1. Message from the Chairman 2

2. Chief Executive’s Summary 3

3. Operating & Financial Review
   - History and background to the Trust 5
   - The services we provide 6
   - The environment in which we operate 7
   - How we are governed and managed 8
   - How we performed in 2006/07 10
   - Our priorities for 2007/08 18
   - Our longer term strategy 19
   - Financial report 20
   - How we are addressing our environmental, social and community responsibilities 25
   - Our emergency planning arrangements 26

4. Staffing Report 27

5. Remuneration Report 32

6. Appendices to the annual report
   - Services provided at Queen Elizabeth Hospital 35
   - Director biographies 36
   - Committee structure 39
   - Clinical directorate structure 40

7. Annual Accounts 41
Welcome to our Annual Report and Accounts for 2006/07. This year’s publication looks rather different to the colourful review we produced last year entitled ‘Life at QEH’, because NHS organisations are now required to incorporate a wide range of mandatory information in their annual reports that has not been expected of them in the past. In view of the success of last year’s review, however, we are planning to produce something similar again in September, so do look out for it.

Reading through the pages of this report, it will be clear to you that the last year has in many ways been one of the toughest we’ve faced, particularly in respect of the financial challenges we’ve had to address, but that in spite of this a great deal has been achieved. At the same time as treating more patients and delivering our financial objectives, we have achieved most of the Government’s targets, we have significantly improved access to many of our services, we have developed a range of new services, we have achieved good results from a number of external quality inspections, and we have again received positive feedback from our staff via the national staff survey. All of this reflects exceptionally well on the dedication and hard work of the management and staff of the hospital, as well as those who provide services to or support the hospital in other ways. The Board’s thanks go to all our staff and supporters for these achievements. I would like to pay particular thanks to the League of Friends and our army of 250 or more volunteers, so capably led by Diane Hudson, who work so hard and do so much to improve the experiences of patients who use the hospital.

Despite these excellent achievements, the picture is not universally positive because our patient survey results were again disappointing. Until we can match our undoubtedly high clinical standards with the same standards in everything else we do, we will not be able to count ourselves as among the best. The Board is determined that we will achieve such standards and has initiated a major programme of work to help us do so.

Finally, a word about the inevitable changes to acute hospital services that will take place in south east London in the coming years. The Board is in no doubt that changes are needed, for both clinical and financial reasons, and we will play a full part in supporting the change process as it develops. We are also aware that these are likely to be times of some anxiety for our local population, our staff and all those who have an interest in Queen Elizabeth Hospital. The Board is committed to ensuring as wide as possible a dialogue before any changes are proposed or implemented, and welcome all contributions as this process progresses.

I commend this report to you.

Colin Campbell
Chairman
2006/07 has been a year of significant progress for Queen Elizabeth Hospital, a year in which we achieved or made good progress with the great majority of our most important short term objectives, at the same time as moving ahead with our partner organisations in south east London in a process of redesigning the ways in which healthcare is provided to patients, with the aim of securing services that are both clinically and financially sustainable in the longer term.

One of our highest priorities was to plan and implement measures to save more than £10 million, without adversely affecting the quality of services we provide. We undertook this task in several phases, at each stage consulting with staff on our proposals before asking the Board to agree them. By the end of the year we had succeeded in reducing our costs as we had planned, and concluded the year with a deficit of £7.3 million. This was some £0.9 million more than originally planned, principally because we had to make provision for further restructuring costs as we moved into the new financial year. These savings resulted in the removal or freezing of more than 150 posts, and 29 members of staff were made redundant. Whilst this was clearly a very difficult time for the staff affected, I am most grateful for the way the organisation as a whole coped with the uncertainties and additional pressures that such changes inevitably caused.

We also needed to comply with or achieve a plethora of standards and service performance targets, as has increasingly been the case in recent years. I am delighted to be able to report that we believe we have met all but one of the more than 25 national performance targets that now exist. This has required a huge effort on the part of a wide range of clinical, professional, administrative and managerial staff to whom my and the whole Board’s thanks are extended.

The one target that we failed to meet was to achieve a significant further reduction in cases of MRSA bloodstream infections, after the impressive improvement we achieved in 2005/06. Having had 41 cases in 2004/05, we managed to reduce this to 23 cases in 2005/06 and were aiming to reduce this to no more than 17 in 2006/07. In the event we had 22 cases, although we know that four of these patients arrived at the hospital already infected. Our efforts to reduce the incidence of all healthcare acquired infections continue, with a particular focus on Clostridium Difficile. From an unsatisfactory position earlier in the year, our rates of infection in the final quarter reduced significantly, and we are continuing to improve in this area.

We were able to develop our clinical services in a number of areas, two of which I mention here. The first was the introduction of a new ‘Greenlight’ laser system for the treatment of enlarged prostates in men. This involves the use of a high-powered laser that immediately vaporises and precisely removes enlarged prostate tissue, allowing most patients to go home the same day and enabling them to return to normal, non-strenuous activity within days. We are one of only a small number of hospitals in London offering this service, benefiting patients as well as generating income for the hospital.

The second was the introduction of a coronary angioplasty service at Queen Elizabeth Hospital, making us one of only a handful of district general hospitals in London providing this service. Otherwise known as percutaneous coronary intervention, this procedure is for people with narrowed or blocked coronary arteries, and involves inserting a small balloon into the artery and inflating it, so allowing blood to flow normally to the muscles of the heart. More often than not a small tube known as a stent is left in place to help prevent the artery from narrowing again.
Introducing this service enables many patients who need this procedure to be able to have it locally rather than have to travel into central London, and again helps our financial position.

We received the results of two national surveys conducted during 2006. The national inpatient survey was a disappointment to us, indicating that despite our best efforts we are not fulfilling the needs and expectations of our patients as well as we should be. We have therefore embarked on a programme of work designed to understand better the reasons why some patients feel dissatisfied with the hospital, and to put in place the changes necessary to address those reasons. I expect some of the solutions to involve relatively simple measures that can be introduced quite quickly and at little cost. Others will require a longer-term programme of individual and organisational performance improvement which will include setting standards for, and monitoring compliance with, the competences, attitudes and behaviours of our staff. I hope to be able to convey better results in next year’s annual report.

More promisingly, our staff survey results were very pleasing. In this survey staff are asked more than 120 questions, which the Healthcare Commission groups into 28 indicators. We are delighted that we scored in the best 20% of trusts for 11 of these, were better than average for a further seven and were only slightly below average for two.

Looking ahead, we have another year in which substantial further financial savings are required of us if we are to get close to breaking even, as we must. Although it is now widely accepted that the principal cause of our financial difficulties stems directly from the high costs of our PFI scheme, we are nonetheless obliged to work as efficiently as we can do to offset these ‘excess’ costs.

We do not believe, however, that continuing as we are is going to enable us to maintain our high clinical standards, deliver positive patient experiences and balance our books in a sustainable way in the longer term. We have therefore been engaged with partner NHS organisations in south east London over the past year to look at ways in which the clinical and financial challenges we all face might be addressed through organising the delivery of health care to our populations differently. With the involvement of a wide range of clinical staff as well as external stakeholders, we are looking at a number of options for change, which I expect we will be consulting on before the end of 2007.

In the pages that follow, we describe more about the hospital and the way we work, as well as some of our achievements and challenges, looking both back over the past year and forward. I hope you find the report interesting. If you have any comments to make please email me at xxxx.xxxxxxxxxxxxx@xxx.xxx or write to me, addressing your correspondence to the Chief Executive, Queen Elizabeth Hospital NHS Trust, Ranken House, Stadium Road, London SE18 4QH.

John Pelly
Chief Executive
History and background to the Trust

Location
Queen Elizabeth Hospital NHS Trust (QEH) was formed in March 2001, when services relocated to a new hospital in Woolwich in the London Borough of Greenwich. QEH was developed via the government’s Private Finance Initiative (PFI) and is located on the site previously occupied by the Queen Elizabeth Military Hospital. The new 500 bed hospital was created partly by rebuilding and partly by refurbishing the military hospital, and now provides a range of acute hospital services mainly to the residents of Greenwich as well as to a natural catchment from our neighbouring borough of Bexley and, increasingly, from further afield.

The hospital is well located in the centre of the borough with excellent road transport and bus service links. A total of seven bus routes serve the hospital and also link the hospital to London and into Kent via rail services from Woolwich Arsenal and Woolwich Dockyard stations, and via the excellent Jubilee line underground service into London from North Greenwich station.

Population
Greenwich is one of 12 inner London boroughs. It has a population of 232,700, which is expected to rise by approximately 40,000 over the next ten years – a rise of some 17%. This rise is principally the result of the Thames Gateway development – the largest housing development in Europe. Whilst a major tourist destination with World Heritage status, the borough has pockets of extreme deprivation with more than half the borough (10 of the 17 wards) in the most deprived 10% of wards in England.

More than 100 different languages are spoken in the borough and approximately 23% of the borough’s population are from minority ethnic groups, compared with 13% of the population of England as a whole. Increasingly, the highest proportion of the population in Greenwich is in the 30 to 34 age group. This is reflected in the increased birth rate which has risen from 14.9 per head in 2001/02, when QEH first opened, to 20.1 in 2005/06.

While the proportion of older people in the borough is decreasing, the number of very elderly people (85+ years of age) is rising, creating its own demands on the hospital and support services. Although older people account for 12% of the general population, about 40% of all elective admissions and 38% of all non-elective admissions (with the exception of obstetrics) to QEH during 2005/06 were people aged over 65 years.

The new housing developments, which form part of the Thames Gateway, will impact on the age profile of the borough, with residents in the new developments expected to be mainly of working age and proportionately fewer older people among the borough’s new entrants.

QEH is also the local healthcare provider to HM Prison at Belmarsh, a maximum security jail. The prison has an operational capacity of 915 inmates and is soon to be expanded by a further 400. The prison population makes a particularly high demand on the Trust’s genito-urinary services. Telemedicine technology has been developed to provide some services to this section of the population.
The services we provide

A full range of clinical services is provided at Queen Elizabeth Hospital, providing both emergency and elective (planned) care to patients. The majority of these are provided by staff employed by QEH; however some specialties, including ophthalmology, oral surgery and ENT (ear, nose and throat) surgery are provided on an outpatient basis only by staff from neighbouring trusts. QEH also provides some services, such as urology and dermatology, to other local trusts. The full list of services available at QEH is set out in Appendix 1.

Activity Review

Since it opened in 2001, demand for services at QEH has grown significantly. This demonstrates that we have strong backing from the community we serve and confirms our credibility as the local provider of choice.

The tables below show that in 2006/07 the hospital was busier than ever and that, in the five years since we opened, A&E attendances have increased by 34%; non-elective admissions by 32%; elective admissions by 33%; outpatient attendances by 21% and births by 39%.

<table>
<thead>
<tr>
<th>A&amp;E Attendances</th>
<th>(including follow-up attendances)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>78,906</td>
<td>77,320</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Elective Admissions (spells)</th>
<th>(excluding Obstetrics)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
<td>2002/03</td>
</tr>
<tr>
<td>13,355</td>
<td>14,854</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Elective Admissions (spells)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
</tr>
<tr>
<td>18,586</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
</tr>
<tr>
<td>155,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001/02</td>
</tr>
<tr>
<td>3,021</td>
</tr>
</tbody>
</table>
The environment in which we operate

Along with all NHS trusts, QEH operates within a financial, competitive and regulatory environment determined by government. This environment has changed and developed significantly in recent years, most notably following the publication of the NHS Plan in 2000 and the NHS Improvement Plan in 2004. Particular features of the current regime that are most relevant to acute hospitals include:

- a requirement to comply with a range of targets and healthcare standards, compliance with which is assessed each year by the Healthcare Commission, which publishes the results of an annual health check for every organisation it has responsibility for assessing (see below for further details);
- a system of funding hospitals known as Payment by Results by which hospitals are paid (at present mainly by commissioning primary care trusts) for the work they do, based on a centrally determined national price tariff;
- the development of practice based commissioning, a system by which GP practices, or groups of practices, are given responsibility by their PCTs for commissioning services from hospitals;
- the introduction of patient choice - and a computer system known as Choose & Book - providing patients with a choice of hospitals to go to for consultations and operations, including private hospitals (see below);
- the introduction of the independent (private) sector into the provision of healthcare to NHS patients through the issue of a number of central government contracts;
- moves to enable a much greater share of healthcare provision to take place in settings outside hospital.

The Healthcare Commission’s annual health check assesses hospitals on the basis of a range of performance measures, which come together to produce two ratings, one for quality of services and the other for use of resources. QEH was rated as ‘Fair’ for quality of services and ‘Weak’ for use of resources based on performance during 2005/06. Whilst we anticipated a poor use of resources rating because of the financial challenges we face, we were disappointed not to have been assessed as ‘Good’ for the quality of our services, where we fell marginally short of the mark required to achieve this. We are hopeful that we will achieve a rating of ‘Good’ when the 2007 annual health check results are published later this year.

Aside from the Healthcare Commission, NHS trusts are also subject to inspections and accreditations from a very wide range of interested bodies including the medical royal colleges, deaneries, peer review teams (most notably those concerned with cancer care), specialty-specific bodies such as Clinical Pathology Accreditation (CPA), the Health & Safety Executive (HSE), the NHS Litigation Authority, Patient Environment Action Teams (PEAT) and many others. These are all designed to ensure that hospitals operate to the highest standards and, where problems are identified, that they are addressed.
How we are governed and managed

The Trust Board and its committees

Governance of the Trust is exercised by the Trust Board and a small number of non-executive led Board committees, supported by a comprehensive framework of executive management.

The Board comprises a non-executive Chairman, five other non-executive directors (NEDs) and eight executive directors (EDs), including the Chief Executive. The Chairman of the Patients’ Forum is also an honorary member of the Board and regularly attends its meetings. The names and short biographies of Board members are set out in Appendix 2.

The Chief Executive is the Trust’s Accountable Officer, accountable via the NHS Chief Executive to Parliament.

The Board meets monthly in public to oversee the management of the entirety of the Trust’s business. Where confidential matters need to be discussed, the Board also meets in closed session, immediately following the open meeting. Detailed minutes of all meetings are recorded and published.

The Board has established four non-executive led committees to oversee particular areas of Trust business that the Board considers require more detailed scrutiny than the full Board can provide. These are:

- Audit & Assurance Committee
- Clinical Governance & Risk Management Committee
- Finance Committee
- Remuneration & Terms of Service Committee.

Minutes are taken and reported to the Board following each committee’s meeting.

The Board has also established a Trust Executive Committee (TEC), chaired by the Chief Executive, as the principal decision-making body of the Trust. TEC comprises the executive directors, clinical directors and the general managers of the clinical directorates. TEC meets twice each month and, as with the Board, detailed minutes are taken of each meeting’s discussions and decisions, which are subsequently reported to the Board.

A number of management committees and groups have been established to support the work of, and report to, TEC. These include the following, some of which have their own sub-committees:

- Clinical Governance Executive
- Control of Infection Committee
- Cancer Board
- Operations Executive
- Risk Management & NHS Standards Committee
- Capital & Service Planning Group
• Estate & Facilities Management Group
• ICT Strategy Programme Board
• Information Governance Steering Group.

The Trust’s committee structure can be seen in diagrammatic form at Appendix 3.

Clinical management structure

The Trust introduced a new clinical management structure in July 2004, establishing five clinical directorates, each led by a part-time clinical director (CD) and supported by a full-time general manager (GM), with responsibility for all aspects of the management of a significant part of the Trust’s business. Following a review of the effectiveness of this structure in early 2007, a number of changes have been introduced which take effect from June 2007. The new clinical directorates manage the following services:

• Acute Medicine – acute medical specialties, elderly care, accident and emergency and therapies;
• Specialist Medicine – a range of medical specialties including cardiology, rheumatology, dermatology, as well as cancer services, critical care, genito-urinary services, imaging and outpatients;
• Surgery – general surgery, urology, trauma and orthopaedics, anaesthetics and theatres;
• Women and Children – maternity services, gynaecology and paediatrics; and
• Pathology – covering all the pathology disciplines.

The clinical directorates have a considerable amount of autonomy, operating within a structured performance management framework. Each of the clinical directorates has established its own management structures and arrangements to enable it to manage its affairs effectively, and each is supported by a member of the Finance and HR departments.

The clinical directorate structure can be seen in diagrammatic form at Appendix 4.

Business planning and performance management

The Trust has a well established planning process that commences in the autumn of each year with the development and agreement by TEC and the Board of the coming year’s corporate objectives. These are developed by reference to the Trust’s longer-term strategic direction, the Department of Health’s priorities and targets, and the Trust’s own immediate priorities. Once agreed, these form the basis of detailed planning guidance which is provided to the clinical and corporate directorates and departments, together with a template and timetable for the submission of their plans for the year ahead. These are reviewed and refined at meetings between the directorates and the executive team prior to final sign-off in the spring.

Performance management operates at three levels: within clinical directorates; at formal performance review meetings of the directorates; and by the Board. These arrangements work well, as evidenced by the operational and financial performance of the directorates, and the Trust as a whole, in recent years where the great majority of Trust and directorate plans and targets have been met.
In parallel with these internal performance management arrangements, regular meetings between senior Trust personnel and those of Greenwich Teaching Primary Care Trust and Bexley Care Trust also take place to review performance against the respective Service Level Agreements, and to consider and agree on any matters requiring action.

**Risk management**

The Trust has comprehensive and robust risk management arrangements in place that enable the Board to be made aware of, and scrutinise the Trust’s arrangements for managing, the risks facing the organisation. These include regular consideration of the content of the Assurance Framework (which has received a Category A rating by the Trust’s internal auditors, confirming that it meets the criteria laid down by the Department of Health), appropriate risk management policies, procedures and systems, an extensive structure of Board and executive committees concerned with clinical and non-clinical risk management, as well as sound anti-fraud arrangements and expertise.

