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QUEEN ELIZABETH HOSPITAL NHS TRUST

ANNUAL REPORT & ACCOUNTS 2007/08



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## MESSAGE FROM THE CHAIRMAN

Welcome to our Annual Report and Accounts for 2007/08. As with last year's publication, we have produced a document which incorporates a wide range of mandatory information which meets the requirements of the Manual for Accounts and the Department of Health. However, as promised in the last full Report, and due to popular demand, we did produce a second copy of Life magazine as a review of the year for patients and staff.

I should say here that we were all delighted that the first edition of Life was not only a great success but also won an award and plaudits on the national scene too.

The past 12 months have again been extremely challenging for all of us, not least because we still have some way to go to achieve a sounder financial position. However, we have still managed to achieve much to be proud of during the year and many of these achievements are highlighted in this document.

During the year we have seen ever more patients coming through our doors for treatment whilst we have continued to deliver our stated financial objectives, achieved most of the Government's targets and significantly improved access to many of our services.

These achievements reflect 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, in particular to the League of Friends and our army of 250 or more volunteers, so capably led by Diane Hudson, Voluntary Services Co-ordinator, who all work so hard and do so much to improve the experiences of our patients. A special mention also goes to the Mammography Unit Appeal which raised £146,000 toward a new mammography scanner.

As part of our Getting it Right for Patients strategy we have also sought to develop our services in response to what patients think and say. The national Patients' Survey this year was still slightly disappointing and was actually carried out before we began work on our strategy in earnest. There were, however, some encouraging signs that we were moving in the right direction. We are confident that once Getting it Right for Patients becomes embedded in our organisation we shall see real improvements next year.

This year we have contributed to A Picture of Health - a programme which has been working to change local health care for the future. Public consultation on the proposals completed on 7 April 2008. We are in no doubt that changes are needed, for both clinical and financial reasons and I would thank those individuals in the Trust, including a number of senior clinicians such as our new Chief Executive, David Robson and new Medical Director, David Sulch, who have taken their own time to attend events and presentations in the local community as well as here at QEH to explain the options. I think it is fair to say that we go forward as an organisation with a great deal of confidence in our future as a major health service provider in South East (SE) London.

Now thanking those who have left. I start with expressing the Board's gratitude to our Chief Executive for the past four years, John Pelly, who left us at the end of the year to take up a new position as Chief Executive of Moorfields Hospital NHS Foundation Trust. Despite our difficult

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financial position, John leaves us in good shape to play our part in A Picture of Health as it unfolds in SE London. The fact we are in such good shape owes much to his excellent stewardship over the last four years. I am sure that the whole organisation will wish him well for the future.

We also said goodbye to two of our Non-executive Directors, Daphne Barnett and Allan McNaught, both of whom gave sterling service – Daphne for a full eight year term.

I would also like to make special mention of the members of our Patient and Public Forum, ably led by William Bruce, who have contributed so much during the Forum's existence to improving the experience of patients in the hospital.

And finally, a special word for Ron White, the Vice Chairman of the Greenwich Pensioners' Forum, who sadly passed away recently. Ron was a marvellous character and great champion for older people's services at QEH. He will be sadly missed by us all.

I commend this report to you.

Colin Campbell  
*Chairman*

## CHIEF EXECUTIVE'S SUMMARY

2007/08 has been another eventful year of steady progress for Queen Elizabeth Hospital in which we have continued to achieve most of our important short term objectives whilst at the same time, working closely with colleagues in other NHS Trusts supporting PCTs in outer SE London to draw up and consult on plans for the future shape of local health care.

Our two highest priorities have been to remain on course to achieve financial stability whilst at the same time we have focused on improving the experience of our patients during their stay in hospital in our Getting it Right for Patients strategy.

I am delighted to be able to report that we have again met almost all of the national performance targets that now exist. In particular, I must highlight the Trust's achievement in meeting the Government's 18 weeks referral to treatment milestones by 31 March, indeed we were one of just 37 Trusts nationally to hit early the targets set for December 2008. The achievement of this challenging target has required a huge effort on the part of a wide range of clinical, professional, administrative and managerial staff to whom my own thanks and those of the whole Board are extended.

Unfortunately, for the second year we failed to achieve the trajectory laid down by the Department of Health for the reduction in cases of MRSA bloodstream infections. Having had 41 cases in 2004/05, we managed to reduce this to 23 cases in 2005/06 and 17 in 2006/07 and for this year we had 19 cases, although at least five of these patients arrived at the hospital already infected. So although we have failed the target of just 12 MRSA bloodstream infections for the year, we have still seen a considerable reduction in the number of infections since 2004/05.

Our efforts to reduce Clostridium Difficile (C. Diff) on the other hand, have been dramatic and have won praise from the SHA and Department of Health. Our rates of infection for C. Diff have continued to reduce significantly and we are continuing to improve in this area.

The Trust was able to complete the Government's deep cleaning programme on schedule by the end of March 2008 and we have been working closely with the Department of Health's Reducing MRSA Improvement Team.

I would like to make special mention of our Matrons and senior nursing team who, with the support of their colleagues and our partners in ISS Mediclean, have done so much over the past year to ensure that the environment of the hospital has improved.

My clinical colleagues continue to impress with the introduction of innovative procedures which benefit our patients and it is gratifying to see services expanding in diagnostics and cardiology. Many of these achievements are highlighted in our Annual Review Magazine, Life, which gained international recognition by being awarded the 2007 PR Week Corporate Publication of the year.

We received the results of two national surveys conducted during 2007. The national inpatient survey has shown some improvements in key areas in the hospital such as giving patients information about their condition or treatment in A&E and on discharge, reducing delays on discharge, explaining test results and explaining anaesthetics and pain control. We have got

better but still have some improvements to make in keeping patients waiting a long time before they get to a bed, giving help to families on discharge, treating people with respect and dignity, doctors washing their hands, cleanliness and food.

We have unfortunately also got worse in patients' eyes in terms of keeping them waiting more than four hours in A&E, the noise they experience at night, and not being available to answer patients' or families' concerns.

These areas will now come under close scrutiny by our action teams as part of the Getting it Right for Patients strategy, along with the work our senior nurses and matrons are doing in improving cleanliness and hand hygiene.

Some of the solutions will 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.

