Royal Brompton & Harefield NHS
NHS Foundation Trust

Royal Brompton & Harefield NHS Foundation Trust

Annual Report and Accounts 2010/11

Royal Brompton & Harefield NHS Foundation Trust

Annual Report and Accounts 2010/11

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

Royal Brompton & Harefield NHS Foundation Trust

Annual Report 2010-11

CONTENTS

1. Chief Executive Introduction

The following pages constitute the Annual Report of the Royal Brompton & Harefield NHS Foundation Trust for its first full year as a Foundation Trust, for the period 1 April 2010 to 31 March 2011.

The information contained in this Report is presented and prepared in accordance with the requirements set out by Monitor in the "*NHS Foundation Trust Annual Reporting Manual 2010-11*" published by Monitor on 31st March 2011.

In the following pages, readers will find:

- A report by the Directors of the Trust on the business of the Trust during the period of report, and of the position of the business as at 31 March 2011, alongside commentary on the risks and other factors which are likely to affect the development, performance or position of the Trust in the future
- A more detailed Operational and Financial Review of the main business areas of the Trust during the reporting period
- An outline of the Governance arrangements in place in the Trust
- A set of "Disclosures in the Public Interest", indicating where information on these is to be found within the Report.

During 2010/11 the Trust has continued to develop the process for production of the Quality Report and has taken steps to ensure that stakeholders have been involved in the choice of three priority areas for 2011/12.

One of the major challenges that faced the Trust during 2010/11 was the threat to our Children's Services posed by the review of children's congenital heart services undertaken on behalf of the Joint Committee of Primary Care Trusts (JCPCT). This review has the objective of reducing the number of centres commissioned to undertake children's congenital heart surgery from the current 11, to around 6 or 7 nationally designated centres. The Trust has sought a judicial review of the JCPCT's consultation process and the business case underpinning it. At the time of writing the outcome of this review is awaited. Whatever the outcome, however, there should be no significant impact on the Trust's funding arrangements prior to 1 April 2013.

The Trust remains committed to the provision of high quality services for patients of all ages. The Trust intends to develop its services, and premises, in the future to ensure ongoing delivery of this commitment.

.....R. Jeu..... **Robert J Bell**
Chief Executive

Date May 31, 2011

Contact information
For queries regarding this annual report please contact, in the first instance:
Richard Connett
Trust Secretary & Head of Performance
Royal Brompton & Harefield NHS Foundation Trust
3 Sydney Street
London SW3 6NP
T: 0207 349 7713 W: www.rbht.nhs.uk

2. Directors' Report / Operational and Financial Review

Introduction

This report represents a performance review for Royal Brompton & Harefield NHS Trust for the period 1 April 2010 to 31 March 2011. It consists of information about our work, our services and our strategic goals, and an overview of some highlights from our heart division, lung division, children's services and support services during this period.

Summaries of the work of our human resources, estates and facilities, information services and public and patient involvement (PPI) teams are also provided.

Our performance against NHS targets in the 12 month period is given in the Quality Report and Financial Statements sections of this Annual Report.

2.1 Who we are and what we do

Royal Brompton & Harefield NHS Foundation Trust is a national and international specialist heart and lung centre based in Chelsea, London and Harefield, Middlesex.

We help patients of all ages who have heart and lung problems. From the moment they arrive, our patients become part of a community of people who have benefited from more than 160 years of expert diagnosis, treatment and long-term care.

Over the years, our experts have been responsible for several major medical breakthroughs – carrying out the first coronary angioplasty in the UK, founding the largest centre for cystic fibrosis in Europe and pioneering intricate heart surgery for newly-born infants.

Our care extends from the womb, through childhood, adolescence and into adulthood. Our foetal cardiologists can perform scans at just 12 weeks, when a baby's heart valve is just over a millimetre in size, and our clinical teams regularly treat patients well into their 90s.

As a specialist trust, our patients come from all over the UK and internationally, not just from our local areas.

Research programmes play a vital role at both our hospitals. This is because the most talented medical experts are rarely content with using tried and tested methods to treat their patients. The opportunity to influence the course of modern medicine by developing new treatments is a prospect which attracts them to specialist centres, where research opportunities are a fundamental part of delivering patient care.

2010 saw the culmination of two years of planning and over £10m investment from the National Institute for Health Research and the Corporate Trustees, with the formal opening of two new state-of-the-art-research facilities for our respiratory and cardiovascular Biomedical Research Units in July and November 2010 respectively. These new facilities host and underpin innovative research in respiratory and cardiovascular medicine and will help to consolidate and build upon our position as a leading clinical cardiothoracic research centre.

❖ Our strategy

Our mission is to be the UK's leading specialist centre for heart and lung disease.

The Trust will achieve this mission by a strategy of focused growth in aspects of heart and lung treatment, such as congenital heart disease, arrhythmia, advanced lung diseases and heart failure.

Our business model can be summarised as:

- Continual development of leading-edge services through clinical refinement and research
- Effective and efficient delivery of core specialist treatment
- Managing the transition of more routine services to other centres to release capacity for new interventions.

Remaining an autonomous, specialist organisation is central to preserving and building on our strong clinical and organisational record.

However, we are equally convinced of the importance of effective partnerships, particularly with major academic bodies, to ensure a continuing pipeline of innovations to develop future treatments.

❖ Our Values

The Trust has three core patient-facing values and four others which support them.

Our three **core** values are:

1. We care

We believe our patients deserve the best possible specialist treatment for their heart and lung condition in a clean and safe place.

2. We respect

We believe that patients should be treated with respect, dignity and courtesy and that they should be well informed and involved in decisions about their care. We always have time to listen.

3. We are inclusive

We believe in making sure our specialist services can be used by everyone who needs them, and we will act on any comments and suggestions which can help us improve the care we offer.

And the following values support us in achieving them:

1. We believe in our staff

We believe our staff should feel valued and proud of their work and know that we will attract and keep the best people by understanding and supporting them.

2. We are responsible

We believe in being open about where our money goes, and in making our hospitals environmentally sustainable.

3. We discover

We believe it is our duty to find and develop new treatments for heart and lung disease, both for today's patients and for future generations.

4. We share our knowledge

We believe in sharing what we know through teaching, so that what we learn can help patients everywhere.

❖ Our position in the healthcare market

A growing market

Heart and lung diseases are the world's biggest killers. Overall, the markets for their treatment are strong and growing, as a result of both increased need and national policy initiatives to meet that need.

Our international role

The Trust does not operate in a single, local health economy. The Trust treats patients referred by the health services in other parts of the United Kingdom as well as treating patients referred from other countries, either though government schemes, or as private patients. Sustained and sustainable growth in patient care, partly as a result of patient choice, has enabled the Trust to absorb the impact of changes in the research and development market, which nonetheless remains an important source of both income and innovation for service development.

A strong reputation

Our strong reputation enables us to maintain and grow our market position, both by developing new interventions and by securing referral patterns through established networks of referring hospitals.

2.2 Overview of performance from 1st April 2010 to 31st March 2011

The period from 1 April 2010 to 31 March 2011 has been the first full year in which the organisation has operated as a Foundation Trust and also the first year in which registration with the Care Quality Commission has been required. During the year, the Trust has achieved all of the governance targets and indicators set out in the Compliance Framework (issued by Monitor) and has been registered by the Care Quality Commission without conditions.

Significant events during the year have included:

- At the start of 2010/11 the Care Quality Commission (CQC) recorded one area of moderate concern in respect of 'safety and suitability of premises'. This related to non compliance with the Firecode. During the early part of the year, the Trust took steps to ensure the delivery of an action plan to achieve full compliance with the requirements of the Firecode. The action plan was completed on 31st July 2010. The CQC has assessed the evidence provided by the Trust and has removed the moderate concern. During the first quarter of the year, the moderate concern had the effect of reducing the Trust Governance from green to amber / green. The Governance rating returned to green for Quarter 2 and remained green through to the year end.

- In April 2011 the Care Quality Commission published the results of the 2010 adult in-patient survey. The survey was based on a sample of in-patients who used Trust services in June 2010. The Trust was in the category of 20% best performing Trusts for 69% of questions.

- During 2010/11 the Trust has achieved all of the Commissioning for Quality and Innovation (CQUIN) measures agreed with commissioners. Pending final confirmation of quarter 4 figures, the Trust will receive payment for the full value of the CQUIN schemes for 2010/11.

The Trust finished 2010/11 with a Governance Rating of Green, and a Financial Risk Rating of 3. A Regulatory Ratings Report of performance against the Compliance Framework targets and indicators is given on page 42 of this document.

Further details of performance are provided in later sections of this report and in the Accounts and the Quality Report appended at Annex 1 and Annex 2.

2.3 Our Services - Review of Operational Activity

Heart Division at Harefield
The Heart Division at Harefield provides tertiary cardiothoracic services including cardiac surgery for ischaemic and structural heart disease, percutaneous coronary intervention including primary angioplasty as a treatment for heart attack, electrophysiological treatment of heart rhythm disturbances, cardiac rehabilitation, specialist cardiothoracic imaging, and treatment of heart failure including heart and lung transplant surgery.

During 2010/11, the primary angioplasty service expanded its boundaries to serve patients from North West London, East of England and South Central strategic health authorities. The time from arriving at the hospital to re opening the artery (the 'door to balloon' time) is amongst the best in the country.

This year has also seen the appointment of a new Director of Transplantation and Mr Andre Simon from the university hospital in Hannover, Germany, has started work to develop the heart and lung transplant service. A second lung transplant physician has been appointed to support the large and growing lung transplant service. Harefield's lung transplant programme is now the biggest in the UK, undertaking approximately 40% of the UK's lung transplants during 2010/11. There has also been investment in new technology – the Organ Care System – to improve heart transplant retrieval.

Other notable achievements of 2010/11 include:

- Refurbishment and relocation of the operating theatres so that they are now all together in one operating suite.
- Commencement of building work on a fourth cardiac catheterisation lab with state of the art equipment for electrophysiology in respect of heart rhythm disturbances.
- Expansion of the Magnetic Resonance Imaging (MRI) service.
- A joint service for acute aortic dissection between Harefield, Royal Brompton and Hammersmith Hospitals has been established
- The Transcatheter Aortic Valve Implantation (TAVI) programme, to augment standard surgical aortic valve replacement, has been expanded.

Heart Division at Royal Brompton
The Heart Division covers Adult Congenital Heart Disease, Heart Failure, Arrhythmias, Revascularisation, Structural heart disease and Heart assessment.

Professor Roxy Senior was appointed as Director of Echocardiography in September 2010. Through Professor Senior's leadership the hospital has already significantly developed the stress echo service and improved recruitment of cardiac ultrasound technicians. Further expansion of the echo research programme and development of an outpatient transoesophageal echo (TOE) service is planned in the next year.

The hospital has recently opened the Cardiovascular Biomedical Research Unit (BRU) in partnership with Imperial College London. This facility offers an MRI scanner, catheter lab and echocardiography suite for research purposes.

Dr Anselm Uebing was appointed as a consultant cardiologist in adult congenital heart disease (ACHD) in September 2010. As well as supporting the ACHD outpatient and day case practice, Dr Uebing is an interventional cardiologist and has been instrumental in

developing the percutaneous pulmonary valve implantation programme with Dr Magee as mentioned above.

Apprentices working in the RBH Heart division have won the London NHS Apprenticeship team of the year award. The six apprentices joined the Trust last July on a one year business administration apprenticeship programme, supporting cardiology and cardiac surgery teams within Royal Brompton's Heart Division. The apprentices make up one of only three teams to have been short listed for the award from the many nominations received from NHS organisations across the London region.

Critical care

The Hospital opened its new High dependency unit in July 2010. The unit consolidated four separate, smaller units into a single 14 bedded service on Elizabeth ward, which can expand up to 26 beds if required. The unit is lead by Dr Phil Marino and Sister Mary Madigan and has a dedicated nursing and medical team, caring for patients from both heart and lung divisions.

Once again our critical care service rose to the challenge when the UK suffered another flu surge in December 2010. The Royal Brompton activated its ECMO service as one of five designated services nationwide. ECMO uses an artificial lung to oxygenate the blood outside the body, preventing further damage while the lungs recover. During this flu season, patients were admitted over a much more intensive period compared to 2009, with a greater acuity of illness particularly amongst new mothers and pregnant women.

Children's Services

Dr Alan Magee has commenced a percutaneous pulmonary valve implantation programme for children and adults with congenital heart disease from January 2011 in collaboration with Dr Anselm Uebing. This procedure, which is undertaken in the cardiac catheter laboratory, aims to prevent right ventricular failure and arrhythmias without the need for surgery.

The children's services team have had a number of high profile visitors to the unit in the last year. Dr Peter Weinstock, director of the most respected medical simulation programme in the world, spent a day in July with Royal Brompton's paediatric resuscitation team, also known as SPRinT. Dr Weinstock leads the simulation programme at the Children's Hospital Boston in the US and is also assistant professor of anaesthesia at Harvard Medical School.

In January 2011, Health Minister, Lord Howe, visited Royal Brompton to see firsthand the pioneering work of the Long-Term Ventilation (LTV) team, who have developed a programme that enables children to get home more quickly. Developed by paediatric intensive care consultant Dr Gillian Halley, the award-winning programme supports decision making and improves communication between hospital and community services.

One of the major challenges that faced the Trust during 2010/11 was the threat to our Children's Services posed by the review of children's congenital heart services undertaken on behalf of the Joint Committee of Primary Care Trusts (JCPCT). This review has the objective of reducing the number of centres commissioned to undertake children's congenital heart surgery from the current 11, to around 6 or 7 nationally designated centres. The Trust has sought a judicial review of the JCPCT's consultation process and the business case underpinning it. At the time of writing the outcome of this review is awaited. Whatever the outcome, however, there should be no significant impact on the Trust's funding arrangements prior to 1 April 2013.

Lung division

The lung division provides tertiary services for a wide range of complex respiratory conditions, and delivers cancer services and lung imaging within the trust. Achievements for 2010/2011 are presented by clinical care group:

Lung Imaging

- Impressive reductions in reporting times, moving from 15 days to 4.5 hrs in radiology, and 5 days to 1.26 hrs in CT scanning
- Royal Brompton Hospital has been chosen as the central reading site for the prestigious UK National Lung Cancer CT screening Pilot Trial which will commence in the summer of 2011

Asthma and Allergy

- The allergy service provides dedicated day-case testing for both food and drug allergies on the Lind day unit. Approximately 200 tests are now carried out every year.
- A dedicated clinic for adults with adverse food reactions with allergic symptoms has been introduced. This is run as a joint dietetic and medical service, accessed as part of the Asthma and Allergy portfolio.
- The team has been awarded 4 years of funding for a large, single-centre study comparing sublingual and subcutaneous immunotherapy for hay fever, which will run on Lind ward and in the Biomedical Research Unit

Lung Infection and Immunity

- The appointment of Dr Nicholas Simmonds in cystic fibrosis has brought additional expertise which has enhanced capability in the diagnosis of cystic fibrosis and lung infection.
- Dr Michael Loebinger's appointment allows the trust to work closely with Chelsea & Westminster hospital in the delivery of tuberculosis services.
- Introduction of a subcutaneous immunoglobulin service which allows many of our patient who previously required an admission to Lind ward to be treated in their own homes.
- A quality improvement program saw collaboration between the Interstitial Lung Disease team and the outpatient staff. It has streamlined Outpatient services, providing a better experience for patients, and created capacity to support service growth.
- Professor Wells was a keynote speaker at the ATS (American Thoracic Society) this year

Cancer services

- The appointment of Dr Alison Leary as the Lead Cancer nurse has been key to strengthing cancer services across the trust
- Lung Laser has now been used in over 50 cases by Mr. George Ladas, predominately for metastatic disease of the lung
- Minimally invasive lung resection techniques have been established within the service
- The department won the Thoracic Medal for best research presentation at the Society of Cardiothoracic Surgeons Annual Meeting 2010 (for the third consecutive year)
- The Trust became the first UK surgical site to participate in a clinical trial of a new lung cancer vaccine.
- Awarded a grant from Point Hope Investment Company for a PhD Scholarship to undertake basic science research in lung cancer

Lung failure

- The Pulmonary Rehabilitation service at Harefield is now managed by Dr Will Man. With his leadership, integration with primary and community care has grown and referrals have increased from 4 to 23 per month: the service is now the largest single site programme in the UK
- We have been part of a pan-London collaboration which has demonstrated that a simple quality of life score can capture improvements in health status associated with pulmonary rehabilitation in chronic obstructive pulmonary disease.
- Patients with chronic obstructive pulmonary disease reported that a programme of singing classes improved their confidence and anxiety levels.
- A streamlined smart card CPAP (continuous positive airway pressure) service has reduced the need for patients to visit the hospital and improved the accuracy of follow-up, thus reducing costs and improving convenience for patients
- Research funded by the National Institute for Health Research into Pandemic Flu led to publication of findings associated with droplet distribution during non-invasive ventilation, oxygen therapy and physiotherapy. This research will inform future Department of Health guidelines
- The "Darzi fellow" working with the Lung Failure group has developed training and competency tools in non-invasive ventilation and tracheostomy care. This will now be developed into simulation training available for staff within and outside of the organisation.

Pharmacy

During 2010/11 the Pharmacy Department at the Royal Brompton Hospital was assessed by the Medicines and Healthcare products Regulatory Agency (MHRA) and was successful in maintaining its MHRA Pharmaceuticals Wholesaler Dealers Licence. The Pharmacy Department was also successful in securing reaccreditation for the Investors in People Award, which recognises the commitment of the pharmacy team to staff support and development.

The Pharmacy team have continued to work with the Royal Marsden Hospital NHS Foundation Trust on a joint project to build a new pharmaceutical aseptic services unit to serve both Trusts – the project plan will deliver a new unit in spring 2012.

Medicines safety has been enhanced during 2010/11 through the formation of a new pharmacy clinical governance working group. This group reviews incidents, both within the department and in clinical areas, including near misses to ensure that lessons are learnt and appropriate systems are in place to minimise risk. The medicines information team has also sought to improve medicines safety through increased awareness of the medicines helpline service, and also through re-design of the helpline cards. During the last year, the medicines information service has received official recognition as the specialist information service for cardiothoracic medicine for the UK and handles enquiries on heart and lung treatment from other hospitals across the country

The pharmacy team has led the re-design and roll out of a new in patient medicines chart Trust wide. The new medicines chart incorporates oral and intravenous medicines administration into one chart and facilitates compliance with a number of NPSA standards.

2010/11 has also seen the full implementation of the Trust wide electronic e-discharge system incorporating electronic prescribing. The system ensures that patients and general practitioners receive clear and timely clinical information following discharge to ensure appropriate ongoing care.

Rehabilitation and Therapies (R&T)
Rehabilitation & Therapies is a multi-professional cross-site clinical support Directorate which contributes to the Trust's strong multi-disciplinary emphasis on patient care. The directorate includes therapy services (Physiotherapy, Occupational Therapy, Speech & Language Therapy, Nutrition & Dietetics) and psycho-social support services (Adult Psychology & Psychiatry, Social Work & Welfare Rights, Chaplaincy, Palliative Care).

Highlights for psycho-social services include the appointment of a Trust Lead for Older people and Complex Discharge based on the Brompton site to support the co-ordination of timely discharge and raise awareness of issues related to the care of older people. The post holder will work closely with the senior social worker at Harefield who has taken on the role of Trust lead for Safeguarding Vulnerable Adults. The Palliative Care team at Harefield organised a highly successful one day Palliative care and heart failure conference. The Brompton/Marsden team have made a successful bid for funding from Marie Curie to develop a hospital to home palliative care nursing service which will commence in April 2011. The Chaplaincy services have raised attracted many new volunteers on both sites, to develop patient services including the establishment of meditation sessions for staff and patients. To further improve patient and relative support on the Brompton site, a new part-time chaplaincy post has commenced, in collaboration with a local church. The lead Chaplain on the Brompton site was invited to preach at St Paul's cathedral.

Highlights for the Therapy services has been the hugely successful development of Physiotherapy outpatient services on both sites, enabling many more patients to access the respiratory physiotherapy they need. The Nutrition and Dietetic department have ensured that the Trust continues to be a national leader in patient nutritional support by auditing the MUST nutritional assessment tool, used to screen all patients for malnutrition. The paediatric dietitians led the Trusts involvement in the Paediatric International Nutrition Study 2010: Over 29 centres from 12 countries (524 patients) participated in this unique collaborative study, to examine bedside nutrition practice in children requiring mechanical ventilation longer than 3 days. The results show the Trust nutritional practice for these patients is outstanding.

Clinical Engineering
The Clinical Engineering services include equipment management, clinical and technical support services, R&D support, and support of the ICIP bedside clinical information system.

The department oversees the medical equipment capital programme that this year included major renewals of ultrasound equipment and patient monitoring for both hospitals, and imaging equipment at Harefield. During the period, the Harefield team have introduced new services supporting ICIP and the ITU ventilator fleet.

The ICIP system has been successfully deployed in Harefield ITU and now extends to 85 critical care beds.

Heart Valve Bank
The Heart Valve Bank continues to supply the Trust and other hospitals both in the United Kingdom and abroad with heart valves taken mostly at the time of multi-organ retrieval. The trend of more requests being received for pulmonary valves for use in paediatric congenital surgery has continued throughout the year.

In October 2010, the department hosted the biennial inspection by the Human Tissue Authority and has maintained its accreditation.

Laboratory Medicine
Laboratory Medicine provides a range of laboratory services across both sites and supports clinical activity in the bed-holding divisions.

This year has seen some key advances in the mass spectrometry service at Harefield including the development of novel mass spectrometry assay for the therapeutic drug monitoring of Milrinone and antifungal drugs to optimise treatment. Additionally, a mass spectrometry service for measuring Vitamin D metabolites has been introduced.

A cross-site Service Manager has been appointed in microbiology and has carried out a detailed review of the service on both RBH and HH sites.

The PCR (polymerase chain reaction) service commissioned last year in microbiology to improve the detection of respiratory viruses is now fully established at RBH and provides a faster service across both sites.

Quality Improvement
During the period the following improvements were delivered:

- The Delivering Quality Review was implemented during 2010/11 and it saw the creation of quality & safety divisional posts. These posts are providing improvement, risk and audit support to the divisions and providing liaison between the central quality and safety team. The divisional focus of these roles are enabling local action plans to be delivered and are providing support for implementation of quality and safety issues /improvements

- The Productive Operating Theatre (TPOT) programme has been launched at both sites and has also been adapted for use in the Catheter Labs (TCUP). Both projects are reaching the final stages of their foundation modules and are setting plans in place for the next phase of work. The projects have begun to:
    - deliver cost savings on stock and consumables, which will continue into 2011/12
    - improve communication between the wards and catheter labs with electronic systems being implemented during 2011/12
    - identify measures to track the improvements from this project
    - Improve start times in catheter labs at RBH
    - Improve team-working and communication in both theatres and catheter labs

  Considerable progress on this project is expected during 2011/12.

- Adaptations of the NHS Institute's Productive Series have been launched at Harefield, with work beginning on The Productive Imaging and Cardiology (TPIC) and Productive Outpatients Department (TPOD)

- The delivering single sex accommodation project has delivered further small reductions in the number of patients reporting sharing sleeping accommodation and bathroom facilities and wards are now factoring in single sex accommodation in their daily decision making

- The length of stay project comprises several programmes of interventions to reduce length of stay by identifying bottlenecks and inefficiency. The interventions include redesigning the ECHO booking system to release more capacity and triage referrals and introducing more pre-admission clinics so that patients are better prepared for their procedure and less likely to be cancelled for medical reasons.

- The integrated care pathway (ICP) programme integrates all clinical notes into one record so that all members of the multidisciplinary team can view each others' comments. The pathway incorporates national and local guidelines and standards and moves with the patient between departments to improve coordination and communication between professionals. ICPs do not remove the need for sound clinical judgement or restrict practitioners from changing the agreed pathway if there are sound reasons to do so. However, standardising the layout of the clinical records assists coding and audit as specific information can be found in the same place in each pathway. The teams involved in developing the ICPs are also required to set specific outcomes or parameters for care. The individual pathways are regularly audited to monitor compliance with guidelines, identify sub optimal outcomes, and provide a mechanism to drive ongoing improvement in terms of both quality and efficiency.

Estates & Facilities

Estates

Given the age of much of the Trust's accommodation, the key focus has been to reduce estates and maintenance risks to the Trust's safe and efficient operation. This has covered the key areas of responsibility including water management, electrical management, fire prevention, medical gases, asbestos, lifts and pressure systems. The investment plan reflected these findings and funding of £2.3m was made available, resulting in improvements in standards in each of the key areas, although further essential works are still necessary and are being planned.

Facilities

Accommodation, Catering, Cleaning, Linen & Laundry, Portering, Security and Transport services are provided by a mix of in-house and external contract providers. During the last year several service contracts were reviewed. As a result, a new domestic waste contract has been introduced, greatly increasing the Trust's waste recycling performance. In addition new contracts for Non-Emergency Patient Transport, Taxi and Courier services have also been negotiated to ensure best value. The Trust is now engaged in a market testing exercise for a new Domestic Cleaning, Linen Services and Pest Control contract from 2011 onwards with neighbouring Trusts in order to secure increased benefits.

A notable success has been the annual PEAT assessment in February 2011 in which the Trust maintained a rating of 'good' for environment and two ratings of 'excellent' for food and privacy & dignity.

Information Services

During 2010-11 the Trust continued its commitment to investing in information technology (IT) and telecommunications.

The main aim of the Trust's IT strategy continues to be to integrate services between the two hospital sites and, by 2014, to offer such a wide range of computer-based systems that a near paperless environment is possible.

Central to this is the Electronic Patient Record System which now incorporates all x-ray, MRI and CT images.

In the past two years the Trust-wide theatre management system has been consolidated and a new order communications system has been introduced. This allows clinical staff to place diagnostic orders electronically, as well as ensuring that all of our inpatients and outpatients take an electronic 'bar-code' wrist-band to secure patient identification.

Roll-out of an electronic staff rostering system was completed on both sites, cutting down on data duplication and errors. The Trust has also successfully designed and rolled out a new corporate Discharge Summary System which has embedded within it the full drugs list prescribed. This is the Trusts first step to implementing Electronic Prescribing.

Improving patient identification and safety continued to progress this year, with the Wrist Band bar-coding of patient's, which links directly to the bar coding of our inpatient and outpatient diagnostic samples, ensuring a safer environment for our patients. All this is achieved by using the Trusts corporate implementation of the wireless data network. This network allows for a huge range of new 'mobile' services to be deployed and the use of hand held devices (i.e. Blackberry's/ IPhones/ Netbooks etc) is standard procedure to support clinical care. Using this network we have also offered our patients and their relatives broadband access for them to use their own personal Lap Tops. We feel that this can enhance the quality of their experience during their in-patient stay with us.

The Trust implemented a new Infection Control system in year which offers much closer monitoring of infections and assists further the Trusts excellent record in keeping serious infections to an absolute minimum.

Finally, a Voice Recognition system which allows for faster access for callers was successfully implemented, reducing the need for operator intervention on routine calls. The Trust is also securing more robust, resilient and cost effective voice services, by linking the computer and telephone systems together so they can commonly use the same cabling. As such the Trust is moving firmly into the arena of Unified Communications.

2.4 Our performance

Patient admissions
A total of 29,146 patients were admitted to the Trust between 1st April 2010 and 31st March 2011. Of these, 23,307 were elective (planned) admissions and 5,839 were emergency admissions.

Outpatient clinics
The number of patients seen in outpatient clinics was 137,239. Of this 13,133 had new appointments and 124,106 had follow-up appointments.

Cancelled operations
The percentage of cancelled operations was 1.05 per cent, against a target of 0.8 per cent. There were no breaches of the 28 day readmission standard.

Cancer patients
The waiting time target for patients referred by their GP with a suspicion of cancer is 14 days (two weeks). There were no breaches of this standard. The waiting time target for patients who have been diagnosed with cancer is 31 days (one month) between the decision to treat and the start of their first treatment. There was one breach of this standard. The waiting time target for patients urgently referred by their GP for suspected cancer is 62 days (two months) from referral to treatment. This includes time spent waiting or having diagnostic tests at other hospitals before being referred to the Trust. During the period 1st April 2010 – 31st March 2011, there were fourteen breaches of the 62 day GP referral to treatment target. This resulted in a performance metric of 86.3% for this national priority indicator which is within the tolerance for achievement of this indicator.

The 18 week wait
The 18 week wait is the definitive target against which NHS waiting times are measured. With this target there is a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary. Tolerances have been set to allow for patient choice, patients not attending appointments and clinical complexity.

The operational standards of delivery for the NHS are:

- 90 per cent of pathways where patients are admitted for hospital treatment should be completed within 18 weeks
- 95 per cent of pathways that do not end in an admission should be completed within 18 weeks.

The 18 week standard for both admitted and non-admitted was met and exceeded in all months between 1st April 2010 and 31st March 2011. The Trust also met the data completeness standard.

Following the change of government in May 2010, the following operational standards of delivery were added to the requirements:

- Admitted median wait should not exceed 11.1 weeks
- Non-Admitted median wait should not exceed 6.6 weeks
- Incomplete pathway median wait should not exceed 7.2 weeks
- Admitted 95th percentile wait should not exceed 23.3 weeks
- Non-Admitted 95th percentile wait should not exceed 18.3 weeks

The Trust is currently achieving all of the new targets, apart from that relating to the non-admitted median wait. The median waiting time in March 2011 was 6.7 weeks, which is slightly above the nationally set threshold of 6.6 weeks. The Trust is working with commissioners to ensure that performance is optimised.