**How we performed in 2006/07**

**2006/07 National Targets**

The Trust has achieved another year of excellent performance against the national performance targets, as summarised in the following table.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Target</th>
<th>Trust Position 2006/07</th>
<th>✓ or x</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E - 4 hour target</td>
<td>% of patients waiting 4 hours or less in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98%</td>
<td>98.1%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancer – 2 week rule</td>
<td>% of patients seen within 2 weeks of urgent GP referral for suspected cancer to first outpatient appointment</td>
<td>98%</td>
<td>99.9%</td>
<td>✓</td>
</tr>
<tr>
<td>All Cancers – 1 month</td>
<td>Proportion of patients treated within 31 days of diagnosis</td>
<td>98%</td>
<td>99.4%</td>
<td>✓</td>
</tr>
<tr>
<td>All Cancers – 2 months</td>
<td>Proportion of patients treated within two months of urgent GP referral</td>
<td>95%</td>
<td>96.5%</td>
<td>✓</td>
</tr>
<tr>
<td>Cancelled Operations</td>
<td><strong>Part 1</strong> - % of elective admissions cancelled on the day of, or after admission for non-clinical reasons</td>
<td>0.8%</td>
<td>0.25%</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><strong>Part 2</strong> - % of elective admissions cancelled on the day of, or after admission for non-clinical reasons, where that patient is not offered a date within 28 days</td>
<td>0%</td>
<td>0%</td>
<td>✓</td>
</tr>
<tr>
<td>Indicator</td>
<td>Measure</td>
<td>Target</td>
<td>Trust Position 2006/07</td>
<td>√ or x</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td>To achieve the target trajectory reduction in the number of incidents of MRSA bacteraemia</td>
<td>17</td>
<td>22</td>
<td>X (see below)</td>
</tr>
<tr>
<td>Convenience and Choice</td>
<td>Elective inpatient and outpatient booking</td>
<td>100%</td>
<td>100%</td>
<td>√</td>
</tr>
<tr>
<td>Convenience and Choice</td>
<td>Provider inpatient information in place to support choice</td>
<td>Yes</td>
<td>Yes</td>
<td>√</td>
</tr>
<tr>
<td>Delayed transfers of care</td>
<td>% of patients whose transfer of care was delayed</td>
<td>3.5%</td>
<td>3.3%</td>
<td>√</td>
</tr>
<tr>
<td>Number of inpatients or day cases waiting longer than the standard</td>
<td>% of patients waiting 26 weeks or more for an elective admission</td>
<td>0%</td>
<td>0%</td>
<td>√</td>
</tr>
<tr>
<td>Number of outpatients waiting longer than the standard</td>
<td>% of patients waiting 13 weeks or more for a first outpatient appointment following a GP referral</td>
<td>0%</td>
<td>0%</td>
<td>√</td>
</tr>
<tr>
<td>Thrombolysis – 60 min. call to needle time</td>
<td>% of eligible patients receiving thrombolysis within 60 min. call to needle time</td>
<td>68%</td>
<td>87.5%</td>
<td>√</td>
</tr>
<tr>
<td>Waiting times for Rapid Access Chest Pain</td>
<td>% of patients to RACP clinics seen within 14 days (where referral received from GP within 24 hours)</td>
<td>98%</td>
<td>99.8%</td>
<td>√</td>
</tr>
<tr>
<td>Waiting times for GUM clinic</td>
<td>Improvement in access to GUM clinics within 48 hours</td>
<td>No threshold</td>
<td>88%</td>
<td>√</td>
</tr>
<tr>
<td>Milestones towards 18 week target</td>
<td>% of patients waiting 20 weeks or less for an elective admission</td>
<td>97%</td>
<td>98.2%</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>% of patients waiting 11 weeks or less for a first outpatient appointment following a GP referral</td>
<td>97%</td>
<td>99.9%</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td>% of patients waiting 13 weeks or less for a diagnostic test</td>
<td>100%</td>
<td>100%</td>
<td>√</td>
</tr>
<tr>
<td>Data quality on ethnic group</td>
<td>% of patient admissions for whom a valid 2001 census coding for ethnic category is recorded</td>
<td>90%</td>
<td>94%</td>
<td>√</td>
</tr>
<tr>
<td>Reduce emergency bed days in hospital for people with long term conditions</td>
<td>Achieve % reduction of bed days by 2008 from 2003/04 baseline</td>
<td>5% achieved by 2008</td>
<td>achieved</td>
<td>√</td>
</tr>
<tr>
<td>Indicator</td>
<td>Measure</td>
<td>Target</td>
<td>Trust Position 2006/07</td>
<td>□ or x</td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>--------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Smoke free NHS</td>
<td><em>Part 1</em> – demonstrating a smoke free trust</td>
<td>achieve</td>
<td>achieved</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><em>Part 2</em> – Recording the smoking status of adult patients</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><em>Part 3</em> - Reducing smoking in adult patients through advice and onward referral</td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Participation of problem drug users in drug treatment programmes</td>
<td>Provision of information, existence of clear screening and referral processes</td>
<td>Yes</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>Treatment of stroke patients</td>
<td>% of stroke patients to have spent more than 50% of their stay on a stroke unit</td>
<td>No threshold</td>
<td>61%</td>
<td>✓</td>
</tr>
<tr>
<td>Infant mortality and life expectancy at birth</td>
<td><em>Part 1</em> - reduction in the number of women known to be smokers at the time of delivery compared to 2005/06</td>
<td>No threshold</td>
<td>0.4%</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td><em>Part 2</em> - Number of mothers known to have initiated breastfeeding within 48 hours compared to 2005/06</td>
<td>No threshold</td>
<td>8% increase</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce mortality rates by 2010 from heart disease and stroke</td>
<td>Participate in comparative clinical audits</td>
<td>Yes</td>
<td>Yes</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce mortality rates by 2010 from suicide and undetermined injury</td>
<td>Ensure compliance with NICE guidelines on the treatment and management of self harm in the emergency department</td>
<td>Yes</td>
<td>Yes</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Reducing healthcare acquired infection**

Whilst we have been pleased with our overall performance against the national targets, we were disappointed not to have achieved our target to reduce the number of MRSA (methicillin-resistant staphylococcus aureus) bacteraemia (bloodstream infections) to a maximum of 17 in 2006/07. We know that the public see cleanliness as one of the most important priorities in their hospitals, with MRSA infection rates viewed as a key indicator of this. Although we did miss our target, with 22 cases for the year, we have continued to invest considerable effort into improving infection control and have secured a reduction in MRSA bacteraemia of 46% in the past two years, a creditable achievement.

Our work during the year has also focused on reducing other healthcare acquired infections and, in particular, on reducing the incidence of Clostridium Difficile (C Diff), which has demonstrated a marked reduction in cases for the last quarter of the year compared to the same period in 2005/06.
We have implemented a number of measures across the hospital to help reduce infection rates, including:

- the introduction of the national ‘Cleanyourhands’ campaign with all areas having alcohol hand rub dispensers;
- regular hand hygiene audits, which have demonstrated an overall improvement in compliance;
- improved surveillance with regular and frequent monitoring;
- introduction of chlorine cleaning across clinical areas and further enhanced cleaning in problem areas;
- active use of the high impact interventions (HII) outlined in the Department of Health’s ‘Saving Lives’ guidance;
- review of antibiotic prescribing and implementation of protocols to reduce the incidence of C Diff;
- regular reporting on progress to the Board through monthly Control of Infection reports.

We are committed to reducing hospital acquired infection rates to the lowest levels achievable, and will continue to pursue all avenues to ensure our success in doing so.

**Other achievements**

As well as performing well against the national targets, Queen Elizabeth Hospital is constantly striving to improve the quality of services delivered to our patients. Summarised below are some examples of how we have successfully improved services for patients during the last year.

**Improvements in care for patients with lung disease**

During this year, working closely together with our partners in Greenwich TPCT, we jointly developed and introduced a new service to improve the care for patients with Chronic Obstructive Pulmonary Disease (COPD). COPD is a chronic lung disease which is traditionally a leading cause of emergency hospital admission.

As part of the new service Dr Jonathan Webb, Consultant Respiratory Physician, heads up a team of specialist nurses, community matrons and physiotherapists who work closely with patients in the community to help them manage their illness and avoid admissions to hospital. Where admission is necessary the team also works to ensure that this stay is as short as it can be so that patients are returned to their home environment as soon as possible.

As a result of this new way of providing the service in Greenwich, both the number of COPD admissions and the length of stay for COPD patients have reduced significantly in the past year compared to previous years. One of the new developments, a pulmonary rehabilitation programme, has been particularly applauded by patients, many of whom have been able to recover mobility and independence and resume activities which they had been unable to undertake prior to the programme.
Achievement of the A&E access target

Our A&E department treated over 100,000 patients during 2006/7 and successfully achieved the 4-hour access target, meaning that over 98% of patients were seen, treated, and admitted or discharged within four hours of arriving at the department.

Clinical and managerial staff across the Trust were involved in modifying processes to ensure that the flow of patients through the hospital is as efficient as possible. One of the biggest changes, and challenges, was the introduction of the new IT system in the A&E department. This system helps to track patients through the stages of their care in the department and enables staff to see, at a glance, what tests a patient has had and which treatments they are waiting for. The system can also generate letters for the patient’s GP and provide advice cards for the patient to take home.

In June 2006, Minister of State for Delivery and Reform, Andy Burnham MP, spent a night shift in A&E as part of his ‘tour’ of the NHS front line. He gained first hand experience of the challenges faced by A&E staff, particularly from patients who might more appropriately seek care in other settings such as primary care. The Trust was pleased to read positive comments regarding his visit in the Department of Health publication ‘Days out In the NHS: Listening to NHS Staff’ (January 2007).

New endoscopy service for gastroenterology

Dr David Rowbotham, Consultant Gastroenterologist, established a new diagnostic service for patients undergoing investigations of the small bowel. Due to the location of the small bowel, it is often difficult to diagnose problems using traditional endoscopy methods. A new technique – Wireless Capsule Endoscopy – is increasingly being used internationally and, during 2006, we introduced this technique at QEH. Patients attend the hospital early in the morning and swallow a small ‘pill’ which contains a device that transmits images of the gastrointestinal tract to a receiver worn by the patient as a belt. The patient is free to leave the hospital during the day and returns to hospital at the end of the afternoon where the recorder is removed and the images are then analysed by Dr Rowbotham.

The technique is very popular amongst patients as it more convenient that a regular endoscopy procedure and often provides medical staff with a definitive diagnosis which until this point has been difficult to determine.

Extension of protected mealtimes for patients

An initiative started in 2005/06 to improve inpatient nutrition was extended across all general medical and surgical wards during 2006/07. This initiative means that, during lunchtimes, nursing staff focus primarily on patient nutrition rather than other clinical activity. As a result, only essential clinical activity is permitted to take place during this time and x-ray investigations, doctors’ ward rounds, therapy interventions etc. have all been restricted. This means that patients have time and assistance where required to eat, and are not distracted by clinical activity. The wards are closed to visitors during this time apart from where the visitor is attending specifically to assist with feeding.
QEH selected as national innovator site for cardiology

The cardiology department has delivered some innovative changes to the way their services are delivered this year. Waiting times for cardiac diagnostic investigations have been a key area of focus, in preparation for achievement of the 18 week target in 2008. As a result of this work, patients needing an echo (echocardiogram - an ultrasound of the heart) as an outpatient will now wait only two weeks - a much shorter wait than the 26 weeks they would have waited for this same investigation in January 2006. In addition, the introduction of a ‘one stop’ cardiology clinic means that patients can have their diagnostic echo done in the clinic, the results are available to the doctor there and then, and this avoids patients having to come back to the hospital on a second visit for their results.

For inpatients the service is even better. Patients now usually have their echo on the same day that the request is made but certainly within 48 hours and this means that patients do not stay in hospital for longer than necessary because they are waiting for this test to be done.

However, it is not only the echo investigation where such dramatic improvements in waiting times have been achieved - all cardiac diagnostic investigations have seen a big reduction in waiting times. As a consequence of the tremendous amount of work undertaken to reduce diagnostic waiting times, the cardiology department has been invited by the Department of Health to become a national Innovator Site. This means that our staff will be sharing the excellent practices at QEH with other hospitals nation-wide so that they can benefit from our work.

During 2006, we have been working on the development of a new service at QEH – the introduction of an elective percutaneous coronary intervention (PCI or coronary angioplasty) service. During March 2007 approval was obtained from the British Cardiac Intervention Society (BCIS) to start the service and in April the first patients were treated. This is excellent news for patients, many of whom will no longer have to travel into central London for these procedures, as well as for QEH.

Shorter waits for all diagnostic tests

The Department of Health has given the NHS its biggest challenge yet in setting an 18 week waiting time target to be achieved by December 2008. This means that by then, no patients will wait more than 18 weeks from the time of a GP referral to the time their treatment starts, whether that start of treatment is an inpatient admission for a surgical procedure or the start of a treatment programme or therapy service as an outpatient.

To make sure that we are able to meet this challenge, we have started work at QEH in looking at the diagnostic phase of our patients’ care. This is the part of the treatment pathway that has not been measured in the past and sometimes patients have had to wait a long time to get these tests done. During 2006, we have started to measure the waits for a whole range of diagnostic tests and have been working to reduce the amount of time patients wait for them. New procedures have been introduced, like the ‘one stop’ clinic for cardiology and the ‘pink slip’ system for x-ray, which mean that patients often get their test done on the same day as their outpatient appointment or now can choose when they come back to have it done at their own convenience.
The changes we have made have meant that by the end of the year no-one was waiting more than 13 weeks to have a diagnostic test done. In the following tests the improvements have been significant:

<table>
<thead>
<tr>
<th>Diagnostic test</th>
<th>Longest Wait at Feb 2006</th>
<th>Longest Wait at Mar 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI</td>
<td>25 weeks</td>
<td>9 weeks</td>
</tr>
<tr>
<td>CT</td>
<td>26 weeks</td>
<td>7 weeks</td>
</tr>
<tr>
<td>DEXA Scan</td>
<td>19 weeks</td>
<td>6 weeks</td>
</tr>
<tr>
<td>Echocardiography</td>
<td>14 weeks</td>
<td>2 weeks</td>
</tr>
</tbody>
</table>

*Genito-urinary medicine (GUM)*

The demand for services at the hospital's Trafalgar (GUM) Clinic is increasing and the team is working hard to ensure that patients are able to access the service within 48 hours of a request for an appointment (a 2008 target). During 2006, we increased the number of open access clinics available each week so that there is now one available every day of the week. This means that patients do not need an appointment and can just turn up, during clinic hours, at a time and on a day convenient to them.

In addition, during this year changes were made to the department to provide additional clinical space to meet the growing demand, and a new computer system was introduced which, among other things, enables us to record accurately the waiting times for all patients who attend the clinic.

As part of its implementation plan for ‘The national strategy for sexual health and HIV’, the Department of Health commissioned a national review of GUM services. The Medical Foundation for AIDS and Sexual Health (MedFASH), a charity supported by the British Medical Association (BMA) and the British Association for Sexual Health and HIV (BASHH), is project managing this review. One of its aims is to undertake a multidisciplinary assessment of each of the 192 GUM services in England to highlight factors that facilitate or obstruct their ability to offer a prompt and high quality service. We were delighted to receive extremely positive feedback on the day of the visit to review the Trafalgar Clinic, and the written report is awaited.

*Improvements to pathology services*

We have invested heavily in pathology services during 2006/07 to ensure that this critical service, used by 80% of patients during their treatment pathway, remains at the forefront of technology. Three key developments were:

- the introduction of a liquid-based cytology service, along with partner organisations in south east London, which will improve the quality of specimen collection and minimise the need for repeat cervical screening;
• the implementation of a new IT system, Winpath Clinisys, to replace the system introduced in the early 1990s, which means we are the first hospital in south east London to introduce the IT system recommended for use across London; and
• through our PFI equipping contract with Toshiba, we have been able to replace five standalone analysers with state of the art modular analysers. The introduction of these analysers means that up to 80 tests can be done on a single sample. As a result we have been able to reduce turnaround times for patient results and GPs now receive all routine results within the working day.

Online booking for hospital clinics
During the year QEH completed its implementation of the Choose and Book system so receiving a date and time of their hospital appointment while in the GP surgery can now be a reality for all patients coming to QEH for their treatment. At the moment about 30% of appointments are booked using the system and the expectation is that this will increase to all appointments over time as GPs make more use of the system.

Maternity and neonatal services
Our maternity and neonatal services have developed further during the year, in part to cater for the continuing growth in activity that has been a feature of the service since moving to QEH in 2001. We were, in particular, pleased to be awarded level two accreditation in the Clinical Negligence Scheme for Trusts (CNST), demonstrating that the unit provides high levels of quality and safety for mothers and babies.

During the year we also established a successful and innovative multidisciplinary team – the ‘Time Team’ – to attend to the mental health needs of pregnant and post-partum women. An integral part of this is a new midwifery service called ‘Best Beginnings’ that caters for the special needs of the most vulnerable members of our community. We also provide a special service for pregnant teenagers and a dedicated midwife running the antenatal screening programme.

The neonatal unit has introduced changed working patterns to achieve the necessary expansion of the service and has cared for an ever-increasing number of complex newborn babies. We are pleased that the unit has now been recognised as a level two unit, reflecting its ability to care for babies with more complex health needs.

Arts Programme
Queen Elizabeth Hospital recognises the importance of the arts as an integral part of healthcare. The Elixir Arts programme is supported by core funding from the Trust’s Charitable Funds, including the employment of an Arts Manager. Project funding is raised from a variety of sources including grants and donations and there is an active Arts Steering Committee, which leads the programme to provide a positive and uplifting environment for patients, visitors and staff and to improve the hospital environment with specially commissioned works of art, performance or activities to help people in a number of ways:

• lowering levels of anxiety, stress and depression for patients and their families;
• making surroundings more pleasant, relaxing and less institutional;
• involving the community in their hospital to encourage ownership;
• raising the spirits - stimulating and inspiring design can brighten up dull, lifeless spaces;
• providing a focus for reflection at difficult times and times of change;
• alleviate boredom and be a distraction;
• being fun and making people laugh!

The staff programme in 2006/07 included ‘Stories of Difference’ - portrait posters and a book of stories and portraits of hospital staff, produced in partnership with Human Resources and the ‘Wanpot’ Black and Minority ethnic staff network. Patients, staff and visitors participated in the creation of a Willow Bower in one of the hospital’s courtyard gardens and demonstrations were held for paper lantern making, calligraphy workshops, classical guitar and cello performances. There was also a demonstration of innovative work with light-reactive surfaces and the effects of light and colour on the human body. Theatre and Puppet companies visited the Children’s Unit and song writing and percussion workshops were held.

National inpatient survey

The single major area of disappointment for the Trust has been the feedback received from the 2006 national inpatient survey. Despite extensive efforts in recent years to improve patient satisfaction levels at QEH, the results of the most recent patient survey, conducted by the Picker organisation on behalf of the Healthcare Commission, indicate that we have considerably more work to do to achieve the levels of patient satisfaction seen in other parts of the country. Trusts in London score consistently less well in the national patient surveys than elsewhere, and many, like QEH, will need to think afresh about how to address the problems raised by the survey.

The Board has decided that improving patient satisfaction will be the Trust's highest priority in 2007/08, and a comprehensive programme of activity is being planned to support this. These are expected to commence implementation during the summer of 2007, and we hope that some improvements will be seen in the next survey, to be published in spring 2008.