In our staff survey, I am pleased to note that we scored better than average for Acute Trusts in England in a number of indicators including the extent of positive feeling within the organisation and managers committed to helping staff achieve work/life balance. However we scored worse than average in indicators such as staff being regularly appraised and having to work extra hours, and I know we have more work to do to restore high levels of appraisals.

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 £3.1M (compared to the end of year deficit of £7.3M in 2006/07). Whilst we have been able to achieve this position without the kind of actions necessary the previous year, which had included some staff redundancies, we nevertheless have continued to place tight controls on expenditure throughout the organisation. These controls remain in place and, indeed, we face further challenges in the coming 12 months. We expect a considerable reduction in commissioners' funding as they seek to provide alternative services in the community in line with national policy. The result of this shift in service and funding means that our agreed deficit for 2008/09 will be £5.5M.

Although a number of independent studies and publications have identified that a significant cause of our financial difficulties stem 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. I believe it is important to point out that our in-year stringency in controlling costs saw 5% efficiency savings equal to £9M. Achieving these kind of savings, on top of the annual £9M excess PFI costs we have to meet, is a clear indication that QEH has become an efficient and effectively run organisation. Much credit for this should go to my predecessor, John Pelly, and our Financial Director, David Wragg and his team.

Looking ahead, whilst we have another year in which substantial further financial savings are required, we are also working within the context of a change programme as set out by A Picture of Health (APOH). We have been working closely with our neighbouring Trusts in SE London

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and our PCT colleagues to draw up models of care and options for the future shape of services which will enable us to maintain our high clinical standards, deliver positive patient experiences and balance our books in a sustainable way in the longer term.

This has involved a full three month PCT led consultation exercise in which QEH, and in particular several senior consultant colleagues, have taken an active part. This Trust has now responded in full to the consultation. As I write we await final decisions from the Joint Committee of the PCTs but it is fair to say that we have supported the direction of travel of the consultation and – with the exception of one or two concerns on detail – support the options as laid down by APOH.

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.xxxxxxxxxxxxxx@xxx.xxx](mailto:xxxx.xxxxxxxxxxxxxx@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.

David Robson  
*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 re-building 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 10 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 also 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 1,000 head of population in 2001/02, when QEH first opened, to 18.6 per 1,000 head of population in 2006. In fact, Greenwich now has a birth rate that is 14% higher than the average for England and Wales.

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 37% of all elective and non-elective admissions (with the exception of obstetrics) to QEH during 2007/08 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 480 places. In addition, planning permission has been sought for a new prison development in Woolwich for a further 600 places. The prison population uses a range of our services but makes a particularly high demand on the Trust's genito-urinary services. Telemedicine tech-

nology has been developed to provide some services to this section of the population, which enables consultation and often treatment to be given without the need for prisoners to leave the prison.

## 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 services are provided by staff employed by QEH; however some specialties, including ophthalmology, oral surgery and ENT (ear, nose and throat) 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 2007/08 the hospital remains as busy as ever and that, in the six years since we opened, A&E attendances have increased by 32%; non-elective admissions by 33%; elective admissions by 27%; outpatient attendances by 25% and births by 41%.

#### A&E Attendances

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Increase over 2001/02	
75,149	73,638	85,223	94,298	100,831	99,700	99,534	24,551	32%

*Note: These are first attendances only. Previous Annual Reports have reported total A&E attendances*

#### Non-Elective Admissions (spells)

(excluding obstetrics)

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Increase over 2001/02	
13,355	14,854	16,584	16,879	16,882	17,669	17,757	4,402	33%

#### Elective Admissions (spells)

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Increase over 2001/02	
18,586	20,946	21,116	21,155	23,497	24,622	23,648	5,062	27%

#### Outpatient Attendances

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Increase over 2001/02	
155,000	169,808	168,234	158,221	169,560	190,077	193,502	38,502	25%

#### Births

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	Increase over 2001/02	
3,021	3,264	3,487	3,753	3,950	4,182	4,263	1,242	41%

## 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 free 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; and
- 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 'Good' for quality of services and 'Weak' for use of resources based on performance during 2006/07. We had anticipated a poor use of resources rating because of the financial challenges we face, and we were pleased to have been assessed as 'Good' for the quality of our services. We were particularly pleased to have been assessed as 'Excellent' for the new national targets and were the only hospital in outer south east London to have been awarded an 'Excellent' score. We expect to have another strong score for our performance in 2007/08.

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 during 2007/08 has also been made an honorary member of the Board and regularly attends its meetings. With the Department of Health shift away from Patients' Forum he has now joined the Board as a Non Executive Associate Director to ensure continued patient representation on the Board. 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 the minutes of public meetings are 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.

### Outer South East London (OSEL) Joint Committee

We have made reference later in this document to the challenging strategic agenda faced by acute trusts in outer south east London. We have recognised the need to work collectively to provide the best care and services to local people and better meet the requirements of the south east London Primary Care Trusts. As a result all four acute trusts - Queen Elizabeth, Queen Mary's, Princess Royal and Lewisham Hospitals - have recognised the need for new interim management arrangements to enable a faster more transparent solution to developments aimed at improving the financial position of the trusts as well as to prepare for the outcome of consultation on the future configuration of services. During the year, a Joint Committee has, therefore, been established and a Transitional Chief Officer appointed, initially for a period of 12 months. The Joint Committee will ensure that collectively each Trust is supported so that business continuity and patient safety are maintained.

### ***Trust Executive Committee***

The QEH 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 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 has 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 were introduced which took 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. The Trust has achieved extensive savings plans in recent years of £7.8M in 2007/08, £10.8M in 2006/07 and £4.5M in 2005/06.

In parallel with these internal performance management arrangements, regular meetings between senior Trust personnel and the local Commissioning Consortium, led by Greenwich Teaching Primary Care Trust, also take place to review performance against the respective Service Level Agreements, including local priorities and performance targets, 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.

### ***Complaints and Principles for Remedy***

The Trust has a formal complaints policy in place, and staff allocated to handling complaints. In dealing with both formal and informal complaints the Trust takes into account the six Principles for Remedy as defined by the Parliamentary and Health Service Ombudsman. The Trust plans to update the Complaints Policy in 2008/2009 specifically to include the Principles for Remedy.

The Trust aims to respond to all complainants within 25 working days. When this is not possible the complainant will be contacted and advised of the reason for delay.