Please note that further detail of performance during 2010/11 is given in the Quality Report, Annex 2 of this document.

Control of pay costs - Mutually Agreed Resignation Scheme (MARS)
During 2010/11 the Trust introduced a MARS scheme in order to achieve a step change reduction in pay expenditure.

MARS is a voluntary resignation scheme under which an individual employee, in agreement with the Trust, chooses to leave employment in return for a severance payment. The scheme was designed by the NHS to help organisations respond to periods of change or service re-design.

As a Foundation Trust we were able to run a local MARS initiative using similar terms and conditions to an earlier national scheme. Employees were invited to apply for MARS in February 2011. Each application was considered by a panel, taking account of the financial and operational interests of the organisation.

Severance payments were fixed at half a month's salary for each full year of reckonable NHS service up to a maximum of 12 months salary, with a minimum payment of 3 months salary.

The Trust received 82 applications for the scheme of which 42 were accepted. The termination dates were mutually agreed between those 42 employees and the Trust and ranged from March until June 2011. The employees were each issued with a compromise agreement to sign which set out the terms under which the employment would end.

Board of Directors
The Board of Directors bring a wide range of experience to the Trust and during 2010/11 have continued to ensure effective governance of the organisation.

During 2010/11 the Executive Directors have comprised:
Chief Executive, Robert J Bell; Medical Director & Deputy Chief Executive, Professor Timothy Evans; Director of Finance & Performance, Mark Lambert [covered by Richard Paterson as Interim Director of Finance from January – March 2011], Chief Operating Officer, Robert Craig and Director of Nursing & Governance, Caroline Shuldham.

During 2010/11 the Non-Executive Directors have comprised:
Chairman, Sir Robert Finch, and Non-Executive Directors: Jenny Hill (Senior Independent Director), Neil Lerner, Nicholas Coleman, Richard Hunting, Professor Sir Anthony Newman-Taylor, Christina Croft (to Oct 2010) and Kate Owen (from October 2010).

Further details of board members are provided in Annex 3 of this Annual Report.

Directors' Statement
So far as the directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware. The directors have taken all steps that they ought to have taken, as directors, in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

R. Bell

Robert J Bell
Chief Executive
On behalf of the Board of Directors

Date May 31, 2011

2.5 Our Financial Performance

Interim Director of Finance Commentary on the Accounts for 2010/11

The Trust reports on its first full year of activities following its authorisation as a Foundation Trust on 1 June 2009. The Trust has reported a retained surplus of £4.7m (£3.6m for 10 months to 31 March 2010).

Comparative figures in the accounts relate to the 10 month period 1 June 2009 to 31 March 2010.

The accounts reflect a revaluation surplus of £4.028m (2009/10 - £2.305m) in relation to the Trust's investment property portfolio; this uplift is included within the retained surplus for the year.

The accounts also reflect costs of £0.9m (2009/10 - £nil) in relation to a Mutually Agreed Resignation Scheme ('MARS') launched in February 2011 as a result of which some 42 employees have left or are leaving the Trust.

International Financial Reporting Standards (IFRS)

The accounts have been prepared in accordance with the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by Monitor, the independent regulator of NHS Foundation Trusts. The accounting policies in the Manual follow IFRS 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.

Going Concern

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

Comprehensive Income

The Trust reports a comprehensive income surplus of £1.0m for the year, the retained surplus (£4.7m) being reduced by fixed asset impairment (£5.9m) and increased by receipts of donated assets in the year, net of transfers (£2.2m).

Financial Position and Liquidity

Fixed assets increased over the year by £8.7m, including the investment property revaluation of £4.0m, net of depreciation charged of £15.1m. Fixed asset additions totalled £25.6m, £5.0m of which was funded by grants received.

Net current assets reduced over the year by £7.9m. Provision has been made for a restructuring of the Trust which commenced in the financial year although most of the related outlays were scheduled after 31 March 2011.

The Trust has faced some pressure on its cash position during the year, which on two separate occasions has required £5m, of the available £18m, working capital facility to be drawn down.

2011/12 and Beyond

With no sign of an early economic upturn, in conjunction with central government plans for the NHS, the Trust will continue to face financial challenges. In particular, the NHS pricing structure for 2011/12 will place pressure on Trust income. In addition, it is expected that the transitional funding from which the Trust has benefited in recent years will no longer be available.

Financial Risk

	Target	Actual for Year
Dividend Cover	>1	4.0x
Interest Cover	>3	453.6x
Debt Service Cover	>2	71.3x
Maximum Debt Service to Revenue (%)	<2.5%	0.1%

3. Trust Governance

3.1 Introduction

The Trust was authorised as a foundation trust on 1st June 2009. The foundation trust is a public benefit corporation.

The powers of the Trust are set out in the National Health Service Act 2006. The Trust governance arrangements are enshrined in the Royal Brompton & Harefield NHS Foundation Trust Constitution. This makes provision for the Trust to be supported by a membership drawn from 3 constituencies, a public constituency, a staff constituency and a patient constituency. The Constitution also makes provision for a Governors' Council comprising both elected and appointed parties. The elected parties are drawn from the membership and the appointed parties represent key stakeholders with whom the Trust is engaged.

The governance structures of the Trust comprise:

The Board of Governors, one of whose sub-Committees, the "Nominations Committee" conducts the selection of the Chairman and Non Executive Directors.

Operational management of the foundation trust is conferred upon the Trust Board of Directors. In turn, the Board has established three Board Sub-committees to facilitate its direction and monitoring role: the Audit Committee, The Risk & Safety Committee and the Remuneration Committee. These committees enable the Board to discharge its responsibilities with regard to management of the risk and control environment within which the Trust operates, and to oversee levels of senior managers' pay and conditions.

The Board Committees' membership exclusively comprises Non-Executive Directors, although Executive Directors also participate.

Non-Executive Directors are appointed to provide an independent perspective on, and challenge to, the discharge of the responsibilities of the Accounting Officer, who has delegated certain of his powers and functions to his colleague Executive Directors.

Detailed disclosures regarding the Board of Governors, the Board of Directors and each of the committees are set out in the next section of this document.

3.2 Committee Disclosures

Council of Governors and sub-Committees

The role of the Governors' Council is to appoint or remove the Chairman and other Non Executive Directors of the Trust; to approve the appointment of the Chief Executive and to decide the remuneration and expenses and other terms and conditions of the Non Executive Directors The Governors' Council should receive and consider the Trust annual accounts, any auditor's reports on those annual accounts and the annual report from the Board of Directors. The Governor's Council provides views to the Board of Directors in respect of forward plans The Governor's Council is consulted by the Board of Directors in relation to strategic matters affecting the Trust and should also approve and review the membership strategy.

The Governor's Council has met four times. Details of attendance, including that of Board members, are given in the table on page 23.

Nominations Committee

The Nominations Committee of the Governors' Council was convened on 2 occasions during 2010/11 (5th and 19th July 2010) in order to consider the appointment of 2 Non Executive Directors to replace those whose term of office had run its course. Members of the Committee included.

- Mr Ray Puddifoot
- Mr Philip Dodd
- Dr Adrian Lepper

An external search consultancy, Saxton Bampfylde, was engaged to advertise the posts and to ensure a high quality field of candidates was identified. The Nominations Committee decided to appoint Ms Kate Owen as a result of this process and to reappoint Mrs Jenny Hill. This decision was ratified by the Governors' Council at its Annual General Meeting held on 6th October 2010.

The Governor's Council

Name	Date of Appointment / Election	Term of Appointment	Constituency	Attendance Record Council of Governors
Governors				
Mr Philip Dodd	1.6.09	3 years	public	4/4
Mr Kenneth Appel	1.6.09	3 years	public	4/4
Mrs Caroline Greenhalgh	1.12.10	3 years	public	2/4
Mr Brian Waylett	1.12.10	3 years	patient	4/4
Mr Ralph Gartenberg	1.6.09	18 months	patient	2/3
Mr Peter Rust	1.6.09	3 years	patient	3/4
Mr Anthony Connerty	1.6.09	3 years	patient	2/4
Mr Irving Shaw	1.6.09	18 months	patient	0/3
Mr Richard Baker	1.7.09	3 years	patient	3/4
Mrs Mary-Anne Parsons	1.6.09	3 years	patient	2/4
Dr Adrian Lepper	1.6.09	3 years	patient -carer	2/4
Mr Peter Kircher	1.12.10	3 years	patient	1/1
Mrs Sheila Cook	1.12.10	3 years	patient	2/2
Dr Ian Balfour-Lynn	1.6.09	3 years	staff	2/4
Professor Margaret Hodson	1.6.09	3 years	staff	3/4
Ms Sue Callaghan	1.6.09	3 years	staff	4/4
Dr Olga Jones	1.12.10	3 years	staff	3/4
Mr Robert Parker	1.12.10	3 years	staff	4/4
Councillor Mrs Victoria Borwick	1.6.09	3 years	L.B. Kensington & Chelsea	0/4
Mr Ray Puddifoot	1.6.09	3 years	L.B. of Hillingdon	2/4
Mrs Allison Seidlar	1.11.09	3 years	NHS Hillingdon	4/4
Professor Michael Schneider	1.6.09	3 years	Imperial College, London	2/4
Professor Peter Rigby	1.6.09	3 years	University of London	1/4
Other Attendees including **Board Members:**				
Chairman				4/4
Chief Executive				4/4
Medical Director				2/4
Director of Finance & Performance				3/4
Director of Nursing & Governance				3/4
Chief Operating Officer				1/4
Interim Director of Finance (17.1.11)				1/1
Trust Secretary				4/4
NED: R Hunting				3/4
NED: J Hill				4/4
NED: C Croft				2/3
NED: N Coleman				3/4
NED N Lerner				2/4
NED: A Newman Taylor				0/4
NED K Owen				1/1

Governors' Interests

PUBLIC CONSTITUENCY 1: North West London	
DODD, Philip Joseph	Member, Harefield Hospital ReBeat Club Company Director: City Airport Rail Enterprises (Holdings) Ltd City Airport Rail Enterprises plc Woolwich Arsenal Rail Enterprises (Holdings) Ltd Woolwich Arsenal Rail Enterprises Ltd Health Management (Carlisle) Holdings Ltd Health Management (Carlisle) Ltd InspirED Education (South Lanarkshire) Holdings Ltd InspirED Education (South Lanarkshire) plc Wastewater Management Holdings Ltd Ayr Environmental Services Ltd InspirED Education (East Dunbartonshire) Holdings Ltd InspirED Education (East Dunbartonshire) Ltd Alternate Director. The Newcastle Estate Partnership Ltd Newcastle Estate Partnership Holdings Ltd Wastewater Management Holdings Ltd Ayr Environmental Services Ltd
PUBLIC CONSTITUENCY 2: Bedfordshire & Hertfordshire	
APPEL, Kenneth	Member: Harefield Hospital ReBeat Club Treasurer: Hertfordshire Local Optometric Committee NICE, Assessor, Advisory Committee of Clinical Excellence Awards Member; NW London Cardiac Network Patient Helpline Adviser: Patients Assoc, Northwick Park Hospital Member: Hertfordshire PSU Committee Member of Executive Board. Hertfordshire LINK

PUBLIC CONSTITUENCY 3: South of England	
GREENHALGH, Caroline	Owner: Consultancy researching issues relating to disability (main client: Leonard Cheshire Disability) Director: Equity Advisers Ltd Member – Asthma UK Member – London Committee of Human Rights Watch Member – The Conservative Party
PUBLIC CONSTITUENCY 4: Rest of England & Wales	
VACANT	

PATIENT CONSTITUENCY: North West London	
GARTENBERG, Ralph	Member, Harefield Hospital ReBeat Club
WAYLETT, Brian Peter	None
RUST, Peter John	Member, Harefield Hospital ReBeat Club
PATIENT CONSTITUENCY: Beds & Herts	
SHAW, Irving	None
CONNERTY, Anthony	Member, Harefield Hospital ReBeat Club
KIRCHER, Peter	Member, Harefield Hospital ReBeat Club Chairman, Kings Langley and District guides HQ
PATIENT CONSTITUENCY: South of England	
BAKER, Richard	None
PATIENT CONSTITUENCY: Elsewhere	
COOK, Sheila	Member, The Conservative Party
PARSONS, Mary-Anne	None
PATIENT CONSTITUENCY: Carers	
LEPPER, Adrian Murray	Company Secretary and Director – Chiltern Society (vol.) Member – Hertfordshire LINK (vol) Company Secretary and Director Chilterns Woodland Project Ltd. (vol). Member - Department of Health Gene Therapy Advisory Committee. (paid/fee).

STAFF CONSTITUENCY	
BALFOUR-LYNN, Ian	Cystic Fibrosis Trust Service Standards & Accreditation Group 2000 Vice President: BPRS 2007 Member specialty Board RCPCH 2007 Member BTS Specialist Advisory Group on Cystic Fibrosis 2008 Member BTS Specialist Advisory Group on Home Oxygen 2008 Member CF Trust Medical Advisory Committee 2009
HODSON, Margaret Ellen	None
CALLAGHAN, Sue	Member RCN (Royal College of Nursing) Respiratory Advisory Group Member British Thoracic Society (BTS) Nursing Member
JONES, Olga	None
PARKER, Robert	None

APPOINTED:	
BORWICK, Victoria (Royal Borough of Kensington & Chelsea)	Councillor, Royal Borough of Kensington & Chelsea Assembly Member, Greater London Authority Metropolitan Police Authority – Member London Crimestoppers Board - appointee Founder and Trustee, Edwin Borwick Charitable Trust Director: Poore Ltd, Second Poore Ltd Member, The Conservative Party, The Conservative Councillors Association
(NHS Kensington & Chelsea)	**VACANT**
PUDDIFOOT, Ray (London Borough of Hillingdon)	Leader, London Borough of Hillingdon Chief Executive, Magdi Yacoub Institute (health research charity) Member, the Conservative Party, The Conservative Councillors Association Member, Leaders Committee London councils Member, London Congress Hon. Member, Harefield Transplant Club
SEIDLAR, Allison NHS Hillingdon	None
Professor Michael D Schneider Imperial College London	Head of Cardiothoracic Science, Imperial College London Member, MRC Council Research Director, Cardiovascular and Renal Clinical Practice Group (CPG4), Imperial College Healthcare NHS Trust Founder and Scientific Board Member, Kardia Therapeutics Consultant, Cardio3 Biosciences
Prof Peter Rigby University of London	Deputy Chairman, The Wellcome Trust Member of Council, Marie Curie Cancer Care

Trust Board and Sub-Committees

Details of Operation

Between 1 April 2010 and 31 March 2011, the Trust Board convened on 8 occasions.

Composition and Committee Duties

Name	Roles	Attendance Record			
		Trust Board	Audit Committee	Risk & Safety Committee	Remuneration Committee
Sir Robert Finch	Chairman; Chair of Remuneration Committee	7/8			2/2
Robert Bell	Chief Executive	8/8			
Executive Directors					
Mark Lambert	Director of Finance and Performance	4/8			
Robert Craig	Chief Operating Officer	8/8			
Caroline Shuldham	Director of Nursing and Governance	8/8			
Prof Tim Evans	Medical Director; Deputy Chief Executive	7/8			
Richard Paterson Joined 7/1/11	Interim Director of Finance	2/8			
Non-Executive Directors					
Jenny Hill	Remuneration Committee; Audit Committee, Risk & Safety Committee	8/8	3/5	4/4	2/2
Prof Sir A Newman Taylor	Remuneration Committee; Risk & Safety Committee	7/8		4/4	1/1
Christina Croft Left Trust 6.10.10	Remuneration Committee; Audit & Risk Committee	4/8	3/5	1/5	1/1
Nick Coleman	Remuneration Committee; Audit Committee Chair of Risk & Safety Committee	8/8	5/5	4/4	1/1

Composition and Committee Duties - Continued

Richard Hunting	Remuneration Committee; Audit Committee Risk & Safety Committee	8/8	5/5	3/4	2/2
Neil Lerner	Remuneration Committee, Chair of Audit Committee, Risk & Safety Committee	7/8	5/5	4/4	1/1
Kate Owen New appointee 6.10.10	Remuneration & Appointments Committee, Audit Committee	4/8	0/5		1/2
Other Attendees					
David Stark Left Trust 30.4.10	Trust Secretary	1/8			
Richard Connett 19 5.10	Trust Secretary & Head of Performance	7/8			

Note - The Chief Executive and the Executive Directors, although attendees at Board Committee meetings, are not formally members of those Committees.

Directors' Interests

The Trust has an obligation under the Codes of Conduct and Accountability for NHS Boards to compile and maintain a register of directors, which might influence their role. The register is available to the public, in accordance with the Freedom of Information Act, through written application to the Trust's Chief Executive. The Trust is also required to publish in the report for the accounting period the directorships of any member of the board in companies that are likely to, or seek to, conduct business with the NHS. In this context declarations of the directors of Royal Brompton & Harefield NHS Trust are as follows:

Chairman

Sir Robert Finch
- Nominated Member, Council of Lloyds of London
- Director, F F & P Russia Ltd (and associated companies)
- Director & Chairman, Aviva Mall Fund
- Governor, College of Law
- Trustee, St Paul's Cathedral Foundation
- Chairman, LSO St Luke's
- Trustee, LSO Endowment Trust
- Trustee, Chichester Harbour Trust
- Alderman, Ward of Coleman Street City of London and as such
  - (i) Member, City Lands
  - (ii) Trustee, Samuel Wilson Loan Trust
  - (iii) President, Coleman Street Ward Club
- Hon Colonel, Inns of Court City, Yeomanry
- Vice President, King Edward's School, Witley
- Governor, Christ's Hospital
- Committee Member, St Paul's School Development Committee DL, City of London
- Magistrate, City of London Bench (non active)
- Trustee, NHLI Foundation

Non-Executive Directors

Mr Nick Coleman
- Consultant, Risk Reputation Consultants Ltd
- Trustee of the Friends of Richmond Park (Charity)

Ms Kate Owen
- Governor, Imperial College
- Non-Executive Director, BIOSS International
- Fellow, Windsor Leadership Trust (Charity)

Mr Neil Lerner
Royal National Lifeboat Institution (RNLI),
- Finance & Investment Committee
- Governor, School of Oriental and African Studies

Non-Executive Directors

Mrs Jennifer Hill
- Consulting Director, Echelon Ltd

Mrs Christina Croft
Non-Executive Director, Juvenile Diabetes Research Foundation

Mr Richard Hunting
- Chairman, Hunting Plc
- Chairman, CORDA, preventing heart disease and stroke

Professor Sir Anthony Newman Taylor
- Principal, Faculty of Medicine, Imperial College
- Director CORDA, preventing heart disease & stroke
- Chairman, Colt Foundation
- Member, Medical Honours Committee
- Trustee, Rayne Foundation
- Member, Bevan Commission
- Member, Independent Scrutiny Group, Armed Forces Compensation Scheme (AFCS) Review , MOD
- Chairman, BOHRF Research Committee
- Chairman Independent Medical Expert Group of the Armed Forces Compensation Scheme (AFCS), MOD

Executive Directors

Mr Robert J Bell
- Board Member, CORDA, preventing heart disease Stroke
- Board Member, NHS Innovations, London

Professor Timothy Evans
- Academic Vice President, Royal College of Physicians
- Advisor, Grant Reviewer and Advisory Board Member for multiple organisations

Mr Mark Lambert
- Deputy Chairman, London Audit Consortium

Mr Robert Craig
- Trustee, QAL Advanced Cardiovascular Network (UK Charity)

Dr Caroline Shuldham
- Tour Leader, Master Travel Ltd
- Trustee of the Foundation of Nursing Studies

Directors' Resumes

Chairman

Sir Robert Finch was appointed by the Appointments Commission as the Trust's chair for a term of three years, effective from 1 January 2009. Sir Robert brings significant board experience to the Trust, both in the business and not-for-profit sectors. He has a legal background, having qualified as a solicitor in 1969. He spent his career at the City law firm Linklaters, latterly as a head of real estate. He is a former Lord Mayor of London and has been a member of a number of City Corporation committees. In 2005 Sir Robert joined the board of Liberty International plc, a FTSE 100 London-based property company, becoming Chairman in mid 2005 until he resigned in 2008. He now, in addition to his responsibilities at the Royal Brompton & Harefield NHS Foundation Trust, is the Chairman of the Aviva Mall Fund, a director of 2 FF&P Russian Property Companies, and is on the Council of Lloyds of London. He remains an Alderman of the City of London and a Trustee of various charities.

Non-Executive Directors

Mr Nicholas Coleman was appointed as a non-executive director in January 2008. He is an experienced business executive with a background in sub-surface numerical simulation and analysis, business administration and corporate governance. He has worked in the international oil, gas and petrochemicals arenas, mainly with BP and most recently as a Vice President in their finance and control and corporate social responsibility areas. He left BP in 2007 and is now engaged in various not-for-profit organisations. He has a BSc in Physics with Geophysics from Imperial College London.

Mrs Jenny Hill is founder and consulting director of Echelon Learning Ltd – where she advises on strategic planning and service development issues. She has worked with clients such as Bupa, Tussauds Group and Channel Tunnel Rail Link. Previously, she worked for the NHS for 10 years, having joined through the graduate training scheme. She has an honours degree in Politics and History is a Fellow of the Chartered Institute of Personnel and Development.

Mr Richard Hunting is chairman of Hunting PLC, the international oil services company. He is also Chairman of CORDA: Charity: preventing heart disease and stroke, a court member of the Ironmongers' Company, one of the 12 principal livery companies of the City of London; chairman of The Battle of Britain Memorial Trust. He has an engineering degree from Sheffield University and an MBA from Manchester Business School.

Mr Neil Lerner was appointed to the Trust Board in February 2010. He is an experienced accountant specialising in all aspects of risk management. He has played a key role in the development of ethical standards for the accountancy profession, globally and in the UK. After becoming partner at leading international provider of professional services, KPMG, in 1984, Mr Lerner held a number of senior positions, including head of privatisations, head of corporate finance and head of transaction services business for KPMG UK, and chairman of the KPMG Global Professional Indemnity Insurance Group. He retired from the firm in 2006 and currently holds a number of non-executive posts.

Professor Sir Anthony Newman Taylor OBE, FRCP, FFOM, FMed Sci is Principal of the Faculty of Medicine, Imperial College, having been Head of Imperial College's National Heart and Lung Institute between 2006 and 2009. He is also head of the Department of Occupational and Environmental Medicine at Imperial College. He was appointed consultant physician at Brompton Hospital in 1977 and became medical director of Royal Brompton Hospital when it became a Trust in 1994. When Royal Brompton merged with Harefield Hospital in 1998, he was appointed medical director of the new organisation and Deputy Chief Executive. Professor Newman Taylor was, until January 2008, chairman of an expert scientific advisory committee to the government (the Industrial Injuries Council). He is currently chairman of the Coit Foundation charity, and of the Independent Medical Expert Group of the Armed Forces Compensation Scheme, MOD.

Mrs Christina Croft is an experienced international banker, with a background in corporate finance and private banking. She has worked for major financial institutions around the world, including Citibank in Hong Kong, New York and Sydney. Mrs Croft is a Director of Juvenile Diabetes Research Foundation; and a part-time financial consultant. She has an MBA from London Business School and a BSc in Physics from University College London.

Ms Kate Owen runs a consulting business advising on change and development in organisations. She retired as vice president executive development at BP in 2005 having worked with the company for 24 years Her 35-year industry career spanned line management, general HR work, training and organisational transformation. Her previous experience was in retail and the public sector. She spent nine years on the Board of HM Revenue and Customs, was chair of the Conference Board (Europe) Organisation and Business Council, a member of the Ministry of Defence Armed Forces Training and Education Steering Group and a member of the UK Government Risk Review Steering Group Ms Owen is currently a Governor of Imperial College, a Fellow of the Windsor Leadership Trust and a non-executive director of BioSS (Biomathematics & Statistics Scotland).

Executive Directors

Mr Robert J Bell joined the Trust as chief executive in March 2005, from the William Osler Health Centre, Ontario, Canada, where he was president and chief executive officer He has had over 30 years' international experience in hospital and health services management He is a member of the Board of Directors of NHS Innovations London and the heart charity CORDA He has previously held positions as vice president, Health Care and Life Sciences Market Sectors, Cap Gemini, Ernst & Young Canada Inc; partner, KPMG (Peat Marwick), Toronto; vice president, Hilton Universal Hospitals UK Ltd, London; vice president, International Services, Extendicare Inc (London and Toronto); executive director of District Health Councils in the Ministry of Health, Ontario; Treasury Board officer, Management Board of Cabinet, Government of Ontario; and systems engineer, Hospital for Sick Children, Toronto He is a Bachelor of Applied Science in Industrial Engineering and a Master of Public Administration.

Mr Robert Craig is the Chief Operating Officer. He joined Harefield Hospital in 1995, having previously worked in community and general hospital services. Following the Trust merger in 1998, he became site director at Harefield and, in 2001, deputy director of operations for the Trust Robert has also fulfilled the roles of director of governance & quality (2003-2006) and director of planning & strategy (2006-2009) – in the latter post, he was responsible for the Trust's Foundation Trust application He was appointed to his current role in mid-2008

Professor Timothy Evans BSc MD PhD DSc FRCP FRCA FMedSci is medical director of the Trust and was appointed deputy chief executive on 31 March 2006 and director of research and development in 2008 He was made responsible officer in 2011 In addition to his clinical roles within the Trust (professor of intensive care medicine and consultant in thoracic and intensive care medicine), he is head of the unit of critical care at Imperial College (National Heart and Lung Institute) and honorary consultant in Intensive Care Medicine to HM Forces, He is Academic Vice President of the Royal College of Physicians (from September 2009) and Vice Dean, Faculty of Intensive Care Medicine (from 2011)

Mr Mark Lambert is the Trust's director of finance and performance He joined the Trust in November 2006 from The Royal Bank of Scotland, where he was finance director of specialised lending services. Mark began his career at Deloitte Haskins & Sells – which subsequently became PricewaterhouseCoopers – and spent a total of 13 years with the firm. He qualified as a chartered accountant in 1991 and has worked for a wide range of clients in both commerce and financial services. In October 2010 Mr Lambert began a period of sickness absence and came back on a phased return to work during the last week of March 2011. An Interim Director of Finance has been appointed to cover his responsibilities

Dr Caroline Shuldham, director of nursing and clinical governance, has worked in the Trust since its inception, having previously been employed at the Royal Brompton Hospital She has a background in cardiac and intensive care nursing, nursing education and research In addition to leading nursing, she is responsible for clinical governance, and patient and public involvement Dr Shuldham is an honorary clinical senior lecturer at the National Heart and Lung Institute of Imperial College London and a nurse fellow of the European Society of Cardiology Dr Shuldham was recognised with an OBE on the Queen's Birthday Honours List in June 2009.

Performance Evaluation of the Board of Directors

During 2010/11, the performance of the Chairman has been evaluated by the Senior Independent Director, Mrs Jenny Hill The performance of the Chief Executive has been evaluated by the Chairman and the Chief Executive has in turn appraised the performance of his direct reports. Evaluation of the performance of the Board and Non Executive Directors is planned during 2011/12.

Audit Committee

The Audit Committee (composed of Non-Executive Directors) met on 5 occasions during 2010/11, each time under the Chairmanship of Mr Neil Lerner. The Audit Committee has discharged its responsibilities to provide the Trust Board with an independent and objective evaluation of the establishment and maintenance of an effective system of integrated governance, risk management and financial and non financial internal controls that support the achievement of the organisation's objectives. The Audit Committee has been supported in its work by internal auditors and counter fraud specialists from the London Audit Consortium and also by the external auditors, Deloitte LLP.

The minutes of the Audit Committee have been submitted to the Trust Board and the Chairman of the Audit Committee has reported the business of the Audit Committee to the Trust Board after each meeting of the Audit Committee. The Chairman of the Audit Committee, in conjunction with the Chairman of the Trust, has undertaken an evaluation of the performance of the committee. This evaluation was discussed at the meeting of the Audit Committee held on 12th April 2011 and the Non Executive Directors indicated that they were content with the manner in which Audit Committee carried out its business.

3.3 Membership and Patient & Public Involvement

2010 – 2011 has been the first full year in which the Trust has operated as a Foundation Trust with an active membership. Members join one of three constituencies: public, staff or patient. The eligibility requirements for joining different membership constituencies, as set out in our constitution, and are as follows:

Public constituency – an individual must reside in one of the four geographical constituencies and have reached the minimum age of 16 years. The Trust is a provider of specialist cardiac and respiratory services to the whole of England and Wales, therefore the 4 geographical areas cover the whole of England and Wales being split into:

- North West London
- Bedfordshire & Hertfordshire
- South of England
- Rest of England and Wales

Staff constituency – an individual who is employed by the Trust under a contract which has no fixed term, or has a fixed term of at least 12 months or has been continuously employed the Trust under a contract of employment for at least 12 months.

Members of staff who are in one of the above categories of employment, and who have not informed the Trust that they do not wish to do so, are automatically members by default. Members of the staff constituency may opt out of staff membership through notification to the Trust Secretary or Membership Office.

Individuals who exercise functions for the Trust but do not hold a contract of employment e.g. those employed by a university or who hold an honorary contact, a contractor or those employed by contractors may become members of the staff Constituency.

