></th>
<th>previous years' financial results.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Sector (IS)</strong></td>
<td>Generally taken to mean healthcare providers who are not within the NHS.</td>
</tr>
<tr>
<td><strong>Integrated Business Plan (IBP)</strong></td>
<td>The integrated business plan is the document that sets out the organisation’s business strategy for the next five years. It sets out the organisation’s plan in strategic, financial, governance and operational terms and evolves over the application process.</td>
</tr>
<tr>
<td><strong>International Financial Reporting Standards (IFRS)</strong></td>
<td>These are the new accounting standards that the NHS has adopted from 1 April 2009.</td>
</tr>
<tr>
<td><strong>Long Term Financial Model (LTFM)</strong></td>
<td>The LTFM is the financial summary of the IBP and shows the historic performance of the Trust over the previous three years and a financial projection for the current year and a forecast for the following five years.</td>
</tr>
<tr>
<td><strong>Market Forces Factor (MFF)</strong></td>
<td>A percentage adjustment, which each NHS Trust receives on all Payment by Results income. This Trust currently receives 20.0% uplift, which is intended to reflect the higher cost of living and land values in some areas of the country compared to others.</td>
</tr>
<tr>
<td><strong>Medical Assessment Centre (MAC)</strong></td>
<td>A high quality, rapid assessment service to determine if patients need any investigations or care in order to treat or stabilise their medical condition.</td>
</tr>
<tr>
<td><strong>Methicillin Resistant Staphylococcus Aureus (MRSA)</strong></td>
<td>It is a bacterium from the staphylococcus aureus family. MRSA bacteria are resistant to some of the antibiotics that are commonly used to treat infection, including methicillin (a type of penicillin originally created to treat staphylococcus aureus (SA) infections).</td>
</tr>
<tr>
<td><strong>National Capitation Targets</strong></td>
<td>In order to decide what NHS funding is allocated to commissioners, the government has a resource allocation working group. They set ‘capitation’ targets that give funding per head of population, adjusted for factors such as age, sex and temporary residents. Because historic allocations were based on location and provision of healthcare rather than population, there is often some distance between the amount of money commissioners receive and their target. Commissioners that are ‘over target’ receive lower increases in funding; commissioners that are under target receive higher increases in funding each year.</td>
</tr>
<tr>
<td><strong>National Institute for Clinical Excellence (NICE)</strong></td>
<td>NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.</td>
</tr>
<tr>
<td><strong>NHS London</strong></td>
<td>This is the Strategic Health Authority (SHA) for London, one of the ten strategic health authorities in England established on 1 July 2006.</td>
</tr>
<tr>
<td><strong>Non-recurrent/recurrent</strong></td>
<td>Recurrent changes are permanent, and non-recurrent changes are temporary and generally they will occur in one year only.</td>
</tr>
<tr>
<td><strong>Normalised</strong></td>
<td>Normalised figures are those where the impact of non-recurrent items has been removed, so we can see the ongoing trend.</td>
</tr>
</tbody>
</table>
### Outturn
The final financial position, which could be the actual or forecast position.

### Patient Advice and Liaison Service (PALS)
The PALS service provides:
- confidential advice and support to families and their carers;
- confidential assistance in resolving problems and concerns quickly; and,
- explanations of complaints procedures and how to get in touch with someone who can help.

### Payment by Results (PbR)
This is the system by which most acute healthcare is priced and paid for by commissioners (usually Primary Care Trusts). It means the Trust gets an amount of money per patient admitted to Hospital which depends on what treatment they receive while they are here. This is calculated using the PbR ‘tariff’ – a set of prices for each sort of activity. Not all activity is covered under the PbR mechanism – for example the Trust receive money for some services direct from the PCT, and receive training money for junior doctors.

### Primary Care Trusts (PCT)
NHS bodies aligned to local government geographic areas which have responsibility for commissioning healthcare on behalf of local residents.

### Private Finance Initiative (PFI)
The private finance initiative provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by a public authority.

### Prudential Borrowing Limit (PBL)
Loan limit agreed by Department of Health for spend on Capital. The limit is based on five Balance sheet ratios.

### Public Dividend Capital (PDC)
When NHS Trusts were set up, an organisation was created with ownership of land and buildings. PDC is the amount of taxpayer’s equity that is judged to be the taxpayer’s stake in that ownership. Each year, we pay a dividend from our income from operations to compensate for the use of this capital.

### Qualified Audit Opinion
When the auditor is of the opinion that there is a problem with the annual accounts of an NHS body, they can issue a qualified audit opinion on the accounts. The qualification may be on the truth and fairness of the accounts, the regularity of the transactions or both.

### Real / Nominal Rate of Growth
‘Real’ growth excludes the effect of inflation, whereas nominal growth includes inflation. The reason we quote both ‘real’ and ‘nominal’ growth is that this makes it easier to see the underlying rate of growth when explaining trends over a long period.

### Reference Cost Index (RCI)
Index value for the cost of a procedure (the average =100) this information informs the value of PbR Tariff in future years.

### Referral to Treatment
This is a term used in connection with the 18-week target. By
(RTT) December 2008, all Trusts had to ensure that elective care was delivered within 18 weeks of the initial GP referral. The total time elapsed is the RTT.

Remuneration The money and other benefits paid to people carrying out a job.

Retail Price Index (RPI) Measure of price inflation comparing year on year movements in price.

Retained Surplus The difference between income earned in a defined period, usually a year, and the associated costs.

Revaluation Reserve A reserve created when an asset is revalued to a higher value than its historic cost.

Ringfenced Usually referring to money or other resources where it can only be used for a defined purpose, e.g. to provide cancer care.

Service Level Agreement (SLA) Agreement between two or more parties to deliver a defined service for a defined rate of pay. In the NHS this is usually an agreement between a PCT or Commissioner, and a Trust Provider.

Service Line Reporting (SLR) Reporting tool to show the costs and income at a specialty level instead of at Departmental level. Costs will included direct and indirect costs and may include Overheads.

Strategic Health Authority (SHA) Strategic Health Authorities manage the NHS locally and are a key link between the Department of Health and the NHS. They hold all local NHS organisations (apart from NHS Foundation Trusts) to account for performance.

Statement of Comprehensive Income Formerly known as the income and expenditure account under UK GAAP.

Statement of Financial Position Formally known as the balance sheet under UK GAAP.

Tariff The value charged for an activity usually known as the National Tariff in the NHS.

True and Fair Opinion Auditors provide an opinion as to whether an NHS body’s accounts have been prepared in accordance with all relevant accounting standards, legislation and guidance.

Unitary Payment The monthly payment made to the PFI consortia. Payment for services provided including hotel services and building maintenance.

Unqualified Audit Opinion When auditors of NHS bodies are satisfied with the annual accounts they will issue an unqualified audit opinion.

Working Capital Working capital is the current assets and liabilities (receivables, inventories, cash and payables) required to facilitate the operation of an organisation.