## How we performed in 2007/08

### 2007/08 National Targets

QEH has achieved another good year of performance against the national performance targets, as summarised in the following table.

Indicator	Measure	Target	Trust Position 2007/08	✓ or x
A&E - 4 hour target	% of patients waiting 4 hours or less in A&E from arrival to admission, transfer or discharge	98%	98.0%	✓
18 Week Referral to Treatment Target (RTT)	Data completeness of the referral to treatment data	No threshold	100%	✓
By March 2008,	85% of admitted patients to be treated within 18 weeks	85%	91%	✓
By March 2008,	90% of non-admitted patients to be treated within 18 weeks	90%	96%	✓
Diagnostic Tests	Proportion of patients receiving specific diagnostic test in 6 weeks or less	100%	94.2%	x
Cancer – 2 week rule	Proportion of patients seen within 2 weeks of urgent GP referral for suspected cancer to first outpatient appointment	98%	100.0%	✓
All Cancers – 1 month	Proportion of patients treated within 31 days of diagnosis	98%	100.0%	✓
All Cancers – 2 months	Proportion of patients treated within two months of urgent GP referral	95%	98.8%	✓
Cancelled Operations	Part 1 - % of elective admissions cancelled on the day of, or after, admission for non-clinical reasons	0.8%	0.36%	✓
	Part 2 - % 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	0%	0%	✓
MRSA Bacteraemia	To achieve the target trajectory reduction in the number of incidents of MRSA bacteraemia (see below)	12	19	x

Indicator	Measure	Target	Trust Position 2007/08	✓ or x
Clostridium difficile	Local target for Clostridium difficile infections agreed with PCTs and in place by March 2008	Yes	Yes	✓
Convenience and Choice	Availability of slots within 13 weeks as shown on Choose and Book slot utilisation reports	No threshold	87.4%	✓
Convenience and Choice	Provider inpatient information in place to support choice	Yes	Yes	✓
Delayed transfers of patients	% of patients whose transfer of care was delayed care	3.5%	3.3%	x
Number of inpatients or day cases waiting longer than the standard	% of patients waiting 26 weeks or more for an elective admission	0%	0%	✓
Number of outpatients waiting longer than the standard	% of patients waiting 13 weeks or more for a first outpatient appointment following a GP referral standard	0%	0%	✓
Waiting times for Rapid Access Chest Pain	% of patients to RACP clinics seen within 14 days (where referral received from GP within 24 hours)	98%	100.0%	✓
Waiting times for clinic	GUM Improvement in access to GUM clinics within 48 hours	100%	97.8%	x
Data quality on ethnic group	% of patient admissions for whom a valid 2001 census coding for ethnic category is recorded	90%	94.8%	✓
Reduce emergency bed days in hospital for people with long term conditions	Achieve % reduction of bed days by 2008 from 2003/04 baseline. Measure is year on year reduction.	5% by 2008	4.6% increase over 2006/07	x
Smoke free NHS	Part 1 – demonstrating a smoke free trust	achieve	achieved	✓
	Part 2 – Recording the smoking status of adult patients			✓
	Part 3 - Reducing smoking in adult patients through advice and onward referral			✓

Indicator	Measure	Target	Trust Position 2007/08	✓ or x
Participation of problem drug users in drug treatment programmes	Provision of information, existence of clear screening and referral processes	Yes	Yes	✓
Infant mortality and life expectancy at birth	Part 1 - reduction in the number of women known to be smokers at the time of delivery compared to 2006/07	No threshold	0.4% increase	x
	Part 2 - Number of mothers known to have initiated breastfeeding within 48 hours compared to 2005/06	No threshold	2% increase	✓
Reduce mortality rates by 2010 from suicide and undetermined injury	Ensure compliance with NICE guidelines on the treatment and management of self harm in the emergency department	Yes	Yes	✓

### ***Reducing healthcare acquired infection***

Whilst we have been very 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 12 in 2007/08 – the very challenging target set for our organisation and much lower than many other London hospitals. 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 missed our target, with 19 cases for the year, we have continued to invest considerable effort into improving infection control and have secured a reduction in MRSA bacteraemia of some 14% over last year, which follows a 46% reduction over the previous two years.

Infection control continues to have an extremely high profile within QEH and this view was supported by the Healthcare Commission in their feedback to us following their unannounced spot-check visit in August 2007. In addition, we have taken part in the Department of Health Reduction in MRSA Improvement Review Programme and the advisory team has been complimentary about areas of best practice at QEH that they have identified to share with other hospitals across the country.

Our work during the year has also focused on reducing other healthcare acquired infections and, in particular, on reducing the incidents of Clostridium Difficile (C. Diff), which has demonstrated a marked reduction in cases during 2007/08 and ensured that the incidents of C. Diff at our hospital were less than half the maximum target set by our host commissioner.

We have implemented and maintained a number of measures across the hospital to help reduce infection rates, including:

- continued participation in the 'Clean your Hands' campaign;

- the availability of alcohol hand rub dispensers in all areas; the introduction of a Hand Hygiene Compliance Policy and regular hand hygiene audits, which have demonstrated an overall improvement in compliance;
- regular audits using both the Saving Lives HII audit tools and the ICNA (Infection Control Nurses Association) audit tools;
- analysis of each MRSA bacteraemia to ensure that we understand the cause, and, where necessary, policies and procedures are reviewed;
- QEH completed the deep clean of all wards by the end of March 2008, in line with the national initiative;
- enhanced chlorine cleaning was introduced in 2007/08;
- the antibiotic protocols were reviewed and re-issued, with every junior doctor receiving a pocket guide.

In addition, during 2007/08 QEH successfully bid for resources from the national infection control improvement funding and as a result achieved the following:

- implementation of screening for MRSA of all admissions from October 2007;
- appointment of an infection control pharmacist to audit and drive best practice antibiotic prescribing;
- commenced a one-year trial in the use of probiotic drinks for all patients on antibiotics; and
- purchase of closed system computer keyboards for high risk areas such as A&E and ITU.

### ***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.

### ***Shorter Waits - Achievement of Access targets***

Key access targets have been achieved, which means that our patients have waited less time for their treatment. Achievement of these targets has required organisation-wide focus, co-operation and effort. Our success has meant that:

- 98% of the 100,000 patients who attended our A&E department during the year were seen, treated, and admitted or discharged within four hours of arriving at the department;
- all patients who were referred by their GP with a suspected cancer were seen in our outpatient department within two weeks;
- all cancer patients had started their treatment within 31 days of having been diagnosed; and
- nearly all cancer patients (99.1%) had started their treatment within 62 days of an urgent referral from their GP.