Volunteers to the Trust do not qualify for membership under the Staff Constituency.

Patients' Constituency – an individual who has attended the Trust's hospitals, in the last 3 years immediately preceding the date of an application to become a member, as either a patient or as the carer of a patient and who has reached a minimum age of 16 years.

Membership Numbers by Constituency and the Trust Strategy for Ensuring a Representative Membership

The Trust has experienced a decline in membership size of 870 between 2009/10 to 2010/11. Membership size was 10,580 in 2009/10 and is currently 9,740 **(Table 1)**. A reduction in the number of members has taken place within each of our three constituencies: public, staff and patient A decline in membership size was anticipated as work had been carried out in 2010 to cleanse the membership database. This was in terms of updating member's details and surveying whether members still wished to be a member of the Trust. A number of members expressed a preference to no longer remain as a member of the Trust and were therefore removed from the membership database. In relation to staff membership, the Trust has an 'opt –out' system in place

The Trust aims to increase membership from 9,740 to 12,000 between 2011-12. The 12,000 figure has been identified as it is based on 10% of the total number of patients who have used our services in the last three years. An analysis of the membership has been undertaken which has identified areas of under-representation. The increases in membership will be targeted at groups that are currently under-represented in the patient and public constituencies

Analysis of Membership at 31 March 2011: Membership size and movements

Table 1

Public			2009-2010	2010-2011
	At year start (April 1)	+ve	1898	1929
	New members	+ve	32	18
	Members leaving	+ve	-	172
	At year end (31 March)		**1930**	**1775**
Staff	At year start (April 1)	+ve	2828	3515
	New members	+ve	687	432
	Members leaving	+ve	-	597
	At year end (31 March)		**3515**	**3350**
Patient	At year start (April 1)	+ve	4885	5135
	New members	+ve	250	21
	Members leaving	+ve		541
	At year end (31 March)		5135	4615
	TOTAL		**10,580**	**9,740**

Membership Strategy and Engagement

The Trust established a Membership Steering Committee in March 2011 whose remit is to develop and implement a Membership Strategy. The Membership Strategy will encompass: the recruitment/retention of members, representativeness of membership and engagement and communication with members. The Committee will report to the Governors' Council.

Managing Membership

The Trust procured an external membership database from Capita Membership Services (CMS) in April 2010. CMS help the Trust to manage the membership and in April 2011 the Trust will migrate to a new system introduced by Capita, with advanced features. The day-to-day administrative management of the database is carried out jointly by the Membership & User Involvement Manager and the Performance Team.

The Trust continues to welcome and provide opportunities for those who wish to be members, through:

- Website and intranet portal and on-line registration facility; and
- Availability of membership forms in patient areas.

Engaging Members

In 2010 the Trust held its inaugural Annual Members' Meeting and around 100 members attended. The next meeting will be held on the 12th October 2011 to which all members will be invited.

The Trust is in the process of updating the current membership form to give the opportunity for members to state their preference for more involvement in Trust activities.

Communication with Members

The Trust's Human Resources Department send out a Welcome Letter, in their correspondence, to new staff. During monthly induction training for new staff, the Membership and User Involvement Manager, covers the role of a Foundation Trust and the 'opt-out' system for staff members. For new patient and public members, a welcome letter is sent to new members

The Trust maintains contact with our members through a bi-annual newsletter. Members are sent this in the post/email and it is also available through accessing the trust website

We involved our members in our Quality Accounts this year and gave them the opportunity to vote on priorities for 2011/12

Contact details for members who wish to communicate with governors and the Membership & User Involvement Manager

There is a generic email address available for members to communicate with governors: governors@rbht.nhs.uk

and for members to contact the Membership & User Involvement Manager. members@rbht.nhs.uk

4. Disclosures in the Public Interest

Monitor guidance indicates that a set of key indicators on the Trust's affairs be incorporated into the Annual Report

Countering Fraud and Corruption
During 2010/11 the Trust engaged an accredited Counter-Fraud specialist as part of the internal audit service provided by London Audit Consortium. Investigations are carried out as required and outcomes reported to the Audit Committee

Better Payment Practice Code/Interest Paid under the Late Payment of Commercial Debts (Interest) Act 1998
Information regarding these is given in the Financial Statements of the Trust.

Staff Consultations
There were no staff consultations undertaken or commenced in the period of report, nor does the Trust have any plans for future staff consultations

Public Consultations
Details of consultations with stakeholder groups engaging with the Trust are given in the Quality Report

Ill-health Retirements
Details of ill-health retirements during the period are given in the Financial Statements of the Trust

Other Income
Details of Other Income are given in the Financial Statements

Data Loss/Confidentiality Breach
There was one serious untoward incident regarding data loss in the period. This related to a book containing bronchoscopy records which went missing and could not be accounted for. The incident was reported as a serious untoward incident, a full root cause analysis was undertaken and the results were reported to NHS Kensington & Chelsea, the host commissioner for governance issues.

Cost Allocation and Charging Requirements
The Trust has complied with HM Treasury and Office of Public Sector Information guidance with regard to cost allocation and charging

Value of Fixed Assets
The Trust's Land and Buildings were valued by the Director of Capital Projects and Development at 31 March 2011 In the opinion of the directors, there is no material difference between the reported holding value and market value of those assets at the balance sheet date.

Donations

The Trust has made no charitable or political donations during the period.

Events since 31 March 2011

Other than the continuing consultation process in respect of the Safer and Sustainable review of children's congenital heart services in England (reported in the Chief Executive Introduction and the Statement of Internal Control) there are no disclosable post balance sheet events.

Financial Instruments

The extent to which Trust employs financial instruments is set out in the financial statements

Occupational Health Service

This year has proven to be an exciting time in the evolution of the Trust occupational health service In response to the Boorman recommendations to develop health and well being strategies that improve staff health and well being, the service has focused on enabling staff to prevent the development of disease and injury with the promotion of activates such as yoga and Pilates, in addition to securing discounted gym membership for our staff The Health and Well Being Manager developed a trust intranet site to raise awareness and promote activities that are designed to promote staff health and well being. Where individuals have identified early signs of injury or illness the service accepts self referrals in order to enable the individual to prevent further deterioration and seek to improve their health and well being without delay. For example following an occupational health assessment the employee may be referred on for physiotherapy or counselling. These interventions can limit the impact of employee sickness absence due to musckoskeletal disorders and mental health illness In addition if disease has developed the Occupational Health Service supports the individual's rehabilitative process by environmental assessment, phased return to work, collaboration between the general practitioner, manager and human resources to ensure that the employee has the maximum opportunity to return to work, so as to limit the risk of long term sickness absence.

The occupational health service was instrumental in preparing the organisation to implement the change from sick note to fit note that came into force from 6th April 2010. Managers and staff within the organisation attended training regarding the principles of this change and how to ensure that the changes were implemented effectively.

The occupational health service conducted a stress audit using the Health and Safety Executive Management Standards of Stress Audit tool from July to September 2010. This report was presented to the Trust operational management team and the Trust Health and Safety Committee.

Schwartz Rounds were introduced in January 2011; they are an open and confidential multidisciplinary forum where caregivers discuss challenging social and emotional issues that arise when caring for patients. Their function is to help reduce staff stress while supporting staff to provide compassionate care.

The Equality Act that became law in October 2010 had a significant impact on the role of occupational health in the management of pre employment health related checks. The Occupational Health Service has developed new forms and processes to ensure that employee health assessments are conducted in accordance with this new legislation.

Health and Safety

The Trust recognises that providing a safe environment for its patients and staff underpins all its other activities. The Trust therefore provides Health and Safety training to all staff on their commencement with the organisation, and then ongoing throughout their employment to ensure safety awareness and good practice is maintained. This may be supplemented by additional training dependent on the specifics of the staff member's role. Site based Committees have been established to ensure that concerns relating to safety can be raised through local Safety Representatives. The Trust also supports staff well-being in their work through a comprehensive Occupational Health service to ensure our staff and, through them, members of the public and of course, our patients enjoy a safe environment where occupational and safety risks are minimised. Health and safety is supported from the Chief Executive down to all levels

Staff Sickness

In common with all other NHS Trusts, the Trust provides quarterly data on sickness absence to the Cabinet Office

Staff Sickness	% of staff sickness	Internal target: 3% or below	Apr 10 - Mar 11	2 57 %	Achieved

Policies in relation to disabled employees and equal opportunities

The Trust has a Diversity Policy which was updated and ratified in June 2010 in order to take into account the requirements of the Equality Act 2010, which became law in October 2010.

The Trust is committed to delivering an equality of opportunity for all patients and staff, to maintain a culture in which all forms of discrimination are considered unacceptable. People are at the very heart of our Trust and the services we provide. Our patients, their carers and our staff deserve to feel respected, valued and empowered. We are committed to eliminating all forms of discrimination on the grounds of people's age, disability, gender, racial group, religion or belief and sexual orientation.

The current legislation expands the scope of our duty for protection on the basis of not only race, gender and disability but to encompass Religion and Belief, Age and Sexual Orientation and Gender Reassignment.

In particular, the Trust takes steps to ensure that in respect of people with a disability, no discrimination takes place during the recruitment process, and that both for people with a disability, and those who become disabled during our employment, reasonable adjustments are made as required. The Trust Diversity Policy contains clear guidance for managers in respect of training, career development and promotion of people with a disability.

5. Staff Survey

Introduction

The 2010/11 Staff Survey was conducted in the months of October and November 2010 and the results were published by the Care Quality Commission in March 2011.

The Trust recognises that staff engagement and quality of communication are key to productivity and job satisfaction. For this reason there are several methods in place to enhance communication, opportunities for information sharing and for rewarding staff established across both hospital sites.

Existing Initiatives

The Trust's Chief Executive holds regular Staff Forums. These are valued opportunities, not just to update staff on recent news and developments from a strategic perspective but to be able to hear from and respond to questions from staff. Questions can be submitted beforehand if they would like to submit them anonymously or will be taken directly at the meeting. The contents of the forums are published on the intranet to inform those who were unable to attend.

The Trust also has a staff magazine, 'intouch', which is complemented by the monthly 'What's New?' news bulletin – these are distributed throughout the Trust The 'Trust News' and 'Trust Matters' pages on the intranet are also available to all staff.

As well as listening to, and communicating with staff, the Trust seeks to promote constructive, open, informal dialogue between staff and managers to ensure effective team performance. The Trust has a range of learning and development tools to support this, which are underpinned by the Trust's own Core Behaviours framework.

Where situations do arise, all parties benefit from informal resolution with the least friction – accordingly mediation is used whenever appropriate. The Trust has a range of policies and procedures which define the informal and formal processes available to address for example complaints, grievances or performance issues, should they be needed. The Human Resources department have dedicated teams for each division within the hospital who are committed to resolving situations as early as possible.

The Trust has continued the popular Staff Recognition Scheme which takes nominations for individuals or teams from their colleagues and customers who feel they have made an outstanding contribution to for example, their team, service improvement, or delivering efficiencies. A ceremony is held where stories are shared, awards are given and successes are celebrated The results are published for everyone in the Trust to see and these often inspire others.

Initiatives recently implemented

Developments to the Trust's strategy for staff have taken place as a result of several factors including the staff survey, a dedicated stress report and the feedback received in forms and both formal and informal processes.

In the past year a new appraisal process has been implemented where employees understand behavioural expectations and are assessed against the Core Behaviours and Trust Values which both have the principles of fairness and respect embedded into them.

During the past year there has been greater pressure put upon managers and their teams to ensure services and standards are maintained. In recognition of this the new Staff Well-being and Stress policies are in place to assist. In addition the Trust has introduced Schwartz Rounds which are open and confidential multidisciplinary forums where caregivers discuss challenging social and emotional issues that arise when caring for patients. Their aim is to help reduce staff stress while supporting them to provide compassionate care.

To help tackle other issues and to help enhance levels of staff engagement 'listening forums' have recently been piloted at Harefield hospital where the divisional HR lead and the General Manager give staff the opportunity to raise issues, share frustrations, and ask questions. The General Manager takes notes, the outcomes are considered with their management team and fed back to the departments, and ongoing progress is monitored.

As a result of understanding the importance of stress on staff, several initiatives have been put in place to assist. These include a buddy and mentor system and individual coaching and Cognitive Behavioural Therapy sessions. Specifically for Consultants a new induction programme has been implemented to ensure that senior clinical leaders are fully integrated into the Trust and are supported by senior management.

Summary of performance - NHS staff survey

The Trust participates in the annual NHS Staff Survey and the results from the 2010 survey are summarised below.

Response Rate:

At the time of sampling, 2846 staff were eligible to receive the survey. Questionnaires were sent to a random sample of 798 staff. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the Trust.

334 staff at the Trust took part in this survey. This is a response rate of 42% which compares favourably with a rate of 35% for the 2009 survey; however, it is still below average for acute specialist trusts in England.

	2009/2010 (Acute Trusts)		2010/2011 (Acute Trusts)		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
Response Rate	35%	50%	42%	51%	+7%

Areas of improvement and deterioration from the prior year:
The largest local improvement is for 'Perceptions of effective action from employer towards violence and harassment'. The score of 3.52 out of 5 in 2009 improved to 3.60 in 2010; however, this score is still slightly below average when compared to other acute specialist trusts in England and we will therefore seek to improve it further

There are four local scores that have significantly deteriorated between the 2009 and 2010 surveys. These are outlined in the table below and show that, despite deterioration, the 2010 results are still in-line with or better than the national average for acute trusts in England. However, the Trust will endeavour to improve these results to the previous levels

Key finding	Change since 2009	2010 survey result	National Average
Percentage of Staff agreeing that their role makes a difference to patients' (higher the score the better)	-5%	90%	90%
Impact of health and well-being on ability to perform work or daily activities (the lower the score the better)	+0 09	1 57	1 57
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (higher the score the better)	-9%	85%	79%
Staff motivation at work (the higher the score the better)	-0.11	3 87	3 85

Top 4 Ranking Scores:

	2009/2010 (Acute Trusts)		2010/2011 (Acute Trusts)		Trust Improvement/ Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF5 Work pressure felt by staff (lower the score the better)	2 70	2 98	2 81	2 96	+0 11
KF1. Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	94%	78%	85%	79%	-9%
KF34 Staff recommendation of the trust as a place to work or receive treatment (higher the score the better)	4 05	3 89	4 02	3 93	-0 03
KF11. Percentage of staff receiving job-relevant training, learning or development in last 12 months	77%	77%	81%	79%	+4%

In addition to the key findings outlined above there are two others areas that have scored significantly better than the national average for acute trusts, namely:

- Percentage of staff feeling there are good opportunities to develop their potential at work
- Percentage of staff suffering work-related injury in the last 12 months

Bottom 4 Ranking Scores:

	2009/2010 (Acute Trusts)		2010/2011 (Acute Trusts)		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	22%	18%	22%	14%	0%
KF36. Percentage of staff having equality and diversity training in last 12 months	27%	40%	23%	45%	-4%
KF38. Percentage of staff experiencing discrimination at work in last 12 months	n/a**	n/a	17%	10%	n/a
KF9. Percentage of staff using flexible working option	n/a**	n/a	54%	65%	n/a

**For Key Findings 38 and 9 outlined in the table above, changes to the format of questions asked this year does not make a comparison with the 2009 score possible

We have been taking steps to further analyse the responses for these four lowest areas over recent months and a number of initiatives have been put in place which we hope will lead to an improvement in staff engagement. These include a Stress Audit undertaken in September 2010, the introduction of the Schwartz Rounds, the introduction of listening forum, the inclusion of commitment to the Trust core values and behaviours in the Trust's appraisal system, and the introduction of 360° feedback for consultants

In addition there are other initiatives that have been in place for some time including the CEO Staff Forums, Championship Awards, staff publications, mentoring and buddying, which should also continue to help achieve high levels of staff engagement

Recommendations for addressing areas requiring improvement

1. Aim to improve response rate for the survey to enhance the quality of data received and consider increasing the number of people we survey and investigate the possibility of appropriate incentives

2. Investigate areas where bullying and harassment and stress may be occurring and consider running specific short employee surveys to obtain more relevant and comprehensive information

3. Ensure all managers are trained properly in recruitment and appraisals and review our recruitment and promotion practices and policies.

4. Continue to develop the listening forums piloted at Harefield Hospital, Trust wide

5. Continue to support the development of the well-being and stress programme.

6. Equality and Diversity training is provided for all new starters and is delivered as part of the induction programme We need to consider including Equality and Diversity training as a mandatory training requirement and work closely with Fulham Road neighbours to adapt best practices

7. Discrimination at work is treated very seriously and with greater awareness of the Core Behaviours and more structured appraisals, greater behavioural expectations can be set. Expectations are also highlighted in other forms of communication and with management support we feel this can be eradicated

8. Flexible working options are widely available for staff, yet are traditionally a difficult area to quantify, with staff having varying perceptions as to what it means. In reality, although it may not formally be labelled as such, many of our staff regularly work flexibly using the policies and processes we have to accommodate this We will also ensure that all staff are fully aware of the flexible working options available to them, and promote our policies more widely

6. Regulatory Ratings Report

2010/11 was our first full year of operation as a Foundation Trust. The planned risk ratings for 2009/10 were those based on the Foundation Trust assessment process.

	Annual Plan 200009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial Risk Rating	4*	4	4	4	3
Governance Risk Rating	Green*	Green	Green	Green	Green

*Note - Plan based upon assessment submissions

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	Q1 & Q2 – 2 Q3 & Q4 - 3	2	2	3	3
Governance Risk Rating	Green	Amber / Green	Green	Green	Green

During 2010/2011, the Trust delivered the financial risk ratings set out in the Annual Plan as detailed by quarter. The financial risk rating fell to 2 for Q1 and Q2 and then rose to 3 for Q3 and Q4. A financial risk rating of 3 is anticipated throughout 2011/12. The Trust has been subject to monthly monitoring for the financial risk rating since month 4 2010/11 and anticipates a return to quarterly monitoring following the Q1 2011/12 return

The Governance rating fell to Amber / Green in Q1 2010/11 This was attributable to a moderate Care Quality Commission concern regarding 'safety and suitability of premises' This moderate concern was resolved by 31st July 2010; following which the governance rating returned to green and remained green during Q2, Q3 and Q4 2010/11

Annex 1

FINANCIAL STATEMENTS OF THE ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST FOR THE YEAR 1 APRIL 2010 TO 31 MARCH 2011

Accounts for the year 1 April 2010 to 31 March 2011

Contents

Accounts of Royal Brompton & Harefield NHS Foundation Trust
for the Year ended 31 March 2011

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

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

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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual 2010-11* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards as set out in the *NHS Foundation Trust Financial Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and

- Prepare the financial statements on a going concern basis

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

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

R. Bell

Robert J Bell
Chief Executive and Accounting Officer

Date May 31, 2011

Accounts of Royal Brompton & Harefield NHS Foundation Trust for the year ended 31 March 2011

Statement on Internal Control

1. Scope of responsibility

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

2. 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 Royal Brompton and Harefield NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically The system of internal control has been in place in Royal Brompton and Harefield NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk

To ensure that the Board and I are able to provide the appropriate levels of assurance on effective internal control to the Trust's patients, the Board of Governors and to other stakeholders, two committees of the Board, the Audit Committee and the Risk and Safety Committee, have been established These committees, with membership of the Trust's Non Executive Directors and attended by myself and other Executive Directors, oversee and scrutinise the systems for internal control, whether financial, clinical or non clinical, relating to external partners or providers, to seek assurance that risks are identified and adequately managed

The Governance and Quality Committee, chaired by the Medical Director and Deputy Chief Executive, provides management scrutiny of the Trust's risk management issues against an integrated governance and patient safety agenda. It receives reports on clinical and non-clinical issues from each of the clinical divisions, to ensure that it has the opportunity to identify examples of both good and poor practice so as to ensure that these areas are operating to the highest clinical and quality standards With representation from each of the clinical and non clinical divisions present the Trust is able to share best practice and respond to identified weaknesses. This committee provides regular performance reports to the Risk and Safety Committee and the Trust Board

The Quality and Safety department, which is led by the Executive Director for Nursing and Clinical Governance, delivers the Trust's agenda to put quality and patient safety at the forefront of the Trust's activities. The Trust has a quality and safety improvement plan which is in the second year of implementation To ensure that all Trust staff are aware of their responsibility for patient safety activity and the management of risk, a range of training, guidance and support is offered to all levels of the Trust's staff.

To ensure that the Trust undertakes its activities within a safe environment, the Trust has appointed an external specialist contractor to monitor compliance with its health and safety obligations Additionally this contractor provides specialist advice and training in fire, health, safety and manual handling issues. To ensure that a risk aware culture is developed, all staff joining the Trust attend an induction and ongoing training programme to provide them with the essential knowledge on health and safety and risk management Risk identification is undertaken at all levels of the Trust activity and is reported through the above committee structure to the Board to ensure that these issues are adequately reviewed. The Trust maintains a Board Assurance Framework (BAF), and each Division maintains a Risk Register, which cumulatively provide me with an overview of the significant risks to achieving our objectives, together with the controls in place to mitigate these risks

4. The risk and control framework

The Board approved Risk Management Strategy has defined the Trust's approach to risk throughout the year The strategy determines the requirements for the identification and assessment of risks and for control measures to be identified and how risks should be managed and the responsibilities of key staff in this process As a healthcare organisation seeking to develop advances in healthcare it is recognised that the Trust encourages a risk aware, rather than a risk averse culture

The risk management strategy assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. This process populates the Risk Register and the Board Assurance Framework (BAF), to form a systematic record of all identified risks All risks are evaluated against a common grading matrix, based on the National Patient Safety Agency model developed at Keele University. This model enables the severity and likelihood of each risk to be quantified, enabling all risks to be considered alike The control measures, designed to mitigate and minimise the identified risks, are recorded within the Risk Register and BAF

The risks detailed within the BAF are aligned to the, the Care Quality Commission 'essential standards of quality and safety' and the Monitor Compliance Framework The BAF is designed to reflect risks from all aspects of the organisation and provide details of the controls in place to mitigate the risks, identify the gaps in control, the sources of internal and external assurance and any gaps. Key actions and timescales are included, hence the BAF provides assurance to the Board, through ongoing review, that these risks are being adequately controlled and informs the preparation of the statement on internal control The BAF reflects the Trust's wider role and risk profile, especially as a leading centre for research and development, innovation, translational research and training. All reported incidents and known risks are entered to the risk register, commonalities and themes are reviewed and evaluated and then the most significant risks are distilled into the BAF which informs the work of the executive

One of the major challenges that faced the Trust during 2010/11 was the threat to our Children's Services posed by the review of children's congenital heart services undertaken on behalf of the Joint Committee of Primary Care Trusts (JCPCT). This review has the objective of reducing the number of centres commissioned to undertake children's congenital heart surgery from the current 11, to around 6 or 7 nationally designated centres The Trust has sought a judicial review of the JCPCT's consultation process and the business case underpinning it At the time of writing the outcome of this review is awaited Whatever the outcome, however, there should be no significant impact on the Trust's funding arrangements prior to 1 April 2013

The Risk Register has been subject to considerable review during 2010/11, which will be completed in 2011/12 During the year an internal audit review of the risk register was carried out which identified certain deficiencies in its governance, maintenance and use, although this did not extend to those key risks set out in the BAF The work in progress will continue to remedy the shortcomings and to ensure that the register is a useful and dynamic document The internal auditors considered it likely that effective risk management was undertaken by the Trust as evidenced by its achievement of level 3 of the NHSLA Risk Management standards

In July 2010, I noted with interest the publication of the White Paper 'Equity and excellence: Liberating the NHS', I have continued to follow the ongoing development of health policy since that date

Equality Impact Assessments are undertaken whenever a new policy is written, or whenever an existing policy requires review. Policies are amended to take account of the issues identified through the Equality Impact Assessments This mechanism ensures that risk management is embedded in the policies which drive core Trust business

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. Deloitte LLP carried out a review of the data quality underpinning the Quality Report 2009/10, and provided the Trust with recommendations to ensure maintenance of high standards of data quality

The Trust Data Quality Policy was updated during 2010/11 and the action plan arising from the review by Deloitte LLP has been implemented in full For 2010/11, the Quality Report has provided a mechanism for feedback to stakeholders on the management of risks during the year and a means by which to engage stakeholders in deciding organisational priorities for risk management during 2011/12. The Quality Report for 2010/11 is set out in Annex 2 of the Annual Report

Stakeholder involvement has been achieved through:

- A web based voting exercise for 2011/12 Quality Account priority areas
- Governors choosing a Quality Account indicator for review by external audit
- Care Quality Commission – regular review of the Quality and Risk Profile which is discussed with the Trust CQC assessor
- Monitor – The Foundation Trust Regulator, assesses the Trust's risk profile throughout the year and its risk ratings inform the BAF
- Local Involvement Networks (LINks) – ongoing engagement with both Royal Borough of Kensington and Chelsea and Hillingdon Borough LINks The LINks have established a management board and a number of sub-groups focusing on particular health areas. The Trust, through the User Involvement Manager, is working with LINks to ensure that it can support their agenda to engage users and identify potential risk issues so as to improve health and social care services in the boroughs In particular, LINks are closely involved with development of the Quality Report and will provide a commentary following a two stage consultation exercise
- External Services Scrutiny Committee – London Borough of Hillingdon – Quality Accounts consultation and performance scrutiny
- Health, Environmental Health and Adult Social Care Scrutiny Committee – Royal Borough of Kensington & Chelsea – Quality Accounts consultation and performance scrutiny
- Monitoring meetings with the Trust's coordinating commissioner, the North West London Commissioning Partnership. Monthly Performance Contract Executive (PCE) meetings are held to review the Clinical Quality Report and provide commissioners with assurance that robust plans are in place to address any in year variances
- The Trust's continued relationship with the National Heart and Lung Institute of Imperial College London and other academic partners

Maintaining the security of the information that the Trust holds provides confidence to the patients and employees of the Trust To ensure that its security is maintained an Executive Director has been identified to undertake the role of Senior Information Risk Owner (SIRO)

The SIRO has overseen the implementation of a wide range of measures to protect the data held by the Trust and a review of personal identifiable information flows to underpin the Trust's information governance assurance statements and its assessment against the information governance toolkit (IGT - issued on behalf of the Department of Health). The results of the review against the IGT provide me with assurance that these aspects are being managed and identified weaknesses addressed It should be noted that version 8 of the IGT contains more stringent requirements for the collection of evidence than previous versions This has led to a lowering of the score for IGT compliance which reflects a need to expend more resources on evidence collation in future rather than an increase in non compliance

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

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

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

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 organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with

In [October] 2010, the Director of Finance went absent on prolonged sick leave He has subsequently returned to work on a part–time basis with a view to resuming full-time duties in July. In January an interim Director of Finance was appointed to cover the Director of Finance role until the latter's return. I consider that no significant loss of control has resulted from these arrangements

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

Clinical divisions and other corporate functions are explicitly made responsible for the delivery of financial and other performance targets through a 'bottom up' system of annual budgeting and planning A Financial Stability Plan (FSP) was developed for 2010/11 with a target to deliver £11 6m from cost improvements, 87% of this plan was delivered in the year.

During 2010/11 the Trust Board established a Financial Stability Sub Committee (FSSC), chaired by a Non Executive Director with recent experience of working in the finance sector. The FSSC provided assurance to the Trust Board as to:

- Monitoring performance against the FSP
- Ensuring delivery of the Cost Improvement Plan (CIP)
- Management of the cash position
- Tracking of financial performance across the whole budget
- Forward Planning – Budget for 2011/12

Deloitte LLP has been engaged to provide external audit assurance in respect of effectiveness of the use of resources.

6. Review of effectiveness

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

My review is also informed by my attendance at the Audit and the Risk and Safety Committees, performance reports to the Board - including the BAF, Governance and Quality reports on clinical activity and patient safety, reviews undertaken by the Trust's external auditors and the assessment against the NHSLA's Risk Management Standards provide me with further assurance It should be noted that during 2010/11 the Trust achieved level 3 of the NHSLA assessment which is the highest possible level of achievement under this scheme

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the above mentioned processes and through reports from executives with responsibility for internal control

The Non Executive Chairs of the Audit Committee and the Risk and Safety Committee provide further assurance as to the effectiveness of internal control, through reports to the Board on the activities and findings of the Trust's external auditors, Deloitte LLP, and its internal auditors, the London Audit Consortium The internal audit provider has delivered against its annual audit plan, which is 'risk based' to reflect potential gaps and control issues identified in the BAF

London Audit Consortium has, throughout the year, reviewed elements of the Trust's internal control arrangements including a review of BAF This activity has informed the Head of Internal Audit's Opinion which has provided me with assurance that an effective system of internal control to manage the principal risks identified by the organisation was in place for 2010/11

Deloitte LLP provides the Trust with its external audit assurance and reports on a range of the organisation's activities and annual accounts

Other means of external review are identified in the areas to which they relate, for example:

Corporate Governance	Monitor
Clinical Governance	Care Quality Commission
Infection Prevention and Control	Infection Prevention Commissioning Liaison Group (Inner North West London PCT Cluster – Commissioners)
Risk Management	NHS Litigation Authority External Audit (Deloitte LLP) Internal Audit (The London Audit Consortium)
Quality Accounts	Local Authority (London Borough of Hillingdon) External Services Scrutiny Committee

In response to the guidance in the Intelligent Board document, the Board has adopted a comprehensive performance report, which it receives at each of its meetings These provide me with benchmarking and exception reports on a range of key performance indicators to ensure that key issues are highlighted and receive the appropriate attention

7. Conclusion

No significant internal control issues have been identified The Board Assurance Framework has been thoroughly reviewed during 2010/ 2011 and further evaluations of its effectiveness are planned to ensure that it continues to be fit for purpose

R. Jeee

Robert J Bell
Chief Executive

Date May 31, 2011

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST

We have audited the financial statements of Royal Brompton & Harefield NHS Foundation Trust for the year ended 31 March 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes 1 to 37. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts.