Our priorities for 2007/08

We have adopted six key objectives to describe our priorities in 2007/08. These are to:

• improve patients’ experiences of our services through the development and implementation of plans to address the principal causes of patient dissatisfaction, as measured by national and local patient surveys;
• deliver safe, high quality clinical care through the application of best practice and by ensuring that the principles of clinical governance underpin our organisation’s culture, our systems and the working practices of our clinical teams and clinical services;
• make significant progress towards demonstrating that the Trust will be fit for Foundation Trust status during 2008/09;
• achieve all existing and new national targets;
• develop a workforce which is sensitive and responsive to the diverse needs of our patients and for whom the experience of working at QEH is a positive one;
• ensure that the buildings, equipment and infrastructure at QEH are fit for purpose and able to respond flexibly to future change in the provision of healthcare within London.

We have identified for each of these objectives a number of actions and expected outcomes, all of which will be monitored by the Board throughout the year. Of particular importance are:

• the development and implementation of a comprehensive programme of action to understand and address the issues raised by the 2006 national inpatient survey results;
• the work (described in the section below) we are doing with our partner hospitals and PCTs in outer south east London to redesign healthcare provision in this part of the capital;
• our continuing drive to reduce the incidence of infections acquired at QEH; and
• the need to prepare a plan to migrate from our current integrated information systems platform to new systems in line with the Department of Health’s Connecting for Health programme.

A full description of our corporate objectives can be found via our website at www.queenelizabeth.nhs.uk.

Our longer-term strategy

Acute hospitals across the country face a number of similar pressures, causing many to consider whether and how they need to change. These arise from a number of factors, including:

• evidence that better clinical outcomes are achieved by creating larger clinical teams and departments that treat greater numbers of patients;
• evidence that the treatment of the acute onset of some quite common conditions such as strokes and heart attacks is better carried out in specialist units;
• the difficulty that smaller hospitals are increasingly facing in providing medical cover 24 hours a day in circumstances where staff can no longer work the hours or working patterns that they used to;
• medical and other therapeutic advances that mean that patients need to come into hospital much less frequently than in the past, and when they do they increasingly spend much shorter times in hospital than used to be the case.

In outer south east London these factors are exacerbated by the difficult financial positions of many of the organisations within the sector. Recognising these pressures, the four primary care trusts and four NHS trusts that make up outer south east London (covering the London Boroughs of Greenwich, Bexley, Lewisham and Bromley) are working together to consider the options for reorganising health services within the area to enable the NHS locally to meet the needs of patients better, at the same time as securing health services that are clinically and financially sustainable. This is being undertaken in parallel with the work being led by Professor Sir Ara Darzi on developing a healthcare strategy for London as a whole.
This programme, entitled ‘A Picture of Health’, has the full commitment of the Boards of all of the organisations involved in it, including the Board of QEH. Senior clinicians and managers are actively engaged in developing and evaluating potential options for change, in conjunction with a wide range of stakeholders, and it is anticipated that proposals for consultation with the public will be published during the autumn of 2007. Further details of this work can be found at www.apictureofhealth.nhs.uk, while progress with the London-wide healthcare strategy can be found at www.healthcareforlondon.nhs.uk.

Financial report

Background

The Trust has been unable to balance its income and expenditure consistently since it came into being in 2001. This has been the result of a number of factors including, in the past, operating inefficiencies and the high costs of our PFI scheme. The ‘excess’ costs of the PFI scheme – the costs that the Trust is unable to recover through the income it receives under the payment by results system of funding hospitals – have been assessed by independent consultants Tribal Consulting, and validated by Cambridge Economic Policy Associates, at approximately £8 million per annum. The consequence of this history is that the Trust’s balance sheet at 31 March 2007 contains a negative income and expenditure reserve of £43 million, and we were reliant on cash borrowings of £65 million at year end.

This position has been made to appear worse in recent years through the application of a controversial financial performance management system known as resource accounting and budgeting (RAB). We are pleased that RAB has now been abolished and that its 2006/07 effects have been reversed in the accounts of those organisations subject to it.

The full accounts for the year ending 31 March 2007 are included with this document on pages 1 to 99. The paragraphs which follow aim to describe in non-technical language our financial performance for the year, and should be read in conjunction with the accounts.

Income and Expenditure

Our income and expenditure plan for 2006/07 was designed to produce a deficit of £6.4 million. With an underlying deficit of £12 million coming into 2006/07 and the need to deal with new cost pressures of £5.6 million, this required us to plan and implement savings measures amounting to more than £11 million in the year. In the event we realised recurrent savings of £10 million and ended the year with a deficit of £7.2 million. The principal reason for the higher deficit than originally planned was the need to provide £0.7 million for restructuring costs arising from our 2007/08 savings programme (see below). The table below compares the main elements of our income and expenditure account in 2005/06 and 2006/07 and comments on the main changes between the two.
## Income and Expenditure

<table>
<thead>
<tr>
<th>Income</th>
<th>2005/06 (£ million)</th>
<th>2006/07 (£ million)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>119.6</td>
<td>134.7</td>
<td>Income in 2005/06 was reduced by £8.1m to reflect repayment of support from previous years to SE London SHA. After correcting for this, income increased by 6% in 2006/07</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>4.8</td>
<td>4.5</td>
<td>Income reduced in 2006/07 as a result of SE London Workforce Development Confederation passing on significant funding shortfalls to NHS Trusts</td>
</tr>
<tr>
<td>Other operating income</td>
<td>8.5</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>132.9</strong></td>
<td><strong>147.9</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay</td>
<td>(94.3)</td>
<td>(92.0)</td>
</tr>
<tr>
<td>Non-pay</td>
<td>(56.2)</td>
<td>(61.3)</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td><strong>(150.5)</strong></td>
<td><strong>(153.3)</strong></td>
</tr>
</tbody>
</table>

| Interest receivable           | 0.2                 | 0.2                 |
| Dividends payable             | (1.9)               | (2.0)               |

| **Surplus/(deficit)**         | **(19.3)**          | **(7.2)**           |

Our income and expenditure plan for 2007/08 is for a deficit of £3.3 million. Gross income is planned to grow by £5.1 million, principally through payment for the higher levels of activity we expect to have to do for our commissioning primary care trusts (PCTs) to bring waiting times down in line with the government’s targets, along with the modest price increases applied to the national tariff by the Department of Health. This is expected to be partially offset by income reductions that reflect PCT demand management plans, with both of our major commissioners intending to divert work away from acute hospitals into community based settings. We will also lose income as transitional financial support for our PFI scheme and the move to payment by results is withdrawn.
Without further measures to reduce costs, we would expect our expenditure to rise by £6.9 million, reflecting additional expenditure associated with the higher planned activity levels referred to above, as well as general inflation. The net effect of these expected income and expenditure increases would be to produce a deficit of £11.8 million, an unacceptable outcome in the context of our need to balance our income and expenditure as soon as we can and to start to repay the deficits we have incurred in the past. We therefore have to find further savings and the Board has decided that £8.5 million of savings is the maximum we can realistically aim to achieve in 2007/08.

The principal risks to this plan are twofold. Firstly it assumes that the ambitious demand management initiatives being developed by our commissioning primary care trusts will only be partially successful. Secondly it relies on our being able to identify and implement significant further savings measures without adversely affecting the quality of patient care. These risks will be kept under review during the year and appropriate steps taken to address them as and when they arise.

Capital expenditure

As a PFI hospital our capital expenditure needs are lower than for similar-sized hospitals that have been financed in the traditional way, and our capital resource limit reflects this. During the year we invested £2.4 million in 36 capital schemes, the single largest element of which was the expenditure of more than £1 million on IT and other investments within our pathology laboratories. The table below summarises our capital expenditure for the year.

### Capital Expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>2006/7 (£ Million)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology IT</td>
<td>1.1</td>
<td>Investment in pathology information systems</td>
</tr>
<tr>
<td>IT Network</td>
<td>0.5</td>
<td>Network equipment to support our IT systems</td>
</tr>
<tr>
<td>Hospital access road</td>
<td>0.2</td>
<td>Resurfacing and substructure works to improve hospital access road</td>
</tr>
<tr>
<td>Imaging works</td>
<td>0.1</td>
<td>Enabling works prior to the replacement of the CT scanner and fluoroscopy equipment</td>
</tr>
<tr>
<td>Theatre upgrading</td>
<td>0.1</td>
<td>Improvements to lighting, trolleys and electrical power systems in the operating theatres</td>
</tr>
<tr>
<td>Other</td>
<td>0.4</td>
<td>Other clinical and IT equipment</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2.4</strong></td>
<td></td>
</tr>
</tbody>
</table>

For 2007/08 the system of allocating capital resources to NHS trusts is changing as part of a wider set of financial changes announced by the Department of Health. From now, NHS Trusts
will, as a minimum, be required to spend the funds they set aside for the depreciation of their assets. If a trust wishes to spend more than this on capital investments, it will need to borrow the funds to do so. Trusts are only allowed to borrow if their financial strength, assessed by the Department of Health, indicates that they will be able to afford to make the repayments associated with these borrowings. QEH has the lowest financial strength rating because of its historic financial difficulties, which means that no borrowing will be available for capital investment in 2007/08 and we will be restricted to investing the sum set aside for depreciation, approximately £1.2 million. This will inevitably limit our investment aspirations and require us to prioritise very carefully all capital expenditure proposals.

**Cash**

We borrowed a further £12 million from the Department of Health in 2006/07, in line with our plan, producing cumulative cash borrowings of £65.4 million at the year end. The plan was set at this level to deal with the expected cash effects of the income and expenditure deficit described above, as well as capital commitments carried over from 2005/06 and a cash requirement associated with our PFI residual interest. In the event our cash needs were lower than expected because PCTs settled invoices sooner than we expected, the SHA made good sums owing to us and our capital programme commitments ran well ahead of the cash payments we actually needed to pay. As a result, at the end of the year we were able to pay our March tax and national insurance bill early as well as deposit £6.0 million with the Department of Health, and undershot our external financing limit by £5.9 million.

Our cash outflow in 2007/08 is expected to be £7 million, which we expect to be able cover without further borrowing because of the advance payment and deposit referred to above.

NHS organisations are expected to comply with the Confederation of British Industry’s code on payment to suppliers, known as the Better Payment Practice Code (BPPC). Details of how we performed in relation to this code can be found in note 7.1 to the accounts.

**Other financial matters**

**PFI**

Queen Elizabeth Hospital was constructed and is maintained under a PFI contract with Meridian Hospital Co plc (Meridian). The contract between Meridian and the Trust was signed in 1998, and Queen Elizabeth Hospital opened to patients in March 2001. Under the arrangement, Meridian has granted a lease to the Trust for the exclusive use of the building, and undertakes to maintain, repair, and replace building, engineering, electrical and other plant and machinery, as well as the fabric of the building and its grounds and gardens, over the 30 operational years of the contract. The Trust has the option to extend this operational period to 45 or 60 years. Meridian also provides catering, portering, domestic and cleaning, and a whole range of other services on the Queen Elizabeth Hospital site. These contracts are subject to market testing every five years (extendable to seven years with the agreement of both Meridian and the Trust). Meridian delivers its obligations through sub-contractors: Skanska Rashleigh Weatherfoil (SRW) and Skanska...
Facilities Services (SFS) provide the “hard” facilities management associated with the building, its fabric and equipment; ISS Mediclean provides the “soft” services, such as catering, portering and domestic services. The Trust retains ownership of the land at the QEH site.

The Trust also has a PFI contract with Toshiba Medical Systems for the repair, maintenance and replacement of our medical equipment. This is a 15 year contract which started in 2001, and requires Toshiba to replace medical equipment to an agreed lifecycle, or before if it fails or wears out, with an equivalent asset in line with the clinical preference of our clinicians. Annual spend on this contract was £3.6m.

Organisations of key importance to the future of the Trust
We receive the majority of our income from two NHS organisations, Greenwich Teaching Primary Care Trust and Bexley Care Trust, each of which commissions clinical services from QEH for the population it serves. We also receive smaller sums of money from the SHA to support undergraduate and postgraduate medical and non-medical education and training, as well as for research and development. We receive income from Oxleas NHS Foundation Trust, which operates a 90 bed mental health facility on the QEH site, from Queen Mary’s Sidcup NHS Trust for use of our facilities in the provision of oral and ophthalmology clinics at QEH, and from King’s College Hospital NHS Foundation Trust which operates a renal dialysis unit on the QEH site.

Other important contractual relationships exist with Meridian Hospital Co plc and Toshiba Medical Systems, as described above, NHS Shared Business Services (NHS SBS) who run most of our finance and accounting services, and McKesson Information Solutions UK Ltd who provide and support our key clinical systems, as well as our Electronic Staff Record (ESR) system.

The Trust is performance-managed by NHS London through its recently established arm’s length provider agency.

Accounting policy changes
Two significant accounting policy changes have been applied in the preparation of the 2006/07 accounts, both required by the Department of Health.

The first concerns the accounting treatment of income due to providers for patients who are in hospital at 31 March 2007. Under the new accounting rules, an appropriate proportion of the income associated with such patients should be brought to book in the year of the patients’ admission. This has resulted in approximately £1 million of additional income being recognised in 2006/07. The Trust has provided £0.3 million against this sum to reflect the fact that one commissioner has not recognised this liability in its accounts at year end.

The second accounting policy change, concerning the abolition of the Resource Accounting and Budgeting regime (RAB), is explained on page 21.
Pension liabilities

Information about the accounting treatment of pension liabilities is provided in note 1.10 of the 2006/07 accounts.

Auditors

The Trust’s auditors are PricewaterhouseCoopers LLP (PwC), who have been appointed by the Audit Commission as our external statutory auditor. Audit was the only service provided by PwC to QEH in 2006/07, at a cost of £218,000.

As far as the directors are aware, there is no relevant audit information of which the Trust’s auditors are unaware, and the directors have taken all steps to make themselves aware of any relevant audit information and to establish that the Trust’s auditors are aware of that information.

How we are addressing our environmental, social and community responsibilities

We take our environmental, social and community responsibilities seriously. Our environmental efforts have focused on our aim of reducing our carbon footprint, and we have been selected by the Carbon Trust (a company set up by the government to help public and private sector organisations reduce their carbon emissions) to be one of only 16 hospitals in the second wave of carbon reduction projects. This will enhance work we are doing which is already yielding success. We have succeeded in the course of 2006/07 in reducing our output of clinical and domestic waste, despite increased activity in the hospital, as a result of new waste segregation arrangements. Energy consumption has fallen as a result of reviewing when our central heating is turned on and off, reducing the number and duration of lights we have in use across the hospital; and in providing guidance to staff about turning off lighting and computers when they are away from their work area. We have also reduced peak electrical usage by reviewing high load periods, and by use of our combined heat and power plant.

We have undertaken simple water economisation work through the use of hippos in toilet cisterns, and future work is likely to increase our usage of intelligent controlled flushing devices in toilets.

Our work with the Carbon Trust will also look at methods of reducing our dependence on fossil fuelled transport, in particular through rationalisation of the supply chain to reduce the number of suppliers and deliveries we have, and reduced usage of Trust funded vehicles through route rationalisation measures. Our use of NHS Logistics and NHS Purchasing and Supplies, in common with most NHS bodies, already ensures that we achieve relatively low carbon emissions in these areas.

Our social and community responsibilities are focused on supporting the work of Greenwich Council’s and Greenwich PCT’s strategies for improving the social, economic and environmental wellbeing of the residents of Greenwich. We do this principally through our involvement with the
Improving Health: Cutting Inequalities Strategic Partnership, a multi-agency partnership that has led on the formulation of the Local Area Agreement, Local Public Service Agreement and the Neighbourhood Renewal Programme. Feeding into this partnership is the Healthy Greenwich Network Group, primarily involving the voluntary and community sectors, with representation from QEH and Greenwich PCT on its Executive Group.

**Emergency planning**

Queen Elizabeth Hospital has in place a Major Incident Plan that is fully compliant with the requirements of Department of Health guidance ‘Handling Major Incidents: An Operational Doctrine’ and all associated and subsequent guidance. This plan was tested through a live rehearsal in July 2006.

We are also in the process of revising our influenza plan to cater for the possibility of a flu pandemic, and are developing our internal crisis plan into a comprehensive business continuity plan which will cover all significant operational threats to the hospital’s ability to continue to provide safe and high quality care to our patients.
Workforce statistics

In 2006/07 we planned to have an average 2,253 whole time equivalent (wte) staff over the course of the year, comprising both permanent and temporarily employed staff. This represented a reduction of around 150 wte compared with 2005/06 levels, as a result of the savings measures we needed to implement to achieve our financial plan. Our actual staffing levels were maintained at or around these planned levels throughout the year, with 2,045 wte permanent staff in post at year end.

Vacancies fell from around 11% at the beginning of the year to 6% mid year, largely as a result of vacant posts being lost, rising slightly to 8% by year end. Staff turnover, excluding junior doctors, fell from 14% to 11%. We cut our recruitment advertising costs to just over a tenth of their previous levels and improved the efficiency of our recruitment processes by fully implementing the e-Recruitment system.

Work within the Trust to address sickness resulted in a reduction in levels of sickness absence from an average of 4.5% in 2005/06. Levels fell to under 3% by the middle of the year, rising to 4% across the winter, giving an average of 3.4% for the year. This was a significant achievement, resulting in levels of sickness well below the 2005/06 public sector average and the average for the NHS of 4.5%.

Reduced sickness absence levels and further improvements in efficiency led to a reduction in the use of bank (internal agency) staff from over 250 wte per month during 2005/06 to an average of 217 for 2006/07, and a significant reduction in the use of agency staff to less than 1% of the total pay bill.

Our savings programme was tightly managed, with relatively little impact on staff employed. We managed to keep dismissals on grounds of redundancy to 29.

During the course of the year we have considerably expanded the provision of routine reports on a variety of workforce indicators to the Board, executive directors and line managers, to support the planning and management process. Successful completion of the 11 month programme to implement the new Electronic Staff Record (ESR) system has assisted this.

Embracing diversity

Our local community is highly diverse, and our staff make-up continues to reflect this. We are mindful of our duties under the various pieces of legislation covering equality of opportunity and human rights, and take care to reflect this in policy development and review. Our local equal opportunities policy is comprehensive and prohibits discrimination on grounds of gender, sexual orientation, race, religion or belief, and age.

We revised and re-published our Race Equality Scheme, now in its fourth year, published our new Disability Equality Scheme, and consulted on our Gender Equality Scheme in readiness for publication in May 2007. All these schemes feature on the new Equality site on our Intranet, and
on our external website. We remain a ‘Two Ticks’ disability accredited employer, recognising our commitment to good practice in employing disabled people.