A key target for 2007/08 has been the introduction of the first stage of the 18 Week Referral to Treatment target (RTT). This target aims to reduce waiting times to ensure that patients start their treatment within 18 weeks of being referred by their GP. To achieve this challenging target we have had to review systems and processes across the whole organisation to improve patient pathways, minimise delays and ensure that our patients receive high quality, effective and timely care. The measurement of this target in March 2008 demonstrated that 91% of admitted patients in that month received their treatment within 18 weeks and 96% of non-admitted patients received their care within 18 weeks. We were delighted to have achieved this target in March, considerably reducing the time that our patients wait for their treatment, but we know that we have a lot more work to do during 2008/09 to sustain this success.

### ***Cardiology***

Our Annual Report for 2006/07 identified the considerable improvements to our cardiology services during that year, including significant reductions to wait times for all cardiac diagnostic tests and the introduction of a 'one stop' cardiology clinic. These improvements led to the QEH becoming one of only seven national innovator sites for cardiology for the Department of Health (DH), who were keen that QEH shared its excellent practices with other hospitals nation-wide so that they could benefit from our work. The DH identified the QEH cardiac diagnostic service as 'an example of what good diagnostic services look like' and described the Trust's cardiac team as 'innovative, high flyers' who could help nationally in the drive to bring down waits for diagnostic tests.

During 2007/08, we built on our success with the introduction of a new service at the beginning of this financial year – an elective percutaneous coronary intervention (PCI or coronary angioplasty) service. Approval to start the service was obtained from the British Cardiac Intervention Society (BCIS) in March 2008 and the first patients were treated in April. This has been an excellent development for QEH and for our patients, many of whom will no longer have to travel into central London for these procedures.

### ***Cancer***

As highlighted in the performance summary above, we have maintained our success in achieving all three cancer targets during 2007/08. In the previous year, the Peer Review process for

cancer services – a system of review which assesses cancer services in a standardised way across a considerable number of measures – had confirmed QEH as a provider of high quality cancer services with over 80% of all measures achieved. During 2007/08 our Haemato-oncology and Chemotherapy services were assessed by the Peer Review Team against the national standards set for staffing, facilities and support services involved in delivering high-dose, complex chemotherapy. The service achieved 100% compliance with the measures and recent benchmarking across London has confirmed that QEH was one of only two hospitals in London to achieve 100%. The Peer Review Team commended the multi-disciplinary team providing these services on a number of aspects of the service provided.

During the year we also achieved successful reviews for our Colorectal, Urology and Thyroid cancer services.

In addition, this year has seen the introduction of video-conferencing for specialist multi-disciplinary team meetings, hosted at the Joint Cancer Centre, for Urological cancers, Anal cancers and Upper Gastro-Intestinal cancers.

### ***Care for patients with lung disease***

During this year, we have continued to work closely with our partners Greenwich TPCT and local GPs to develop even further the integrated clinical service for patients suffering from Chronic Obstructive Pulmonary Disease (COPD), which was introduced in 2006/07. COPD is a chronic lung disease, which is traditionally a leading cause of emergency hospital admission. This service improves the quality of life for these patients by supporting them to manage their condition at home and at the same time facilitates the shift of activity from secondary to primary care, thereby reducing hospital admissions. Dr Jonathan Webb, QEH Consultant in Respiratory Medicine, has been the driving force for change in this service. Specific initiatives include:

- the introduction of community matrons specialising in COPD, who visit patients in their own homes;
- a nurse-led oxygen clinic;
- specialist physiotherapists to help patients improve their lung function;
- a pulmonary rehabilitation service, which is largely based around exercise, but also looks at medication and diet; and
- support for patients in giving up smoking.

### ***Investments in Imaging***

We are in the sixth year of our innovative PFI contract with Toshiba Medical Services Ltd for the management of medical equipment. This 15 year contract provides for the maintenance, repair and replacement of our medical equipment. During 2007/08 we have made additional investment under the contract to improve access and facilitate timely diagnosis and treatment

for patients by upgrading from a single slice CT scanner to a 64-slice model. The introduction of this new equipment provides significant benefits:

- improved patient comfort during the procedure and a shortened duration of procedure;
- shorter examination times results in increased throughput and, therefore, more patients can be scanned each day, reducing wait times;
- the diagnostic capability of the CT is extended, which results in earlier diagnosis and treatment and improving patients' long-term prognosis.

In addition, the Toshiba contract was due to replace the existing traditional mammography equipment during 2007/08. This equipment takes x-rays of the breast and plays a key role in the detection of breast cancer. Our staff were keen to enhance this replacement with a digital camera and set about fund raising to achieve that. Their significant efforts raised £146,000, which has meant that the mammography equipment has been replaced with a state of the art Full Field Digital mammography unit, which has the following benefits:

- significantly improved the image quality, whilst reducing the patient's radiation exposure by 50%;
- shorter examination times will reduce waiting times for mammograms;
- the digital unit now means that the images are available on the hospital's Picture Archiving Communications (PACS) system almost immediately and ensures that results are discussed with the patient on the same day in the one-stop breast clinic.

### ***End of life care***

During 2007/08 we consulted on a proposal to merge the management of Specialist Palliative care under the umbrella of Greenwich and Bexley Cottage Hospice (GBCH). Following consultation, this service merged in April 2008 and will ensure the service delivery changes necessary to meet NICE guidance on supportive and palliative care for adults with cancer. Uniting the separately managed services under one management structure will result in a seamless service for patients as well as economic efficiency. The combined service will also allow for service developments and provide a more comprehensive range of services to meet national recommendations for Greenwich palliative care patients.

In summary the merged management of the service includes development of a "hub and spoke" model under the management of GBCH to include:

- one Community services department to allow for improved in and out of hours cover;
- an in-reach service for QEH patients;
- development of additional therapies;

- co-ordination of psychological, spiritual and social work services working across the Hospice, Hospital and Community; and
- review of senior clinical posts to develop education input that is tailored to the requirements of specific groups.