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Royal Brompton & Harefield NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the accounting officer and auditor
As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code of NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view of the state of the trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by Monitor – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST (CONTINUED)

Opinion on other matters prescribed by the National Health Service Act 2006
In our opinion:

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

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters where the National Health Service Act 2006 requires us to report to you if, in our opinion:

- proper practices have not been observed in the compilation of the financial statements; or
- the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources

Certificate
We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts.

Heather Bygrave (Senior Statutory Auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
St Albans
7 June 2011

Accounts of Royal Brompton & Harefield NHS Foundation Trust for the Year ended 31 March 2011

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2011 have been prepared by the Royal Brompton & Harefield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

R. Bell ..... **Robert J Bell**
Chief Executive

Date May 31, 2011

ACCOUNTS FOR THE PERIOD

1 April 2010 to 31 March 2011

Trust name:	Royal Brompton & Harefield NHS Foundation Trust
This year	Year to 31 March 2011
Last year	Ten months to 31 March 2010
This year end	31 March 2011
Last year end	31 March 2010
This year beginning	1 April 2010

Royal Brompton and Harefield NHS Foundation Trust - for the Year to 31 March 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR TO 31 MARCH 2011

	NOTE	Year to 31 March 2011	Ten months to 31 March 2010
		£000	£000
Revenues from patient care activities	4	**253,484**	186,921
Other operating revenues	5	**30,536**	29,936
Operating expenses	6-9	**(276,804)**	(210,058)
OPERATING SURPLUS		**7,216**	6,799
Investment income	11	**32**	22
Revaluation gain on investment properties	12	**4,028**	2,305
Finance costs	13	**(58)**	(63)
SURPLUS FOR THE FINANCIAL PERIOD		**11,218**	9,063
Dividends payable on Public Dividend Capital		**(6,509)**	(5,496)
RETAINED SURPLUS FOR THE PERIOD		**4,709**	3,567
OTHER COMPREHENSIVE INCOME:			
Impairments	14	**(5,892)**	(7,896)
Revaluation gain on Operating Properties	14	**947**	2,831
Receipt of donated/government granted assets	14	**5,015**	2,067
Reduction in the Donation Reserve in respect of depreciation and impairment of fixed assets	5	**(2,862)**	(1,883)
Total comprehensive income for the period		**1,917**	(1,314)

The notes on pages 5 to 34 form part of these accounts

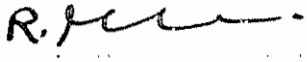
All revenue and expenditure is derived from continuing operations

These accounts relate to the year 1 April 2010 to 31 March 2011 The comparatives relate to the ten month period 1 June 2009 to 31 March 2010, the Trust having been authorised as a Foundation Trust on 1 June 2009.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
NON-CURRENT ASSETS			
Property, plant and equipment	14	**189,224**	183,612
Investment properties	16	**25,828**	21,800
TOTAL NON-CURRENT ASSETS		**215,052**	205,412
CURRENT ASSETS			
Inventories	19	**10,843**	9,317
Trade and other receivables	20	**18,570**	20,730
Cash and cash equivalents	22	**16,679**	13,023
TOTAL CURRENT ASSETS		**46,092**	43,070
TOTAL ASSETS		**261,144**	248,482
CURRENT LIABILITIES			
Trade and other payables	23	**(32,787)**	(32,182)
Borrowings	24	**(12,959)**	(2,520)
Provisions	26	**(143)**	(184)
TOTAL CURRENT LIABILITIES		**(45,889)**	(34,886)
NET CURRENT ASSETS		**203**	8,184
TOTAL ASSETS LESS CURRENT LIABILITIES		**215,255**	213,596
NON-CURRENT LIABILITIES			
Borrowings	24	**(210)**	(488)
Provisions	26	**(1,047)**	(1,028)
TOTAL NON-CURRENT LIABILITIES		**(1,257)**	(1,516)
TOTAL ASSETS EMPLOYED		**213,998**	212,080
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital (PDC)		**104,759**	104,759
Retained earnings		**37,890**	33,180
Revaluation reserve		**56,055**	60,935
Donated asset reserve		**15,294**	13,206
TOTAL TAXPAYERS' EQUITY		**213,998**	212,080

The financial statements on pages 1 to 34 were approved by the Board on 25 May 2011 and signed on its behalf by :

Chief Executive : 

Robert J Bell

Date : 31 May 2011

Royal Brompton and Harefield NHS Foundation Trust - for the Year to 31 March 2011

Statement of Changes in Taxpayers' Equity

Year to 31 March 2011	Public dividend capital £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Opening Balance at 1 April 2010	104,759	33,181	60,935	13,206	**212,081**
Changes in taxpayers' equity for the year to 31 March 2011					
Receipt of donated assets	-	-	-	5,015	**5,015**
Net (loss) on revaluation of property, plant and equipment	-	-	(4,880)	(65)	**(4,945)**
Transfers to the income statement for depreciation, impairment and disposal of donated assets	-	-	-	(2,862)	**(2,862)**
Transfer of revaluation gain on investment property reclassified to property, plant & equipment	-	0	-	-	**0**
Retained surplus for the year	-	4,709	-	-	**4,709**
Public Dividend Capital received	-	-	-	-	**0**
Balance at 31 March 2011	104,759	37,890	56,055	15,294	213,998

Ten months to 31 March 2010	Public dividend capital £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Total £000
Opening Balance at 1 June 2009	99,836	31,313	66,048	12,974	**210,171**
Changes in taxpayers' equity for the year to 31 March 2011					
Receipt of donated assets	-	-	-	2,067	**2,067**
Net (loss) on revaluation of property, plant and equipment	-	-	(5,113)	48	**(5,065)**
Transfers to the income statement for depreciation, impairment and disposal of	-	-	-	(1,883)	**(1,883)**
Transfer of revaluation gain on investment property reclassified to property, plant &	-	(1,700)	-	-	**(1,700)**
Retained surplus for the year	-	3,567	-	-	**3,567**
Public Dividend Capital received	4,923	-	-	-	**4,923**
Balance at 31 March 2010	104,759	33,180	60,935	13,206	212,080

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Note	Year to 31 March 2011 £000	Ten months to 31 March 2010 £000
Cash flows from operating activities			
Operating surplus		7,216	6.799
Depreciation	14	15,089	9,407
Transfer from donated asset reserve		(2,862)	(1,883)
Interest paid	13	(58)	(63)
Dividend paid		(6,480)	(6,600)
(Increase)/decrease in inventories		(1,526)	(1,957)
(Increase)/decrease in trade and other receivables		2,160	9,318
Increase/(decrease) in trade and other payables		577	(235)
(Decrease) in provisions		(22)	(36)
Net cash inflow from operating activities		14,094	14,750
Cash flows from investing activities			
Interest received	11	32	22
Net payments for property, plant and equipment	14	(20,631)	(12,477)
Net cash outflow from investing activities		(20,599)	(12,455)
Net cash inflow before financing		(6,505)	2,295
Cash flows from financing activities			
Public dividend capital received		0	4,923
Increase in bank borrowing		10,439	2,242
Capital element of finance leases		(278)	(313)
Net cash (outflow)/inflow from financing		10,161	6,852
Net increase in cash and cash equivalents		3,656	9,147
Cash and cash equivalents at the beginning of the financial period		13,023	3,876
Cash and cash equivalents at the end of the financial period		16,679	13,023

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual, which shall be agreed with HM Treasury Consequently, these financial statements have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by Monitor The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) 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 Foundation Trust Annual Reporting Manual 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 fair view has been selected The particular policies adopted by the Trust are described below They have been applied consistently in dealing with items considered material in relation to the accounts

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Acquisitions and discontinued operations

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

1.3 Care Trust designation

The Trust is not a 'Care Trust' for the purposes of this note.

1.4 Pooled Budgets

There are no pooled budget arrangements in place within the Trust

1.5 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 The estimates and underlying assumptions are reviewed on an ongoing basis 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

1.5.1 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

Provisions

A provision is recognised when the trust has a legal or constructive obligation as a result of a past event and it is probable that an outflow of economic benefits will be required to settle the obligation. In addition to widely used estimation techniques, judgement is required when determining the probable outflow of economic benefits relating to early voluntary retirement pension and injury benefit liabilities.

Provision for impairment of receivables

Management will use their judgement to decide when to write-off revenue or to provide against the probability of not being able to collect debt

Impairments and estimated asset lives

The Trust is required to review property, plant and equipment for impairment In between formal valuations by qualified surveyors, management make judgements about the condition of assets and review their estimated lives.

1.5.2 **Key sources of estimation uncertainty**
Management has made the following critical judgement in the process of applying the entity's accounting policies and this has had a significant effect on the amounts recognised in the accounts:

1) The use of estimated asset lives in calculating depreciation (see note 14)
2) Provisions for early voluntary retirement pension contributions and injury benefit obligations are estimated using expected life tables and discounted at the pensions rate of 1 8% (see note 1 20)

1.6 **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 is recognised on partially completed patient episodes in progress at each 31 March based on estimated costs at the balance sheet date insofaras commissioning NHS bodies agree to recognise the corresponding expenditure

The Trust's activities do not include the selling of goods

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable

1.7 **Employee benefits**

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees

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

1.8 **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

1.9 **Property, plant and equipment**

Recognition
Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;

and
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- the 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

Valuation of Operational Property

Land and buildings used for the Trust's services or for administrative purposes are stated in the balance sheet at their revalued amounts, Under IAS 16 this is the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date Fair values are determined as follows:

Land and non-specialised buildings - market value for existing use

Specialised buildings - depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location Since then, 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.

Land and buildings were valued as at 31 March 2010 valuation was conducted by Drivers Jonas LLP (an independent valuer) who performed this in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and in accordance with International Financial Reporting requirements The assets were valued by reference to the market conditions prevailing at the valuation date

At 31 March 2011, the carrying valuation, as updated for movments arising in 2010/11, was considered by the Director of Capital Projects and Development (a qualified Chartered Surveyor) who has provided the Trust Board with assurance that property values are not unfairly stated in these financial statements

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

Until 31 March 2008, all fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation on assets of low value ceased and the carrying value of existing assets from that date could be written off over their remaining useful lives and new fixtures and equipment 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 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 Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income

Subsequent expenditure

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

1.10 Intangible assets

Recognition

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

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

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

Measurement

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

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

1.11 Depreciation, amortisation and impairments

Freehold land and properties under construction 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, or, where shorter, the lease term

At each reporting period end, the Trust checks whether there is any indication that any of its tangible 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

If there has been an impairment loss arising from market movements, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure Where an impairment loss arises due to consumption of economic benefits, the loss arising is charged to operating expenses and a transfer is made from revaluation reserve to income and expenditure reserve to the extebnt that there is revaluation reserve available

1.12 Donated assets

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

1.13 Government Grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the offset the expenditure

1.14 Non-current assets held for sale

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

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

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

1.15 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of 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 Leased land is treated as an operating lease Leased buildings are assessed as to whether they are operating or finance leases

The Trust as a 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

The Trust does not currently lease assets under finance leases as lessor, but does lease investment property under operating leases as a lessor

1.16 Private Finance Initiative (PFI) transactions

The Trust has no PFI transactions to report

1.17 Investment properties

Investment property is defined in IAS 40 as property (land or a building or part of a building, or both) held (by the owner or by the lessee under a finance lease) to earn rentals or for capital appreciation or both, rather than for:
(a) use in the production or supply of goods or services or for administrative purposes; or
(b) sale in the ordinary course of business
Properties rented out for the purpose of staff or relatives accommodation or insignificant parts of buildings rented out under an operating leases are not classified as investment property

Investment property is initially valued at cost and thereafter stated at fair value Fair value is the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction

The property was valued as at 31 March 2010 valuation was conducted by Drivers Jonas LLP (an independent valuer) who performed this in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual and in accordance with International Financial Reporting requirements The assets were valued by reference to the market conditions prevailing at the valuation date
At 31 March 2011, the carrying valuation, as updated for movments arising in 2010/11, was considered by the Director of Capital Projects and Development (a qualified Chartered Surveyor) who has provided the Trust Board with assurance that property values are not unfairly stated in these financial statements
Under IAS 40 revaluations will be performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the balance sheet date
Gains and losses arising from the revaluation of Investment properties are recognised in the surplus for the year

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value This is considered to be a reasonable approximation to fair value due to the high turnover of stocks Work-in-progress comprises goods in intermediate stages of production Partially completed contracts for patient services are not accounted for as work-in-progress but are accounted for as receivables This is because partially completed patient episodes are verified between NHS providers and commissioners as part of the intra-NHS Debtor/Creditor balances agreement

1.19 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.

1.20 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 balance sheet date, 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 or 1 8% for pension related liabilities.

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 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 restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

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

1.22 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

1.23 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

1.24 Financial Assets

Financial assets are initially recognised at fair value This is determined as follows:

- the fair value of financial assets and financial liabilities with standard terms and conditions and traded on active markets are determined with reference to quoted market prices
- the fair value of other financial assets and financial liabilities (excluding derivative instruments) are determined in accordance with generally accepted pricing models based on discounted cash flow analysis
- the fair value of derivative instruments are calculated using quoted prices. Where such prices are not available, use is made of discounted cash flow analysis using the applicable yield curve for the duration of the instrument

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

Financial assets at fair value through profit and loss

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

The Trust has not into entered any contracts that have different risks and characteristics to their host contract.

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

The Trust does not hold any held to maturity investments and it is thought that any NHS trust is unlikely to have these.

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

The Trust does not hold any 'available for sale' financial assets.

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

Other than for current trade receivables, fair value is determined by reference to quoted market prices where possible, otherwise by discounted cash flow techniques

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

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

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

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

1.25 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

Financial liabilities are classified as either financial liabilities at fair value through profit and loss or other financial liabilities

Financial liabilities at fair value through profit and loss

Derivatives and contracts with embedded derivatives that are separable from the host contract under IAS 39 but 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 income statement. The net gain or loss recognised in the income statement incorporates any interest paid on the financial liability.

The Trust has not entered into any such contracts

Other financial liabilities

Other financial liabilities including borrowings are initially measured at fair vali amortised cost using the effective interest method, with interest expense recc method is a method of calculating the amortised cost of a financial liability an effective interest rate is the rate that exactly discounts estimated future cash

1.26 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in genera recoverable. Irrecoverable VAT is charged to the relevant expenditure categ Where output tax is charged or input VAT is recoverable, the amounts are sta

1.27 Foreign currencies

The Trust's functional currency and presentational currency is sterling Trans sterling at the exchange rate ruling on the dates of the transactions. At the e foreign currencies are retranslated at the spot exchange rate on 31 March R recognised in the Trust's surplus/deficit in the period in which they arise

1.28 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) a beneficial interest in them Details of third party assets are given in Note 31 t

1.29 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital represents taxpayers equity in the NHS Foundation T and require repayments of, PDC from the Trust. PDC is recorded at the valu under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payabl dividend The charge is calculated at the real rate set by HM Treasury (curre liabilities, except for donated assets and cash balances with the Governemer General) The average carrying amount of assets is calculated as a simple a

1.30 Losses and special payments

Losses and special payments are items that Parliament would not have conte legislation By their nature they are items that ideally should not arise. They with the generality of payments They are divided into different categories, wl Losses and special payments are charged to the relevant functional heading would have been made good through insurance cover had NHS foundation tr then being included as normal revenue expenditure) The note on losses and compensations register which reports amounts on an accruals basis with the

1.31 Going concern

The accounts have been prepared on a going concern basis since the Directors are satisfied that the activities of the Trust are sustainable for the foreseeable future

1 32 Accounting standards issued but not yet effective

The following standards, amendments and interpretations have been issued by the International Accounting Standards Board (IASB) and International Financial Reporting Interpretations Committee (IFRIC) but are not yet required to be adopted or are not yet effective:

Change	Published by IASB	Financial year to which change may first apply
IFRS 7 Financial Instruments; disclosures amendments (transfers of financial assets)	Oct-10	Effective date noted as 2012/13. but not yet adopted by EU
IFRS 9 Financial Instruments		Uncertain Notlikely to be adopted by EU until IASB has completed its financial instrument study
- Financial Assets	Nov-09	
- Financial Liabilities	Oct-10	
IAS24 Income Taxes Amendment	Nov-09	2011/12
Annual Improvements 2010	May-10	2011/12
IFRIC 14 Amendment	Nov-09	2011/12
IFRIC 19 "Extinguishing financial lioabilities with equity instruments"	Nov-09	2011/12

The Directors anticipate that the adoption of these standards and interpretations in future periods will have no material impact on the financial statements All other revised and new standards have not been listed here as they are not considered to have an impact on the Trust The Department of Health does not permit the early adoption of accounting standards, amendments and interpretations that are in issue at the reporting date but effective at a subsequent reporting period

2. Segmental Analysis

Service line reporting is currently being implemented by foundation trusts and will enable the Trust to produce more detailed information relating to income and expenditure by operating segments The system is expected to be operational from 1 April 2011

2.1 Revenue analysis by customer type

	Year to 31 March 2011				Ten months to 31 March 2010
	English NHS bodies	Other UK NHS bodies	Non NHS	Total	Total
	£000	£000	£000	£000	£000
Patient care activities	223,263	2,736	3,098	229,097	168,372
Private patient healthcare	-	-	24,387	24,387	18.549
Other non patient care services to other bodies	-	-	534	534	175
Education. training and research	15,219	-	2,818	18,037	20,444
Income from ancillary services	-	-	7,650	7,650	6,303
Charitable funding	-	-	4,315	4,315	3,014
	238,482	2,736	42,802	284,020	216,857

Revenue from ancillary services consists of:	£000	£000
Clinical excellence awards	2,633	2,082
Rental revenue from staff accommodation	1,146	927
Rental revenue from operating leases	1,088	950
Catering revenue	1,219	990
Childcare services	623	530
Car parking	151	119
Other	790	705
	7,650	6,303

The majority of funding is provided via Primary Care Trusts which accounted for 10% or more of the trusts total income for the year to 31 March 2011 (all PCTs are classed as a single customer because they are under common control) Revenue for patient care and other operating activities from this body was as follows:

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Primary Care Trusts	202,117	147.978
Percentage of total revenue	71%	68%

3 Private patient income

	Year to 31 March 2011	Base year 2002/03	Ten months to 31 March 2010
	£000	£000	£000
Private patient income	24,387	15,708	18,549
Total patient related income	253,484	109,452	186,921
Proportion (as a percentage)	9.6%	14.4%	9.9%

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 (the Private Patient Cap)

4. Revenues from patient care activities

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Strategic Health Authorities	**16,318**	12,745
NHS Trusts	**2,918**	2,067
Primary Care Trusts *	**202,117**	147,978
Foundation Trusts	**1,910**	1,939
NHS Other	**2,736**	2,777
Non NHS:		
- Private patients	**24,387**	18,549
- Overseas patients (non-reciprocal)	**387**	405
- Ancillary services	**2,711**	461
	253,484	186,921

* Income from Primary Care Trusts includes £3,561,000 at 31 March 2011 (2010 - £2,260,000) recognised for partially completed patient episodes

5. Other Operating Revenues

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Education, training and research	**18,287**	20,444
Charitable and other contributions to expenditure	**1,454**	1,131
Transfers from Donated Asset Reserve	**2,862**	1,883
Non-patient care services to other bodies	**283**	175
Other revenue	**7,650**	6,303
	30,536	29,936

Revenue is almost totally from the supply of healthcare services Revenue from the sale of goods, other than as part of healthcare provision, is immaterial.

6. Operating Expenses

Operating expenses comprise:

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Directors' costs	927	766
Staff costs	163,996	126,870
Supplies and services - clinical	69,706	49,570
Supplies and services - general	9,105	7,142
Professional services	1,453	944
Establishment	4,271	4,065
Transport	1,558	1,167
Premises	8,021	6,354
Increase in provision for impairment of receivables	281	185
Depreciation	15,089	9,407
Audit fees	148	132
Clinical negligence	1,137	891
Education and training	717	617
Other	395	1,948
	276,804	210,058

Staff costs include £851,000 (2010 - Nil) incurred under the Mutually Agreed Resignation Scheme (MARS) to enable restructuring of the Trust.

Exit packages included in staff costs above are summarised:

Exit Package Cost Band	No of Compulsory Redundancies	No of Other Departures agreed	Total number of exit packages by cost band
<£10,000		15	15
£10,000 - £25,000		18	18
£25,001 - £50,000		10	10
£50,001 - £100,000		2	2
Total No of exit packages by type	0	45	45
Total Resource Cost (£'000)		851	851

7 Operating leases

7.1 As Lessee

The Trust was a party to seven operating leases with a total expenditure of £160,000 during the year to 31 March 2011 Terms of renewal or extension to leases are agreed towards the end of the contract at market rent

Purchase options are not included in operating lease contracts. Any decision to purchase the asset at the end of the lease period would be based on market prices at the time

In the case of any dispute between the Trust and the lessor regarding the condition of the assets when returned to the lessor a jointly appointed expert will be used to arbitrate and to deliver a binding decision Early termination sums are generally payable in respect of the period up to the end of the full contract, for the full contract price discounted at 4% per annum, and in the event of total loss of the asset, the discounted residual value of the asset

There were no contingent rents or sub leases payable

Payments recognised as an expense

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Minimum lease payments	160	249

Total future minimum lease payments

	Equipment Leases	Equipment Leases
	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Operating leases which expire:		
Within 1 year	115	274
Between 1 and 5 years	-	115
After 5 years	-	-
	115	389

7.2 As Lessor

The Trust has eight investment properties on the Brompton and Harefield sites that are leased out under operating leases Up to 31 March 2011, the leases were typically for 5 to 10 years and rents are received quarterly

Each lease is subject to the Landlord and Tenant Act 1954 and the 1995 Landlord and Tenant (Covenants) Act and will be renegotiated at market rate at the end of the lease term None of the lease agreements provide for an option to purchase

From 1 April 2011, new operating leases were agreed, involving a minimum occupancy period of two years, thereafter either party being able to provide six months' notice to vacate

Rental Revenue

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Basic rent	1,088	714
Contingent rent	-	236
Total	1,088	950

Total future minimum lease payments receivable

	Year to 31 March 2011	Ten months to 31 March 2010
	£000	£000
Receivable within one year	1,708	846
Receivable between 1 and 5 years	1,708	448
Payable after 5 years	0	72
Total	3,416	1,366

8. Employee costs and numbers

8.1 Employee costs

	Year to 31 March 2011			Ten months to 31 March 2010
	Permanently Employed	Agency Staff	Total	Total
	£000	£000	£000	£000
Salaries and wages	121,463	17,029	**138,492**	108,061
Social Security costs	11,528	-	**11,528**	9,012
Employer contributions to NHS BSA- Pensions Division	13,615	-	**13,615**	10,563
Termination costs (inc Restructuring cost of £851,000)	1,288		**1,288**	
	147,894	**17,029**	**164,923**	127,636

8.2 Average numbers of persons employed

	Year to 31 March 2011			Ten months to 31 March 2010
	Permanently Employed	Agency Staff	Total	Total
	Number	Number	Number	Number
Medical	364	27	**391**	364
Administration and estates	676	43	**719**	695
Healthcare assistants and other support staff	104	32	**136**	141
Nursing, midwifery and health visiting staff	1,129	126	**1,255**	1,239
Scientific, therapeutic and technical staff	469	14	**483**	470
Total	**2,742**	**242**	**2,984**	2,909

8.3 Retirements due to ill-health

During the period there were two (10 months to 31/03/10 - Nil) early retirements on the grounds of ill-health The cost of ill-health retirements is borne by the NHS Business Services Authority - Pensions Division

9 Pension costs

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

The Scheme is subject to a full actuarial valuation every four years by the Government Actuary (until 2004, based on a five year valuation cycle) and an accounting valuation every year

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 However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8 5% of their pensionable pay depending on total earnings

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service A lump sum normally equivalent to 3 years pension is payable on retirement

Scheme provisions from 1 April 2008

The Scheme is a "final salary" scheme and is split into two Pension 'sections':

- the "1995 section", which has an annual pension based on the 1/80th of the best of the last 3 years' service and a lump sum normally equivalent to 3 years pension for staff with pensionable service pre-April 2008 and less than a 5 year gap in service
- the "2008 section" which has an annual pension based on 1/60th of the best 3 out of the last 10 years' pensionable pay for each year of service No lump sum is payable on retirement

Staff have been provided with the opportunity to remain in the 1995 section or move into the 2008 section

General

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 This will be based on consumer prices with effect from 1 April 2011

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through mental or physical infirmity A death gratuity is payable for death in service or after retirement, the terms of which differ depending on the section to which the member belonged

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 income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions provided by an approved panel of life companies Under the arrangement employees can make additional contributions to enhance their pension benefits The benefits payable relate directly to the value of the investments made

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

Where a scheme member ceases NHS employment with more than two years' service they can preserve their accrued NHS pension for payment when they reach the scheme's retirement age

Where a scheme member is made redundant they may be entitled to early receipt of their pension plus enhancement at the employer's cost

Further details of both schemes, including the changes made in 2008, can be found on the NHS Pensions website www nhsbsa nhs uk/pensions

10 Better Payment Practice Code

10.1 Better Payment Practice Code - measure of compliance

	Number	£000
	Year to 31 March 2011	
Total non-NHS trade invoices paid in the year	**61,916**	**138,788**
Total non-NHS trade invoices paid within target	**27,459**	**49,362**
	44%	**36%**
	10 Months to March 2010	
Total non-NHS trade invoices paid in the period	54,997	98,150
Total non-NHS trade invoices paid within target	39,749	63,801
Ten months to 31 March 2010	72%	65%
Total NHS trade invoices paid in the year	**2,060**	**32,597**
Total NHS trade invoices paid within target	**518**	**23,205**
Percentage of NHS trade invoices paid within target	**25%**	**71%**
	10 Months to March 2010	
Total NHS trade invoices paid in the period	1,825	26,515
Total NHS trade invoices paid within target	927	20,436
Ten months to 31 March 2010	51%	77%

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

There was no interest paid for late payments in the year to 31 March 2011 (10 months to 31/03/10 - Nil)

11. Investment income

	Year to 31 March 2011 £000	Ten months to 31 March 2010 £000
Interest revenue:		
Bank accounts	**32**	22
	32	22

12. Other gains and losses

	Year to 31 March 2011 £000	Ten months to 31 March 2010 £000
Revaluation gain on investment properties	**4,028**	2,305
	4,028	2,305

13. Interest payable

	Year to 31 March 2011 £000	Ten months to 31 March 2010 £000
Interest on obligations under finance leases	**(38)**	(46)
Other interest and finance costs	**(20)**	(17)
Total	**(58)**	(63)

14. Property, plant and equipment

2010/2011 :	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	46,639	100,534	6,352	10,387	53,720	15,315	232,947
Additions purchased	-	-	-	20,631	-	-	20,631
Additions donated	-	-	-	5,015	-	-	5,015
Reclassifications	-	21,144	-	(31,952)	9,120	1,688	-
Disposals other than by sale	-	-	-	-	(280)	-	(280)
Revaluation gains	947	-	-	-	-	-	947
Impairments (note 17)	-	(5,892)	-	-	-	-	(5,892)
Balance at 31 March 2011	**47,586**	**115,786**	**6,352**	**4,081**	**62,560**	**17,003**	**253,368**
Depreciation at 1 April 2010	-	4,550	605	-	36,859	7,321	49,335
Disposals other than by sale	-	-	-	-	(280)	-	(280)
Charged during the period	-	7,820	523	-	4,235	2,511	15,089
Balance at 31 March 2011	**-**	**12,370**	**1,128**	**-**	**40,814**	**9,832**	**64,144**
Net book value at 31 March 2011	**47,586**	**103,416**	**5,224**	**4,081**	**21,746**	**7,171**	**189,224**
Net book value at 31 March 2011							
Purchased	47,586	100,476	5,224	3,983	11,801	4,238	173,308
Finance Leased					622		622
Donated	-	2,940	-	98	9,323	2,933	15,294
Balance at 31 March 2011	**47,586**	**103,416**	**5,224**	**4,081**	**21,746**	**7,171**	**189,224**
Net book value at 31 March 2011							
Protected assets	45,986	96,924	-	-	-	-	142,910
Unprotected assets	1,600	6,492	5,224	4,081	21,746	7,171	46,314
Total at 31 March 2011	**47,586**	**103,416**	**5,224**	**4,081**	**21,746**	**7,171**	**189,224**

Specialised buildings are valued at depreciated replacement cost, and whilst there is no direct market for these they were referenced to the current costings in the market and the demands of healthcare providers in the market.

Land and non specialised buildings are valued at Existing Use Value (i.e. fair value assuming ongoing use) which will have reference to market conditions.

Internally let accommodation (i.e. nurses accommodation) has been valued on an Existing Use Value for Social Housing.

Additions to donated assets have been mainly funded by Royal Brompton and Harefield Charitable Funds.
See note 1.9 for further details on the valuation methods applied.