Conscious of the need to ensure that its impact did not fall disproportionately, we equality assessed the impact of our redundancy programme.

We celebrated International Women’s Day in March 2007 with a week of events organised by our thriving Wanpot (BME) network. As part of the week’s events a short film was launched, produced by Wanpot with support from amateur film-makers in the Trust’s IT department and Meridian Radio, the Trust’s hospital radio service. The 15 minute film features women from different backgrounds and cultures, who all work at the hospital. They talk about who has inspired them or helped shape their professional and personal lives, and how they face up to challenges in their respective roles. It also gives an insight into their aspirations and plans for the future. The film can be viewed on our website.

We began a programme of Trust-wide diversity training that commenced with the Board.

**Staff satisfaction**

We were pleased with the results of the annual staff satisfaction survey for 2006. 400 staff responded, a response rate of over 50%. We had set ourselves the target of improving on our results for 2005, and we were pleased to see significant reductions in the proportion of staff reporting work-related stress, from 38% to 30%, and a reduction in the number of staff affected by incidents of violence and aggression from patients and visitors, from 8% to 6%. We were delighted that out of the 28 Healthcare Commission indicators, we scored in the top 20% of acute trusts for 11, and were above average for a further seven. Staff gave positive feedback about the support they received from their manager, their work-life balance, teamwork, quality of work design, and job relevant training and development. Scores for positive feeling within the organisation and job satisfaction were also high.

We had a nearly 100% record for consultant appraisal, but for other staff groups we scored less well. The proportion of staff appraised in the previous 12 months has fallen significantly, from 68% in 2004 and 63% in 2005, to 52% in 2006. In spite of significant investment in training, coaching and other support, staff have found the new NHS-wide Knowledge and Skills Framework (KSF) and its associated e-KSF software programme quite difficult to implement. In addition, staff were not as satisfied as we would have liked with the support we offer when they encounter harassment or abuse from patients and visitors. An action plan to address these issues is already under way.

**Disciplinary action, grievances and appeals**

Grievances and appeals have increased from two per month to an average of three per month. Tighter absence and performance management, together with the implementation of redundancies, have contributed to this increase.

We dismissed 39 members of staff during the year. Of these, 29 were redundancies and three were for poor attendance.
Staff involvement and consultation

Our Joint Staff Council (JSC) has met regularly and continues to involve itself in all aspects of our business. This was a testing year for staff relations as we progressed through three phases of our savings programme, having lost our indefatigable staff side chairperson, Joyce Conway, to a well deserved retirement. We were delighted that Joyce was honoured by the Queen for her efforts through the award of an MBE.

We helped our Trade Union partners increase their representation of staff, and worked hard with them to ensure staff were supported through organisational change including redundancy. The JSC’s involvement in our savings programme was particularly supportive. Staff and their representatives were fully involved and consulted in a series of special meetings, which gave them the opportunity to engage with our most senior managers as they were working on their savings proposals.

We have made explicit the role of representatives in our newly reconstituted Health and Safety Committee.

Communication with staff has developed further within our clinical directorates, supplemented by our monthly Team Brief, the intranet, our all-desks emails and the regular Staff Open Forum, hosted by the Chief Executive and his director colleagues.

Learning and Development

We ran more than 1,000 training events or study days during the year covering a wide range of clinical, professional, interpersonal and managerial skills. Our learning and development team expanded their roles to provide coaching and other developmental support to teams ‘on the job’.

Academic success was recognised at the annual Trust Awards event in November 2006. 103 staff received certificates, recognising success in courses ranging from NVQs in care to masters degrees, some 40 more staff than in 2005.

We consulted on a revised and simplified appraisal guide, to support the implementation of KSF and restore the proportion of staff regularly appraised. Our KSF lead has provided full training sessions, direct support to directorates and staff groups, drop-in sessions, and 1:1 sessions to support the process, as well as promoting KSF through email, posters, flyers and stalls.

We have used ESR and its linked learning management system, Oracle Learning Management (OLM), to bring together our disparate databases recording training attendance, to ensure a comprehensive and effective process for monitoring mandatory training attendance, to ensure that all relevant staff attend. We are among the first trusts to use OLM in this way.
Investors in People

We had ambitious plans to achieve Investors in People (IiP) accreditation for the whole trust, and clinical directorates’ plans for IiP assessment were developed, but these were temporarily put on hold during the implementation of our savings programme and the associated redundancies. We will return to this work in 2007/08.

Knowledge Services

The new Library Management System was implemented in June 2006, successfully project managed across south east London by our Library Services Manager on secondment.

Staff Wellbeing, Occupational Health and Safety

We ran a survey in early 2006 with support from the Health and Safety Executive (HSE) to identify the levels of work related stress experienced by our staff. Focus groups across the organisation helped us identify priorities for action, and as a result we produced a leaflet for staff on coping with stress, ran a number of road shows, and set up conflict resolution training. Levels of stress had dropped from 38% to 30% over the course of the year and, even though this is below the NHS average, we intend to continue this work with the aim of reducing the rate further.

Our Occupational Health (OH) team have increased the amount of business they bring in to the Trust, through providing OH services to other trusts and local businesses. We extended the roles of our specialist occupational health nurses to carry their own client workload, and expanded the department to include staff health and safety.

We re-tendered for the provision of our independent and confidential counselling service, to improve the support provided to staff.

We extended staff accommodation options through maintaining direct contact with NHS Estates, and developing stronger links with estate agents, private landlords, Greenwich Council and social landlords.

Our staff social club has continued to provide a range of activities to bring staff together in a social setting, ranging from quiz nights to weekend trips away.

Spiritual and pastoral care

We were particularly pleased with the development of our Chaplaincy Service, which has a regular team of paid chaplains and volunteers from Hindu, Muslim, and Sikh faiths as well as Christian. We have established positive links between our hospital chaplains and our Chinese and Western Buddhist and Baha’i faith communities. The service supports patients as well as staff, and has worked especially closely with other hospital services, for example to support women and families facing the bereavement of miscarriage.
Modernising Medical Careers (MMC)

For the past two years QEH has been introducing the first part of a new national training programme for young doctors. Foundation Training, as it is known, is a focused training programme for doctors in the first two years after leaving medical school. The programme is designed to equip these doctors with the most important skills and aptitudes required for working in today’s NHS. The formal educational content is backed up by workplace-based competency assessments. The programme is working well with many additional benefits, including better multi-professional working and increased liaison with our community based colleagues.

The second part of the MMC programme involves the introduction of training programmes that begin at the end of the second Foundation Year and carry young doctors through to completion of their training as either hospital specialists or General Practitioners. The start of this part of the training programme has been fraught with difficulties in 2007, as a result of national problems that have attracted widespread publicity. We are working hard to support individual doctors experiencing difficulties in finding training programme places, while many consultants and other staff have devoted time to conducting interviews that are part of the selection process. Much work remains to be done before this programme is in a satisfactory state at a national level, and we will continue to play our part in supporting this work.
This report covers the remuneration of the Trust’s executive and non-executive directors, these being the only individuals with responsibility for directing or controlling the major activities of the Trust.

Remuneration of the executive directors is determined by the Remuneration and Terms of Service Committee, membership of which is indicated in the table overleaf. The Department of Health determines the remuneration of the non-executive directors.

Executive directors are paid a spot salary, and do not receive performance related pay.

Our policy on the remuneration of executive directors for 2005/06 and 2006/07 was to bring their salaries broadly into line with the average for posts in similar trusts, over a two-year period, subject to satisfactory performance. Salaries were benchmarked against external comparators’ published information, and the second of a two-stage adjustment, inclusive of inflation increases, was implemented in 2006/07. Increases ranged between 2% and 9%, depending on how far salaries were from the published benchmarks.

The performance of directors is assessed each year by the Chief Executive, and considered by the Remuneration and Terms of Service Committee. The Chairman of the Trust assesses the performance of the non-executive directors.

All substantive executive directors’ contracts are open ended, and provide for six months’ notice on either side on termination. In the event of early termination, the Trust’s liabilities are limited to payment in lieu of notice, except in the event of redundancy, when standard NHS conditions apply. There is no provision for compensation for early termination resulting from summary dismissal. The absence on secondment of one director was covered on an interim basis by a six-month contract for service from 16 January 2006 to 6 July 2006, with a notice provision of one month on either side, and no provision for compensation in the event of early termination.

All other senior managers are on national contracts, pay and conditions, following job matching or evaluation within the Agenda for Change framework.

The salaries, allowances and pensions benefits of the directors are set out in the tables overleaf. No significant awards have been made to past directors.
## Salaries and Allowances

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>Other Remuneration</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Colin Campbell*</td>
<td>20-25</td>
<td>0</td>
</tr>
<tr>
<td>Daphne Barnett**</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Louise Burke</td>
<td>15-20</td>
<td>0</td>
</tr>
<tr>
<td>Nora Flanagan</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lady Ann Jenkins**</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Dr Allan McNaught**</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>John Pelly*</td>
<td>140-145</td>
<td>0</td>
</tr>
<tr>
<td>Sylvia Perrins**</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Terina Riches</td>
<td>75-80</td>
<td>0</td>
</tr>
<tr>
<td>Dr David Robson</td>
<td>45-50</td>
<td>150-155</td>
</tr>
<tr>
<td>Lynn Saunders</td>
<td>75-80</td>
<td>0</td>
</tr>
<tr>
<td>Elisa Steele</td>
<td>75-80</td>
<td>0</td>
</tr>
<tr>
<td>Sally Storey</td>
<td>60-65</td>
<td>0</td>
</tr>
<tr>
<td>Ruth Russell</td>
<td>30-35</td>
<td>0</td>
</tr>
<tr>
<td>Gary Kent**</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>Susan Walker**</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>David Wragg</td>
<td>85-90</td>
<td>0</td>
</tr>
</tbody>
</table>

*Member of the Remuneration and Terms of Service Committee.
°Member of the Audit and Assurance Committee

Changes in executive directors 2006/07

- Louise Burke was Director of Nursing and Quality on an interim basis between 16 January and 6 July 2006
- Terina Riches became Director of Nursing and Patient Care on 10 July 2006, having been Director of Clinical Services prior to this
- Ruth Russell became Director of Clinical Services on 9 October 2006

Changes in non-executive directors 2006/07

- Susan Walker’s term of office as a non-executive director ended on 30 November 2006.
- Gary Kent was appointed a non-executive director from the 1 January 2007.
Pension Benefits

<table>
<thead>
<tr>
<th>Name and title</th>
<th>Real increase in pension and related lump sum at 31 March 2007 (bands of £2500)</th>
<th>Total accrued pension and related lump sum at 31 March 2007 (bands of £2500)</th>
<th>Cash Equivalent Transfer Value at 31 March 2006 £000</th>
<th>Cash Equivalent Transfer Value at 31 March 2007 £000</th>
<th>Real Increase in Cash Equivalent Transfer Value £000</th>
<th>Employers Contribution to Stakeholder Pension To nearest £100</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Pelly</td>
<td>5-7.5</td>
<td>90-95</td>
<td>356</td>
<td>395</td>
<td>20</td>
<td>-</td>
</tr>
<tr>
<td>Terina Riches</td>
<td>2.5-5</td>
<td>115-120</td>
<td>389</td>
<td>419</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Dr David Robson</td>
<td>15-17.5</td>
<td>325-330</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Ruth Russell</td>
<td>7.5-10</td>
<td>60-65</td>
<td>158</td>
<td>198</td>
<td>25</td>
<td>-</td>
</tr>
<tr>
<td>Lynn Saunders</td>
<td>5-7.5</td>
<td>45-50</td>
<td>158</td>
<td>189</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Elisa Steele</td>
<td>5-7.5</td>
<td>75-80</td>
<td>217</td>
<td>254</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td>Sally Storey</td>
<td>7.5-10</td>
<td>80-85</td>
<td>264</td>
<td>304</td>
<td>23</td>
<td>-</td>
</tr>
<tr>
<td>David Wragg</td>
<td>7.5-10</td>
<td>65-70</td>
<td>166</td>
<td>210</td>
<td>27</td>
<td>-</td>
</tr>
</tbody>
</table>

- As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for them.

- 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 2005/06 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.

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

- The accrued pension and lump sum represent the current value that would be received at retirement age, given that no further pension contributions are made.

John Pelly
Chief Executive

22.06.07
<table>
<thead>
<tr>
<th>Department</th>
<th>Service Provided at Queen Elizabeth Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident &amp; Emergency</td>
<td>Medical Diagnostic Centre</td>
</tr>
<tr>
<td>Adult Medicine</td>
<td>Metabolism Clinic</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Microbiology</td>
</tr>
<tr>
<td>Anti-coagulation Services</td>
<td>Mortuary</td>
</tr>
<tr>
<td>Bereavement Services</td>
<td>MRI Scanning</td>
</tr>
<tr>
<td>Biochemistry</td>
<td>Neurology</td>
</tr>
<tr>
<td>Blood tests (phlebotomy)</td>
<td>Nuclear Medicine</td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>Obstructive Therapy</td>
</tr>
<tr>
<td>Breast Services</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>Cancer Services (Oncology)</td>
<td>Oncology (Cancer Services)</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>Ophthalmology Clinics**</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Oral Surgery Clinics**</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>Orthopaedics</td>
</tr>
<tr>
<td>Clinical Haematology</td>
<td>Paediatric Medicine</td>
</tr>
<tr>
<td>Colorectal Surgery</td>
<td>Pain Management</td>
</tr>
<tr>
<td>Community paediatric nursing</td>
<td>Palliative Care</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>Pathology</td>
</tr>
<tr>
<td>CT scanning</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Cytology</td>
<td>Phlebotomy (blood tests)</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>DEXA Scanning</td>
<td>Plastic Surgery</td>
</tr>
<tr>
<td>Diabetic Medicine</td>
<td>Podiatry</td>
</tr>
<tr>
<td>Dietetics and Nutrition</td>
<td>Radiology</td>
</tr>
<tr>
<td>Ear, Nose and Throat Clinics*</td>
<td>Respiratory Medicine</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Rheumatology</td>
</tr>
<tr>
<td>Endoscopy</td>
<td>Sexual Health</td>
</tr>
<tr>
<td>Fracture Clinic</td>
<td>Sleep Studies</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Social Services</td>
</tr>
<tr>
<td>General Medicine</td>
<td>Special Care Baby Unit</td>
</tr>
<tr>
<td>General Radiology</td>
<td>Speech and Language Therapy</td>
</tr>
<tr>
<td>General Surgery</td>
<td>Stroke Unit</td>
</tr>
<tr>
<td>Genitourinary Medicine</td>
<td>Surgical Appliances</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>Trauma Surgery</td>
</tr>
<tr>
<td>Haematology</td>
<td>Ultrasound</td>
</tr>
<tr>
<td>Histopathology</td>
<td>Upper Gastrointestinal Surgery</td>
</tr>
<tr>
<td>Imaging</td>
<td>Urology</td>
</tr>
<tr>
<td>Immunology</td>
<td>Virology</td>
</tr>
<tr>
<td>Infection Control</td>
<td>Women’s Services</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>X-ray</td>
</tr>
<tr>
<td>Lipid Clinic</td>
<td></td>
</tr>
</tbody>
</table>

* Service provided by The Lewisham Hospital NHS Trust  ** Service provided by Queen Mary’s Sidcup NHS Trust
Colin Campbell - Chairman

Colin is a former technology director with a global accounting and financial services firm. He has been involved with the NHS since the late 1980s and previously served as Chairman of Queen Mary's Sidcup NHS Trust. He is an elected Local Government Councillor and lives in Bexley. Colin chairs the Finance Committee.

Lady Ann Jenkins - Vice-Chairman and Non-Executive Director

Ann, who lives in Blackheath, previously served as a Non-Executive Director at Queen Mary's Sidcup NHS Trust. She is Chairman of the Ranyard Memorial Charitable Trust, which runs two nursing homes, Dowe House and Mulberry House on the Lewisham/Blackheath borders. Ann chairs the Clinical Governance and Risk Management Committee.

Daphne Barnett - Non-Executive Director

Daphne is a long term Greenwich resident and retired member of Lewisham Social Services. She was a school governor for many years. She is the Trust's Champion for Older People and chairs the Joint Staff Committee.

Gary Kent - Non-Executive Director

Gary, who became a Non-Executive Director in January 2007, is an independent consultant specialising in procurement and has 25 years experience working in the commercial sector in fleet management, travel management and real estate.

Dr Allan McNaught - Non-Executive Director

Allan, who lives in Eltham, is a Senior Lecturer in Management and Health Policy at Greenwich University. Previously he worked on projects in the health and social care field both in the UK and overseas. In his spare time Allan is involved with many charitable organisations including "AHEAD", which provides support and services to black and ethnic minorities who have AIDS or are HIV positive and the Sickle Cell Trust. Allan's term of office ended on 30 April 2007.
Sylvia Perrins - Non-Executive Director

Sylvia lives in Eltham and is employed as the National Director for the National Skills Academy, Financial Services. She is a qualified accountant and chairs the Audit and Assurance Committee.

John Pelly - Chief Executive

John first worked for the NHS in 1990 when he joined West Lambeth Health Authority as Director of Finance. He moved to Guy’s & St Thomas’ NHS Trust in 1993 and remained in post as Director of Finance until 1998 when he was appointed Chief Operating Officer. In January 2004 John was seconded to Queen Elizabeth Hospital NHS Trust as acting Chief Executive. John was appointed Chief Executive with effect from 1 April 2005. John chairs the Trust Executive Committee.

Lynn Saunders – Deputy Chief Executive

Lynn has worked in the local NHS since the early 1980s. As Project Manager, she helped develop the new Queen Elizabeth Hospital and then, as Director of Strategy and Planning, was responsible for opening the hospital in 2001. As the Trust’s Director of Service Improvement Lynn has had responsibility for leading the organisation to achieve the NHS modernisation agenda. Lynn was appointed Deputy Chief Executive in May 2007 and now leads on corporate planning and development, business planning, performance monitoring, information, communications and external relations.

Terina Riches - Director of Nursing & Patient Care

Terina started in the NHS in 1976 and trained as a registered nurse. She joined the Trust in May 2000 as Director of Clinical Services following a variety of senior nursing and general management posts at St Mary’s Hospital NHS Trust. She was appointed Director of Nursing and Patient Care in July 2006 and leads on ensuring the delivery of high quality nursing care. She is also the Director of Infection Prevention and Control.