### ***New Substance Misuse Service for A&E***

In July 2007 we introduced the Substance Misuse Liaison Team into the A&E Department. The service is joint funded by the Greenwich Drug and Alcohol Action Team (DAAT) and Greenwich TPCT and was set up to improve access to treatment in the community for patients who have a drug or alcohol problem. The team of experienced nurses support the doctors and nurses in the A&E department in managing this difficult patient group. The team works closely with A&E staff and in our wards to provide assessment and referral to community services for patients who have a drug or alcohol problem.

### ***Communications***

During this year the Trust's Annual Review for 2006 – 'Life at QEH' - gained international recognition in the world of public relations and advertising by scooping the PR Week magazine's Corporate Publication of the year. The judges praised Life magazine and commented that it was "very impressive - good, clean and well presented". The magazine pipped The Prince's Trust and the trade magazine of the World Jewellery Confederation to win the coveted award. QEH was the only NHS organisation to be recognised in these international awards this year.

### ***Arts Programme***

The QEH Arts programme, Elixir Arts, developed several new strands during 2007/08. The programme was fortunate to be awarded a grant from the Leverhulme Trust towards the hospital's first artist in residence scheme and was pleased to welcome Rachel Wingfield and Mathias Gmachl of Loop.pH, a London-based design studio. In December, Loop installed a temporary window feature of spectrum-coloured gels; passers-by were consulted to find which colours were considered to be more calming and relaxing. Rachel and Mathias also spent time consulting with different departments before coming up with proposals.

In March 2008 the artists submitted a proposal to create lightweight garden features and window panels, to transform a section of the first floor in the hospital and existing gardens. As well as proposing attractive architectural features, the artists have sought to address issues of energy conservation through this project. The Residency will culminate in June 2008.

The children's arts programme, which is funded by Capital Radio's Help A London Child, continued until early 2008 and has been working in partnership with the schoolroom and playroom, providing workshops in decorative flag-making, lantern-making to celebrate autumn festivals, a Chinese New Year celebration and a visiting theatre company performance.

To launch Black History Month celebrations in October 2007, Elixir Arts commissioned photographer Laura Mtungwazi to spend a day on site photographing patients, visitors and staff

with the plants of their choice. This resulted in some stunning portraits which have been framed and hung near the outpatients' department.

Tesco Charity Trust provided an award to Elixir Arts to offer a new programme specifically for older patients – 'Creative Days' – throughout 2008. This will include monthly performances of music for patients on Ward 4 and the Stroke Unit. In the summer, patients will be encouraged to take part in crafts and other creative activities in the ward gardens. As well as providing a stimulating and inspiring break in the afternoons, music and singing has been found to help the recovery of stroke patients.

### ***Patient Experience***

The Trust's annual Inpatient Survey is undertaken by the Picker Institute, which enables us to benchmark ourselves against other Trusts. Given our comparatively poor results in previous years, the Trust Board decided that tackling the issues giving rise to patient dissatisfaction at QEH would be our top priority for 2007/08. Consequently we launched a major and detailed programme of action called 'Getting it Right for Patients'. The Director of HR & OD is leading the programme and each strand of work is led by an Executive Director, with a rigorous performance monitoring process in place involving our full Trust Executive Committee.

The vision of the programme is to remove the obstacles to providing high quality care and high quality interaction with our patients and their carers. It concentrates on those areas where patient feedback in the survey was poor and through that aims to ensure the delivery of first class communications and behaviours towards our patients in support of first class healthcare. In so doing it also focuses on relationships between our staff, between departments within the hospital and between us and our partners in care outside the Trust so that these relationships work well for our patients. The programme also includes workstreams, which focus on our processes for admission and discharge, on the training, development and supervision of our staff and on the environment within which we provide patient care and where our staff work.

The preliminary annual Inpatient Survey results for 2007 show that the overall scores for the hospital's care, and the extent to which patients would recommend the hospital to others, have shown a significant improvement, bringing us closer to, though still slightly below, the Picker average for these two overall indicators.

Our score is at or above the Picker average on 12 out of 81 indicators (seven out of 80 in 2006), but below average on 46 out of 81 indicators (71 out of 80 in 2006). Of these, our scores have shown improvement in 19, 12 have worsened, and 11 have remained the same.

We can be pleased with our progress in giving patients information about their condition or treatment in A&E and on discharge, reducing delays on discharge, explaining test results and explaining anaesthetics and pain control. We have got better but still have improvements to make in keeping patients waiting a long time before they get to a bed, giving help to families on discharge, treating people with respect and dignity, doctors washing hands, cleanliness and food.

We have unfortunately got worse in patients' eyes in terms of keeping them waiting more than four hours in A&E, the noise they experience at night, and not being available to answer patients' or families' concerns. There are also some new questions, about feeling unsafe, and respect for religious beliefs, in which we also do not do well.

We know that Trusts in similar situations to ours fare worse than average in national surveys, and that we have to work extra hard to improve patients' satisfaction. The Getting it Right for Patients strategy, launched in July 2007, just before this survey was conducted, is aimed at tackling all these areas.

The Board has decided that improving patient satisfaction will continue to be the Trust's highest priority in 2008/09, and the comprehensive programme of activity is being extended to support this.

### ***Our priorities for 2008/09***

The Trust's plans for 2008/09 are centred around six core objectives:

- improving patients' experience of our services through the delivery of the 'Getting it Right for Patients' strategy and improved arrangements for involving patients and the public in the work of the Trust;
- delivering safe, high quality clinical care through the application of best clinical 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;
- securing the future service and financial viability of acute healthcare across south east London in conjunction with partner organisations;
- demonstrating that QEH is providing high quality, cost effective services through the performance measures included within the Annual Health Check;
- developing a workforce that is increasingly sensitive to the needs of patients, exploits every opportunity to improve its productivity without sacrificing quality of care, and is proactive and flexible in its approach to service change; and
- ensuring our buildings, equipment and infrastructure are fit for purpose and able to respond flexibly to future change in the provision of healthcare within London.