14. Property, plant and equipment (continued)

10 Months to 31 March 2010 :	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Information technology	Total
	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 June 2009	42,208	99,681	7,108	11,551	49,650	12,740	222,938
Additions purchased	-	-	-	12,477	-	-	12,477
Additions donated	-	-	-	2,067	-	-	2,067
Reclassifications	-	7,993	-	(15,708)	5,140	2,575	-
Reclassification of investment property to property, plant and equipment	1,600	-	-	-	-	-	1,600
Disposals other than by sale	-	-	-	-	(1,070)	-	(1,070)
Revaluation gains	2,831	-	-	-	-	-	2,831
Impairments (note 17)	-	(7,140)	- 756	-	-	-	(7,896)
Balance at 31 March 2010	**46,639**	**100,534**	**6,352**	**10,387**	**53,720**	**15,315**	**232,947**
Depreciation at 1 June 2009	-	760	35	-	34,868	5,335	40,998
Disposals other than by sale	-	-	-	-	(1,070)	-	(1,070)
Charged during the period	-	3,790	570	-	3,061	1,986	9,407
Balance at 31 March 2010	**-**	**4,550**	**605**	**-**	**36,859**	**7,321**	**49,335**
Net book value at 31 March 2010	**46,639**	**95,984**	**5,747**	**10,387**	**16,861**	**7,994**	**183,612**
Net book value at 31 March 2010							
Purchased	46,639	93,497	5,747	10,155	9,173	4,264	169,475
Finance Leased					902	29	931
Donated	-	2,487	-	232	6,786	3,701	13,206
Balance at 31 March 2010	**46,639**	**95,984**	**5,747**	**10,387**	**16,861**	**7,994**	**183,612**
Net book value at 31 March 2010							
Protected assets	45,039	88,910	-	-	-	-	133,949
Unprotected assets	1,600	7,074	5,747	10,387	16,861	7,994	49,663
Total at 31 March 2010	**46,639**	**95,984**	**5,747**	**10,387**	**16,861**	**7,994**	**183,612**

14. Property, plant and equipment (continued)

14.1 Economic lives of property, plant and equipment

Asset lives for each class of asset generally fall within the following ranges:

	Minimum life in years	Maximum life in years
Buildings excluding dwellings	25	40
Dwellings	25	40
Plant and machinery	4	7
Transport Equipment	2	7
Information Technology	2	4
Furniture and fittings	4	7

15. Intangible assets

The Trust has no intangible assets to report

16 Investment properties

Properties owned by the Trust are leased out on operating leases The asset values are as follows:

Year to 31 March 2011	Land £000	Buildings £000	Total £000
Fair value at 31 March 2010	12,200	9,600	21,800
Revaluation	1,150	2,878	4,028
Fair value at 31 March 2011	13,350	12,478	25,828

Ten months to 31 March 2010	Land £000	Buildings £000	Total £000
Valuation at 1 June 2009	14,000	8,795	22,795
Revaluation	1,500	805	2,305
Reclassification of investment property to property, plant and equipment	(1,600)	-	(1,600)
Reclassification of investment property to retained earnings reserve	(1,700)	-	(1,700)
Fair value at 31 March 2010	12,200	9,600	21,800

At 31 March 2011, the carrying valuation, as updated for movments arising in 2010/11, was considered by the Director of Capital Projects and Development (a qualified Chartered Surveyor) who has provided the Trust Board with assurance that property values are not unfairly stated in these financial statements

The rental terms are typically for 5 to 10 years

The properties are leased out on tenants repairing leases (meaning that the lessor retains responsibility for repairs and maintenance) so any direct operating expenses relating to the property are considered immaterial and are not recorded

17. Impairments to Fixed Assets

	Year to 31 March 2011 £000	Ten months to 31 March 2010 £000
Impairments charged to the revaluation reserve and donated asset reserve	(5,892)	(7,896)

18. Capital Commitments

Contracted capital commitments not otherwise included in these financial statements are:

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	**2,966**	4,314

19. Inventories

	31 March 2011 £000	31 March 2010 £000
Drugs	**1,060**	1,039
Consumables	**9,783**	8,278
Total	**10,843**	9,317

20. Trade and other receivables

20.1 Trade and other receivables

	31 March 2011 £000	31 March 2010 £000
Amounts falling due within one year:		
NHS receivables	**13,084**	14,348
Other trade receivables	**7,172**	6,892
VAT	**639**	329
Accrued income	**778**	3,453
Provision for impairment of receivables	**(4,451)**	(6,335)
Prepayments	**1,269**	1,637
Other receivables	**79**	406
Total	**18,570**	20,730

NHS receivables include £3,561.000 (31 March 2010 £2,260,000) as the value of partially completed patient episodes at 31 March 2011

Receivables include £325,000 from the Royal Brompton and Harefield Hospital Charitable Fund (31 March 2010 £410.000)

The great majority of activity 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 is considered necessary

20.2 Receivables past due date but not impaired	31 March 2011 £000	31 March 2010 £000
By up to 3 months	4,127	2,839
By 3 to 6 months	890	373
By more than 6 months	126	225
Total	5,143	3,437

20.3 Provision for impairment of receivables

	31 March 2011 £000	31 March 2010 £000
Balance brought forward	6,335	1,790
Amount written off during the period	(2,165)	(59)
Increase in receivables impaired	281	4,604
Balance carried forward	4,451	6,335

Receivables written off in the year represent debts where management have come to the view that all appropriate means and methods of collection have been exhausted

21 Other financial or current assets

The Trust has no other financial or current assets to report

22 Cash and cash equivalents

	31 March 2011 £000	31 March 2010 £000
Balance as at 1 April	13,023	3,876
Net change in period	3,656	9,147
Balance carried forward at 31 March	16,679	13,023

The cash and cash equivalents balance comprises:

Cash with Government Banking Service accounts	16,673	13,017
Commercial banks and cash in hand	6	6
Total cash and cash equivalents	16,679	13,023

23 Trade and other payables

	Current	
	31 March 2011	31 March 2010
	£000	£000
NHS payables	**2,956**	3,324
Non-NHS trade payables	**5,345**	5,474
Tax and social security costs	**3,707**	3,558
Accruals	**10,016**	7,918
Deferred Income	**4,087**	5,070
Other	**6,676**	6,838
Total trade and other payables	**32,787**	32,182

Payables include £1,761,000 outstanding pension contributions at 31 March 2011 (31 March 2010 £1,625,000)

There were no non-current trade and other payables

24 Borrowings

	31 March 2011	31 March 2010
	£000	£000
Current		
Finance lease liabilities	**278**	278
Bank borrowing	**12,681**	2,242
Total current borrowings	**12,959**	2,520
Non-Current		
Finance lease liabilities	**210**	488
Total non-current borrowings	**210**	488
Total borrowings	**13,169**	3,008

The Trust benefits from a Working Capital Facility of £18million as authorised by Monitor, against which £5million had been drawn down at 31 March 2011 (2010 - Nil).

25 Finance lease obligations

Amounts payable under finance leases:

	Minimum lease payments		Present value of minimum lease payments	
Plant and equipment	**31 March 2011**	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Within one year	**278**	306	**278**	278
Between one and five years	**245**	510	**210**	488
After five years	**-**	-	**-**	-
Less future finance charges	**(35)**	(50)		
Present value of minimum lease payments	**488**	766	**488**	766
Included in:				
Current borrowings	**278**	278	**278**	278
Non-current borrowings	**210**	488	**210**	488
Total	**488**	766	**488**	766

The Trust has not entered into any finance leases for the use of land or buildings and no contingent rents are payable

The finance lease terms typically do not contain options to purchase the equipment and where leases are renewed, they are renegotiated towards the end of the lease term

Early termination sums are payable by the Trust where contracts are terminated early

In the majority of cases, it is the responsibility of the Trust to keep the goods serviced. maintained and repaired and in good working order

All lease contracts are governed and construed according to English law

The total future minimum lease payments is discounted by the interest rate inherent in the leases at their inception to arrive at the present value of minimum lease payments The difference between the two figures represents the finance charge to be treated as interest payable the term of the leases

26 Provisions

	Current		Non current	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
Pensions relating to other staff	**42**	83	**1,047**	1,028
Legal claims	**101**	101	**-**	-
	143	184	**1,047**	1,028

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	**Total**
	£000	£000	£000	**£000**
At 1 April 2010	-	1,111	101	1,212
Arising during the period	-	-	-	0
Utilised during the period	-	(42)	-	(42)
Unwinding of discount	-	20	-	20
Balance at 31 March 2011	**-**	1,089	101	1,190
Expected timing of cash flows:				
Within one year	-	42	101	143
Between one and five years	-	168	-	168
After five years	-	879	-	879

The provision for pensions is calculated using expected life tables and is discounted over the estimated period of the pension recipient They are therefore subject to a degree of uncertainty in amount and timing

£19,655.000 is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010 £14,150,000)

27 Contingencies

During 2010/11 a review of children's congenital heart services in England was launched on behalf of the Joint Committee of Primary Care Trusts (JCPCT). The Trust has sought a judicial review of the JCPCT's consultation process and the business case underpinning it. The outcome of this is awaited; however, whatever the result there should be no significant impact on the Trust's funding arrangements prior to 1 April 2013

	At 31 March 2011	At 31 March 2010
	£000	£000
Advised by NHS Litigation Authority in respect of clinical negligence cases	16	28

28 Financial Instruments

28.1 Financial assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
NHS receivables	-	13,084	-	13,084
Non NHS receivables	-	5,486	-	5,486
Cash at bank and in hand	-	16,679	-	16,679
Total at 31 March 2011	-	35,249	-	35,249
NHS receivables	-	14,348	-	14,348
Non NHS receivables	-	6,382	-	6,382
Cash at bank and in hand	-	13,023	-	13,023
Total at 31 March 2010	-	33,753	-	33,753

28.2 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	£000	£000	£000
NHS payables	-	(2,956)	(2,956)
Non NHS payables	-	(29,831)	(29,831)
Borrowings (bank debt)	-	(12,681)	(12,681)
Borrowings (finance lease obligations)	-	(488)	(488)
Total at 31 March 2011	-	(45,956)	(45,956)
NHS payables	-	(3,324)	(3,324)
Non NHS payables	-	(28,858)	(28,858)
Borrowings (bank debt)	-	(2,242)	(2,242)
Borrowings (finance lease obligations)	-	(766)	(766)
Total at 31 March 2010	-	(35,190)	(35,190)

As allowed by IFRS 7, short term trade receivables and payables measured at amortised cost may be excluded from the above disclosure as their book values reasonably approximate their fair values.

28.3 Financial risk management

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

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

Currency risk

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

Interest-rate risk

Where appropriate, the Trust borrows from Government for capital expenditure subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1-25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. During the year, the Trust drew down funds against its working capital facility on two occasions. The related interest cost is based on LIBOR; however, the total interest cost from this arrangement did not exceed £10,000 in the year. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because of the majority of the Trust's income comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposure as at 31 March 2011 is in receivables from other customers, as disclosed in the Trade and Other Receivables note.

Liquidity risk

Most of the Trust's operating costs are incurred under contract with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust currently funds its capital expenditures from its own resources and from grants recieved from external bodies.

29 Events after the balance sheet date

Other than the matter described under Note 27. there were no disclosable post balance sheet events

30 Prudential Borrowing Limit (PBL)

	31 March 2011 Authorised £000	Actual £000
Total long term borrowing	47,100	210
Working capital facility	18,000	5,000
Total	65,100	5,210

30.1 Financial Ratios

	2010/11 Approved PBL Ratio	Year to 31 March 2011 Actual PBL Ratio
Minimum dividend cover (times)	> 1x	4.0x
Minimum interest cover (times)	> 3x	453.6x
Minimum debt service cover (times)	> 2x	71.3x
Maximum debt service to revenue (%)	< 2.5%	0.1%

The Trust's actual performance for the period was within the ranges set by Monitor for the PBL financial ratios disclosed above

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

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

- The amount of any working capital facility approved by Monitor

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

31 Third Party Assets

Under the Tenancy Deposit Scheme, the Trust holds £107,665 (31 March 2010 £96,134) in a deposit account for tenants renting accommodation owned by the Trust. These arrangements are not recognised in the accounts as the Trust has no beneficial interest in them

32 Intra-Government and Other Balances

	Current receivables	Current payables
	£000	£000
Balances with other Central Government Bodies	11,627	1,377
Balances with Local Authorities	-	3
Balances with NHS Trusts and Foundation Trusts	1,457	1,576
Intra Government balances	13,084	2,956
Balances with bodies external to Government	5,486	29,831
Balance at 31 March 2011	18,570	32,787
Balances with other Central Government Bodies	7,783	1,745
Balances with Local Authorities	-	3
Balances with NHS Trusts and Foundation Trusts	1,457	1,576
Intra Government balances	9,240	3,324
Balances with bodies external to Government	11,490	28,858
Balance at 31 March 2010	20,730	32,182

33 Losses and Special Payments

There were 86 cases of losses and special payments totalling £37,000 during the year to 31 March 2011 (2010 - 116 cases; £32,000) These amounts are reported on an accruals basis when identified but exclude provisions for future losses

34 Related Party Transactions

The Royal Brompton and Harefield NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health
During the period none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust

The Department of Health is regarded as a related party. During the period the Royal Brompton and Harefield NHS Foundation Trust has had numerous material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are Strategic Health Authorities, Primary Care Trusts, NHS Trusts, the NHS Litigation Authority and the NHS Supplies Chain

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 Imperial College of Science, Technology and Medicine (relating to research projects) and the London Borough of Hillingdon and the Royal Borough of Kensington and Chelsea (relating to National Non-Domestic Rates). The Trust operates in close collaboration with the National Heart and Lung Institute of Imperial College of Science, Technology and Medicine to deliver education, research and medical care.
The Trust has also accounted for revenue and capital receipts and receivables from Royal Brompton & Harefield Hospital Charitable Funds £325,000 was owed to the Trust by the charity on 31 March 2011 (31 March 2010 - £410,000) and this is included in the Trust's debtors figure (see note 20) The Trust acts as a corporate trustee of the charitable funds, whose audited accounts are available separately

35 Interest In Subsidiary

The Royal Brompton and Harefield NHS Foundation Trust owns 100 per cent of the ordinary share capital of The Chelsea Private Hospital Ltd The cost of this investment is £100 The Chelsea Private Hospital Ltd is a dormant company Group accounts have not been prepared

36 Corporate Trustee

The Royal Brompton and Harefield NHS Foundation Trust is the Corporate Trustee of the Royal Brompton and Harefield Hospital Charitable Fund, registered charity no 1053584 The Corporate Trustee is responsible for preparing the Trustee's Report and the financial statements of the Charitable Fund These are available on the Charity Commission's website

IAS 27 would otherwise require the consolidation of the accounts of the NHS Foundation Trust with the accounts of the Royal Brompton & Harefield Hospital Charitable Fund. However, the requirement to consolidate has been specifically excepted in guidance applying to these accounts.

37 Remuneration Report

Salary and Pension entitlements of senior managers

Remuneration

	1st April 2010-31st March 2011			1st June 2009-31st March 2010		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	Rounded to the nearest £100
Sir Robert Finch. Chairman	60 - 65			45 - 50		
Robert J Bell. Chief Executive	215 - 220			165 - 170	15 - 20	
Prof T Evans. Medical Director	40 - 45	210 - 215*		35 - 40	180 - 185*	
Robert Craig, Chief Operating Officer	125 – 130			95 - 100	10 - 15	
C Shuldham, Director of Nursing, Governance and Informatics	105 – 110			85-90	5 - 10	
M Lambert. Director of Finance and Performance	140 -145			115 -120	10 - 15	
J Hill , Non-Executive Director	15 - 20			10 - 15		
Prof A. Newman-Taylor. Non-Executive Director	10 - 15			10 - 15		
Richard Hunting, Non-Executive Director	10 - 15			10 - 15		
C Croft, Non-Executive Director (resigned 31/10/10)	5 - 10			10 - 15		
Nicholas Coleman Non-Executive Director	15 - 20			10 - 15		
Kate Owen Non-Executive Director (appointed 06/10/10)	5 - 10					
Neil Lerner Non-Executive Director	20 - 25			0 - 5		

* of which £75,000 to £80,000 is National Award (2010 - £60,000 - £65,000) and £130,000 to £135,000 remuneration as hospital consultant (2010 - £115,000 - £120,000)

Pension entitlements of senior managers

Pension Benefits

Name and title	Real increase in pension and related lump sum at retirement age at 31 March 2011 (bands of £2.500) £000	Total accrued pension and related lump sum at retirement age at 31 March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase/(Decrease) in Employer Funded Cash Equivalent Transfer Value £000
Robert J Bell Chief Executive	10 0 – 12 5	50 - 55	n/a	240	n/a
Prof T Evans. Medical Director	37 5 – 40 0	385 - 390	2,042	1,879	63
Robert Craig,Chief Operating Officer	10 0 – 12 5	140 - 145	482	493	-38
C Shuldham. Director of Nursing & Quality	0 0 – 2 5	195 - 200	1,068	1064	-52
M Lambert. Director of Finance and Performance	5 0 – 7 5	30 - 35	105	91	10

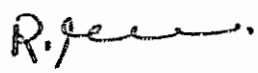
Pension calculations are provided by NHS Pensions Agency (NHSPA)

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

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme. not just their service in a senior capacity to which the disclosure applies The CETV figures. and from 2004-05 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 CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries

There is no CETV for employees who have reached retirement age

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



Robert J Bell, Chief Executive
(on behalf of the Board)
31-May-11

Annex 2

Quality Report for the year ended 31 March 2011

Independent Auditor's Assurance Report to the Board of Governors of Royal Brompton & Harefield NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Royal Brompton and Harefield NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Royal Brompton & Harefield NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

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

Scope and subject matter

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

Respective responsibilities of the Directors and auditors

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

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

We read the other information contained in the Quality Report and considered whether it is inconsistent with the specified documents in the Monitor guidance.

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

Assurance work performed

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

- Making enquiries of management;

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

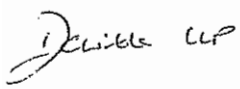
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

Conclusion

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



Deloitte LLP

Chartered Accountants

St Albans

1 June 2011

Quality Report 2010-11

Contents

Statement of Directors' Responsibilities

The directors of the Royal Brompton and Harefield NHS Foundation Trust have prepared this Quality Account 2011-12, as required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010.

The directors are satisfied that that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- that the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010 to June 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
    - Feedback from the commissioners dated 21/05/2011
    - Feedback from governors dated 09/05/2011
    - Feedback from Hillingdon LINks dated 25/05/2011 and Kensington and Chelsea LINks dated 26/05/2011
    - The trust's draft complaints report due to published under regulation 18 of the Local Authority, Social Services and NHS Complaints Regulations 2009, dated 27/07/2011
    - The national inpatient survey 2009 and 2010
    - The national staff survey 2010
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 12/04/2011
    - CQC quality and risk profiles dated 02/03/2011
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft gov uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www monitornhsft gov uk/annualreportingmanual)).

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

By order of the Board

Sir Robert Finch
Chairman
31st May 2011

Robert J Bell
Chief Executive
31st May 2011

Part 1: Chief Executive Statement

Royal Brompton & Harefield NHS Foundation Trust is a national and international specialist heart and lung centre based in Chelsea, London and Harefield, Middlesex
We help patients of all ages who have heart and lung problems. From the moment they arrive, our patients become part of a community of people who have benefited from more than 160 years of expert diagnosis, treatment and long-term care.
Our care extends from the womb, through childhood, adolescence and into adulthood and as a specialist trust, our patients come from all over the UK, not just from our local areas.

We are committed to providing patients with the best possible specialist treatment for their heart and lung condition in a clean, safe place, ensuring that evidence-based care is provided at the right time, in the right way, by the right people.
Our vision is to be 'the UK's leading specialist centre for heart and lung disease' and we have set three main strategic goals to ensure we achieve this;

- Service Excellence
- Organisational Excellence
- Productivity and Investment

These are underpinned by a set of key objectives and values of which the most important is to continuously improve the patient experience.

In order to achieve this we have established a robust system to ensure that we are accountable for continuously monitoring and improving the quality of our care and services. Our highly skilled workforce is dedicated to pursuing the best outcomes for patients through delivery of excellent clinical care and research into new treatments and therapies.

Our outcomes in both adult and paediatric care are amongst the best in the country and we have achieved some of the lowest MRSA and *clostridium difficile* rates in England.

We were assessed by the NHS Litigation Authority in September 2010 in relation to our risk management and were awarded Level 3 status – which is the highest possible level and reflects the emphasis placed on ensuring quality and safety are at the heart of everything we do.

Despite an impressive record in quality and safety we are not complacent; weaknesses are dealt with promptly and openly so that better and safer systems of care can be developed.

Signed by the Chief Executive to confirm that, to the best of his knowledge, the information in this document is accurate.

Robert J Bell
Chief Executive Royal Brompton & Harefield NHS Foundation Trust

Part 2a: Priorities for Improvement

Review of Priorities for Quality Improvement 2010-11

In 2010/11 the Trust identified three priority areas for improvement which were put forward by a working group consisting of clinicians and managers and taking account of patient input and feedback. The priorities were shared with Trust stakeholders including patient groups, local LINks, Foundation Trust Governors, and Overview and Scrutiny Committees via the quality account consultation process in 2010. The priorities were also in alignment with the Commissioning for Quality and Innovation (CQUIN) scheme which was agreed with our commissioners.

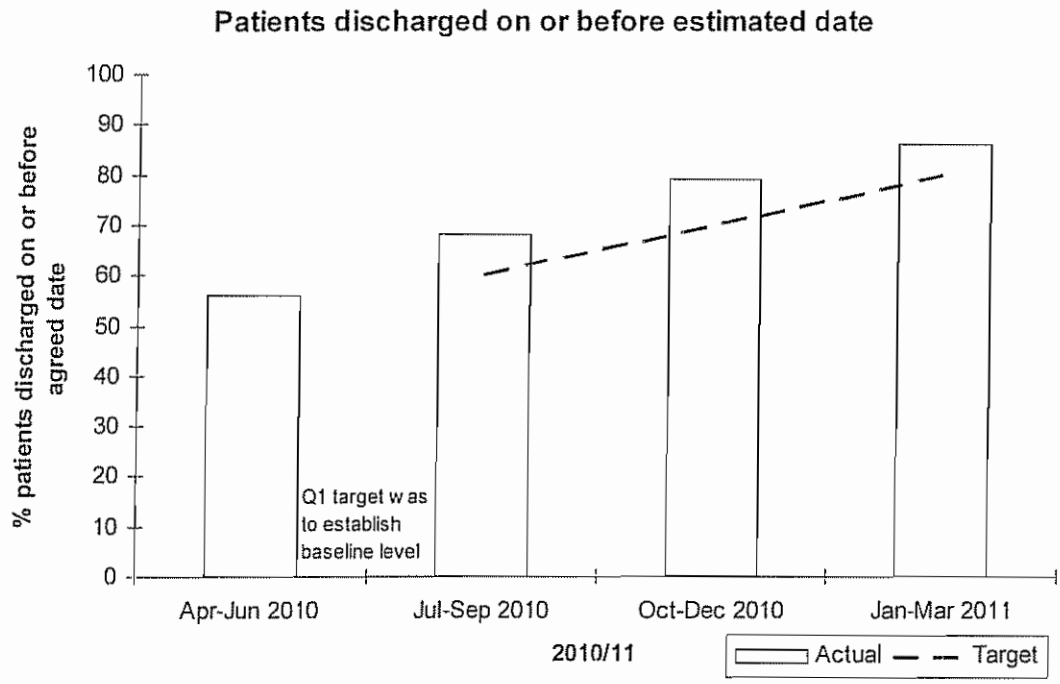
The priority areas for 2010/11 fall within three categories:

- Patient Experience – making the discharge process easier for patients
- Clinical Effectiveness – providing more training for staff in safeguarding children
- Patient Safety – ensuring the incidence of surgical site infection is reduced

Discharge on agreed date

The Trust has been working on making sure we advise our patients of their estimated date of discharge and that we keep to this date whenever it remains clinically appropriate to do so. With this in mind, in 2010/11 we have been working to improve the numbers of patients who go home on or prior to their agreed discharge date when clinically appropriate.

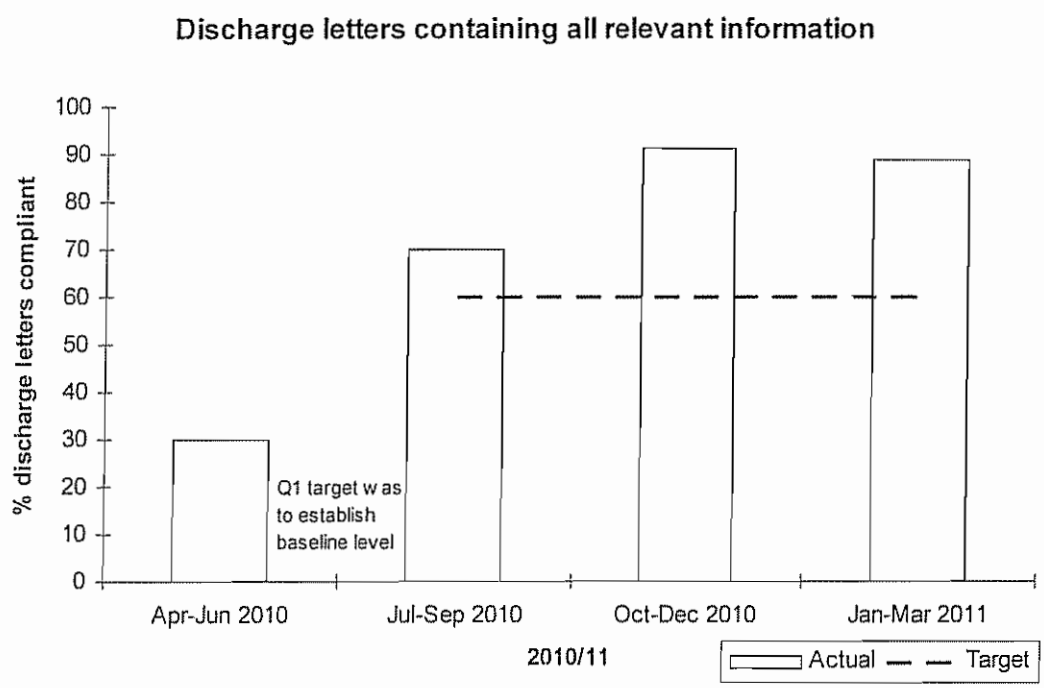
The chart below shows how the Trust has been performing against this target and demonstrates that there has been a steady increase in the number of patients being discharged on or before their agreed date. In the first quarter of the year the baseline was set, from which the targets were set for each quarter with a final target of 80% of patients being discharged on or before their agreed date. In the subsequent three quarters the chart shows the target has been exceeded with 86% of patients discharged in quarter 4 having been discharged on or before their agreed date.



Information in discharge letters

In conjunction with the discharge improvements above, in 2010/11 the Trust has also been working to improve the quality and timeliness of the discharge information which we provide to our patients and their general practitioners. The Trust is compliant with the national contract for inpatient discharge summaries which dictates what information must be included in the summary. The Trust has been working to routinely include additional information in discharge summaries in order to improve the quality and provide more information to the patient and their GP.

The chart below shows how the Trust has performed in 2010/11 on including additional information in inpatient discharge summaries. This data is based on sample audits carried out each quarter (total summaries audited by end of Q4 was 252). In the first quarter the baseline was established from which the target of 60% was set for the rest of the year. As the chart shows the target has been exceeded in the subsequent quarters of the year with 89% of the discharge summaries audited in Q4 having the additional information included. This inclusion of additional information in the discharge summary should provide a comprehensive source of information for both the patient and their GP on the admission at the Trust.

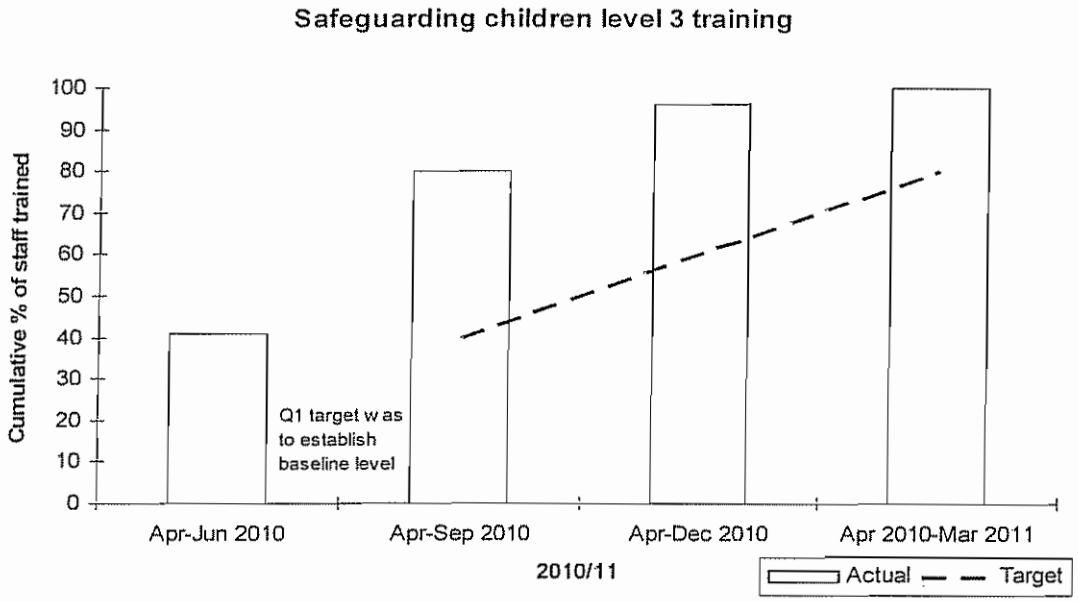


Safeguarding children: level 3 training for staff working in children's areas

The Trust takes the safety of its youngest patients extremely seriously. All new members of staff are assessed to determine whether a Criminal Records Bureau (CRB) check is required and those who will be working with children undergo an enhanced level of assessment. The Trust's process around safeguarding children was reviewed by the Safeguarding Children Improvement Team in September 2010 as part of a peer review of NHS safeguarding children processes within the borough of Kensington & Chelsea. In this review the Royal Brompton Hospital was commended for its processes throughout its services. In late 2010 the Trust appointed to a new post, Safeguarding Children and Young People Nurse Advisor, to support the designated nurse for safeguarding children.