Dr David Robson - Medical Director

David was appointed Medical Director in 2004. Prior to this he was the Director for IM&T. David was appointed as a Consultant Physician at Greenwich District Hospital in 1978. He is still very active as a clinical doctor, working in Intensive Care and Cardiology. As Medical Director his key concerns are the quality and organisation of the clinical services, together with the clinical governance arrangements of the Trust.
David Wragg - Director of Finance

David has been the Finance Director at QEH since January 2000. He leads the finance function and estates and facilities management. David has worked in the NHS since 1987, as finance professional, management consultant and external auditor. David is a qualified accountant and is one of the NHS appointed directors of NHS Shared Business Services (a joint venture company set up by the NHS and the private sector to deliver financial services to NHS clients).

Ruth Russell - Director of Clinical Services

Ruth qualified as a registered nurse in 1984 and pursued a career in nursing until she became General Manager of the Directorate of Surgery at Guy’s and St Thomas’ NHS Foundation Trust in 2003. She joined Queen Elizabeth Hospital as General Manager, Surgery in August 2004. In October 2006 she was appointed Director of Clinical Services and has overall responsibility for the performance of the clinical services provided by the Trust.

Elisa Steele - Director of Information Communication Technology

Elisa joined the Trust as Director of Information Communication Technology (formally known as Information Management and Technology) in July 2004. She was previously Head of IT Services at King’s College Hospital. Elisa has worked in IT for over 22 years including positions at the National Hospital, Queen Square, South East Regional Health Authority and the private sector. Her outside interests include acting as a volunteer telephone counsellor for a national charity.

Sally Storey - Director of Human Resources & Organisational Development

Sally joined the Trust as Director of HR & OD in 2002. She has over 20 years’ experience in HR in health care and in independent consultancy, in mental health, community, children’s and learning disability services as well as general hospitals. A Chartered Fellow of the CIPD, Sally has a particular interest in the areas of diversity and leadership development, and maintains close involvement in these areas within her role. She is co-author of a number of published training packages for GP Practice Staff.
### Director of Clinical Services
- Clinical Site Management Team (including Emergency Planning)
- Pharmacy

#### Directorate of Acute Medicine
- Emergency Department
- Acute Admitting Medicine
- Respiratory Medicine (including the Respiratory Laboratory)
- Diabetes Services (including the Diabetic Day Centre)
- Emergency Department Care of the Elderly (including Medical Diagnostic Centre)
- Stroke Unit
- Inpatient and Outpatient Gastroenterology Physiotherapy
- Surgical Appliances
- Occupational Therapy
- Speech and Language Therapy
- Dietetics

#### Directorate of Pathology
- Haematology (including Blood Transfusion)
- Biochemistry
- Immunology
- Microbiology (including the Infection Control Team)
- Virology
- Cytopathology

#### Directorate of Specialist Medicine
- Critical Care Services
- Resuscitation Training
- Cardiology (including cardiac diagnostics)
- Cancer Team
- Palliative Care
- Haemato-Oncology and Chemotherapy
- Rheumatology
- Neurology
- Dermatology
- Imaging Services (including Reprographics and Medical Photography)
- Anticoagulation Service
- Outpatient Services
- Medical Records

#### Directorate of Surgery
- General Surgery
- Trauma and Orthopaedics
- Urology
- Endoscopy Services
- Anaesthetics
- Theatre Services
- Waiting List Administration
- Sterile Supply Services
- Discharge Lounge
- Hospital's Main Reception Area

#### Directorate of Women's and Children's Services
- Paediatrics (including dedicated outpatient facility)
- Community Paediatric Nursing
- Maternity Services
- Gynaecology
ANNUAL ACCOUNTS 2006/07

CONTENTS

Statement of the Chief Executive’s responsibilities as the accountable officer of the Trust 42
Statement of Internal Control 43
Statement of Directors’ responsibilities in respect of the accounts 48
Independent Auditors’ Report to the Board of Queen Elizabeth Hospital NHS Trust 49
Income and Expenditure Account for the Year Ended 31 March 2007 53
Note to the Income and Expenditure Account 54
Balance Sheet as at 31 March 2007 55
Statement of Total Recognised Gains and Losses for the year ended 31 March 2007 56
Cash Flow Statement for the year ended 31 March 2007 57

Note

Notes to the Accounts

1 Accounting policies 58
1.1 Accounting convention 58
1.2 Income recognition 58
1.3 Intangible fixed assets 58
1.4 Tangible fixed assets 59
1.5 Donated fixed assets 63
1.6 Private Finance Initiative (PFI) transactions 63
1.7 Stocks and work-in-progress 63
1.8 Research and development 64
1.9 Provisions 64
1.10 Pension costs 65
1.11 Liquid resources 66
1.12 Value Added Tax (VAT) 66
1.13 Foreign exchange 66
1.14 Third party assets 66
1.15 Leases 67
1.16 Public dividend capital (PDC) and PDC dividend 67
1.17 Losses and special payments 67
1.18 Financial instruments 68
2 Segmental analysis 68
3 Income from activities 69
4 Other operating income 69
5 Operating expenses 70
5.1 Operating expenses comprise 70
5.2 Operating leases 71
5.2.1 Operating leases include 71
5.2.2 Annual commitments under non-cancellable operating leases 71
6 Staff costs and numbers 72
6.1 Staff costs 72
6.2 Average number of persons employed 72
6.3 Employee benefits 73
6.4 Management costs 73
7 Better payment practice code 74
7.1 Better payment practice code - measure of compliance 74
7.2 The Late Payment of Commercial Debts (Interest) Act 1998 74
8 Profit (Loss) on disposal of fixed assets 75
9 Interest payable 75
10 Intangible fixed assets 76
11 Tangible fixed assets 77
11.1 Tangible fixed assets at the balance sheet date comprise 77
11.2 The net book value of land, buildings and dwellings 78
12 Stocks and work-in-progress 78
13 Debtors 78
14 Investments 79
14.1 Fixed asset investments 79
14.2 Current asset investments 79
15 Creditors 80
15.1 Creditors at the balance sheet date comprise 80
15.2 Loans 81
15.3 Finance lease obligations 81
15.4 Finance lease commitments 81
16 Provisions for liabilities and charges 82
17 Movements on reserves 83
18 Notes to the cash flow statement 84
18.1 Reconciliation of operating surplus to net cash flow from operating activities: 84
18.2 Reconciliation of net cash flow to movement in net debt 85
18.3 Analysis of changes in net debt 86
19 Capital commitments 87
20 Post balance sheet events 87
21 Contingencies 87
22 Movements in public dividend capital 88
23 Financial performance targets 89
23.1 Break-even performance 89
23.2 Capital cost absorption rate 90
23.3 External financing 90
23.4 Capital resource limit 90
24 Related party transactions 91
25 Private finance transactions 92
25.1 PFI schemes deemed to be off-balance sheet 92
26 Financial instruments 94
27 Financial assets and liabilities 95
27.1 Financial assets 95
27.2 Financial liabilities 96
27.3 Fair values 97
28 Third party assets 98
29 Intra-Government and other balances 98
30 Losses and special payments 99
STATEMENT OF THE CHIEF EXECUTIVE’S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Secretary of State has directed that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers, including their responsibility for the propriety and regularity of the public finances for which they are answerable, and for the keeping of proper records, are set out in the Accountable Officers’ Memorandum issued by the Department of Health.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer, except that as disclosed in the Income and Expenditure Account on page 1 of the financial statements and in the Operating and Financial Review on pages 6-27 of the Annual Report, the Trust produced a deficit for the year of £7.2 million (2005/06 £19.3 million) and is planning for a deficit of £3.3 million in 2007/08.

John Pelly
Chief Executive

22.06.07
STATEMENT ON INTERNAL CONTROL 2006/07

QUEEN ELIZABETH HOSPITAL NHS TRUST

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

As Accountable Officer I am formally accountable both to the Board and, via the NHS Chief Executive, to Parliament. I exercise my accountability to the Board through attendance at, and provision of reports to, formal meetings of the Board and its committees.

My accountability to the NHS Chief Executive and Parliament is exercised through the regular provision of a wide range of information to the Department of Health, and through the formal monitoring of Trust performance by NHS London.

I also have a responsibility to report on performance against service agreements with the commissioners of clinical services from the Trust, principally Greenwich Teaching Primary Care Trust and Bexley Care Trust. This responsibility is discharged through regular meetings of officers of those organisations, including at Chief Executive level.

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 organisation’s policies, aims and objectives;
- 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 Queen Elizabeth Hospital NHS Trust for the year ended 31 March 2007 and up to the date of approval of the annual report and accounts.
3. Capacity to handle risk

As Chief Executive I have overall responsibility for risk management. The Director of Finance is identified as the Board lead for non-clinical risk management, and the Medical Director and Director of Nursing & Patient Care are the joint Board leads for clinical governance and clinical risk management. The Trust invests in staff and systems resources to support these Directors in carrying out their risk management roles. The Head of Clinical Governance attends both the Clinical Governance and Risk Management Committee as well as the Risk Management and NHS Standards Committee.

A formal Board committee structure is in place, which oversees the Trust’s risk management activities and performance. There is a Non-Executive Clinical Governance and Risk Management Committee reporting to the Board. Executive management of risk is co-ordinated through the Trust Executive Committee, which reports to the Board, and is supported by the Risk Management and NHS Standards Committee (covering non-clinical risk and supported by the Health and Safety Committee) and the Clinical Governance Executive, which manages clinical risk through the coordination of eight specific sub-committees. The Audit and Assurance Committee is a Non-Executive committee which monitors the delivery of elements of the risk agenda.

The Trust provides risk management training for staff, which includes risk assessment, for those with management responsibility, as well as basic risk management training for all new staff as part of their corporate induction.

Communication of risk management matters, including sharing good practice, takes place in a wide variety of ways, both at corporate and departmental level. These include the use of email and Team Briefing on matters of general interest or concern; the circulation of findings, and development of action plans, following reviews of complaints and incidents; clinical audit meetings; and departmental newsletters.

4. The risk and control framework

There is a comprehensive Risk Management Strategy and Policy in place, which was updated and approved by the Board in 2006/07. This describes the overall approach and methodology for managing risks, and identifies corporate and departmental responsibilities. It also includes guidance on risk identification and assessment processes using a matrix-based model. Key risks are entered on to the Trust’s risk register and are reported to the Trust Board or its sub-committees.

Assessing and evaluating risk, and monitoring the environment of the organisation for fire and health and safety hazards, are a responsibility of line managers. In the course of 2006/07, the Trust improved its CNST accreditation in maternity services to Level 2. The CNST accreditation for other services remains at Level 1.

The Trust has a comprehensive incident reporting system in place, and a “whistle blowing” policy, which was revised in February 2006, for the anonymous reporting of staff concerns. Complaints are actively monitored and managed in line with Department of Health recommendations.
The Assurance Framework embodies a summary of the assurances in place, and an assessment of the effectiveness of internal controls to mitigate the risks to the Trust achieving its organisational objectives. It describes the key risks to achieving each objective, the internal controls in place, and an assessment of the assurances reported to the Board and its sub-committees. It also identifies where there are areas of poor control, or where a lack of assurance exists. This, together with other key processes, is used to provide the Board with assurance that an effective system of internal control is in place for the Trust. As part of its ongoing development it is intended that the Assurance Framework will be developed in line with the requirement of Integrated Governance and has been subject to quarterly reporting to the Board.

The Trust engages with its key stakeholders in a number of ways, including hosting and being involved in meetings of the Patients’ Forum; holding regular open staff meetings; liaising with senior officers of the London Borough of Greenwich and with the Health Scrutiny Panels of the London Boroughs of Greenwich and Bexley; and regular meetings with the Trust’s PFI partners and their sub-contractors. Objectives are clearly linked to the priorities of other partners and the wider community. The Trust engages formally with a range of statutory and voluntary sector partners to reflect the diverse needs of the catchment population.

Trust Board meetings are held in public; staff and members of the public regularly attend and question Board members on a wide variety of matters.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation’s achieving its principal objectives have been reviewed. My review is also informed by:

- Reports from External Auditors;
- Reports from Internal Auditors;
- The results of the Clinical Negligence Scheme for Trusts (CNST) assessment;
- The assessment of the Information Governance Toolkit;
- The monthly finance and performance reports to the Board;
- Reports from a wide variety of other external bodies, including the Medical Royal Colleges, London Deanery, Clinical Pathology Accreditation (CPA), the Health & Safety Executive and the London Fire & Civil Defence Authority;
- The Trust’s assessment of compliance with the standards set out in Standards for Better Health;
- The Auditors’ Local Evaluation (ALE) to be reported as part of the Healthcare Commission’s Annual Healthcheck for 2006/07;
- Third party assurances on NHS Shared Business Services and Electronic Staff Record activities.
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 & Assurance Committee, the Clinical Governance and Risk Management Committee, and the Trust Executive Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board approves Corporate Objectives each year, and a Service & Development Plan designed to achieve those objectives. During the year the Trust Executive Committee and Board receive monthly financial and performance management reports, which set out performance against the key plans and targets. The Board also reviews overall progress in achieving the Corporate Objectives two or three times per year.

The Audit and Assurance Committee has monitored both internal and external audit activity, and the effectiveness of key internal controls. An independent Internal Audit function is established and an annual plan of Internal Audit activity is approved and monitored by the Audit and Assurance Committee. The committee also reviews any incidence of fraud. Minutes of the Audit and Assurance Committee are reported to the Board.

The Clinical Governance and Risk Management Committee scrutinises the Trust’s actions and performance on all clinical risk and governance matters. Minutes of this committee are reported to the Board. The Trust succeeded in achieving high scores for its CNST level 2 maternity assessment in 2006/07. The Trust has also achieved a high overall score for the assessment of the Information Governance Toolkit.

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 in to 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.

The Trust’s Standards for Better Health declaration included two core standards for which the Board believes there was insufficient assurance as to whether the standards had been met throughout the year (standards C16 and C20b), and one core standard (standard 13a) which the Board believes the Trust had not fully met throughout the year, but had met by year-end.

The Trust has identified the following significant control issues, which could impact on its services:-

- The Trust had a significant underlying financial deficit in 2006/07, of approximately £7 million per annum. The actual reported deficit was £7.2 million in 2006/07, of which £0.7 million relates to restructuring costs (details are shown in Note 23.2 of the accounts on Continued Financial Standing). The underlying deficit in 2007/08 has increased to approximately £12 million as a result of income reductions (financial support for payment by results and PFI are planned to reduce), having to pay interest on cash borrowings for the first time, and significant PCT demand management aspirations. A plan to reduce costs by £8.5 million in 2007/08 has been approved by the Board, leaving a planned deficit of £3.3 million to be addressed in 2007/08.
• Because of the Trust’s financial deficit in 2006/07 the Trust’s external auditors, PricewaterhouseCoopers LLP, following the Code of Audit Practice, have concluded adversely that:
  • the Trust has not put in place arrangements to ensure that its spending matches its available resources; and
  • the Trust has not put in place a medium-term financial strategy, budgets and a capital programme that are soundly based and designed to deliver its strategic priorities;
• The Trust is unlikely to generate material surpluses that will enable it to recover historic services without a configuration of clinical services within SE London. It is therefore actively engaged in a project, known as ‘A Picture of Health’, which is considering options for achieving this, consultation on which is expected to commence in late 2007.

John Pelly
Chief Executive

22.06.07
STATEMENT OF DIRECTORS’ RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

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

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

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

By order of the Board

John Pelly       David Wragg
Chief Executive  Finance Director

22.06.07         19.06.07
Independent Auditors’ report to the Directors of the Board of the Queen Elizabeth Hospital NHS Trust

Opinion on the financial statements

We have audited the financial statements of Queen Elizabeth Hospital NHS Trust for the year ended 31 March 2007 under the Audit Commission Act 1998. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to the National Health Service set out therein. We have also audited the information in the Remuneration Report that is described as having been audited.

This report, including the opinion, has been prepared for and only for the Board of Queen Elizabeth Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission. We do not, in giving this opinion, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Respective responsibilities of Directors and Auditors

The directors’ responsibilities for preparing the financial statements and the Remuneration Report in accordance with directions made by the Secretary of State are set out in the Statement of Directors’ Responsibilities.

Our responsibility is to audit the financial statements and the part of the Remuneration Report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view and whether the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

We review whether the directors’ statement on internal control reflects compliance with the Department of Health’s requirements “Statement on Internal Control 2006/07 – Disclosures”, issued on 2 April 2007. We report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors’ statement on internal control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust’s corporate governance procedures or its risk and control procedures.
We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only the Foreword, the unaudited part of the Remuneration Report, the Chairman’s Statement and the Operating and Financial Review. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of audit opinion

We conducted our audit in accordance with the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission, which requires compliance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust’s circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In our opinion:

the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust’s affairs as at 31 March 2007 and of its income and expenditure for the year then ended; and

the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.
**Emphasis of matter – liquidity**
Without qualifying our opinion, we draw attention to note 22 in the financial statements which indicate that the Trust has £65 million cash borrowing which it is required to repay in 2007/08. These conditions indicate the existence of a material uncertainty which may cast significant doubt about the Trust’s liquidity.

PricewaterhouseCoopers LLP
Southwark Towers
32 London Bridge Street
London
SE1 9SY

PricewaterhouseCoopers LLP
22.06.07

The maintenance and integrity of the Queen Elizabeth Hospital NHS Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

**Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources**

**Directors’ Responsibilities**
The directors are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust’s use of resources, to ensure proper stewardship and governance, and regularly to review the adequacy and effectiveness of these arrangements.

**Auditor’s Responsibilities**
We are required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion in relation to proper arrangements, having regard to the criteria for NHS bodies specified by the Audit Commission. We report if significant matters have come to our attention which prevent us from concluding that the Trust has made such proper arrangements. We are not required to consider, nor have we considered, whether all aspects of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.
**Adverse Conclusion**

We have undertaken our audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, we are not satisfied that, in all significant respects, the Queen Elizabeth Hospital NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2007, in that it did not put in place:

- a medium-term financial strategy, budgets and a capital programme that are soundly based and designed to deliver its strategic priorities; or

- arrangements to ensure that its spending matches its available resources.

**Certificate**

We certify that we have completed the audit of the accounts in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

PricewaterhouseCoopers LLP  
Southwark Towers  
32 London Bridge Street  
London  
SE1 9SY

PricewaterhouseCoopers LLP  
22.06.07
INCOME AND EXPENDITURE ACCOUNT
FOR THE YEAR ENDED 31 March 2007

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Income from activities</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td>134,362</td>
<td>119,611</td>
</tr>
<tr>
<td>4</td>
<td>Other operating income</td>
<td>13,163</td>
<td>13,372</td>
</tr>
<tr>
<td>5</td>
<td>Operating expenses</td>
<td>(153,006)</td>
<td>(150,513)</td>
</tr>
</tbody>
</table>

OPERATING SURPLUS/(DEFICIT)

(5,481) (17,530)

SURPLUS/(DEFICIT) BEFORE INTEREST

(5,481) (17,530)

<table>
<thead>
<tr>
<th>NOTE</th>
<th>Interest receivable</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Other finance costs - unwinding of discount</td>
<td>(66)</td>
<td>(66)</td>
</tr>
<tr>
<td></td>
<td>Other finance costs - change in discount rate on provisions</td>
<td>0</td>
<td>(39)</td>
</tr>
</tbody>
</table>

SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR

(5,259) (17,402)

Public Dividend Capital dividends payable

(1,985) (1,887)

RETAINED SURPLUS/(DEFICIT) FOR THE YEAR

(7,244) (19,289)

The notes on pages 58 to 99 form part of these accounts.