For each of these objectives we have identified a number of actions, which will be monitored by the Board throughout the year. Of particular importance are:

- delivery of the 'Getting it Right for Patients' strategy to address the issues raised by our patients through the national patient survey results;
- the work we are doing with partner organisations in outer south east London – known as A Picture of Health - to redesign healthcare provision in this part of the capital (see below);

- our continuing drive to reduce the incidence of infections acquired at QEH;
- a 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](http://www.queenelizabeth.nhs.uk)

## **Our longer-term strategy**

### ***A Picture of Health (APOH)***

In our Annual Report for 2006/07, we referred to the pressures faced by a number of hospitals across the country, which was forcing many of them to consider how they needed to change. These arise from a number of factors, which remain in place today:

- 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 the working patterns that they used to; and
- medical and other therapeutic advances which 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. We reported last year that organisations in outer south east London (covering the boroughs of Greenwich, Bexley, Lewisham and Bromley), faced with these challenging pressures, had decided to work together to consider 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. The programme - known as 'A Picture of Health' (APOH) - continues to have the full commitment of the Boards of all the organisations involved in it, including QEH.

During the year, a clinical strategy has been developed under the guidance of the APOH Project Board and Executive with the engagement and involvement of local clinicians, managers, patients and the public. Medical directors have led work across the four hospital trusts in outer south east London to consider ways in which hospital services can be reorganised in the area to improve clinical quality and outcomes and to make more effective use of the resources available to us. The case for change is a strong one and now generally accepted within the local NHS and our communities.

The work of these clinical groups led to the development of a number of options for the future reconfiguration of services in outer south east London. The project board measured each of these options against a set of 'must pass' criteria and the three options, judged to have met these criteria, have been the subject of a public consultation led by the four Primary Care Trusts. The consultation period ended in early April and the outcome is expected to be known in the summer. This consultation was undertaken in parallel with the work being led by Professor Lord Ara Darzi on developing a healthcare strategy for London as a whole.

In all three options being considered, QEH remains a fully admitting hospital, providing the full range of accident and emergency and intensive care facilities. The QEH Board is in full agreement with this element of the proposals and looks forward to working with partner organisations in outer south east London to develop services and, if necessary, facilities, to ensure that QEH can accommodate all of the activity that is expected to flow to it in the future under the preferred option.

### ***Project SARK***

Project Sark was initiated across the four 'financially challenged' trusts in OSEL to enable us to reduce costs in a number of key areas by working together, principally by consolidating some of our clinical and non-clinical support functions. The main areas of project work are as follows:

- Estates – this workstream is looking at whether surplus land and buildings at the four hospitals exists and/or can be created such that it can be sold, producing both capital receipts and reductions in recurring expenditure. QEH has identified a section of the site that is surplus to requirements and we are investigating the feasibility of disposing of it.
- Management functions – this element comprises several separate workstreams including Finance, HR, Payroll and IT, and is considering the opportunity to consolidate some aspects of the work of these departments across the four trusts.
- Pathology – this workstream is evaluating the possibility of consolidating routine laboratory pathology activity on one, or possibly two, of the existing hospital sites, and comparing the feasibility and costs of such an arrangement with alternative 'contracted out' options involving either Guy's & St Thomas' and King's or a private laboratory.

## **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 con-

sultants Tribal Consulting, and validated by Cambridge Economic Policy Associates, at approximately £8M per annum. The consequence of this history is that the Trust's balance sheet at 31 March 2008 contains a negative income and expenditure reserve of £46M, and we were reliant on cash borrowings of £65M at year end.

The full accounts for the year ending 31 March 2008 are included with this document on pages 47–94. 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 2007/08 was designed to produce a deficit of £3.3M. With an underlying deficit of £12M coming into 2007/08 resulting from the need to deal with new cost pressures of £4M, this required us to plan and implement savings measures amounting to more than £8M in the year. In the event we realised recurrent savings of £8M and ended the year with a deficit of £3.1M. The Trust initially planned to pay £3.1M in respect of interest on past cash borrowings, but did not have to account for this during the year. This benefit was used to subsidise other expenditure pressures that arose in year of £2M, asset write offs of £0.5M and other expenditure of £0.5M. In addition the Trust achieved £1M more income than initially planned.

The following table compares the main elements of our income and expenditure account in 2006/07 and 2007/08 and comments on the main changes between the two.

## Income and Expenditure

Income	2006/07 (£ million)	2007/08 (£ million)	Comment
Income from activities	134.4	141.3	Income from activities increased by 5% in 2007/08.
Education, training and research	4.5	5.1	Income was reduced in 2006/07 when funding short falls were passed to NHS Trusts. This amount has been returned to the Trust in 2007/08.
Other operating income	7.2	5.7	Income has reduced between years after the loss of support income for PFI and PBR support.
<b>TOTAL INCOME</b>	<b>146.1</b>	<b>152.1</b>	
<b>EXPENDITURE</b>			
Pay	-91.5	-92.1	This represents a £3M reduction in pay costs after adjusting for 2007/08 pay awards. Average whole time equivalent staff numbers fell by 37 during the year
Non-pay	-60.1	-62.6	Non-pay expenditure increased by £4M after inflation is accounted for.
<b>TOTAL EXPENDITURE</b>	<b>-151.6</b>	<b>-154.7</b>	
Interest receivable	0.2	0.6	
Dividends payable	-2.0	-0.6	
Asset Write Off		-0.5	
<b>SURPLUS/(DEFICIT)</b>	<b>-7.2</b>	<b>-3.1</b>	

Our income and expenditure plan for 2008/09 is for a deficit of £5.5M. Gross income is planned to reduce by £1.3M as our activity is expected to remain static from 2007/08 levels while there are significant planned 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 £4M, reflecting additional expenditure associated with general inflation and cost pressures.

The net effect of these expected income and expenditure increases would be to produce a deficit of £14.2M, 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 £8.7M of savings is the maximum we can realistically aim to achieve in 2008/09.

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 £1.2M in 26 capital schemes. The table below summarises our capital expenditure for the year.

#### **Capital Expenditure**

	<b>2007/08 (£ Million)</b>	<b>Description</b>
IT Network and Equipment	0.5	Network and equipment to support our IT systems
Surgical Equipment	0.2	Purchase of Orthopaedic and other required surgical equipment
Imaging	0.2	Enabling works and contribution to the replacement of the Mammography scanner
Other	0.3	Other clinical / IT equipment and enabling works
<b>Total</b>	<b>1.2</b>	

From 2007/08 the system of allocating capital resources to NHS trusts has changed as part of a wider set of financial changes announced by the Department of Health. 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 has been available for capital investment in 2007/08, and we have been restricted to investing the sum set aside for depreciation and amortisation of, approximately £1.2M.