The trust has also been working to ensure all relevant staff undertake the correct level of training. In light of the nationwide review of child protection carried out by Lord Laming following the death of Baby P, the Department of Health revised the training requirements of people working with children in relation to safeguarding. In response to this, the Trust reviewed its policy on safeguarding children and the training provided and established which staff groups needed training at level 1, 2 or 3. Level 3 is the most comprehensive training and is required by all staff who work predominantly with children, young people and their parents. In response to this level 3 courses were commissioned from the start of February 2010 to ensure eligible staff received level 3 training by the end of 2010/11.

The chart below shows the progress made in 2010/11 in delivering level 3 training to relevant staff. A cumulative target was set to aim to have trained 80% of relevant staff by the end of the year but as the chart shows the target was consistently overachieved and by the end of the year 100% of staff had received training.

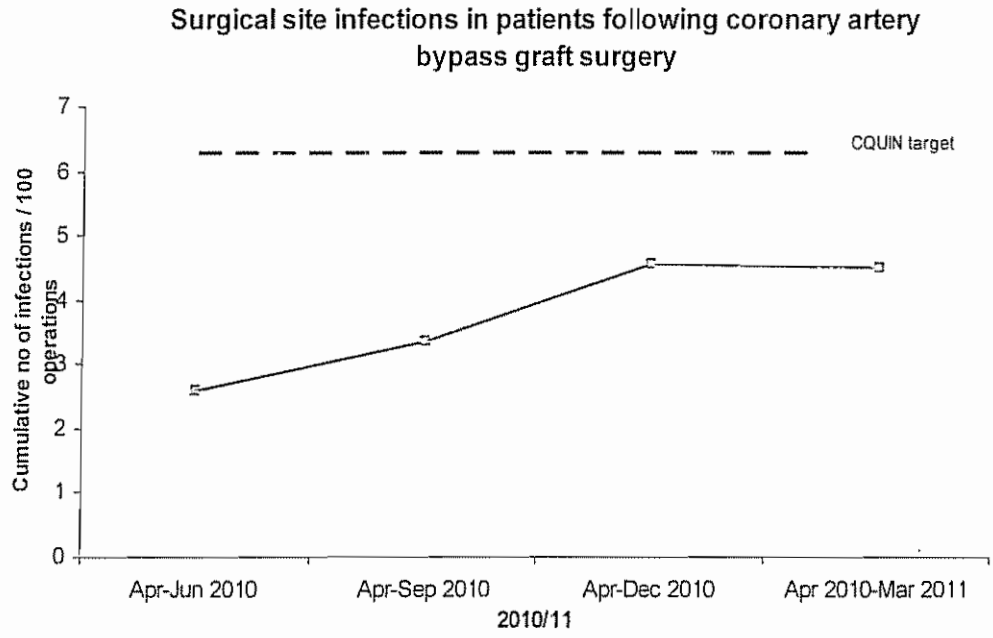


The Trust has continued to work to maintain its excellent record of incidences of infections which for both MRSA and *C difficile* have remained very low. Whilst these rates are very low, our surgical site infection rates (wound infections following surgery) can be improved and hence the Trust has been aiming to reduce surgical site infections with an initial focus on patients undergoing coronary artery bypass grafts and cardiac valve replacement operations. The Trust has a team of infection control nurses who carry out surveillance on all patients undergoing cardiac operations to monitor their wounds and capture and record infections at the site of surgery.

Reduce surgical site infections for coronary artery bypass grafts (CABG)

The Trust routinely collects surgical data on patients undergoing cardiac procedures. This includes data from the Infection Control team who have been collecting and reporting infection data on patients undergoing CABG since 2000 which is reported within the Trust and also to the Health Protection Agency (HPA).

As part of the commissioning for quality and innovation scheme (CQUIN) the Trust has agreed set targets with our commissioners for reducing the number of infections experienced by patients following CABG procedure. As part of the CQUIN scheme the targets set were linked to financial payments where the number of infections is reflected in the percentage of payment received. The chart below shows the Trust's cumulative number of infections over 2010/11. The chart demonstrates that the number of infections at the Trust at year end 2010/11 for patients undergoing CABG was 4.5 / 100 operations This level of infection is well below the upper target set and therefore the Trust has achieved the highest level of compliance and will receive 100% of the CQUIN payment.



The table below shows the number of surgical site infections per 100 operations following a CABG procedure for the two previous years. As can be seen the target for 2010/11 was considerably lower than the rate for previous years yet has been easily achieved.

Infection rate following CABG procedures

Year	Number of infections / 100 operations
2008/09	6.91
2009/10	7.16[1]
2010/11	4.50

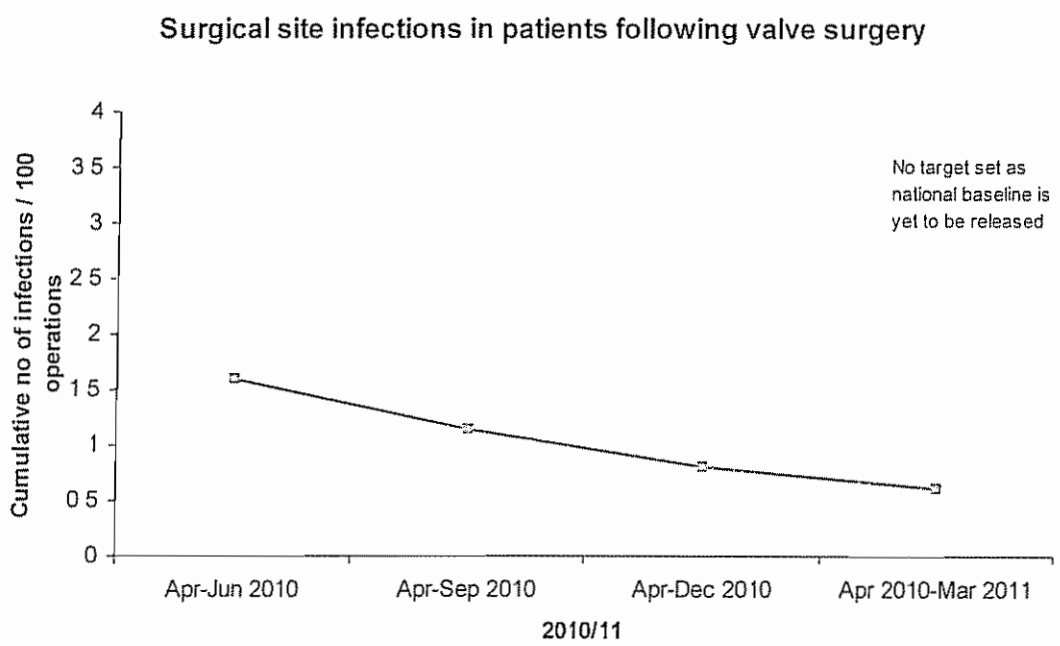
The Trust has been working hard to reduce surgical site infections and has introduced various new practices which have contributed to this. There is a new option for harvesting the vein required for patients undergoing CABG. The vein is harvested endoscopically therefore reducing the infection risk and also enabling the patient to mobilise more rapidly following the procedure.

The Trust is using a new wound dressing for both cardiac and thoracic surgery which allows the wound to be examined without removal thereby reducing the exposure to infection. Patients have also reported finding the new wound dressing comfortable.

[1] Please note: in the 2009-10 Quality Report this figure was reported as 7 45. The difference is because the data in the Quality Report represents preliminary figures for SSI only The national deadlines for production of the Quality Report do not give time for final, validated figures to be included.

Reduce surgical site infections for cardiac valve procedures

The Trust routinely collects surgical data on patients undergoing cardiac valve procedures. The Infection Control team have carried out surveillance of patients undergoing valve procedures since April 2009. The chart below shows there has been a reduction in the number of infections per 100 operations over the year 2010/11 with a rate of 0.62 infections / 100 operations. No target was set for this indicator as the national baseline has yet to be released, however, it was agreed to aim to reduce the rate or maintain the level if performance was good by year end. However, the overall rate of infections per 100 operations in 2009/10 was 1.96 which is considerably higher than the year end figure for 2010/11. This demonstrates a considerable reduction in the infection rate in the past 12 months



Priorities for Quality Improvement 2011/12

The Trust is required to choose between 3 and 5 priorities for improvement in relation to quality each year. These priorities must encompass the key areas of patient safety, clinical effectiveness and patient experience.

This year, the Trust has taken a new approach to the choice of these priorities to better understand what really matters to patients, carers, staff, FT members and governors and other key stakeholders, such as our local LINks, and to better engage our health community in the activities of the Trust.

To this end, we have asked individuals to vote on-line for what is their preferred quality project in each of the three key areas for the Trust to focus on in 2011/12. Voters had the chance to choose from a shortlist of 14 topics, and this list had been carefully selected to reflect key national, local and trust areas for improvement.

The process for this and the topics selected for the shortlist were developed in consultation with both Hillingdon and Kensington and Chelsea LINks, and with our Governors.

The shortlist is shown below with the topics which received the most votes emboldened. The priority topics are detailed on the following pages.

Patient Safety:

- Accuracy of medication prescribing
- **Availability of patient notes for appointments and hospital stays**
- Use of national guidelines e.g. NICE
- **Discussion of Treatment Plans at a Multi-Disciplinary Team (MDT)**
- Accurate training records of nursing staff

Patient Experience

- Minimising cancellation of planned operations
- Minimising the waiting time when coming for an outpatient appointment
- **Planning the care of patients who are terminally ill**
- Care of patients who experience a stroke whilst in hospital

Patient Outcomes

- **Care of patients who have a cardiac arrest (heart attack) whilst in hospital**
- Minimising unnecessary delays for patients on day of discharge
- Planning the care of diabetic patients undergoing surgery
- Maximising nutrition for paediatric patients
- Use of patient reported outcome measures (PROMS tool)

These quality priorities will be monitored routinely throughout the year, and reported up to Trust Board on a quarterly basis.

Availability of patient notes for appointments and hospital stays

Patient Safety – ensuring patient records are always available for outpatient clinics

Rationale

It is important that the full patient record is always available when patients attend the outpatient clinic. The Trust takes this very seriously and has a good record in achieving this, but we feel we could do better, particularly in ensuring we always know where every set of paper records are, so we can easily locate them if they are needed at short notice.

Quality Standards

1) 99% of paper patient records are available at the start of the outpatient clinic
2) 95% of clinics have access to the electronic patient record
3) 75% of paper patient records are tracked to the location they are in

Discussion of Treatment Plans at a Multi-Disciplinary Team (MDT) Meeting for Elective Patients Undergoing Surgery

Patient Safety – ensuring elective patients where appropriate have their treatment plans discussed and agreed in an MDT meeting prior to surgery.

Rationale

The Trust carried out a survey on priority areas for quality improvement asking patients, staff, public, FT members and Governors to vote for their priority topics. Shared decision-making for treatment plans was selected as one of the topics.

The Trust's electronic patient record (EPR) is very limited at the moment and does not contain key information on records of multidisciplinary team discussions, clinical examinations and assessment by specialist teams. For example assessment and recommendations of Speech and Language Therapists - are key for management of many advanced respiratory patients.

Quality Standards

As per the relevant MDT operational policy:
1) 90% of elective patients who need to be discussed at an MDT have their treatment plans discussed and agreed in an MDT meeting prior to cardiac surgery
2) 90% of elective patients who need to be discussed at an MDT have their treatment plans discussed and agreed in an MDT meeting prior to thoracic surgery (excluding lung cancer)
3) 100% of elective patients have their treatment plans discussed and agreed in an MDT meeting prior to lung cancer surgery

Planning the Care of Patients Who Are Terminally Ill

Patient Experience - improving end of life (EOL) care for our patients.

Rationale

In England around half a million people die each year, nearly two thirds over the age of 75. For the majority, death is preceded by a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. In London there were 50,265 deaths in 2007, representing 0.66 per cent of the population.

This is also a regional CQUIN measure for all Trusts within NHS London.

Quality Standards

1) 95% of patients identified as end of life (last 48 hours of life for expected deaths) are offered an EOL care planning discussion
2) 80% of patients offered a discussion should have an advanced care plan
3) 98% of patients who have an advanced care plan should have a record of the decision to resuscitate stated clearly in the notes
4) 50% of patients who die in hospital (expected deaths) should die on a Liverpool care pathway
5) Trusts, commissioners and community care should work together to audit achievement of death in the preferred place (within the specified RBH pilot project areas (Foulis ward/Adult Intensive Care Unit (AICU)).

In addition we will monitor the number of patients who die in their preferred choice of place and aim to improve on this.

Care of patients [illegible] (Unexpected) Cardiac Arrests

Patient Outcomes – decrease the number of cardiac arrests occurring across the Trust. (excluding those which occur in the high risk area of Intensive Care).

Rationale

DH / NICE evidence shows that reducing out-of-ICU cardiac arrests is a marker of good clinical care of the acutely unwell patient. Ward based patients should either be on an end of life care pathway or should be recognised as deteriorating via the completion of the patient at risk (PAR) scoring system and moved to a higher level of care prior to their arrest.

Quality Standards

1) 95% patients should have a PAR score which is acted upon appropriately.
2) 100% patients who have a cardiac arrest outside of intensive care should be identified and their case reviewed as part of the resuscitation audit.

Part 2b: Statements of Assurance

Provision of NHS Services

During 2010/11 the Royal Brompton and Harefield NHS Foundation Trust provided 16 NHS services.

The Royal Brompton and Harefield NHS Foundation Trust has reviewed all the data available to them on the quality of care in all 16 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Royal Brompton and Harefield NHS Foundation Trust for 2010/11.

The Trust reviews the NHS services it provides to assess the quality of care via many different approaches including: patient and staff surveys; participation in national and local audits; and service improvement projects.

Since 2007 the Trust has carried out a programme of patient safety "walkrounds" where a senior member of the Quality & Safety team and an executive director visit a patient area (such as wards, x-ray, theatres and catheter labs) to listen to staff and patients regarding any safety issues and to address these. These are carried out on a quarterly basis where the executive director is linked to the same area for a period of 12 months.

The programme is constantly evolving and recent changes include: recording the results from all walkrounds electronically to simplify reporting; Trust Governors have begun attending the walkrounds; and the programme has been extended to include patient support areas such as laboratory medicine.

Participation in clinical audit

During 2010/11, 17 national clinical audits and 3 national confidential enquiries covered NHS services that the Royal Brompton and Harefield NHS Foundation Trust provides.

During 2010/11 Royal Brompton and Harefield NHS Foundation Trust participated in 94.4% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Brompton and Harefield NHS Foundation Trust was eligible to participate in, and for which data collection was completed during 2010/11, including actual participation rates, are listed below:

National Clinical Audit[1]	Did trust participate?	Participation rate[2]
Lung Cancer (LUCADA)	✓	100%
Adult Cardiac Interventions	✓	100%
Adult Cardiac Surgery	✓	100%
Cardiac Rhythm Management	✓	100%
Heart failure	✓	100%
Myocardial Ischaemia (MINAP)	✓	100%
Congenital Heart Disease (children and adults)	✓	100%
Paediatric Intensive Care Audit (PICANet)	✓	100%
Endocarditis	✓	100%
Familial Hypercholesterolaemia	✓	100%
Major Complications of Airway Management in the UK	✓	100%
National Audit of Pulmonary Hypertension	✓	100%
National Cardiac Arrest Audit[2]	X	n/a
National Comparative Audit of Blood Transfusion	✓	100%
SCTS Adult Thoracic Surgery	✓	100%
UK Cystic Fibrosis Registry	✓	100%
UKT Cardiothoracic Transplant	✓	100%
Trans-aortic valve implantation (TAVI)	✓	100%

[1] *list of all national clinical audits which RBHNFT was eligible to participate in*

[2] *cases submitted/number of cases required, as a percentage*

National Confidential Enquiry[1]	Did trust participate?	Participation rate[2]
Surgery in Children	✓	100%
Peri-operative Care	✓	100%
Cardiac Arrest Procedures	✓	100%

[1] *list of all national confidential enquiries which RBHNFT was eligible to participate in*

[2] *cases submitted/number of cases required, as a percentage*

[2] **Please note:** The Trust is has made cardiac arrest a Priority topic for 2011-12, and will look to participate in this national audit, as part of this

The reports of 73 national and local clinical audits were reviewed by the provider in 2010/11. Details of some of the key findings and actions taken to improve the quality of healthcare are listed below.

National clinical audits

A process has been put in place to ensure we record and verify all key findings for patients undergoing procedures in the Trust. As well as submitting this data to the national clinical audit registries, we have developed an in-house monitoring system whereby trends in clinical outcomes are monitored and reported monthly. This allows us to identify and investigate at an early stage where outcomes do not meet the high standards we expect. Indeed, this often then leads to more targeted local clinical audits, some examples of which are below.

Local clinical audits

Patient Identification

Audit showed that the way porters identified patients did not always follow the policy, and that they were often expected to remember verbal instructions of where to take patients. Over the last year, the porters have all attended specific training and have started to use a form to record the key information they need, which acts as a reminder and checklist.

Re-audit has shown significant improvement both in understanding the procedure to correctly identify patients and in carrying this out.

PAR Score

The **P**atient-**A**t-**R**isk score allows staff on the ward to quickly identify patients who are becoming acutely unwell, and to take appropriate action to ensure they receive timely care. All wards have a sample of cases audited monthly, and wards are now consistently demonstrating that over 90% of the time patients are correctly scored, and the appropriate action is taken. The next stage is to link this information to the number of cardiac arrests occurring (outside of an intensive care environment). This is one of the Quality Priorities for the trust in 2011/12 (see page 5 of this report).

Bleeding following cardiac surgery

Following a trend noted in the monthly monitoring of outcomes, a trustwide project was initiated on both sites to better understand the reasons for post-operative bleeding and to identify best practice for managing it and preventing it.

This has resulted in a reduction in the rate of re-operation for bleeding to below the national average. See part 3 of this document for more information.

Continuous Positive Airway Pressure (CPAP) therapy for patients with sleep apnoea

The introduction of CPAP machines with integrated smartcards has allowed the sleep apnoea team to access data directly from the machines used by new patients in conjunction with feedback from the patients. This approach is not only more convenient and saves time for patients but it identifies if the machine settings need to be changed to increase symptomatic relief for the patient. In 98% of cases audited the issues were dealt with by the technicians or practitioner and removed the need for the patient to wait for a consultant appointment.

Participation in Research

Staying at the forefront of research and innovation is vital to the delivery of our services as a specialist medical centre for cardiothoracic disease. We have a broad portfolio of research ranging from studies aimed at identifying and validating new therapeutic targets through to pioneering research aimed at developing and evaluating new technologies and treatments. Many of our studies are led scientifically by Trust researchers although we also work in collaboration with other partners.

Our research activities are facilitated through two NIHR Biomedical Research Units; one in cardiovascular disease and one in advanced lung disease, both of which provide the organisational vehicles, state-of-the-art facilities and active patient-public involvement programmes for translational research in the Trust. In addition the Trust participates widely in large-scale evaluative clinical trials, many of which are underpinned by the Trust's clinical trials unit, to determine the effectiveness of new treatments whether developed within or outside of the Trust.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Royal Brompton and Harefield NHS Foundation Trust to the end of quarter 4 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 4177.

In addition a further 1366 patients consented to donate their tissue for retention within the Trust's ethically approved Research BioBank. This tissue will be used in future research within the conditions governing the BioBank's ethical approval.

These patients were recruited to one or more of 229 clinical research studies ongoing in respiratory and cardiovascular disease during quarters 1-4 of 2010/11, approved by a research ethics committee. These studies involved a total of 178 clinical staff.

Our involvement and leadership in clinical research has resulted in 1327 publications in the last three years (2007–2009).

This involvement and leadership in clinical research demonstrates the Royal Brompton and Harefield NHS Foundation Trust's commitment to improving the quality of care we offer and its contribution to the wider health improvement agenda. The involvement of many of our medical staff in research enables them to stay abreast of the latest treatment possibilities and facilitates the Royal Brompton and Harefield NHS Foundation Trust's commitment to testing and offering to its patients the latest and most promising treatments.

Commissioning for Quality and Innovation (CQUIN) 2010/11

1.5% of the Trust's contract income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Royal Brompton and Harefield NHS Foundation Trust and North West London Commissioning Partnership for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/2010%1011_cquin_schemes_in_london.html#1

The Trust believes it has achieved 100% of CQUIN payment for 2010/11, which equates to £2.7 million of income for the Trust. Please note: Achievement of CQUIN goals for quarter 4 has not yet been ratified by the Commissioners.

For more information on the Trust's CQUIN indicators please see part 3 of this document.

Care Quality Commission Registration

Royal Brompton and Harefield NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Royal Brompton and Harefield NHS Foundation Trust applied for registration with the CQC in January 2010 and has been registered, without conditions, since the registration system became effective on 1st April 2010.

At the time of registration, the Trust notified the CQC of some issues in respect of compliance with the essential standard relating to safety and suitability of premises in connection with the Fire Code. In response the CQC noted a 'moderate' concern regarding the safety and suitability of premises standard. During 2010/11, the Trust has undertaken work to ensure full compliance with the Fire Code and full compliance was achieved on 31st July 2010. The CQC have since confirmed satisfaction with the Trust declaration of full compliance with the essential standard relating to safety and suitability of premises.

The CQC has not taken enforcement action against Royal Brompton and Harefield NHS Foundation Trust during 2010/11.

Royal Brompton and Harefield NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

NHS Number and General Medical Practice Code Validity

Royal Brompton and Harefield NHS Foundation Trust submitted records during 2010/11 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. The percentage of records in the published data is as follows:

At 31st March 2011

Indicator	Patient Group	Trust Score	Average National Score
% of patients with a valid NHS number	In-patients	96.2%	98 3%
	Out-patients	97 9%	99.0%
% of patients with a valid GP Practice code	In-patients	99.5%	99 8%
	Out-patients	99 4%	99 6%

Royal Brompton and Harefield NHS Foundation Trust is taking the following actions to improve data quality:

- Implementing the PAS data quality manual, this sets out the framework for managing data quality in that system.
- Raise the profile of data quality across the Trust. Identify areas of weakness and co-ordinate the development of local /system specific data quality manuals.

Information Governance Toolkit attainment levels

Royal Brompton and Harefield NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 76% and was graded satisfactory for all 45 requirements.

Clinical coding error rate

Royal Brompton and Harefield NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

Part 3: Other Information

Quality and Safety Indicators 2010/11

This year, the Trust has chosen to feature some changes to list of indicators from the Quality Account 2009/10. This has been for a number of reasons.

- The Trust wanted to reflect the commentary and recommendations made in the Department of Health (DH) review of last years Quality Account, which showed that many of the indicators used by trusts were difficult to interpret and not able to be benchmarked or compared against national standards.
- The Trust wanted to reflect the key quality and safety indicators which were routinely reported to Trust Board.
- Surgical Site Infection and Pressure Ulcers have been excluded from this section as they were CQUIN measures for 2010/11 - see pages 9 and 33 respectively.
- The staff experience indicators have been excluded because this information is now required to be made publicly available through the Annual Report.
- The World Health Organisation (WHO) surgical checklist indicator has been excluded, as the target was to implement this by the national deadline of Feb 2010. Therefore, this indicator is not relevant for 2011/12.
- Some new indicators have been added: mortality following primary percutaneous coronary intervention (PCI), readmissions, outbreaks of infection, never events, serious incidents, single sex accommodation.

Indicator	Target	Score 2010/11	Score 2009/10	Score 2008/09	Indicator Met?
Patient Safety					
Outbreaks of infection[3]	0	1	1	1	x
Serious Incidents[4]	-	17	9	5	-
Never Events[5]	0	1	-	-	x
PAR Score[6]	≥90%	95.6%	90.5%	-	✓
Catheter-related bloodstream infection[7]	≥90%	90.4%	83.5%	-	✓
Ventilator-acquired pneumonia[8]	≥90%	96.2%	94.5%	-	✓

[3] During February 2011, one bay was closed at Harefield for 5 days due to 4 cases of diarrhoea due to a virological cause (no organism was isolated). No staff or other patients were affected.

[4] Serious Incidents are reported nationally to London SHA and the National Patient Safety Agency. Individual hospitals decide which incidents to report (based on national guidelines) The increase in the number of incidents reported is due to the Trust opting to report more incidents this year.

[5] Never event that occurred was: Misplaced NG tube not correctly identified No historical data available , as this is a new national indicator for 2010-11.

[6] Patient-At-Risk score. A local indicator to monitor the recognition of patients who are deteriorating

[7] A national indicator, part of the Matching Michigan scheme. Assesses completion of care bundle

[8] A national indicator, part of the Matching Michigan scheme Assesses completion of care bundle

Indicator	Target	Score 2010/11	Score 2009/10	Score 2008/09	Indicator Met?
Clinical Effectiveness					
HSMR[9]	Top 20% of Trusts	80.0 (14th)	76 3 (16th)	63.3 (12th)	✓
In-hospital mortality rates[10]					
• 1st time, elective, isolated CABG	≤ 1.0%	1.1%	0.9%	0.9%	x
• 1st time, elective, isolated AVR	≤ 2.8%	1.0%	0.4%	1.8%	✓
• Elective PCIs	≤ 2.0%	0 2%	0.4%	0 6%	✓
• Primary PCIs	≤ 6.5%	5 8%	-	-	✓
• Paediatric congenital procedures	≤ 1 4%	0.9%	1.0%	1.1%	✓
• 1st time heart transplant	≤ 15 0%	See comment below	14.3%	33 3%	-
• 1st time lung transplant	≤ 6.0%	5 2%	5.9%	5.9%	✓
Neurological injury[11]	≥ 90%	95.4%	90.2%	n/a	✓
Readmissions[12]	≤ 7%	1 5%	1.2%	1.4%	✓

[9] HSMR is the Hospital Standardised Mortality Rate, as published by Dr Foster Intelligence Please note: the scores shown here are different to those reported in the Quality Report 2009/10, as Dr Foster have amended the algorithm to calculate these scores

[10] All mortality targets are the national rates published by the Central Cardiac Audit Database and Societies Although 1st time elective CABG is marked as 'not met', this is against the high standard the Trust has set itself At a national level, the Trust is within the expected outcome parameters

[11] Neurological injury – this indicator has changed from the Quality Report 2009/10, to make it more outcome focussed.

[12] Readmissions – this is the % of patients readmitted to hospital within 30 days of discharge. The target for this indicator has been set by the Standard Contract.

Please note: In 2010, 9 heart transplants were performed, which resulted in 4 deaths within 30 days of operation. The small number of transplants performed means that a % mortality rate is not statistically relevant. Mortality following transplant is monitored nationally by the National Commissioning Group and, for 2010/11, the Trust has remained within the expected range.

Indicator	Target	Score 2010/11	Score 2009/10	Score 2008/09	Indicator Met?
Patient Experience					
Complaints per 1000 patient contacts[13]	< 4	3.4	3.6	4.0	✓
Complaints response time[14]	90%	82.8%	-	-	x
Single sex accommodation[15]	0 breaches	0	-	-	✓
Patients would recommend this hospital to family/friends[16]	95%	99%	99%	99%	✓
Key national patient survey indicators[17]					
• Patients were offered a choice of food	89%	94%	91%	92%	✓
• Patients always had enough help with eating meals	78%	82%	79%	75%	✓
• Patients felt they were treated with dignity and respect	90%	95%	91%	92%	✓
• Patients felt the room or ward was clean or very clean	90%	93%	100%	99%	✓

[13] Local indicator.

[14] National Indicator, Trusts should respond to formal complaints with 25 working days.

[15] National indicator, as defined by Care Quality Commission. This is one of the Registration requirements. No historical data available – new indicator for 2010-11.

[16] Local indicator from Trust survey which patients are encouraged to participate in at discharge.

[17] Indicators from NHS Inpatient Survey 2010. The targets have changed from the Quality Report 2009-10, and are now the threshold scores for the top 20% of trusts, as defined by the Care Quality Commission. i.e. a score above the target means the Trust is in the 20% of trusts nationally for this indicator.

National Priorities

The table below shows the key national priorities from the Department of Health's Operation Framework and Monitor's Compliance Framework which were relevant for this Trust in 2010-11.