All income and expenditure is derived from continuing operations.
NOTE TO THE INCOME AND EXPENDITURE ACCOUNT
FOR THE YEAR ENDED 31 March 2007

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>(7,244)</td>
<td>(19,289)</td>
</tr>
<tr>
<td>Financial support included in retained surplus/(deficit) for the year - NHS Bank</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Financial support included in retained surplus/(deficit) for the year - Internally Generated</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year excluding financial support</td>
<td>(7,244)</td>
<td>(19,289)</td>
</tr>
</tbody>
</table>

Financial support is income provided wholly to assist in managing the NHS Trust’s financial position. Internally generated financial support is financial support received from within the local health economy, consisting of the area of responsibility of the NHS London.

In 2006/07 the locally agreed I & E based financial support has been replaced by a regime of loans and deposits with the Department of Health. Details of deposits placed with the Department of Health can be found in note 14.2 to the accounts.
### BALANCE SHEET AS AT
31 March 2007

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>NOTE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>10</td>
<td>1,090</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>11</td>
<td>61,387</td>
</tr>
<tr>
<td>Investments 14.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>62,477</td>
<td>56,271</td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>12</td>
<td>1,636</td>
</tr>
<tr>
<td>Debtors 13</td>
<td>60,842</td>
<td>34,069</td>
</tr>
<tr>
<td>Investments 14.2</td>
<td>6,000</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand 18.3</td>
<td>480</td>
<td>612</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>68,958</td>
<td>36,201</td>
</tr>
<tr>
<td><strong>CREDITORS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due within one year 15</td>
<td>(8,753)</td>
<td>(14,667)</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS/(LIABILITIES)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>60,205</td>
<td>21,534</td>
</tr>
<tr>
<td><strong>CREDITORS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due after more than one year 15</td>
<td>(632)</td>
<td>0</td>
</tr>
<tr>
<td><strong>PROVISIONS FOR LIABILITIES AND CHARGES</strong></td>
<td>16</td>
<td>(3,770)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>118,280</td>
<td>74,431</td>
</tr>
<tr>
<td><strong>FINANCED BY:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TAXPAYERS’ EQUITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital 22</td>
<td>115,476</td>
<td>67,486</td>
</tr>
<tr>
<td>Revaluation reserve 17</td>
<td>44,876</td>
<td>41,688</td>
</tr>
<tr>
<td>Donated asset reserve 17</td>
<td>416</td>
<td>501</td>
</tr>
<tr>
<td>Other reserves 17</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>Income and expenditure reserve 17</td>
<td>(42,488)</td>
<td>(35,288)</td>
</tr>
<tr>
<td><strong>TOTAL TAXPAYERS’ EQUITY</strong></td>
<td>118,280</td>
<td>74,431</td>
</tr>
</tbody>
</table>

The financial statements on pages 53 to 99 were approved by the Audit Committee on the 19th of June 2007 and signed on its behalf by:

John Pelly  
Chief Executive  
22.06.07
<table>
<thead>
<tr>
<th>Description</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(deficit) for the financial year before dividend payments</td>
<td>(5,259)</td>
<td>(17,402)</td>
</tr>
<tr>
<td>Fixed asset impairment losses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Unrealised surplus/(deficit) on fixed asset revaluations/indexation</td>
<td>3,200</td>
<td>2,247</td>
</tr>
<tr>
<td>Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets</td>
<td>87</td>
<td>33</td>
</tr>
<tr>
<td>Defined benefit scheme actuarial gains/(losses)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions/(reductions) in &quot;other reserves&quot;</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td><strong>Total recognised gains and losses for the financial year</strong></td>
<td>(1,972)</td>
<td>(15,078)</td>
</tr>
<tr>
<td>Prior period adjustment</td>
<td>0</td>
<td>(4,417)</td>
</tr>
<tr>
<td><strong>Total gains and losses recognised in the financial year</strong></td>
<td>(1,972)</td>
<td>(19,495)</td>
</tr>
</tbody>
</table>
CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2007

<table>
<thead>
<tr>
<th>OPERATING ACTIVITIES</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOTE</td>
<td>£000</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>18.1</td>
<td>(36,337)</td>
</tr>
<tr>
<td>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest received</td>
<td></td>
<td>288</td>
</tr>
<tr>
<td>Interest paid</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Interest element of finance leases</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from returns on investments and servicing of finance</td>
<td></td>
<td>288</td>
</tr>
<tr>
<td>CAPITAL EXPENDITURE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Payments to acquire tangible fixed assets</td>
<td></td>
<td>(3,816)</td>
</tr>
<tr>
<td>Receipts from sale of tangible fixed assets</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(Payments to acquire intangible assets</td>
<td></td>
<td>(72)</td>
</tr>
<tr>
<td>Receipts from sale of intangible assets</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>(Payments to acquire)/receipts from sale of fixed asset investments</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from capital expenditure</td>
<td></td>
<td>(3,888)</td>
</tr>
<tr>
<td>DIVIDENDS PAID</td>
<td></td>
<td>(1,985)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before management of liquid resources and financing</td>
<td></td>
<td>(41,922)</td>
</tr>
<tr>
<td>MANAGEMENT OF LIQUID RESOURCES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Purchase) of investments with DH</td>
<td></td>
<td>(6,000)</td>
</tr>
<tr>
<td>(Purchase) of other current asset investments</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Sale of investments with DH</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Sale of other current asset investments</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from management of liquid resources</td>
<td></td>
<td>(6,000)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) before financing</td>
<td></td>
<td>(47,922)</td>
</tr>
<tr>
<td>FINANCING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital received</td>
<td></td>
<td>113,422</td>
</tr>
<tr>
<td>Public dividend capital repaid (not previously accrued)</td>
<td></td>
<td>(65,432)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from financing</td>
<td></td>
<td>47,990</td>
</tr>
<tr>
<td>Increase/(decrease) in cash</td>
<td></td>
<td>68</td>
</tr>
</tbody>
</table>
NOTES TO THE ACCOUNTS

1 Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trust Manual for Accounts which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2006/07 NHS Trusts’ Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow UK generally accepted accounting practice (UK GAAP) and HM Treasury’s Government Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Income recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements (NHS contracts). Income is recognised in the period in which services are provided, for patients in whose treatment straddles the year end this means income is apportioned across the financial years on the basis of length of stay. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

The Trust has recognised £802k in respect of patients whose treatment straddles the year end. This accounting policy is in line with current UK accounting practice. Although this partially relates to a prior accounting period, as the amount is immaterial the Trust has opted not to make a prior period adjustment.

1.3 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust’s activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.
1.4 **Tangible fixed assets**

**Capitalisation**

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

- individually have a cost of at least £5,000; or

- collectively 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

- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Expenditure on digital hearing aids in the year ended 31 March 2004 (but not in earlier years) was treated as capital expenditure, in accordance with the amendment to the Capital Accounting Manual issued in July 2003, giving rise to an increase in fixed assets regardless of the cost of the individual hearing aids. Subsequent purchases of digital hearing aids are capitalised only when the total value is greater than £5,000. Where small numbers of appliances are purchased the costs are expensed as incurred.

The finance costs of bringing fixed assets into use are not capitalised.

**Valuation**

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.
Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department.

The Department of Health has directed certain departures from the RICS Appraisal and Valuation Manual in this and all preceding periodic NHS valuation exercises. The most significant of these are as follows:-

Specialised operational NHS assets and valued on the basis that the existing building will be replaced by an asset of similar construction, whereas the RICS Appraisal and Valuation Manual requires the valuer to have regard to a modern substitute building where the cost is lower, except in cases where there is a paramount commitment to the retention of an existing building.

In valuing assets under construction, no deduction is made for the risk of failure to complete the project, whereas the RICS Appraisal and Valuation Manual requires such deductions to be made.

Additional assumptions, in addition to those required by the RICS Appraisal and Valuation Manual, are required in the valuation of non-operational assets to market value:
- the NHS body is assumed not to be in the market for the asset;
- regard is had to dividing properties into lots to achieve the best price;
- no adjustments are made to reflect hypothetical “flooding of the market”;

A prospective valuation date has been used (valuations were provided in 2004 as at 31 March 2005), which is a departure from the retrospective methodology of the RICS Appraisal and Valuation Manual;

The RICS Appraisal and Valuation Manual requires adjustments to be made to the valuation of a building in respect of dilapidations. The Department of Health has directed that such adjustments should not be made for NHS properties. However, dilapidations are still reflected in the remaining useful economic life attached to properties;

No adjustments are made to valuations for perceived functional or economic obsolescence, whereas the RICS Appraisal and Valuation Manual includes such adjustments.

The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on the 31 March 2005.
The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets once they have been taken out of operational use and subsequently disposed of.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Total Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost using the indexes as for land and buildings, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets as 'assets under construction and payments on account' where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer should provide an estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.
Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset using the following lives:

<table>
<thead>
<tr>
<th>Years</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 to 15</td>
<td>Medical equipment and engineering plant</td>
</tr>
<tr>
<td>10</td>
<td>Furniture</td>
</tr>
<tr>
<td>8</td>
<td>Mainframe information technology installations</td>
</tr>
<tr>
<td>7</td>
<td>Soft furnishings</td>
</tr>
<tr>
<td>5</td>
<td>Office and information technology equipment</td>
</tr>
<tr>
<td>10</td>
<td>Set-up costs in new buildings</td>
</tr>
</tbody>
</table>

Impairment losses resulting from short-term changes in price that are considered to be recoverable in the longer term are taken in full to the revaluation reserve. These include impairments resulting from the revaluation of fixed assets from their cost to their value in existing use when they become operational. This may lead to a negative revaluation reserve in certain instances.

Where buildings and their underlying or associated land are to be disposed of, they will be subject to an impairment review and revalued or subject to depreciation to reach open market value for alternative use at the point at which they are taken out of operational use. In these circumstances, the building and its underlying or associated land are treated as one single asset for the purposes of the impairment review. Consequently, movements in the value of land and buildings are considered together in these circumstances when calculating any impairment to be charged to revenue or recognised in the statement of total recognised gains and losses. This is a change in accounting policy from previous years. Prior to 2005/06, land and buildings were considered separately in impairment reviews. Opening balances and prior year comparatives have also been restated to the values at which they would have been stated if this accounting policy had been applied in prior years.

Where the useful economic life of an asset is reduced from that initially estimated due to the revaluation of an asset for sale, depreciation is charged to bring the value of the asset to its value at the point of sale.
Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income may be paid by the Trust’s main commissioner using funding provided by the NHS Bank.

Where this funding is received it is included in income from PCTs and is separately disclosed at the foot of note 3.

1.5 Donated fixed assets
Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also 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 the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.6 Private finance initiative (PFI) transactions
The NHS follows HM Treasury’s Technical Note 1 (Revised) “How to Account for PFI transactions” which provides definitive guidance for the application of the Application Note F to FRS 5 and the guidance ‘Land and Buildings in PFI schemes Version 2’.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI obligations are recorded as an operating expense. Where the Trust has contributed land or buildings to the PFI provider to be used in the PFI scheme, a prepayment is recognised, valued at the net present value of the resulting reduction in the unitary charge payable under the PFI contract, and amortised over the life of the PFI contract by charge to the Income and Expenditure Account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.7 Stocks and work-in-progress
Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost 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.
1.8 **Research and development**

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- there is a clearly defined project;
- the related expenditure is separately identifiable;

- the outcome of the project has been assessed with reasonable certainty as to:
  - its technical feasibility;
  - its resulting in a product or service which will eventually be brought into use;

- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Trusts are unable to disclose the total amount of research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

Fixed assets acquired for use in research and development are amortised over the life of the associated project.

1.9 **Provisions**

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is material, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

**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. 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 16.
Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2006/07 relates to the Trust’s contribution to the Clinical Negligence Scheme for Trusts.

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.

1.10 Pension 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. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full valuation for FRS 17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme’s assets and liabilities to allow a review of the employers’ contribution rates, this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Services Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers’ contributions are set at 14% of pensionable pay from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme’s liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th of the best of the last three years’ pensionable pay for each year of service. A lump sum normally equivalent to three years’ pension is payable on retirement. 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. On death, a pension of 50% of the member’s pension is normally payable to the surviving spouse.
Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final years pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years pensionable pay less their retirement lump sum for those who die after retirement is payable.

Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements 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 NHS 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 (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

1.11 Liquid resources

Deposits and other investments that are readily convertible into known amounts of cash at or close to their carrying amounts are treated as liquid resources in the cashflow statement. The Trust does not hold any investments with maturity dates exceeding one year from the date of purchase.

1.12 Value Added Tax

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

1.13 Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.14 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 28 to the accounts.
1.15 **Leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.16 **Public dividend capital (PDC) and PDC dividend**

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.17 **Losses and special payments**

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

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). Note 30 is compiled directly from the losses and compensations register which is prepared on a cash basis.
1.18 **Financial instruments**

The Trust may hold any of the following financial assets and liabilities:

1 **Assets**
   - investments
   - long-term debtors and accrued income
   - short-term debtors and accrued income (not disclosed in note 26 under exemptions permitted by FRS 13)

2 **Liabilities**
   - loans and overdrafts
   - long-term creditors
   - short-term creditors (not disclosed in note 26 under exemptions permitted by FRS 13)
   - provisions arising from contractual arrangements
   - finance lease obligations

Trusts have no powers to invest or borrow and can only draw cash from the Office of the Paymaster General when it is required. Cash, Bank and Overdraft balances are recorded at current values. Account balances are set-off only where there is a formal agreement with the bank to do so. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, ‘Interest receivable’ and ‘Interest Payable’ in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

All other financial instruments are held for the sole purpose of managing the cash flow of the Trust on a day to day basis or arise from the operating activities of the Trust. The management of risks around these financial instruments therefore relates primarily to the Trust’s overall arrangements for managing risks to their financial position.

**Cash, bank and overdraft**

Cash, bank and overdraft balances are recorded at current values. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, “interest receivable” and “interest payable” in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

2 **Segmental reporting**

The Trust only provides healthcare, therefore no segmental analysis is required.
3. **Income from activities**

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Strategic Health Authorities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NHS Trusts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary Care Trusts</td>
<td>114,437</td>
<td>116,242</td>
</tr>
<tr>
<td>Foundation Trusts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Department of Health</td>
<td>19,137</td>
<td>2,656</td>
</tr>
<tr>
<td>NHS Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non NHS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Private patients</td>
<td>92</td>
<td>48</td>
</tr>
<tr>
<td>- Overseas patients (non-reciprocal)</td>
<td>241</td>
<td>295</td>
</tr>
<tr>
<td>- Road Traffic Act</td>
<td>455</td>
<td>370</td>
</tr>
<tr>
<td>- Injury cost recovery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>134,362</td>
<td>119,611</td>
</tr>
</tbody>
</table>

Road Traffic Act income is subject to a provision for doubtful debts of 30% to reflect expected rates of collection (8.7% in 2005/06)

4. **Other operating income**

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Patient transport services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>4,499</td>
<td>4,829</td>
</tr>
<tr>
<td>Charitable and other contributions to expenditure</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfers from donated asset reserve</td>
<td>184</td>
<td>175</td>
</tr>
<tr>
<td>Transfers from government grant reserve</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Income Generation</td>
<td>632</td>
<td>684</td>
</tr>
<tr>
<td>Other income</td>
<td>7,848</td>
<td>7,684</td>
</tr>
<tr>
<td></td>
<td>13,163</td>
<td>13,372</td>
</tr>
</tbody>
</table>

Included within other income are the following material items:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxleas SLA (This SLA is not activity related, and is generated as a result of the occupation of a Trust owned building. The SLA also includes a recharge for work carried out by the Trust PFI partner.)</td>
<td>1,665</td>
<td>2,078</td>
</tr>
<tr>
<td>PFI Smoothing monies. This income has been received as the Trust were one of the first to enter a PFI partnership.</td>
<td>713</td>
<td>683</td>
</tr>
<tr>
<td>Greenwich PCT non-patient SLA, for finance and payroll services.</td>
<td>560</td>
<td>617</td>
</tr>
</tbody>
</table>
### 5. Operating expenses

#### 5.1 Operating expenses comprise:

<table>
<thead>
<tr>
<th>Item</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from other NHS Trusts</td>
<td>838</td>
<td>629</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>962</td>
<td>853</td>
</tr>
<tr>
<td>Services from Foundation Trusts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Purchase of healthcare from non NHS bodies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Directors’ costs</td>
<td>813</td>
<td>673</td>
</tr>
<tr>
<td>Staff costs</td>
<td>92,603</td>
<td>94,334</td>
</tr>
<tr>
<td>Supplies and services - clinical</td>
<td>23,124</td>
<td>21,938</td>
</tr>
<tr>
<td>Supplies and services - general</td>
<td>6,941</td>
<td>4,946</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,871</td>
<td>2,278</td>
</tr>
<tr>
<td>Transport</td>
<td>257</td>
<td>223</td>
</tr>
<tr>
<td>Premises</td>
<td>18,780</td>
<td>18,700</td>
</tr>
<tr>
<td>Bad debts</td>
<td>563</td>
<td>660</td>
</tr>
<tr>
<td>Depreciation</td>
<td>939</td>
<td>893</td>
</tr>
<tr>
<td>Amortisation</td>
<td>378</td>
<td>347</td>
</tr>
<tr>
<td>Fixed asset impairments and reversals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees</td>
<td>218</td>
<td>246</td>
</tr>
<tr>
<td>Other auditor’s remuneration</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>2,400</td>
<td>2,448</td>
</tr>
<tr>
<td>Redundancy costs</td>
<td>464</td>
<td>129</td>
</tr>
<tr>
<td>Other</td>
<td>1,855</td>
<td>1,216</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>153,006</strong></td>
<td><strong>150,513</strong></td>
</tr>
</tbody>
</table>

Other Expenditure includes the amortisation of the Trust Deferred Asset of £1,054k.
5.2 Operating leases

5.2.1 Operating leases include:

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Hire of plant and machinery</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other operating lease rentals</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>31</td>
</tr>
</tbody>
</table>

There is a total of £18k (2005/06 £18k) of operating leases in the Trust’s name where the obligation to pay for these leased assets rests with Toshiba the Trust’s PFI partner.