The Trust urgently needs to upgrade the electricity power supply to the hospital and plan to carry out the work in 2008/09. An application for funding has been submitted to NHS London. The capital costs are expected to be £2.5M in 2008/09 followed by a further £2M in 2009/10.

### **Cash**

Although we posted a £3.1M deficit, we were able to fund this adverse cash outflow with internal resources and did not need to borrow any further cash from the Department of Health in 2007/08. This was in line with our plan, and the funding source amounts relating to 2007/08 that were paid in 2006/07, and increased cash payments from PCT commissioning bodies. We were able to make our March tax and national insurance bill early, pay council rates in advance and make advance payments to our PFI partner. These will reduce the amounts owing in 2008/09, and we anticipate being able to meet our estimated £5.5M cash outflow next year without further borrowing, or with a small loan.

The Trust has cumulative cash borrowings of £65.4M at the year end. This relates to historic borrowing received by the Trust to fund past deficits. The Trust has planned that £3.1M of interest on the cumulative cash borrowing will become a liability in 2008/09.

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*

There have been no significant accounting policy changes in 2007/08.

#### *Pension liabilities*

Information about the accounting treatment of pension liabilities is provided in note 1.14 of the 2007/08 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 2007/08, 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.

### *Other Disclosures*

The Operating and Financial Review has been prepared in accordance with the NHS Trusts Manual for Accounts for 2007/08, as directed by the Secretary of State in accordance with Reporting Standard 1.

### **How we are addressing our environmental, social and community responsibilities**

We take our environmental, social and community responsibilities seriously and our environmental efforts have focused on our aim of reducing our carbon footprint. In 2007/08, we were successful in being selected to join phase 2 of the Carbon Trust's NHS Carbon Management programme. This innovative programme will enable us to cut carbon emissions and reduce energy bills. The programme expects that, through their participation, the 16 trusts selected across England, Wales and Scotland will cut their collective carbon footprint by 15% or 64,000 tonnes of carbon dioxide emissions per year as well as reduce their combined energy bill by approximately £8M per year.

We have succeeded in the course of 2007/08 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. We also actively promote recycling of non-clinical waste and provide facilities within the hospital to recycle paper and other materials.

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 TPCT'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 TPCT 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 and is due to be tested again via a communications exercise during 2008 and another live rehearsal in 2009.

The role of Emergency Planning Officer has now been combined with the role of Head of Nursing for the Clinical Site Management Team and a new Emergency Planning Committee has been established under her chairmanship, with responsibility for the development and implementation of the Trust's Emergency Preparedness Action Plan. This comprehensive business continuity plan will cover all significant operational threats to the hospital's ability to continue to provide safe and high quality care to our patients.

# STAFFING REPORT

In 2007/08 we planned to have an average 2,195 whole time equivalent (WTE) staff over the course of the year, comprising both permanent and temporarily employed staff. We maintained our staff in post close to plan throughout the year.

## ***Key achievements***

Workforce development has continued its high profile during the course of 2007/08 and the following were key elements in our strategy:

- The single biggest priority for the year has been Getting it Right for Patients, our strategic response to the disappointing results of the 2006 Inpatient Survey, designed to improve significantly the experience of patients using our services.
- Also high on the workforce agenda was the implementation of Modernising Medical Careers, and the national MTAS (Medical Training and Staffing) recruitment process for doctors in training, the adverse impact of which was widely reported, but was successfully managed within the organisation with minimal impact on patient services.
- Improvements in cost effectiveness of temporary staffing were achieved through bringing all temporary staff on to Agenda for Change on competitive rates of pay, although changes in the labour market towards the end of the year led to minor revisions in our approach in the light of a reduced supply.
- The increasing numbers of Trusts using ESR, (Electronic Staff Record - the NHS National Payroll System) together with the development of the FIMS (Financial Information Management Submission) reporting framework, has led to an increasing ability to benchmark against workforce productivity and other indicators in similar Trusts.
- We have worked on succession planning for the most senior roles within the Trust, which in turn has built on our wide range of leadership and management development activity. Specific leadership modules for consultants have included managing the trainee in difficulty, leading teams, and appraisal.
- An extensive programme of internal and external development activity has been maintained, which has included the launch of e-learning for a range of mandatory training and the development of bespoke learning interventions. Our major training activity for medical staff each week is the Grand Round, attracting an average of 80 participants weekly. A full programme of weekly Foundation Programme teaching is provided, at which attendance at 70% is mandatory, and programmes of weekly teaching in medicine, surgery and anaesthetics.
- Significant outer south east London collaboration, within Project Sark and in preparation for A Picture of Health, has included the development of a joint framework for organisational change, and the establishment of joint staff side and management partnership arrangements.

The coming year is one in which we will build on these achievements to deliver real, tangible benefits, and continue our work to develop a caring, adaptable and highly skilled workforce, fully engaged in its twin purpose of providing high quality clinical care and a positive experience for patients.

### **Key workforce metrics**

- Workforce actual against plan

Workforce whole time equivalent (w.t.e.) actual was maintained within 3% of plan throughout the year whilst vacancy levels fluctuated from month to month, the overall level remained fairly steady at around 9%, with bank staff employed flexibly largely making up the gap. (Source: FIMS up to month 12 2007/08).

- Sickness absence

The Trust set a target of 3% sickness absence, and whilst it did not achieve this every month, benchmarks showed steady improvement during the first half of the year. The sickness rate climbed during the second half of the year, but fell back in the last quarter to a rate below the NHS London average. The Trust has ranked between 8 and 34 of 171 Trusts nationally over the past year. (Source: NHS Institute Quarterly Scorecard up to Q3 2007/08).

- Staff turnover

The Trust enjoys low staff turnover and consistently remained in the top ten Trusts within London. (Source: NHS Institute Quarterly Scorecard up to Q3 2007/08).