National Priority	Source	Target/ Threshold	Monitor Weighting	2010/11 Score	Indicator Met
Clostridium difficile - year on year reduction to comply with the trajectory for the year agreed with Kensington & Chelsea PCT	Compliance Framework and Operating Framework (Vital Signs)	27	1.0	18	✓
MRSA – maintaining the annual number of MRSA bloodstream infections at 5 or less (baseline year 2003/04) as agreed with commissioners	Compliance Framework and Operating Framework Vital Signs	2	1.0	2	✓
Maximum waiting time of 31 days for subsequent surgical treatment for all cancers	Compliance Framework and Operating Framework (Vital Signs)	94%	1.0	100%	✓
Maximum two month wait from referral to treatment for all cancers*	Compliance Framework and Operating Framework (Vital Signs)	79%	1.0	86.3%	✓
Maximum two month wait from consultant upgrade to treatment for all cancers*	Compliance Framework and Operating Framework (Vital Signs)	79%	1.0	81.48%	✓
Maximum waiting time of two weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	Compliance Framework and Operating Framework (Existing Commitments)	93%	0.5	100%	✓
Maximum waiting time of 31 days from diagnosis to treatment of all cancers	Compliance Framework and Operating Framework (Existing Commitments)	96%	0.5	98.9%	
Screening all elective in-patients for MRSA	Compliance Framework	-	0.5	1.06	
Self certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliance Framework	-	0.5	-	
Maximum two-week wait standard for Rapid Access Chest Pain Clinics	Operating Framework (Existing Commitments)	98%	-	100%	
All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Operating Framework (Existing Commitments)	<0.8%	-	1.05%	✓^
Delayed transfers of care to be maintained at a minimal level	Operating Framework (Existing Commitments)	-	-	0.31%	✓
Percentage of patients seen within 18 weeks for admitted and non-admitted pathways	Operating Framework (Vital Signs)	Admitted: 90% Non-admitted: 95%	-	Met for all months	✓

*Threshold adjusted to account for 6% additional tolerance applied by CQC in recognition of the complexity of lung cancer pathways

^Indicator underachieved owing to ongoing difficulties balancing capacity and demand >1.5% = Fail

Compliance Framework

In addition to the key national indicators listed on the previous page, Monitor's Compliance Framework also scores the level of concern regarding the safety of healthcare provision. In 2010-11, Monitor had no concerns with the safety of health provision in the Trust.

	Monitor Weighting	Trust Score in 2010-11	Indicator Met
Moderate CQC Concerns regarding the safety of healthcare provision	1.0	0	✓
Major CQC Concerns regarding the safety of healthcare provision	2.0	0	✓
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) or as subsequently amended with the CQC's agreement	4.0	0	✓

The combination of meeting all the Compliance Framework indicators and the CQC having no concerns regarding the safety of healthcare provision has meant that the Trust has been given a Green rating for Governance by Monitor in 2010-11.

Monitor Compliance Framework 2010-11

Governance Rating	Score 0 0	Status – Green

CQUIN Goals 2010/11

The Trust agreed 10 goals with the commissioners for 2010/11, and these measures were a mix of nationally mandated, regionally suggested and locally developed indicators.

These goals were linked to the Trust's contractual income and in total equated to 1.5% of the income (£180 million). In 2010-11, the Trust believes it has achieved all the CQUIN goals, which equates to £2.7 million of income for the Trust. Please note: Achievement of CQUIN goals for Quarter 4 has not yet been ratified by the Commissioners.

1. National CQUIN Indicators			
Goal	Target	Achievement 2010-11	CQUIN met?
Improve VTE Prevention	National Target 90%	90%	✓
Responsiveness to Patient needs	Top 20% of trusts	Top 20% of trusts	✓
2. Regional (London) CQUIN Indicators			
Discharge on agreed date	Q2 – 60% Q3 – 70% Q4 – 80%	86%	✓
Information in Discharge Letters	60% across all divisions	89%	✓
Outpatient letters sent within 5 days	70% across all divisions	82%	✓
Global Trigger Tool	10 sets of notes audited per fortnight	10 sets of notes audited per fortnight	✓
3. Local CQUIN Indicators			
CABG SSI	6 3 per 100 operations	4 5 per 100 operations	✓
Valve SSI	To be agreed – National baseline not released yet	0.62 operations	✓
Safeguarding Children Level 3 Training	80% Trained by Q4	100%	✓
Pressure Ulcers	Improvement in reporting compliance	100%	✓

Five of the indicators and achievement of the goals are detailed in the Quality Improvement Priorities for 2010/11 section (page 5) as they had been identified as priority topics: discharge on agreed date, information in discharge letters, safeguarding children training, surgical site infection following CABG and cardiac valve procedures. The other five indicators are detailed on the following pages

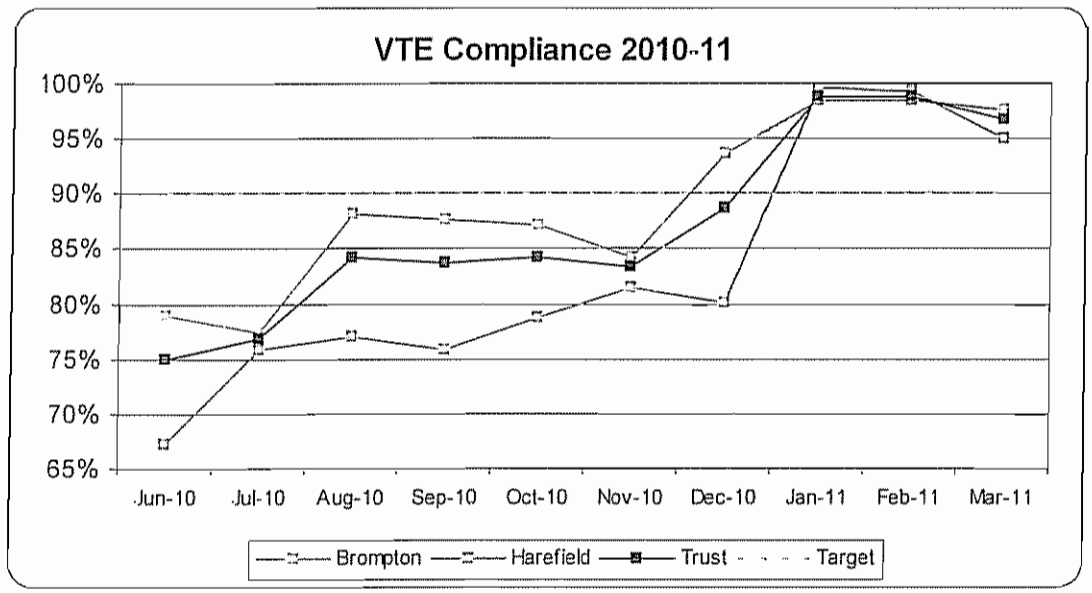
Improve venous thromboembolism (VTE) prevention

Venous Thromboembolism (VTE) is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments can be used. The Department of Health (DH) has commenced data collection to quantify the number of adult admissions who are being risk assessed for VTE from June 2010.

A cohort approach to managing the indicator has been adopted since the DH recognised that the risk assessment is pointless in a large number of patients. The low risk cohorts are procedures where that risk is deemed to be small and so each patient does not need to have an individual assessment. Patients who are in a cohort are added automatically to the numerator in CQUIN.

The percentage of VTE assessments completed in Q4 is 98.1% which means achievement against the target of 90%. January and February showed the highest performance to date with over 99% compliance at Harefield and over 98% compliance at Brompton. This has been achieved through regular ward rounds and logging of assessments by the Trust lead.

VTE compliance since reporting began in June 2010



Improve patient experience as per adult inpatient survey

Responsiveness to patient needs is measured through the NHS inpatient survey once a year. The survey is based on a sample of consecutively discharged inpatients who attended our Trust in June 2010 (see part 3 for more information on the inpatient and outpatient surveys and the actions taken following the 2009 surveys).

This indicator is calculated from 5 survey questions known to be important to patients and where past data indicates room for improvement:

- Involved in decisions about treatment/care
- Hospital staff available to talk about worries/concerns
- Privacy when discussing condition/treatment
- Informed about medication side effects
- Informed who to contact if worried about condition after leaving hospital

The target, agreed with commissioners, is to remain within the top 20% trusts nationally for each of the five questions in order to receive 100% payment.

Achievement of the CQUIN goal is based upon the Care Quality Commission report which was published in April 2011. The Care Quality Commission benchmarks our results with 100% of trusts in England.

The scores in the table below show the Trust scores for 2010 survey in comparison to the results from 2009. It demonstrates that on all five questions the Trust has scored in the top 20% of trusts as reported by the Care Quality Commission.

Trust inpatient survey scores 2009 and 2010

Improving responsiveness to personal needs of patients (CQUIN)	2009	2010	In top 20% of trusts
Care: wanted to be more involved in decisions	76/100	77/100	✓
Care: could not always find staff member with whom to discuss concerns	68/100	72/100	✓
Care: not always enough privacy when discussing condition or treatment	86/100	88/100	✓
Discharge: not fully told side-effects of medications	48/100	55/100	✓
Discharge: not told who to contact if worried	86/100	86/100	✓

The target, as mentioned above, is to remain within the top 20 nationally for each of the five questions in order to receive 100% payment. The Trust is in the top 20% of trusts for all five questions in the Picker report and also in the CQC report which compares the Trust to all trusts in England. Therefore, at year end 2010/11 this has been achieved and the Trust will receive 100% of the payment.

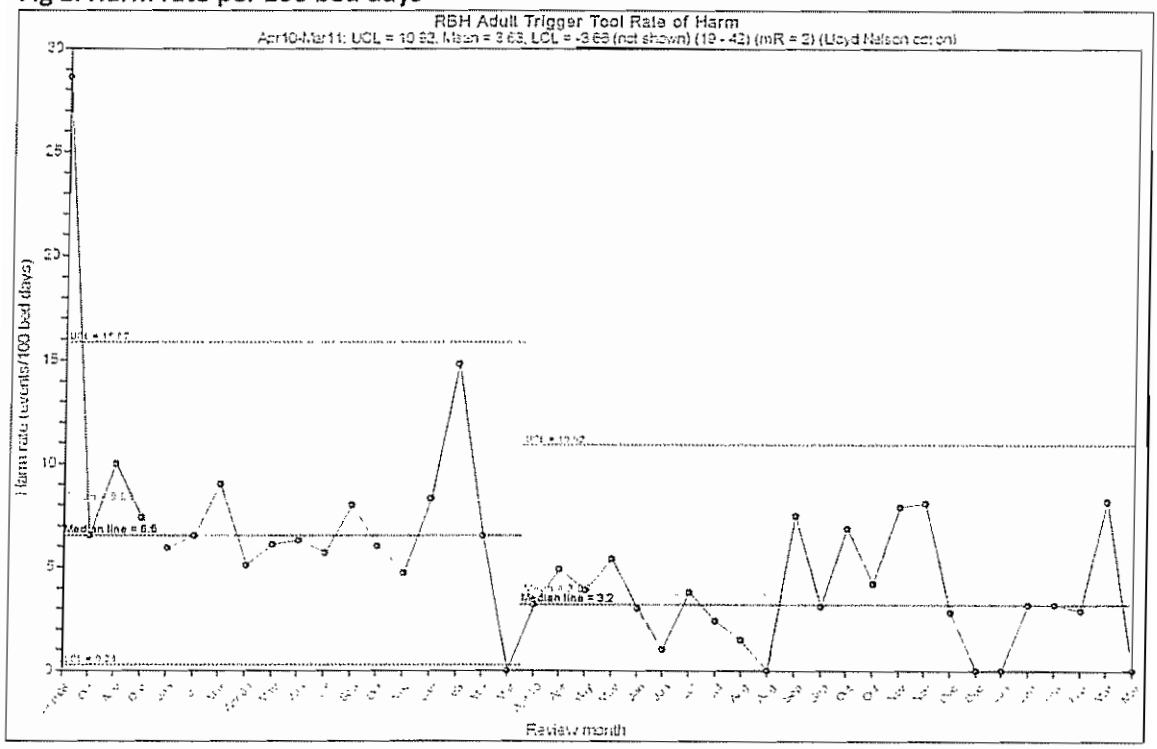
Implement the IHI global trigger tool (GTT)

The adult trigger tool (ATT) was introduced at Brompton Hospital in August 2008 and at Harefield Hospital in September 2010. Regular reviews are now being carried out and, to date, 420 patients have been reviewed over a period of 42 reviews.

At each review 10 sets of patient notes (per site) are reviewed using the trigger tool to measure how many triggers are present in that episode of care and how many events have occurred as a consequence. Each event is then given a harm rating.

Figure 1 below shows the harm rate per 100 bed days. The mean, median and control limits have been calculated for 2010/11 reviews to demonstrate the reduction in harm rate since the introduction of the trigger tool.
Between the period of Sep 08 and Mar 10 the harm rate fluctuated around the median of 6.5 events/100 bed days with two peaks in Sep 08 and Feb 10.
For 2010/11 the median has reduced significantly to 3.2 events/100 bed days with the harm rate continuing to fluctuate around the median to the year end.

Fig 1: Harm rate per 100 bed days



In response to the findings a number of improvement projects have been started:

- Recommendations from the NICE guideline 'Acutely ill patients in Hospital' have been implemented. This means the Trust now has a track and trigger system for identfiying deteriorating patients and monthly monitoring currently demonstrates >95% compliance across the trust.
- Both sites have multidisciplinary groups looking at peri-operative bleeding. There is evidence of a reduction in patients being returned to theatre for bleeding over the last year as a result of this work.

- A cross site group looking at Wound Infection Prevention, has implemented a number of changes to reduce Surgical Site Infection rates. The current rate is comparable to the national rate (as reported by the HPA) and below the CQUIN indicator rate. Wound infections in first time CABG and valve patients are monitored monthly, as is compliance with the SSI prevention care bundle. This has been extended recently to include thoracic wounds and pacemaker implant wounds.
- Work to improve the management of diabetic patients who are at high risk of wound infections is underway, including a business case for a diabetic specialist nurse.

Future Plans

The UK version of Paediatric Trigger Tool was piloted on the Brompton site but it was found to be unsuitable, as it was not sensitive or specific enough for our specialist paediatric patient population. Therefore, we are now working to develop a bespoke tool for use at the Brompton.

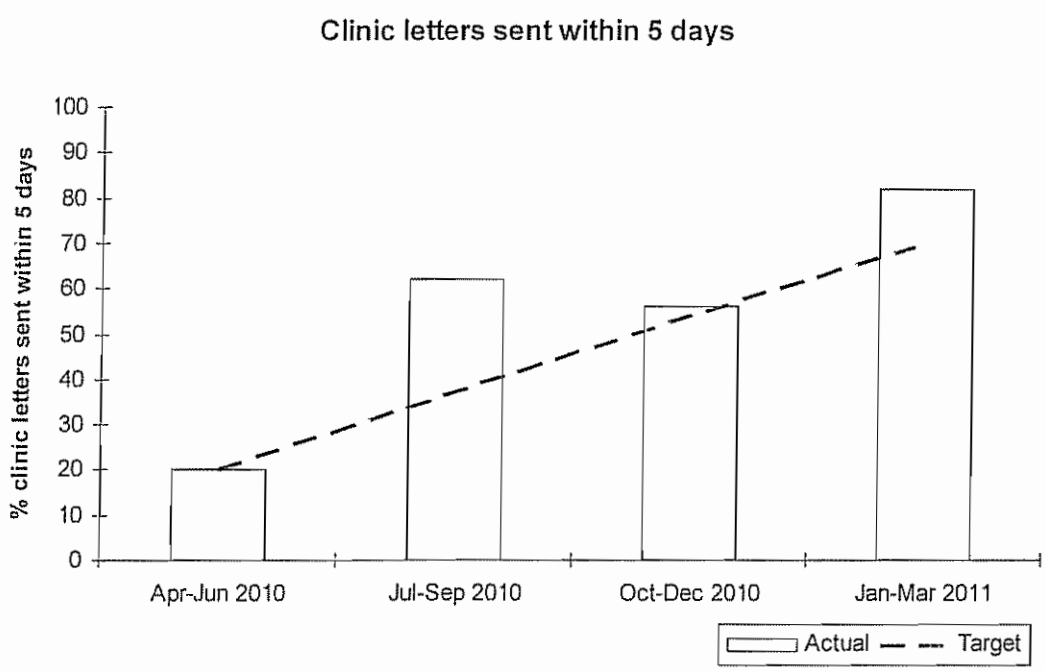
Improve planning of outpatient care

There is a significant increase in new outpatients who have a letter sent to their GP and any other relevant primary care clinician within five days of their first outpatient appointment summarising:

- the ongoing care plan
- if no follow-ups are needed at what point the GP should re-refer or explore other avenues of care (if applicable)
- estimated number of follow up appointments required (if applicable)
- medication and an explanation of why medication has been changed (if applicable)

The indicator requires a minimum of 20% of letters sent within 5 days with the target rising to 70% in the last quarter.

The chart below shows the percentage of clinic letters sent within 5 days of the outpatient appointment. This data was collected from the audits carried out on a quarterly basis which on average looked at approximately 100 sets of notes. The chart shows that by quarter 4 the Trust had exceeded the target of 70% with 82% of letters audited being sent within 5 days.



Preventing pressure ulcers

In 2004, it was estimated that the NHS in the UK spent between £1.4-2.1bn on treating pressure ulcers. In 2008/9 there were over 51,000 pressure ulcers identified, and, of these 6,700 were graded 3 and 5,600 graded 4. While many of these will be present on admission, many are developed in acute care.

This indicator measures the monitoring and prevention of pressure ulcers. During 2010/11 the emphasis was on setting up a robust system across all areas of the Trust which would allow the Trust to accurately monitor the number of pressure ulcers patients were admitted with, and/or occurred whilst an in-patient

The compliance is calculated weekly at ward level. Each ward sends a report including patients who have been admitted with or acquired a pressure ulcer that specific week. The compliance is calculated as the number of times each ward reported during the month divided by the number of weeks in the month. This is then aggregated for all the wards across the trust.

The table below shows that with new management emphasis being placed upon weekly pressure ulcer incidence reporting compliance by nursing management, the reporting on both sites has shown a significant improvement, and we are now confident that the number of pressure ulcers reported is accurate.

No. of patients	Apr-Jun 2010	Jul-Sep 2010	Oct-Dec 2010	Jan-Mar 2011
Admitted with ulcers	43	25	32	28
Hospital acquired ulcers	57	58	81	78
Ulcer reporting compliance	83%	92%	93%	100%

Q4 has shown an increasing improvement in reporting compliance across the trust, rising from 83% in Q1, 92% in Q2, 93% in Q3 and 100% compliance in Q4.

With the increase in reporting compliance there has been a corresponding increase in reported hospital acquired pressure ulcers. Across the Trust in total the hospital acquired pressure ulcers showed an increase of approximately 33% in Q3 However that has been followed by a small reduction in Q4. In Q4 the proportion of Grade 1 pressure ulcers to Grade 2 and above however was 62%:38%.

Actions completed or in progress:

- The implementation of 8 Tissue Viability Champions at Harefield ITU is complete.
- All grade 3 and 4 pressure ulcers have a root cause analysis investigation completed to ascertain cause of ulcer
- The trial introduction of "Anchor Fast" Oral Endotracheal Tube Fastener in ITU Harefield occurred. This device relieves the pressure of the tube from the lips, corners of the mouth and surrounding tissue and eliminates the need for re-taping. Incidence of oral pressure ulcers have reduced and the device will now be rolled out with supporting guidance.
- The P.U.M.P (Pressure Ulcer Management Process) Tool was formally launched in February 2011 in Harefield ITU and is now being uploaded onto the Intensive Care electronic information system. This tool incorporates the Waterlow Risk Assessment Score, NICE Pressure Ulcer Management Guidelines (2005) and RBH and Harefield NHS Foundation Trust Pressure Ulcer Prevention and Management Guidelines for Very High/High Risk Patients (2010). It also gives a measure for dependency and substantiates the use of specialist pressure relieving devices.
- "Aderma" pressure relieving gel pads continue to be the first line management of pressure ulcer prevention and management for very high/high risk patient category patients in accordance with trust guidelines.
- Quarterly Critical Care Magazine to be launched in April 2011 with a specific section for tissue viability issues.

CQUIN Goals 2011/12

The following CQUIN measures have been agreed with the North West London Commissioning Partnership for 2011/12. Goals 5 and 6 were also identified as priority topics for quality improvement and have been detailed in Part 2a (page 5). Further details of the other CQUIN measures for 2011/12 can be found in the table below and on the following pages.

Goal Number	Goal Name	Description of Goal	Goal Weighting[18]
1	**VTE prevention**	Reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)	**15%**
2	**Patient experience-personal needs**	Improve responsiveness to personal needs of patients	**15%**
3	**Pressure Ulcers**	Reduction of grade 2 and 3 pressure ulcers	**10%**
		Evidence in achieving grade 4 ulcer prevention and reduction trajectory	**10%**
4	**Falls**	Reduce the total number of falls according to the agreed trajectory	**10%**
		Reduce the number of falls resulting in "harm" according to the agreed trajectory	**10%**
5	**End of Life Care**	Improving end of life care for people and achieving the quality standards.	**15%**
6	**Availability of patient records in outpatient clinics**	Improving availability of patient records in outpatient clinics	**15%**

[18] as a % of the CQUIN scheme available

Quality and Risk Profile (QRP)

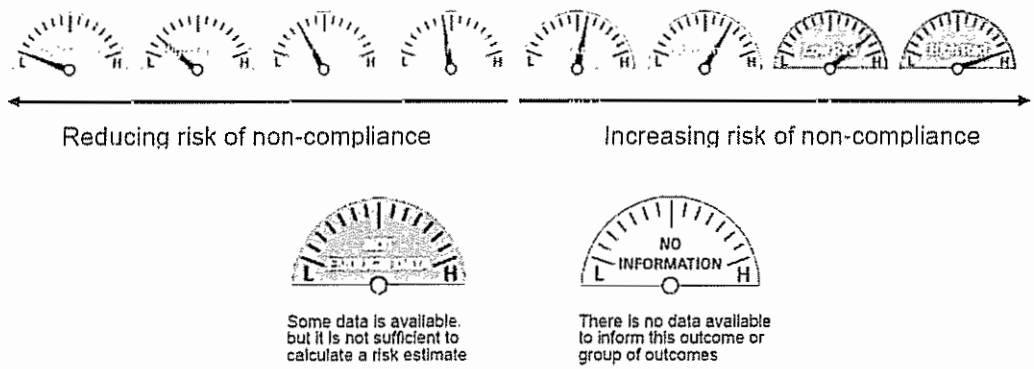
From 1 October 2010, all health and adult social care providers are legally responsible for making sure they meet essential standards of quality and safety and must be licensed with Care Quality Commission (CQC).

The essential standards are monitored by the CQC through the Quality and Risk Profile (QRP). The information presented in the profiles is organised using 16 outcomes and includes both qualitative and quantitative data from:

- Other regulatory bodies – for example the National Patient Safety Agency.
- NHS Litigation Authority.
- Routine data collections – for example, Hospital Episode Statistics and estates return information collection.
- Other CQC regulatory activity – for example, monitoring of compliance with the regulation on cleanliness and infection control.
- National clinical audit datasets.
- Information from people using services – for example NHS Choices and feedback from Local Involvement Networks (LINks).
- National Priorities and Existing Commitments

The CQC will inspect all healthcare providers within two years of registration. The CQC may use the Trust's Quality and Risk Profile as one of the tools to inform them on how the Trust is performing in conjunction with provider compliance assessment (PCA) tools which Trusts complete to detail their compliance against essential standards. These may be requested at any time by the CQC. Inspections by the CQC will be unannounced and will last 2-3 days.

Each standard is measured on a scale from Low Green to High Red.
Low green is the best possible score
High red is the worst possible score



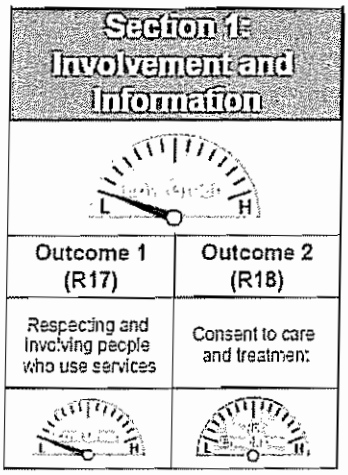
As at March 2011, the Trust scored either green or for all 16 outcomes, which indicates a low risk of non-compliance with the essential standards of care.

The essential standards

The results below are extracted from the QRP for March 2011. The Trust scored between low green and high neutral for all 5 essential standards.

Standard 1: You can expect to be involved and told what's happening at every stage of your care

- You will always be involved in discussions about your care and treatment, and your privacy and dignity will be respected by all staff.
- You will be given opportunities, encouragement and support to promote your independence.
- You will be able to agree or reject any type of examination, care, treatment or support before you receive it.



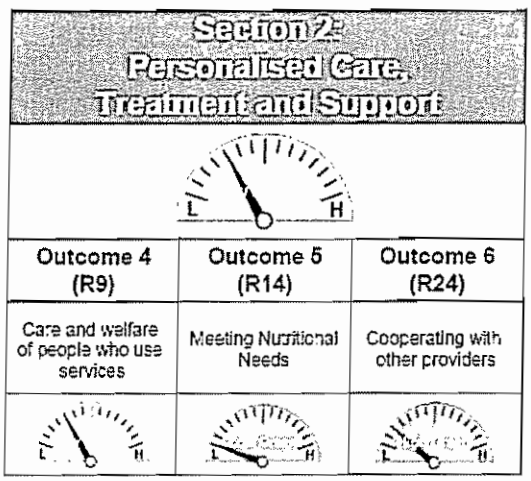
Scores range from low green to high red

Low green is the best possible score

There is only one indicator relating to consent to care and treatment, which his why Outcome 2 is scored as 'Not enough data'.
The Trust scored 'much better than expected' for this indicator

Standard 2: You can expect care, treatment and support that meets your needs

- Your personal needs will be assessed to make sure you get care that is safe and supports your rights.
- You will get the food and drink you need to meet your dietary needs.
- You get the treatment that you and your health or care professional agree will make a difference to your health and wellbeing.
- You will get safe and co-ordinated care where more than one care provider is involved or if you are moved between services.



Scores range from low green to high red

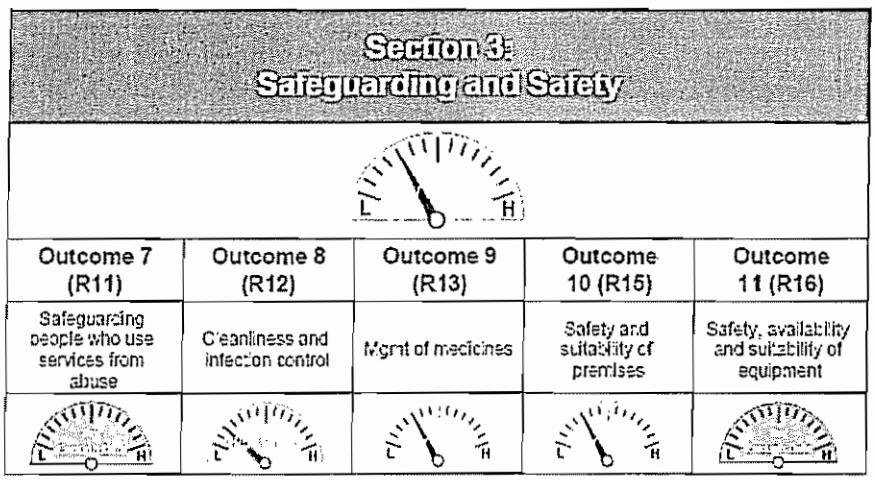
is a better than average score

Low green is the best possible score

High green is the second best possible score

Standard 3: You can expect to be safe

- You will be protected from abuse or the risk of abuse, and staff will respect your human rights.
- You will be cared for in a clean environment where you are protected from infection.
- You will get the medicines you need, when you need them, and in a safe way.
- You will be cared for in a safe and accessible place that will help you as you recover.
- You will not be harmed by unsafe or unsuitable equipment.



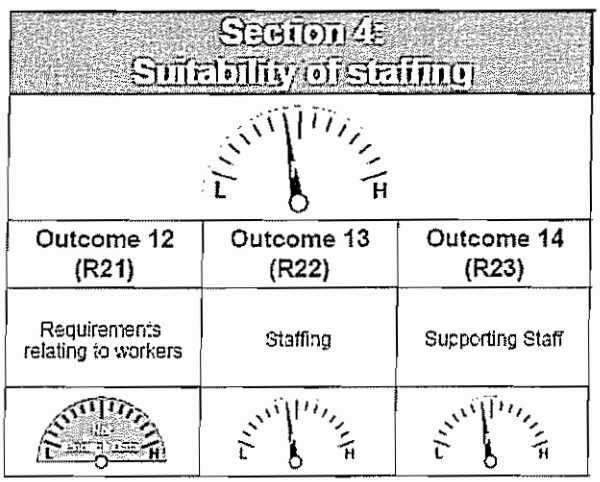
Scores range from low green to high red

is a better than average score

High green is the second best possible score

Standard 4: You can expect to be cared for by qualified staff

- Your health and welfare needs are met by staff who are properly qualified.
- There will always be enough members of staff available to keep you safe and meet your health and welfare needs.
- You will be looked after by staff who are well managed and have the chance to develop and improve their skills.