5.2.2 Annual commitments under non-cancellable operating leases are:

<table>
<thead>
<tr>
<th></th>
<th>Land and buildings</th>
<th>Other leases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2006/07</td>
<td>2005/06</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Operating leases which expire:

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 1 year</td>
<td>0</td>
<td>31</td>
</tr>
<tr>
<td>Between 1 and 5 years</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>After 5 years</td>
<td>38</td>
<td>0</td>
</tr>
</tbody>
</table>

The operating lease relates to the rental of a warehouse owned by the London Borough of Greenwich.
6. Staff costs and numbers

6.1 Staff costs

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total £000</td>
<td>Permanently £000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>78,302</td>
<td>72,108</td>
</tr>
<tr>
<td>Social Security Costs</td>
<td>6,880</td>
<td>6,362</td>
</tr>
<tr>
<td>Employer contributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to NHS Pension Scheme</td>
<td>8,184</td>
<td>8,016</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>93,366</td>
<td>86,486</td>
</tr>
</tbody>
</table>

The total employer contribution payable in 2006-07 was £8,016,000 (2005-06 £7,829,000).

6.2 Average number of persons employed

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Permanently Number</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>321</td>
<td>305</td>
</tr>
<tr>
<td>Ambulance staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>506</td>
<td>491</td>
</tr>
<tr>
<td>Healthcare assistants and other support staff</td>
<td>319</td>
<td>244</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>847</td>
<td>745</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting learners</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Scientific, therapeutic and technical staff</td>
<td>264</td>
<td>252</td>
</tr>
<tr>
<td>Social care staff</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2,277</td>
<td>2,057</td>
</tr>
</tbody>
</table>

The figures disclosed above for 2005/06 and 2006/07 are not comparable due to the fact that the Trust has implemented a new payroll and HR system during the year. The new system classifies staff grouping more accurately as it is a nationally designed system. As such analysis of the movement of individual staff groups will not give a true and accurate picture of how the makeup of the Trust’s workforce has changed between the two years.
6.3 Employee benefits

There were no employee benefits in 2006/07 (2005/06, £0)

6.4 Management costs

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management costs</td>
<td>5,160</td>
<td>6,239</td>
</tr>
<tr>
<td>Income</td>
<td>147,525</td>
<td>132,983</td>
</tr>
</tbody>
</table>

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en

6.5 Retirements due to ill-health

During 2006/07 there were seven (2005/06, 2) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £242,720 (£68,289). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.
7. Better payment practice code

7.1 Better payment practice code - measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>2006/07 Number</th>
<th>2006/07 £000</th>
<th>2005/06 Number</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>32,533</td>
<td>58,667</td>
<td>30,987</td>
<td>52,474</td>
</tr>
<tr>
<td>Total Non NHS trade invoices paid within target</td>
<td>25,201</td>
<td>48,453</td>
<td>16,941</td>
<td>39,773</td>
</tr>
<tr>
<td>Percentage of Non-NHS trade invoices paid within target</td>
<td>77%</td>
<td>83%</td>
<td>55%</td>
<td>76%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>1,252</td>
<td>39,657</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>732</td>
<td>37,554</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>58%</td>
<td>95%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

During 2005/06, the performance of payments to other NHS bodies was not available due to insufficient data.

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

<table>
<thead>
<tr>
<th></th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts included within Interest Payable (Note 9) arising from claims made under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
8. Profit/(Loss) on disposal of fixed assets

Profit/(loss) on the disposal of fixed assets is made up as follows:

<table>
<thead>
<tr>
<th></th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit on disposal of fixed asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Loss) on disposal of fixed asset investments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profit on disposal of intangible fixed assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Loss) on disposal of intangible fixed assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profit on disposal of land and buildings</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Loss) on disposal of land and buildings</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Profits on disposal of plant and equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Loss) on disposal of plant and equipment</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

9. Interest payable

<table>
<thead>
<tr>
<th></th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finance leases</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Late payment of commercial debt</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loans</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


## 10. Intangible fixed assets

<table>
<thead>
<tr>
<th>Software licences £000</th>
<th>Licenses and trademarks £000</th>
<th>Patents £000</th>
<th>Development expenditure £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross cost at 1 April 2006</td>
<td>2,489</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Indexation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>72</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions donated</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Additions government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross cost at 31 March 2007</strong></td>
<td>2,561</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amortisation at 1 April 2006</td>
<td>1,093</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Indexation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reversal of impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>378</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Amortisation at 31 March 2007</strong></td>
<td>1,471</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net book value</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Purchased at 1 April 2006</td>
<td>1,337</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Donated at 1 April 2006</td>
<td>59</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Government granted at 1 April 2006</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>- Total at 1 April 2006</strong></td>
<td>1,396</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Purchased at 31 March 2007</td>
<td>1,049</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Donated at 31 March 2007</td>
<td>41</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Government granted at 31 March 2007</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>- Total at 31 March 2007</strong></td>
<td>1,090</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
11. Tangible fixed assets

11.1 Tangible fixed assets at the balance sheet date comprise the following elements:

<table>
<thead>
<tr>
<th></th>
<th>Land</th>
<th>Buildings excluding dwellings</th>
<th>Dwellings</th>
<th>Assets under construction and payments on account*</th>
<th>Plant and machinery</th>
<th>Transport equipment</th>
<th>Information technology</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cost or valuation at 1 April 2006</td>
<td>45,150</td>
<td>751</td>
<td>0</td>
<td>6,156</td>
<td>1,868</td>
<td>89</td>
<td>5,991</td>
<td>46</td>
<td>60,051</td>
</tr>
<tr>
<td>Additions purchased</td>
<td>0</td>
<td>355</td>
<td>0</td>
<td>3,401</td>
<td>283</td>
<td>0</td>
<td>125</td>
<td>0</td>
<td>4,164</td>
</tr>
<tr>
<td>Additions donated</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>77</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>87</td>
</tr>
<tr>
<td>Additions government granted</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Impairments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reclassifications</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(1,057)</td>
<td>0</td>
<td>0</td>
<td>1,057</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Indexation</td>
<td>2,580</td>
<td>93</td>
<td>0</td>
<td>499</td>
<td>82</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3,257</td>
</tr>
<tr>
<td>Other in year revaluation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cost or Valuation at 31 March 2007</strong></td>
<td><strong>47,730</strong></td>
<td><strong>1,209</strong></td>
<td><strong>0</strong></td>
<td><strong>8,999</strong></td>
<td><strong>2,310</strong></td>
<td><strong>91</strong></td>
<td><strong>7,173</strong></td>
<td><strong>47</strong></td>
<td><strong>67,559</strong></td>
</tr>
</tbody>
</table>

Depreciation at 1 April 2006
- 0 0 0 0 896 55 4,215 10 5,176
- Charged during the year
- 0 49 0 0 269 13 602 6 939
- Impairments
- 0 0 0 0 0 0 0 0 0
- Reversal of Impairments
- 0 0 0 0 0 0 0 0 0
- Reclassifications
- 0 0 0 0 0 0 0 0 0
- Indexation
- 0 32 0 0 24 1 0 0 57
- Other in year revaluation
- 0 0 0 0 0 0 0 0 0
- Disposals
- 0 0 0 0 0 0 0 0 0
- **Depreciation at 31 March 2007**
- 0 81 0 0 0 0 0 0 0

Net book value
- Purchased at 1 April 2006
- 45,150 744 0 6,156 606 7 1,766 4 54,433
- Donated at 1 April 2006
- 0 7 0 0 366 27 10 32 442
- Government granted at 1 April 2006
- 0 0 0 0 0 0 0 0 0
- **Total at 1 April 2006**
- 45,150 751 0 6,156 972 34 1,776 36 54,875
- Purchased at 31 March 2007
- 47,730 1,110 0 8,999 818 0 2,351 4 61,012
- Donated at 31 March 2007
- 0 18 0 0 303 22 5 27 375
- Government granted at 31 March 2007
- 0 0 0 0 0 0 0 0 0
- **Total at 31 March 2007**
- 47,730 1,128 0 8,999 1,121 22 2,356 31 61,387

There were no fixed assets held under finance lease at the balance sheet date (2005/06 £0).
Of the totals at 31 March 2007, the Trust had no assets held at open market valuation (2005/06 £0).
The Reversionary Interest in the hospital is shown under assets under construction at a value of £8.2m (2005/06 £6.2m).
11.2 The net book value of land, buildings and dwellings at 31 March 2007 comprises:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Freehold</td>
<td>48,858</td>
<td>45,901</td>
</tr>
<tr>
<td>Long leasehold</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Short leasehold</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>48,858</strong></td>
<td><strong>45,901</strong></td>
</tr>
</tbody>
</table>

12. Stocks and work-in-progress

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Raw materials and consumables</td>
<td>1,636</td>
<td>1,520</td>
</tr>
<tr>
<td>Work-in-progress</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finished goods</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,636</strong></td>
<td><strong>1,520</strong></td>
</tr>
</tbody>
</table>

13. Debtors

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Amounts falling due within one year:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS debtors</td>
<td>35,566</td>
<td>7,486</td>
</tr>
<tr>
<td>Provision for irrecoverable debts</td>
<td>(1,265)</td>
<td>(1,149)</td>
</tr>
<tr>
<td>Other prepayments and accrued income</td>
<td>1,262</td>
<td>1,129</td>
</tr>
<tr>
<td>Other debtors</td>
<td>3,330</td>
<td>4,545</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>38,893</strong></td>
<td><strong>12,011</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Amounts falling due after more than one year:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS debtors</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Provision for irrecoverable debts</td>
<td>(237)</td>
<td>(22)</td>
</tr>
<tr>
<td>Other prepayments and accrued income</td>
<td>21,396</td>
<td>21,789</td>
</tr>
<tr>
<td>Other debtors</td>
<td>790</td>
<td>291</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>21,949</strong></td>
<td><strong>22,058</strong></td>
</tr>
</tbody>
</table>

**TOTAL** | **60,842** | **34,069** |

Other Debtors include £0 prepaid pension contributions at 31 March 2007 (£0 at 31 March 2006)
Within the Prepayments and Accrued Income greater than one year is the PFI Deferred Asset Value of the Hospital.
Included within NHS Debtors is an amount due of £29.2million in relation to the reversal of the RAB income reduction in 2006/07.
14. Investments

14.1 Fixed asset investments

The Trust has no fixed asset investments (2005/06 £0).

14.2 Current asset investments

<table>
<thead>
<tr>
<th>EU emissions trading scheme</th>
<th>Department of Health</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Balance at 1 April 2006      0 0 0 0
Additions                   0 6,000 0 6,000
Disposals                   0 0 0 0
Revaluations                0 0 0 0

Balance at 31 March 2007    0 6,000 0 6,000

The Trust had £6 million on deposit with the National Loan Fund as at 31 March 2007 (2005/06 £0).
15. Creditors

15.1 Creditors at the balance sheet date are made up of:

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Amounts falling due within one year:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank overdrafts</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>NHS creditors</td>
<td>3,836</td>
<td>5,350</td>
</tr>
<tr>
<td>Non - NHS trade creditors - revenue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non - NHS trade creditors - capital</td>
<td>687</td>
<td>339</td>
</tr>
<tr>
<td>Tax</td>
<td>0</td>
<td>2,390</td>
</tr>
<tr>
<td>Other creditors</td>
<td>1,893</td>
<td>3,393</td>
</tr>
<tr>
<td>Accruals and deferred income</td>
<td>2,337</td>
<td>2,995</td>
</tr>
<tr>
<td><strong>Sub Total</strong></td>
<td><strong>8,753</strong></td>
<td><strong>14,667</strong></td>
</tr>
</tbody>
</table>

| Amounts falling due after more than one year: |                |               |
| Long - term loans | 0             | 0             |
| Obligations under finance leases and hire purchase contracts | 0             | 0             |
| NHS creditors     | 0             | 0             |
| Other             | 632           | 0             |
| **Sub Total**     | **632**       | **0**         |
| **TOTAL**         | **9,385**     | **14,667**    |

Other creditors of £632k relates the contract between Oxleas NHS Foundation Trust, Meridian and Queen Elizabeth Hospital NHS Trust.

- There were no outstanding pensions contributions at 31 March 2007 (31 March 2006 £1,022k).
15.2 Loans

The Trust has no loans outstanding as at 31 March 2007 (£0 as at 31 March 2006).

15.3 Finance lease obligations

Queen Elizabeth Hospital NHS Trust has no finance lease obligation (2005/06 £0).

15.4 Finance lease commitments

Queen Elizabeth Hospital NHS Trust has no finance lease commitments (2005/06 £0).
### 16. Provisions for liabilities and charges

<table>
<thead>
<tr>
<th></th>
<th>Pensions relating to former directors</th>
<th>Pensions relating to other staff</th>
<th>Legal claims</th>
<th>Restructurings</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>At 1 April 2006</td>
<td>0</td>
<td>3,018</td>
<td>125</td>
<td>102</td>
<td>129</td>
<td>3,374</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>0</td>
<td>491</td>
<td>35</td>
<td>464</td>
<td>0</td>
<td>990</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>0</td>
<td>(254)</td>
<td>(6)</td>
<td>(102)</td>
<td>(129)</td>
<td>(491)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>0</td>
<td>(83)</td>
<td>(86)</td>
<td>0</td>
<td>0</td>
<td>(169)</td>
</tr>
<tr>
<td>Unwinding of discount</td>
<td>0</td>
<td>66</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>66</td>
</tr>
<tr>
<td><strong>At 31 March 2007</strong></td>
<td><strong>0</strong></td>
<td><strong>3,238</strong></td>
<td><strong>68</strong></td>
<td><strong>464</strong></td>
<td><strong>0</strong></td>
<td><strong>3,770</strong></td>
</tr>
</tbody>
</table>

#### Expected timing of cashflows:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one year</td>
<td>0</td>
<td>255</td>
<td>6</td>
<td>464</td>
<td>0</td>
<td>725</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>0</td>
<td>2,983</td>
<td>62</td>
<td>0</td>
<td>0</td>
<td>3,045</td>
</tr>
<tr>
<td>After five years</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

£8,638k is included in the provision of the NHS Litigation Authority at 31 March 2007 in respect of clinical negligence liabilities of the Trust (31 March 2006 £8,808k).

Pension provisions relate to staff under early retirement arrangements. The timing of payment has been calculated based on payments made to the NHS Pensions Agency during 2006/07. The value of the provision is based upon estimated lifespan of individuals, and final salaries at the date of retirement.

Legal claims represent the insurance excess applied to legal claims against the Trust. The timing of payment has been calculated based on payments made to the Pensions Agency during 2006/07. The value of the provision is based on information provided by the NHS Litigation Authority on a case by case basis.

The restructuring provision comprises redundancy payments expected to be made after March 2007 relating to 2006/07.
17. Movements on reserves in the year comprised the following:

<table>
<thead>
<tr>
<th>Revaluation Reserve</th>
<th>Donated Asset Reserve</th>
<th>Government Grant Reserve</th>
<th>Other Reserves</th>
<th>Income and Expenditure Reserve</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

At 1 April 2006 as previously stated
Prior Period Adjustments
At 1 April 2006 as restated
Transfer from the income and expenditure account
Fixed asset impairments
Surplus/(deficit) on other revaluations/indexation of fixed/current assets
Receipt of donated/government granted assets
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/government granted assets
Other transfers between reserves

At 31 March 2007
18. Notes to the cash flow statement

18.1 Reconciliation of operating surplus to net cash flow from operating activities:

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total operating surplus/(deficit)</td>
<td>(5,481)</td>
<td>(17,530)</td>
</tr>
<tr>
<td>Depreciation and amortisation charge</td>
<td>1,317</td>
<td>1,240</td>
</tr>
<tr>
<td>Fixed asset impairments and reversals</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transfer from donated asset reserve</td>
<td>(184)</td>
<td>(175)</td>
</tr>
<tr>
<td>Transfer from the government grant reserve</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Increase)/decrease in stocks</td>
<td>(116)</td>
<td>127</td>
</tr>
<tr>
<td>(Increase)/decrease in debtors</td>
<td>(26,773)</td>
<td>3,149</td>
</tr>
<tr>
<td>Increase/(decrease) in creditors</td>
<td>(5,430)</td>
<td>(8,213)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>330</td>
<td>(1,510)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) from operating activities before restructuring costs</strong></td>
<td><strong>(36,337)</strong></td>
<td><strong>(22,912)</strong></td>
</tr>
<tr>
<td>Payments in respect of fundamental reorganisation/restructuring</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net cash inflow from operating activities</strong></td>
<td><strong>(36,337)</strong></td>
<td><strong>(22,912)</strong></td>
</tr>
</tbody>
</table>
### 18.2 Reconciliation of net cash flow to movement in net debt

<table>
<thead>
<tr>
<th>Description</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase/(decrease) in cash in the period</td>
<td>68</td>
<td>38</td>
</tr>
<tr>
<td>Cash (inflow) from new debt</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash outflow from debt repaid and finance lease capital payments</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash (inflow)/outflow from (decrease)/increase in liquid resources</td>
<td>6,000</td>
<td>0</td>
</tr>
<tr>
<td>Change in net debt resulting from cash flows</td>
<td>6,068</td>
<td>38</td>
</tr>
<tr>
<td>Non - cash changes in debt</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net debt at 1 April 2006</td>
<td>412</td>
<td>374</td>
</tr>
</tbody>
</table>

**Net debt at 31 March 2007**

<table>
<thead>
<tr>
<th></th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6,480</td>
<td>412</td>
</tr>
</tbody>
</table>
## Analysis of changes in net debt

<table>
<thead>
<tr>
<th></th>
<th>At 1 April 2006</th>
<th>Cash Transferred (to)/from other NHS bodies</th>
<th>Other cash changes in year</th>
<th>Non-cash changes in year</th>
<th>At 31 March 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>OPG cash at bank</td>
<td>602</td>
<td>0</td>
<td>(132)</td>
<td>0</td>
<td>470</td>
</tr>
<tr>
<td>Commercial cash at bank and in hand</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Bank overdraft</td>
<td>(200)</td>
<td>0</td>
<td>200</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loan from DH due within one year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other debt due within one year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Loan from DH due after one year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other debt due after one year</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Finance leases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Current asset investments</td>
<td>0</td>
<td>0</td>
<td>6,000</td>
<td>0</td>
<td>6,000</td>
</tr>
<tr>
<td></td>
<td>412</td>
<td>0</td>
<td>6,068</td>
<td>0</td>
<td>6,480</td>
</tr>
</tbody>
</table>

Current asset investments of £6m relate to the deposit with National Loan Funds.
19. Capital commitments
Commitments under capital expenditure contracts at 31 March 2007 were £643k (31 March 2006 £221k).