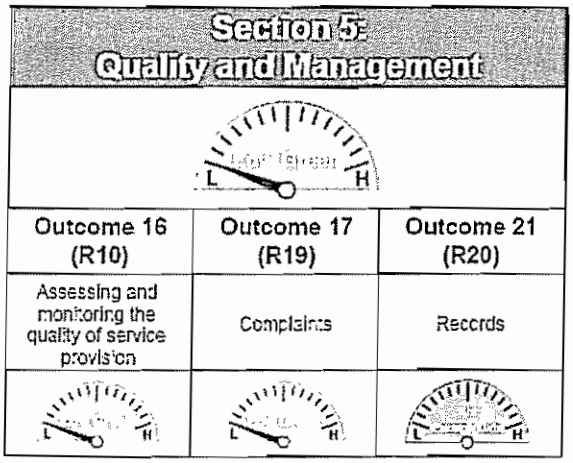
Scores range from low green to high red

is a better than average score

There are only two indicators relating to requirements relating to workers, which his why Outcome 12 is scored as 'Not enough data'.
The Trust scored 'much better than expected' for one indicator, and the other indicator is not yet updated to reflect 2010 results

Standard 5: You can expect your care provider to constantly check the quality of its services

- Your care provider will continuously monitor the quality of its services to make sure you are safe.
- If you, or someone acting on your behalf makes a complaint, you will be listened to and it will be acted upon properly.
- Your personal records, including medical records, will be accurate and kept safe and confidential.



Scores range from low green to high red

Low green is the best possible score

The majority of the indicators relating to records are not relevant to the Trust, which his why Outcome 21 is scored as 'Not enough data'.

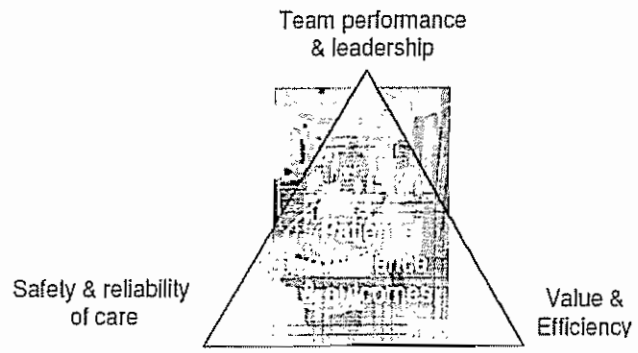
Other Quality Improvement Projects in 2010/11

The Productive Operating Theatre and Catheter Lab Utilisation programme

The Productive Operating Theatres (T-POT) is part of the Productive Series - an improvement programme produced by the NHS Institute for Innovation and Improvement. The Trust had already successfully implemented the Productive Ward in the Trust and intended to use the programme in both theatres and catheter labs. The Trust programme was therefore named TPOT & CUP: The Productive Operating Theatre and Catheter Lab Utilisation Programme.

There are three main areas of the programme, which aim to contribute to improved clinical outcomes and experience for the patient:

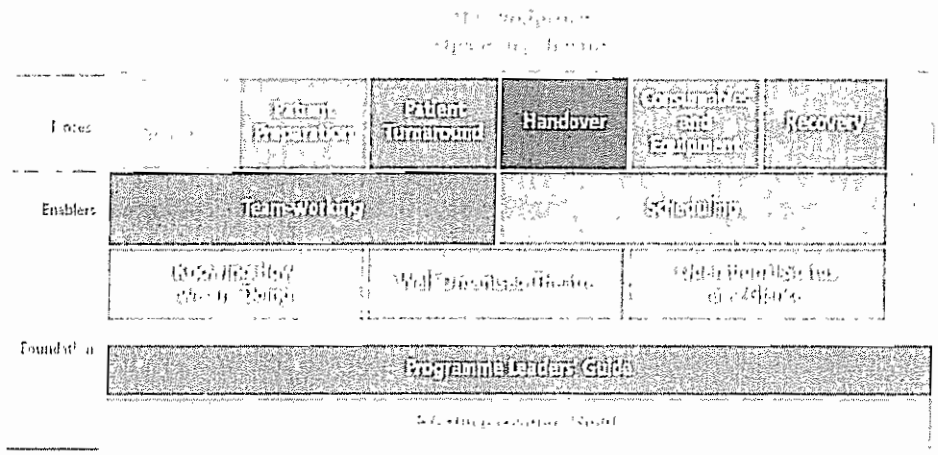
- Increase the **safety and reliability of care** through reducing errors and incidents of harm
- Improve **team-working** and performance, staff morale and leadership
- Add value and improve **efficiency**



The programme utilises lean methodology and effective team-working principles to create the 'perfect operating list' and environment. It is aligned to the principles and methodology outlined in the national quality, innovation, productivity and prevention (QIPP) agenda.

The structure of T-POT can be seen in the figure below: the model being based on the concept of a 'house' with three sets of modules; foundation, enablers and process modules:

T-POT structure



Both projects are reaching the final stages of their foundation modules and are setting plans in place for the next phase of work. The projects have begun to:

- deliver cost savings on stock and consumables, which will continue into 2011/12
- improve communication between the wards and catheter labs with electronic systems being implemented during 2011/12
- identify measures to track the improvements from this project
- Improve start times in catheter labs at Royal Brompton Hospital
- Improve team-working and communication in both theatres and catheter labs

Considerable progress on this project is expected during 2011/12.

Adaptations of the NHS Institute's Productive Series have been launched at Harefield, with work beginning on The Productive Imaging and Cardiology (TPIC) and The Productive Outpatients Department (TPOD).

Patient Survey results

The Trust participates in both the national inpatient and outpatient surveys. The sample size is approximately 850 patients for each survey; the questions are nationally set and may not be amended by the Trust.

Inpatient Survey 2009 - actions taken

The Trust had a 61% response rate in comparison to the national average of 52%. The feedback from patients is very encouraging and the Trust rated in the best performing 20% of Trusts for 76.6% (49/64) of the questions. These included questions on cleanliness of the hospital, having confidence in the nurses and doctors, hospital food, privacy, respect and dignity, and overall rating of the hospital. The Trust was rated in the worst performing 20% of Trusts for only one question: ensuring that the correspondence between the hospital and their GP is written in way patients could understand.

The Trust policy is for letters written by clinicians regarding patient care to be routinely copied to patients. These letters are intended for use by another clinician, and at times it may be difficult for a patient to understand. However, this is in addition to many other ways patients receive information about their care e.g. patient information leaflets, local area support, direct line access to staff etc.

The results of the 2010 survey were published by the CQC in April 2011 and again show very positive feedback for the Trust, with the Trust being in the top 20% of Trusts for 69% of the questions. This survey has also shown that the Trust has improved significantly for provision of understandable correspondence.

Outpatient Survey 2009 – actions taken

The Trust had a 58% response rate in comparison to the national average of 53%. The Trust again performed well in this survey and was rated in the best performing 20% of Trusts within the survey for 55% (22/40) of the questions. These included questions on choice of appointment times, communication with and confidence in the doctor, information provided, privacy and overall satisfaction.

The Trust was rated in the worst 20% for four areas: told how long to wait, why you had to wait, explanation of need for a test and how to find out about test results.

In response to waiting times, the Trust has recognised that good communication is key and have implemented several actions including informing patients of known delays when arriving in outpatients and of unexpected delays in clinic and regularly updating electronic waiting time boards.

In response to patients undergoing tests, the issues have been discussed at local staff meetings to raise awareness amongst staff the importance of explaining the test required and how the patient can find out about their results.

Since the survey was carried out, snapshot audits have been conducted to gain feedback from patients attending outpatient clinics. This has generally been very positive on many aspects of the service but reinforced the need to reduce waiting times in clinic. The feedback also gave an insight into what matters most to patients and has provided them with some ideas for further improvement work in 2011/12.

The outpatient survey is carried out every two years therefore the next survey will take place in 2011 with the results published in spring 2012.

Reducing Re-operations for Bleeding following Cardiac Surgery

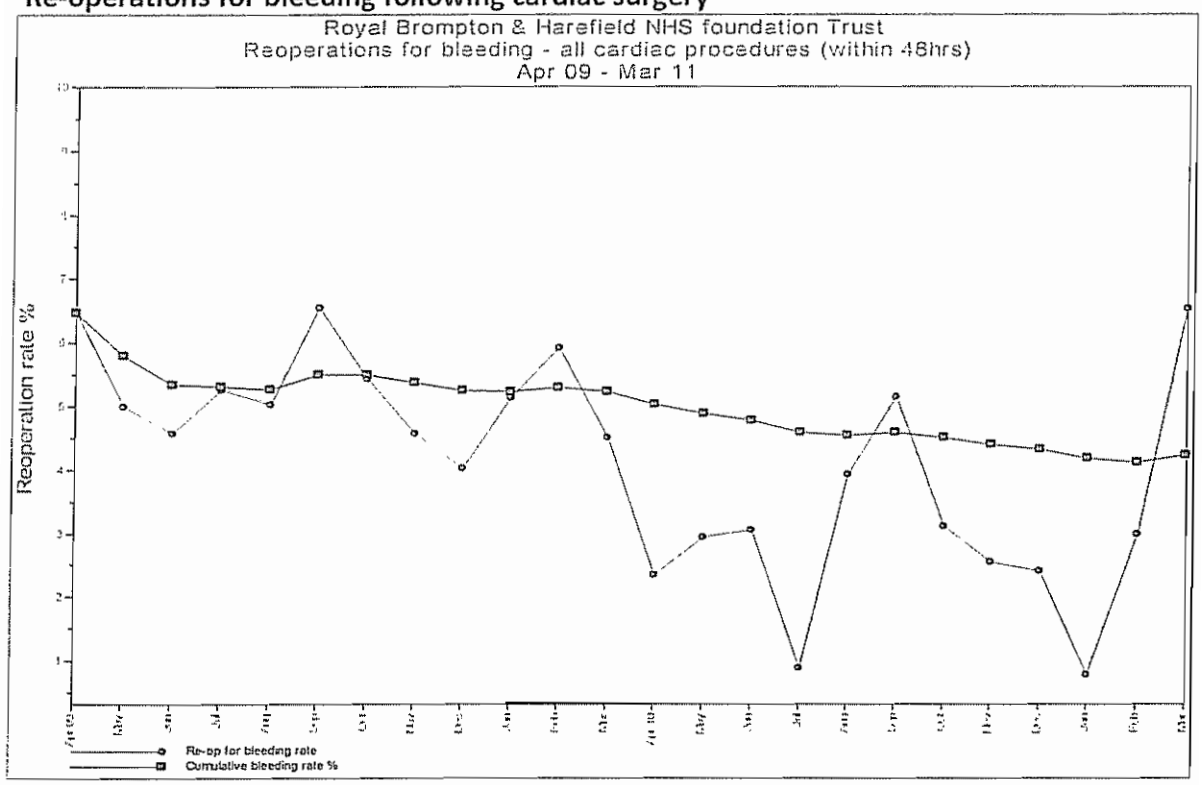
The Trust routinely reports on the number of patients who return to theatre for a re-operation after they have undergone cardiac surgery. Patients may return for several reasons, one being exploration for bleeding following surgery which, dependent on the cause and severity, may be managed medically or surgically. The Trust set up a group to look specifically at patients who returned to theatre for bleeding and to establish whether a reduction could be made and whether this impacted on their length of stay in the hospital.

The study found that patients who underwent a re-operation experienced an increased average length of stay in intensive care from 2.7 days to 9.8 days and on the ward from 13.4 days to 21 days. Several strategies were put in place to help reduce peri-operative bleeding such as updating guidelines in light of new national guidance, publishing guidance on how to manage peri-operative bleeding and how to respond to thromboelastography data (a form of monitoring coagulopathy), and clarification of lines of accountability.

The chart below shows the Trust-wide re-operation rate by month and cumulatively since April 2009. As the chart shows, on a monthly basis there is still fluctuation in the re-operation rate however, when comparing the overall cumulative figure for 2010/11 against 2009/10 there is a consistent decrease with a 39.6% reduction in the number of patients returning to theatre which equates to 40 fewer patients over the year.

When breaking this down by site the rate of patients returning to theatre for a re-operation at RBH has reduced by 54.6% and at HH by 27.2% over the year 2010/11 when compared to 2009/10.

Re-operations for bleeding following cardiac surgery



Annex: Statements from Commissioners, Local Involvement Networks and Overview and Scrutiny Committees

The Local Involvement Networks, Oversight and Scrutiny Committees and our local commissioners have been offered the opportunity to comment on the draft copy of this document, and hence offer some valuable feedback regarding it's content, and in particular it's accessibility for members of the public, which can be incorporated into the final version.

The same groups have also been invited to make a formal review and comment on the final report for 2010/11 – and these statements are represented on the following pages.

Kensington and Chelsea LINks

Kensington and Chelsea Local Involvement Network (K&C LINk) welcome the opportunity to comment on the Royal Brompton & Harefield NHS Foundation Trust Quality Account. The LINk would like to thank Trust staff for their support over the consultation period.
To summarise, the main issues of concern to K&C LINk in the Royal Brompton & Harefield NHS Foundation Trust Quality Account are:
1. The performance report contained within the QA is very slight. The QA should we think, give a clear idea of the FT's performance in absolute and comparative terms so that the public can form a view about whether they want to use the RB&H or go elsewhere.
2. Although there is an improved level of detail compared to last year on the level of patient/public involvement, we would appreciate further information on how exactly the Quality Account reflects the year-long stakeholder engagement process and locally identified priorities.

The K&C LINk wishes to strengthen the relationship it has with the Trust and suggests establishing a formal liaison arrangement. We are happy to share the information and intelligence we collect and to offer our support to the Trust with patient & public involvement.

We strongly recommend the Trust considers their approach to the Quality Account process for 2011/12 now. Engagement with the public and patients, should be continuous throughout the year. Then, the public, the target audience for the QA, will have the opportunity to feedback in a timely and effective way throughout the year. The Quality Account should also be more reflective of local priorities as a result.

Hillingdon LINks

We are grateful for the opportunity to comment on the QA for Royal Brompton and Harefield Hospitals. This was carried out by a sub committee of the Hillingdon Link dedicated to Quality Accounts following the guidance issued to Links for this task.

However, despite having some very interesting content regarding the hospitals activity such as improvements following audit and involvement of staff patients and other stakeholders in choosing priorities for development there are points in the report which need addressing.

The most obvious comment from the group is that it is very long and as such becomes inaccessible to the public who simply would not struggle through it. The QA is aimed at a local, public readership and this seems to have been forgotten in some areas. The document contains many areas of jargon and use of abbreviations which are not always explained.

Using the links guidance notes for assessing QAs the following applies

Provider priorities reflective of population?	Yes
Important issues missed from Account ?	Not obviously
Demonstration of public and patient involvement	Yes
Clear presentation to public	Not fully met as yet

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee

Introduction

As Chairman of this Council's Health, Environmental Health and Adult Social Care Scrutiny Committee, I welcome the opportunity to comment on the Royal Harefield and Brompton NHS Foundation Trust's Quality Account 2010/2011.

The Royal Borough of Kensington and Chelsea's Health, Environmental Health and Adult Social Care Scrutiny Committee (HEHASC SC) and Council both have good working relationships with the Royal Harefield and Brompton NHS Foundation Trust.

Comments

I am concerned about the financial outlook for Royal Harefield and Brompton NHS Foundation Trust and particularly about any impact on the Trust of changes to Children's Congenital Heart Services in England. Cash pressures could lead to cuts to patient care. The Trust's efforts to make efficiency savings without loss of service are to be supported.

There is also concern about the effects of removing Royal Brompton's children's heart surgery on other services at the Trust, most notably those for children with cystic fibrosis. The knock-on effects at Chelsea and Westminster Hospital Foundation Trust also need to be borne in mind when considering changes to paediatric services at Royal Brompton & Harefield, and the Scrutiny Committee will be responding to the relevant public consultation accordingly.

It remains unclear as to how the Royal Harefield and Brompton NHS Foundation Trust's long-term plans fit with the long-term plans of Imperial College Healthcare NHS Trust, but I am aware that the first shared service to be launched as part of the two trusts' Academic Health Science System, the aortic dissection service, was launched successfully in February.

The HEHASC SC has found it a challenge to make a meaningful response to the Trust's draft Quality Account. The Trust needs to pay due attention to how readable and accessible its Quality Account is. For example, it is difficult to analyse these Quality Accounts, as much information is not included (e.g. data comparisons over a long timeframe to show the ups and downs of performance).

Overall, the progress that the Trust has made over the last year is to be welcomed, particularly with respect to patient safety issues such as surgical site infections, and I look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

Councillor Mary Weale

Chairman for the Health, Environmental Health and Adult Social Care Scrutiny Committee

External Services Scrutiny Committee at the London Borough of Hillingdon

The External Services Scrutiny Committee welcomes the opportunity to comment on the Trust's 2010/2011 Quality Account and acknowledges the Trust's commitment to attend its meetings when requested. It is noted that the Trust has formulated its 14 priority topics for the forthcoming year in consultation with Hillingdon and Kensington & Chelsea councils. Individuals were then invited to vote on line for their preferred quality project in each of the three key areas. The views of the Committee have been broadly categorised under these three key areas:

1. Patient safety;
2. Patient experience; and
3. Patient outcomes.

1. Patient safety

We are pleased to note that the Trust has been awarded Level 3 status (the highest level) by the NHS Litigation Authority in September 2010 in relation to its risk management. This is undoubtedly a reflection on the Trust's emphasis on ensuring that quality and safety are at the heart of everything it does.

With regard to the availability of patients' records, we are concerned that the availability of paper records has been given a higher target (99%) than electronic records (95%). Given that electronic records are more easily accessible across an indefinite area, we would have liked to have seen that electronic records were awarded the same target.

It is reassuring to note that, where there are areas for improvement, the Trust has put measures in place to address the issues. For example, the work that is currently underway to increase the percentage of Venous Thromboembolism (VTE) assessments undertaken at Harefield will go a long way to ensure that the Trust reaches its target by the end of Q4.

2. Patient experience

As the Trust's primary angioplasty workload has increased by 40% over the last 4 years, bed capacity is tight, particularly at Harefield with regard to acute cardiac interventions. This does cause the Committee some concern.

We congratulate the Trust for the various consultation exercises that it has carried out with patients, staff, FT members and Governors to establish where improvements can be made.

3. Patient outcomes

Consideration should be given by the Trust to ensuring that there is information about current performance available within the report so that the targets that are being set can be put in context. For example, on page 7, a quality standard has been set for the next year to ensure that "95% of patients should have a PAR [Patient At Risk] score which is acted upon appropriately". It would be useful for the report to include the current figures for such targets, where possible. Furthermore, the use of subjective words such as "appropriately" should be discouraged.

Overall, the Committee is pleased with the continued progress that the Trust has made over the last year and looks forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

North West London Commissioning Partnership

The Royal Brompton and Harefield BNHS Foundation Trusts Quality Account for 2010/11 is a statutory requirement under the Health Act 2009 and Monitor's regulations for Foundation Trusts. The Trust has combined the two reports into one document for the purposes of filling the dual requirements.

The presentation of the account details largely follows the format laid out in the Quality Account Toolkit published by the Department of Health and also details the consultation process that lead to the identification of the three priority areas - which is an improvement from last year. It would be beneficial to have a longer consultation period on the choice of priority topics for next year.

It is noted that Royal Brompton & Harefield NHS Foundation Trust has achieved the targets for quality improvement through the CQUIN scheme and has participated in a wide range of national audit programmes and research.

Glossary

A

Adult Intensive Care Unit (AICU)	A special ward for people who are in a critically ill or unstable condition and need constant medical support to keep their body functioning.

B

Biobank	A cryogenic storage facility used to archive tissue samples for use in research
Biomedical Research Unit (BRU)	A nationally recognised and funded unit to provide the NHS with the support and facilities it needs for first class research

C

Cancelled operations	This is a national indicator. It measures the number of elective procedures or operations which are cancelled for administrative reasons e.g. lack of time, staffing, equipment etc.
Cardiac surgery	Heart surgery
Cardiac valve procedures	A type of heart surgery, where one or more damaged heart valves are repaired or replaced
Care Quality Commission (CQC)	The independent regulator of health and social care in England www.cqc.org.uk
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes by measuring the quality of care and services against agreed standards and making improvements where necessary.
Clostridium difficile infection	A type of infection which can be fatal. There is a national indicator to measure the number of C. difficile infections which occur in hospital.
Coagulopathy	Defects in the body's mechanism for clotting blood
Commissioning for Quality Innovation (CQUIN)	A payment framework which enables commissioners to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals
Compliance Framework	The *Compliance Framework* sets out the approach Monitor uses to assess the compliance of NHS foundation trusts with their terms of authorisation and to intervene where necessary.

Coronary Artery Bypass Graft (CABG)	A type of heart surgery where the blocked or narrowed arteries supplying the heart are replaced with veins taken from another part of the patients body
D	
Delayed transfers of care	A national indicator. Assesses the number of patients who are delayed when being transferred from one health organisation to another e.g. from one hospital to another, or from hospital to community care
Department of Heath (DH)	The government Department which provides strategic leadership to the NHS and social care organisations in England www.dh.gov.uk/
Dr Foster Intelligence	Dr Foster Intelligence is a joint venture with the Department of Health. It offers a range of information tools to help the NHS and other organisations improve the quality and efficiency of services. http://www.drfosterintelligence.co.uk/
E	
Eighteen (18) week wait	A national target to ensure that no patient waits more than 18 weeks from GP referral to treatment. It is designed to improve patients' experience of the NHS, delivering quality care without unnecessary delays.
Elective operation/procedure	An operation or procedure which is planned It is usually a lower risk procedure, as the patient and staff have time to prepare.
Emergency operation/procedure	An operation or procedure which is unplanned, and must occur quickly as the patient is deteriorating. Usually associated with higher risk, as the patient is often acutely unwell
End of life care (EOL)	Care in last 48 hours of life for expected deaths
Endoscopic Vein Harvest (EVH)	A new technique using keyhole surgery to remove a section of vein for use in a CABG procedure. This technique minimises the size of the wound required, reducing the risk of infection and the recovery time for patients.
Expected death	an anticipated patient death caused by a known medical condition or illness
F	
Foundation Trust (FT)	NHS foundation trusts were created to devolve decision making from central government to local

	organisations and communities. They still provide and develop healthcare according to core NHS principles - free care, based on need and not ability to pay. Royal Brompton and Harefield became a Foundation Trust on 1st June 2009.
G	
Global trigger tool (GTT)	A tool to measure adverse events via a system of specific triggers. The triggers identify possible adverse events and actual events are rated by harm level to the patients. Over time the results are used to identify areas for improvement.
Governors	Foundation Trusts have a Board of Governors, who are elected by the members. http://www.rbht.nhs.uk/about/our-work/foundation-trust/governors/
H	
Health Protection Agency (HPA)	The Health Protection Agency is an independent organisation set up to protect the public from threats to their health from infectious diseases and environmental hazards. It provides advice and information to the government, general public and health professionals http://www.hpa.org.uk/
HH	Harefield Hospital
Hospital Episode Statistics (HES)	The national statistical data warehouse for the NHS in England HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations
Hospital Standardised Mortality Ratio (HSMR)	A national indicator that compares the actual number of deaths against the expected number of deaths in each hospital and then compares Trusts against a national average.
I	
Indicator	A measure which determines whether the goal or an element of the goal has been achieved
Inpatient	A patient who is staying in hospital
Inpatient survey	An annual, national survey of the experiences of

	patients who have stayed in hospital. All NHS Trusts are required to participate.
L	
Local clinical audit	A type of quality improvement project which involves individual healthcare professionals evaluating aspects of care that they themselves have selected as being important to them and/or their team
Local Involvement Networks (LINkS)	Local Involvement Networks (LINks) are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. http://www.nhs.uk/NHSEngland/links/Pages/links-make-it-happen.aspx
Liverpool care pathway	a care pathway specifically for patients who are dying
M	
MINAP	Myocardial Ischaemia National Audit Project A national registry of patients admitted in England and Wales who have had a heart attack or have severe angina and need urgent treatment
Monitor	The independent regulator of NHS Foundation Trusts http://www.monitor-nhsft.gov.uk/
Multi-disciplinary team meeting (MDT)	a meeting involving health-care professionals with different areas of expertise to discuss and plan the care and treatment of specific patients
Multi-Resistant Staphylococcus Aureus (MRSA)	A type of infection which can be fatal. There is a national indicator to measure the number of MRSA infections which occur in hospital.
N	
National clinical audit	A clinical audit which engages healthcare professionals across England and Wales in the systematic evaluation of their clinical practice against standards and to support and encourage improvement and deliver better outcomes in the quality of treatment and care. The priorities for national audits are set centrally by the Department of Health and all NHS trusts are expected to participate in the national audit programme

National Institute for Health and Clinical Excellence (NICE)	NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health http://www.nice.org.uk/
National Patient Safety Agency (NPSA)	An Arm's Length Body of the Department of Health which leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. http://www.npsa.nhs.uk/
Never events	Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Trusts are required to report nationally if a never event does occur. Never relevant to the Trust is 2010-11 were: • wrong site surgery • retained instrument post-operation • misplaced naso-gastric or orogastric tube not detected prior to use • inpatient suicide using non-collapsible rails • intravenous administration of mis-selected concentrated potassium chloride
NHS Innovation and Improvement NHSIII)	Assists the NHS in transforming healthcare for patients by developing and spreading new work practices, technology and improved leadership
NHS London	NHS London is the Strategic Health Authority (SHA) for the Greater London area. They provide strategic leadership for the capital's healthcare. http://www.london.nhs.uk/
NHS number	A 12 digit number that is unique to an individual, and can be used to track NHS patients between organisations and different areas of the country. Use of the NHS number should ensure continuity of care.
Northwest London Commissioning Partnership	The group responsible for commissioning the services provided by the Trust.
Operating Framework	An NHS-wide document which outlines the business and planning arrangements for the NHS. It describes the national priorities, system levers ...
Outpatient	A patient who goes to a hospital and is seen by a doctor or nurse in a clinic, but does not stay overnight

Outpatient survey	An annual, national survey of the experiences of patients who have been an outpatient. All NHS Trusts are required to participate.
Overview and Scrutiny Committee (OSC)	OSC looks at the work of the primary care trusts and NHS trusts and London Strategic Health Authority. It acts as a 'critical friend' by suggesting ways that health related services might be improved. It also looks at the way the health service interacts with our social care services, the voluntary sector, independent providers and other council services to jointly provide better health services to meet the diverse needs of the area.
PAR Score – Patient At Risk score	This is a national tool to help staff recognise and act appropriately when a patient's condition is deteriorating. Patients are scored depending on key observations such as blood pressure, pulse rate, respiratory, temperature etc. A patient with a high score may be deteriorating and should be referred for further review
Patient Record	a single unique record containing accounts of all episodes of health care delivered to the patient at the Trust and any other relevant information
Pressure Ulcers	A sore which develops from sustained pressure on a particular point of the body. Pressure ulcers are more common in patients then in people who are fit and well, as patients are often not able to move about as normal.
Primary Coronary Intervention (PCI)	Often known as coronary angioplasty or simply angioplasty. A procedure used to treat the narrowed coronary arteries of the heart found in patients who have a heart attack or have angina.
Priorities for Improvement	There is a national requirement for Trusts to select 3-5 priorities for quality improvement each year. This must reflect the 3 key areas of patient safety, patient experience and clinical effectiveness.
Productive Ward	The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency

Quality and Risk Profile (QRP)	A tool for used by the CQC to monitor compliance with the essential standards of quality and safety. They help in assessing where risks lie and play a key role in providers' own internal monitoring as well as informing the commissioning of services. The QRPs include data from a number of sources which is analysed to identify areas of potential non compliance.
Re-admissions	A national indicator. Assesses the number of patients who have to go back to hospital within 30 days of discharge.
RBH	Royal Brompton Hospital
Safeguarding	Safeguarding is a new term which is broader than 'child protection' as it also includes prevention It is also applied to vulnerable adults
Secondary Uses Service (SUS)	A national NHS database of activity in Trusts, which is used for performance monitoring, reconciliation and payments
Serious Incidents	An incident requiring investigation that results in one of the following: • Unexpected or avoidable death • Serious harm • Prevents an organisation's ability to continue to deliver healthcare services • Allegations of abuse • Adverse media coverage or public concern • Never Events
Surgical Site Infection	An infection which develops in a wound created by having an operation
Single sex accommodation	A national indicator which monitors whether ward accommodation has been segregated by gender
Sleep apnoea	A sleep disorder characterized by abnormal pauses in breathing or instances of abnormally low breathing, during sleep
Society of Cardiothoracic Surgeons (SCTS)	http://www.scts.org/

Standard Contract	The annual contract between commissioners and the Trust The contract supports the NHS Operating Framework
Surgical Site Infection Surveillance Service (SSISS)	A national scheme whereby Trusts must collect and analyse data on Surgical Site Infections (SSI) using standardised methods. It provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service.
Trans-Aortic Valve Implantation (TAVI)	A new technique for valve replacement, using keyhole surgery This prevents the need for open heart surgery, reduces the risk of infection and reduces the length of recovery for patients
The Productive Operating Theatre (TPOT)	A national programme to improve performance across four dimensions of quality: • safely and reliability of care; • team performance and staff well-being; • value and efficiency; and • patient outcomes and experience
Thromboelastography (TEG)	A diagnostic test used to assess the efficiency of clotting in the blood
Venous thrombo-embolism (VTE)	An umbrella term to describe venous thrombus and pulmonary embolism. Venous thrombus is a blood clot in a vein (often leg or pelvis) and a pulmonary embolism is a blood clot in the lung. There is a national indicator to monitor number of patients admitted to hospital who have had an assessment made of the risk of their developing a VTE.