20. Post balance sheet events
There are no post balance sheet events.

21. Contingencies

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingent liabilities</td>
<td>(644)</td>
<td>(644)</td>
</tr>
<tr>
<td>Amounts recoverable against contingent liabilities</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net value of contingent liabilities</strong></td>
<td>(644)</td>
<td>(644)</td>
</tr>
<tr>
<td>Contingent Assets</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The Contingent liability of £644k relates to the possible compensation on termination of a contract between Macmillan Cancer Relief and Queen Elizabeth Hospital NHS Trust, for contribution towards the Oncology Unit at Queen Elizabeth Hospital.

The compensation on termination clause is activated in the event that the agreement is terminated at any time in the period of 10 years from the completion of the hospital (2006/07 represents year 6 of the 10 year period).
## 22. Movement in public dividend capital

<table>
<thead>
<tr>
<th>Description</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Dividend Capital as at 1 April 2006</td>
<td>67,486</td>
<td>38,957</td>
</tr>
<tr>
<td>New Public Dividend Capital received (including transfers from dissolved NHS Trusts)</td>
<td>66,832</td>
<td>28,573</td>
</tr>
<tr>
<td>Public Dividend Capital repaid in year</td>
<td>(18,842)</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital repayable (creditor)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital written off</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital issued as originating capital on new establishment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Public Dividend Capital transferred to Foundation Trust</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other movements in Public Dividend Capital in year</td>
<td>0</td>
<td>(44)</td>
</tr>
<tr>
<td><strong>Public dividend capital as at 31 March 2007</strong></td>
<td>115,476</td>
<td>67,486</td>
</tr>
</tbody>
</table>

### Cash

To maintain liquidity in 2007/08 the Trust will need a cash loan that can be repaid in 2008/09 to the value of £65.4m. This will need to be secured via the London Health Authority from the NHS Bank. This has not yet been secured, and management believe it is expected to be secured late in the financial year. Any such permanent borrowing will require repayment in the following financial year to which it is obtained and does not present a permanent solution to the Trust’s cash shortfall.
23. Financial performance targets

23.1 Breakeven performance

The trust’s breakeven performance for 2006/07 is as follows:

<table>
<thead>
<tr>
<th></th>
<th>1997/98 £000</th>
<th>1998/99 £000</th>
<th>1999/2000 £000</th>
<th>2000/01 £000</th>
<th>2001/02 £000</th>
<th>2002/03 £000</th>
<th>2003/04 £000</th>
<th>2004/05 £000</th>
<th>2005/06 £000</th>
<th>2006/07 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover</td>
<td>93,837</td>
<td>97,161</td>
<td>100,637</td>
<td>119,356</td>
<td>107,191</td>
<td>125,696</td>
<td>125,436</td>
<td>130,090</td>
<td>132,983</td>
<td>147,525</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>42</td>
<td>1,319</td>
<td>(7,952)</td>
<td>(1,583)</td>
<td>288</td>
<td>7,213</td>
<td>917</td>
<td>(9,186)</td>
<td>(19,298)</td>
<td>(7,244)</td>
</tr>
</tbody>
</table>

Adjustment for:

- 2005/06 Prior Period Adjustment (relating to 1997/98 to 2004/05) 0 0 0 0 0 0 (4,417) (136)
- 2006/07 Prior Period Adjustment (relating to 1997/98 to 2005/06) 0 0 0 0 0 0 0 0 0 0
- Other agreed adjustments 0 0 0 0 0 0 0 0 200 0

Break-even in-year position 42 1,319 (7,952) (1,583) 288 7,213 (3,500) (9,322) (19,089) (7,244)

Break-even cumulative position 42 1,361 (6,591) (8,174) (7,886) (673) (4,173) (13,495) (32,584) (39,828)

The Trust’s recovery plan, approved by the SHA aims to achieve break-even in 2008/09. This should be the date of the financial year end e.g. 2008.

If anticipated financial year of recovery is more than two years state the period agreed with SHA 0

Materiality test (i.e. is it equal to or less than 0.5%):

- Break-even in-year position as a percentage of turnover 0.04% 1.36% (7.90%) (1.33%) 0.27% 5.74% (2.79%) (7.17%) (14.35%) (4.91%)
- Break-even cumulative position as a percentage of turnover 0.04% 1.40% (6.55%) (6.85%) (7.36%) (0.54%) (3.33%) (10.37%) (24.50%) (27.00%)

The Trust received an adverse I & E movement of £0.2m in 2005/06 relating to RAB system. This movement has been adjusted.

The Trust’s break-even performance is compared to a materiality threshold of 0.5% of turnover, below which recovery of deficit within the framework of a recovery plan will not be required by the Department of Health.
23.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £1,985,000, bears to the average relevant net assets of £95,358k, that is 2.1%.

The Trust is set a dividend payment based on estimates of future assets and liabilities, completed a year in advance of the opening period to which the dividend relates. During 2006/07, the Trust has recognised a material debtor with its PCT partner, which was not expected at the time of the estimated calculation. This has therefore caused the absorption rate to drop below the allowed 3% threshold.

23.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>External financing</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cash flow financing</td>
<td>41,922</td>
<td>28,573</td>
</tr>
<tr>
<td>Finance leases taken out in the year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>External financing requirement</td>
<td>41,922</td>
<td>28,535</td>
</tr>
<tr>
<td>Undershoot/(overshoot)</td>
<td>6,068</td>
<td>38</td>
</tr>
</tbody>
</table>

23.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to overspend

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross capital expenditure</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Less: book value of assets disposed of</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Plus: loss on disposal of donated assets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: capital grants</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Less: donations towards the acquisition of fixed assets</td>
<td>(87)</td>
<td>(33)</td>
</tr>
<tr>
<td>Charge against the capital resource limit</td>
<td>4,236</td>
<td>3,522</td>
</tr>
<tr>
<td>Capital resource limit</td>
<td>4,585</td>
<td>3,833</td>
</tr>
<tr>
<td>(Over)/Underspend against the capital resource limit</td>
<td>349</td>
<td>311</td>
</tr>
</tbody>
</table>
24. Related party transactions

Queen Elizabeth Hospital NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Queen Elizabeth Hospital NHS Trust.

The Department of Health is regarded as a related party. During the year Queen Elizabeth Hospital NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

- Greenwich PCT
- Bexley PCT
- The London Health Authority
- The NHS litigation Authority
- The Pensions Agency
- Lewisham PCT
- London Ambulance Service NHS Trust
- NHS Blood and Transplant
- NHS Business Services Authority

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds, certain Trustees are also members of the NHS Trust Board. The Trust has received £87,000 worth of capital donations during 2006/07.

David Wragg, the Trust Finance Director is a Director of the NHS Shared Business Service, a joint venture between Xansa and the Department of Health created to manage finance transaction processing for NHS bodies. Mr Wragg receives no remuneration for this post.

The Trust has outsourced some of its finance processing functions to the NHS Shared Business Service part owned by the Department of Health.
25. Private finance transactions

25.1 PFI schemes deemed to be off-balance sheet

<table>
<thead>
<tr>
<th></th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross</td>
<td>25,013</td>
<td>24,842</td>
</tr>
<tr>
<td>Amortisation of PFI deferred asset</td>
<td>(1,025)</td>
<td>(1,025)</td>
</tr>
<tr>
<td>Net charge to operating expenses</td>
<td>23,988</td>
<td>23,817</td>
</tr>
</tbody>
</table>

The NHS Trust is committed to make the following payments during the next year.

<table>
<thead>
<tr>
<th>PFI scheme which expires;</th>
<th>2006/07 £000</th>
<th>2005/06 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one year*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2nd to 5th years (inclusive)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6th to 10th years (inclusive)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>11th to 15th years (inclusive)*</td>
<td>3,754</td>
<td>3,549</td>
</tr>
<tr>
<td>16th to 20th years (inclusive)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21st to 25th years (inclusive)*</td>
<td>21,891</td>
<td>21,872</td>
</tr>
<tr>
<td>26th to 30th years (inclusive)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31st to 35th years (inclusive)*</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Etc*</td>
<td>£000</td>
<td>£000</td>
</tr>
</tbody>
</table>

Estimated capital value of the PFI scheme | 116,633 | 109,714 |
Contract Start date: | 01/01/2001 | 01/01/2001 |
Contract End date: | 31/12/2060 | 31/12/2060 |
The Trust has entered into a 60 year PFI contract with Meridian Hospital Company PLC supply the hospital premises and a range of services. The Trust has undertaken an assessment of the contract under SSAP 21 (Accounting for leases and hire purchase contracts) and FRS 5 (Reporting the substance of transactions) and determined that the contract should be accounted for off balance sheet.

The Trust takes the view that the rights and privileges of ownership of the Hospital will transfer to the NHS after 30 years and there is the option to terminate the concession to provide Facilities management services from the PFI contractor at 30 and 45 years.

The Trust retains the freehold to the land on which the new hospital is based. The Trust has granted a headlease to Meridian Hospital Company Plc for a period of 125 years.

The Trust has assessed the lease agreement under SSAP 21 and FRS 5 and determined that the land should be accounted for on balance sheet. The net book value of this land (disclosed in note 11.1) is £48 million.

**Toshiba managed equipment**

- Estimated capital value of the PFI scheme: £6,414

<table>
<thead>
<tr>
<th>Contract Start date:</th>
<th>27/09/2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract End date:</td>
<td>14/09/2016</td>
</tr>
</tbody>
</table>

The Trust has entered into a 15 year PFI contract with Toshiba Medical Systems for maintenance and replacement of medical equipment.

The Trust has undertaken an assessment of the contract under SSAP 21 (Accounting for leases and hire purchase contracts) and FRS 5 (Reporting the substance of transactions) and determined that the contract should be accounted for off balance sheet.
26 Financial instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS 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 the listed companies to which FRS 13 mainly applies. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions are shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. Queen Elizabeth Hospital NHS Trust is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

2.3% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Queen Elizabeth Hospital NHS Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:
27. Finance assets and liabilities
27.1 Financial assets

<table>
<thead>
<tr>
<th>Currency</th>
<th>Total £000</th>
<th>Floating rate £000</th>
<th>Fixed rate £000</th>
<th>Non-interest bearing £000</th>
<th>Fixed rate Weighted average interest rate %</th>
<th>Weighted average period for which fixed Years</th>
<th>Non-interest bearing Weighted average term Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sterling</strong></td>
<td>27,876</td>
<td>21,396</td>
<td>6,470</td>
<td>10</td>
<td>2.20%</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross financial assets</strong></td>
<td>27,876</td>
<td>21,396</td>
<td>6,470</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Currency</th>
<th>Total £000</th>
<th>Floating rate £000</th>
<th>Fixed rate £000</th>
<th>Non-interest bearing £000</th>
<th>Fixed rate Weighted average interest rate %</th>
<th>Weighted average period for which fixed Years</th>
<th>Non-interest bearing Weighted average term Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sterling</strong></td>
<td>22,401</td>
<td>21,789</td>
<td>602</td>
<td>10</td>
<td>0.00%</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross financial assets</strong></td>
<td>22,401</td>
<td>21,789</td>
<td>602</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 27.2 Financial liabilities

<table>
<thead>
<tr>
<th>Currency</th>
<th>Total</th>
<th>Floating rate</th>
<th>Fixed rate</th>
<th>Non-interest bearing</th>
<th>Fixed rate</th>
<th>Weighted average interest rate</th>
<th>Weighted average period for which fixed</th>
<th>Non-interest bearing</th>
<th>Weighted average term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterling</td>
<td>119,878</td>
<td>0</td>
<td>4,402</td>
<td>115,476</td>
<td>2.20%</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross financial liabilities</strong></td>
<td><strong>119,878</strong></td>
<td><strong>0</strong></td>
<td><strong>4,402</strong></td>
<td><strong>115,476</strong></td>
<td><strong>2.20%</strong></td>
<td><strong>8</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Currency</th>
<th>Total</th>
<th>Floating rate</th>
<th>Fixed rate</th>
<th>Non-interest bearing</th>
<th>Fixed rate</th>
<th>Weighted average interest rate</th>
<th>Weighted average period for which fixed</th>
<th>Non-interest bearing</th>
<th>Weighted average term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterling</td>
<td>70,504</td>
<td>0</td>
<td>3,018</td>
<td>67,486</td>
<td>2.20%</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross financial liabilities</strong></td>
<td><strong>70,504</strong></td>
<td><strong>0</strong></td>
<td><strong>3,018</strong></td>
<td><strong>67,486</strong></td>
<td><strong>2.20%</strong></td>
<td><strong>8</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

Note: The public dividend capital is of unlimited term.

### Maturity profile

<table>
<thead>
<tr>
<th>Maturity profile</th>
<th>Total</th>
<th>Floating rate</th>
<th>Fixed rate</th>
<th>Non-interest bearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Than 1 Year</td>
<td>254</td>
<td>0</td>
<td>254</td>
<td>0</td>
</tr>
<tr>
<td>Between one and two years</td>
<td>254</td>
<td>0</td>
<td>254</td>
<td>0</td>
</tr>
<tr>
<td>Between two and five years</td>
<td>879</td>
<td>0</td>
<td>879</td>
<td>0</td>
</tr>
<tr>
<td>More than five years</td>
<td>3,015</td>
<td>0</td>
<td>3,015</td>
<td>0</td>
</tr>
</tbody>
</table>
Foreign currency risk
The Trust has no/negligible foreign currency income or expenditure.

27.3 Fair values
Set out below is a comparison, by category, of book values and fair values of the NHS Trust’s financial assets and liabilities as at 31 March 2007.

<table>
<thead>
<tr>
<th></th>
<th>2005/06 Book Value (£000)</th>
<th>2005/06 Fair Value (£000)</th>
<th>Basis of fair valuation</th>
<th>2005/06 Book Value (£000)</th>
<th>2005/06 Fair Value (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash</td>
<td>480</td>
<td>480</td>
<td>612</td>
<td>612</td>
<td></td>
</tr>
<tr>
<td>Debtors over 1 year:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Agreements with commissioners to cover creditors and provisions</td>
<td>21,396</td>
<td>21,396</td>
<td>22,058</td>
<td>22,058</td>
<td></td>
</tr>
<tr>
<td>Investments</td>
<td>6,000</td>
<td>6,000</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>27,876</td>
<td>27,876</td>
<td>22,670</td>
<td>22,670</td>
<td></td>
</tr>
</tbody>
</table>

Financial liabilities

<table>
<thead>
<tr>
<th></th>
<th>2005/06 Book Value (£000)</th>
<th>2005/06 Fair Value (£000)</th>
<th>Basis of fair valuation</th>
<th>2005/06 Book Value (£000)</th>
<th>2005/06 Fair Value (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overdraft</td>
<td>0</td>
<td>0</td>
<td>(200)</td>
<td>(200)</td>
<td></td>
</tr>
<tr>
<td>Creditors over 1 year:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Early retirements</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- Finance leases</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Provisions under contract</td>
<td>(4,402)</td>
<td>(4,402)</td>
<td>Note a (2,767)</td>
<td>(2,767)</td>
<td></td>
</tr>
<tr>
<td>Loans</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Public dividend capital*</td>
<td>(115,476)</td>
<td>(115,476)</td>
<td>Note b (67,486)</td>
<td>(67,486)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>(119,878)</td>
<td>(119,878)</td>
<td>(70,453)</td>
<td>(70,453)</td>
<td></td>
</tr>
</tbody>
</table>

Notes
a Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.
b The figure here is the full value of PDC in the balance sheet and 'book value' equals 'fair value'.
28 Third party assets

The Trust held £7k cash at bank and in hand at 31 March 2007 (£9k - at 31 March 2006) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29 Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Debtors: amounts falling due within one year</th>
<th>Debtors: amounts falling due after more than one year</th>
<th>Creditors: amounts falling due within one year</th>
<th>Creditors: amounts falling due after more than one year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balances with other Central Government Bodies</td>
<td>32,817</td>
<td>0</td>
<td>2,874</td>
<td>0</td>
</tr>
<tr>
<td>Balances with Local Authorities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balances with NHS Trusts and Foundation Trusts</td>
<td>2,749</td>
<td>0</td>
<td>950</td>
<td>0</td>
</tr>
<tr>
<td>Balances with Public Corporations and Trading Funds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Balances with bodies external to government</td>
<td>3,327</td>
<td>21,949</td>
<td>4,929</td>
<td>632</td>
</tr>
<tr>
<td><strong>At 31 March 2007</strong></td>
<td><strong>38,893</strong></td>
<td><strong>21,949</strong></td>
<td><strong>8,753</strong></td>
<td><strong>632</strong></td>
</tr>
</tbody>
</table>

|                                | £000                                      | £000                                                  | £000                                          | £000                                                   |
| Balances with other Central Government Bodies | 6,052                                     | 0                                                     | 5,168                                         | 0                                                      |
| Balances with Local Authorities | 0                                         | 0                                                     | 0                                             | 0                                                      |
| Balances with NHS Trusts and Foundation Trusts | 1,434                                     | 0                                                     | 3,277                                         | 0                                                      |
| Balances with Public Corporations and Trading Funds | 0                                         | 0                                                     | 128                                           | 0                                                      |
| Balances with bodies external to government | 4,525                                     | 22,058                                                | 6,094                                         | 0                                                      |
| **At 31 March 2006**            | **12,011**                                | **22,058**                                            | **14,667**                                    | **0**                                                   |
30 Losses and special payments

There were 200 cases of losses and special payments (2005/06: 35 cases) totalling £1,040,000 (2005/06: £41,458) paid during 2006/07.

The Trust has written off £1,016,000 of debt against provisions that were made against specific debts in previous accounting periods.

There were no clinical negligence cases where the net payment exceeded £100,000 (0 cases, 2005/2006).

There were no fraud cases where the net payment exceeded £100,000 (prior year 0 cases 2005/2006).

There were no personal injury cases where the net payment exceeded £100,000 (prior year 0 cases 2005/2006)

There were no compensation under legal obligation cases where the net payment exceeded £100,000 (prior year 0 cases 2005/2006).

There were no fruitless payment cases where the net payment exceeded £100,000 (prior year 0 cases 2005/2006)

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on a cash basis.

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

These payments are charged to the income and expenditure account in accordance with UK GAAP but are recorded in the losses and special payments register when payment is made. Therefore, this note is compiled on a cash basis.

Clinical negligence cases are managed by the National Health Service Litigation Authority and transactions relating to such cases is held in their accounts. The NHS Trust pays a premium for their services and excesses on some cases. Therefore, these cases have not been accounted for in the NHS Trust’s accounts.

Note: The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.