- Bank and agency staff usage

The Trust makes good use of flexible staffing through its own internal bank, which has consistently met over 90% of demand. Costs per w.t.e. have been kept down through careful management of pay rates. As a result, agency spend has remained consistently low, placing the Trust amongst the top performing Trusts in London. However, a dramatic increase in agency use, largely for medical and AHP staff, saw the percentage of the paybill spent on agency staff rise from less than 1% to 4.69% in the second quarter of the year. A combination of factors contributed to this change, including a significant increase in demand for temporary staff, and the reduced availability of medical locums. The position in relation to nursing locums has been changing too, and the hitherto strong supply of nursing bank staff has fallen. The situation appeared to stabilise in quarter three as the percentage fell back to 2.72% (Source: NHS Institute Quarterly Scorecard up to Q3 2007/08)

- Equality and diversity

We have a diverse mix of employees, with nearly 35% of non-white ethnicity, compared with about 23% in the local population. Our active Black and Minority Ethnic network and annual

programme of cultural activities for staff and patients help to make the hospital an interesting and inclusive environment. We have race equality, disability equality and gender equality schemes, and actively pursue action plans in each of these areas, reporting annually to our Board. The Trust is a “Two Ticks” accredited employer of people with a disability.

- Staff survey results

We were pleased to note that we scored better than average for Acute Trusts in England in a number of indicators including the extent of positive feeling within the organisation and managers committed to helping staff achieve work/life balance. However, we scored worse than average in indicators such as staff being regularly appraised and having to work extra hours. We know we have more work to do to restore the high levels of appraisals we were used to before the introduction of the national Knowledge & Skills Framework (KSF). In a multi-cultural environment such as ours, it is vital to maintain staff awareness of cultural and diversity issues. Sadly, though we looked hard for a partner to work with us to help us develop our thinking beyond traditional diversity awareness towards developing much deeper understanding of the barriers to effective health care, we were not able to find one that met our high specification. It was not surprising therefore, that we scored low on staff having received recent training in this area. This is work we are determined to progress in 2008/09.

- Recruitment spend

In 2007 we implemented e-recruitment for all posts, reducing spend on advertising to almost nil. However spend on press advertising was resumed in early 2008 as part of a major push to recruit permanent staff, to reduce reliance on temporary staff, the supply of which has become a challenge.

- FCEs per consultant

We have reviewed the consultant productivity metrics currently available, though because these relate to 2005/06, a decision was made not to develop action plans until more recent data are published.

### ***Board development***

Work on succession planning, within a framework which included Clinical Director, General Manager and Head of Nursing posts as well as Executive Director posts, demonstrated strength in relation to short-term cover for most senior posts but weaknesses in succession to some Executive posts and significant weaknesses in terms of succession to Clinical Director, General Manager and Head of Nursing posts. The development of Project Sark and the potential for change introduced through the A Picture for Health Strategy have increased the risks in these areas. During the year, we lost two non-executive directors but were only successful in recruiting one new NED. We are hoping to acquire two new recruits in early 2008/09 but future risks to the Trust include the potential loss of the Trust Chairman and our two experienced NEDs (Vice Chair and Audit Chair) during late 2008, at the end of their second term of office.

### ***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, receiving regular reports on the Trust's financial performance, supporting staff through organisational change, reviewing and developing staffing policies, and contributing to external consultations on issues ranging from the national ill health retirement review to A Picture of Health. Representatives have joined with management in a Joint Partnership Committee established to oversee issues affecting all four outer south east London acute Trusts.

Communication with staff has continued to develop within our clinical directorates, supplemented by our monthly Team Brief, the intranet, our all-desks e-mails and the regular Staff Open Forum, hosted by the Chief Executive and his director colleagues.

A regular programme of 'walking the patch' by the Chief Executive and Executive Directors has given staff the opportunity to share their views with members of the senior team.

### ***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 December 2007. In total 103 staff received certificates, recognising success in courses ranging from NVQs in care to masters degrees, six more staff than in 2006.

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.

## **Knowledge Services**

Knowledge Services is committed to ensuring evidence based practice assists in embedding patient care within the organisation. During 2007/08 two new courses have been introduced. Introduction to Appraisal Skills teaches staff the basics of how to appraise both quantitative and qualitative evidence while basic Research Skills allows staff to update and refresh their skills in navigating through the mass array of information available both in print and electronically.

Staff are regularly assisted in conducting literature searches for systematic reviews and research proposals. The Trust has continued to develop its Library Management System to allow all staff to renew and reserve books online as well as allowing them to search for items in eight Health Libraries across South East London.

## ***Staff Wellbeing, Occupational Health and Safety***

We have worked closely with local safety representatives to increase the role and influence of the Health and Safety Committee and began consultation on a Health & Safety Strategy in anticipation of new corporate manslaughter legislation.

We were pleased to see that our scores for staff suffering work related stress or injury were lower than national averages (source: 2007 staff survey) though staff reported a higher than average incidence of violence and aggression by patients and visitors. We intend to continue our work in this area with the aim of reducing this.

Our Occupational Health (OH) team have continued to increase the amount of business they bring in to the Trust, through providing OH services to other NHS organisations and local businesses.

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

## ***Spiritual and pastoral care***

As well as our employed chaplains (2.6 WTE) the team now includes around 20 volunteer visitors, supporting patients and families across diverse areas such as A&E and the stroke unit. This year a highlight has been chaplaincy involvement with the implementation of the Liverpool Care Pathway, to enable more integrated end of life care including the spiritual aspect. Chaplains also support staff, not least encouraging them in a time of uncertainty, and through facilitating the Contact Officer Group. Sharing the lead with the Training Department on Mediation training means we may help promote more understanding between parties when tensions arise.

### ***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.

A new clinical skills laboratory was set up in the Education Centre to enable staff to practise their clinical skills. The hospital has recently used the laboratory to host the Royal College of Surgeons' approved basic surgical skills course which allows the hospital to train clinicians in surgical techniques. The new laboratory allows both pre and post registration practical skills to be honed prior to attempting the chosen skill on a patient. It also provides a range of anatomical models, manikins and simulators, together with audiovisual equipment and video camera facilities to enable simulated consultations and team based patient scenarios. This enables clinicians to practise their verbal and non-verbal communications with patients in a more realistic environment.

# REMUNERATION REPORT

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 below. 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 2006/07 and 2007/08 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. Further detailed benchmarking in 2007/08 revealed that parity had once more been eroded. A staged increase was implemented, ranging from 2.5% to 7%, depending on how far salaries were from the published benchmarks.

The performance of Executive 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.

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 below. No significant awards have been made to past directors.

## Salaries and Allowances

Name and Title	2007/08			2006/07		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £000	Salary (bands of £5,000)	Other Remuneration (bands of £5,000) £000	Benefits in Kind Rounded to the nearest £000
Colin Campbell*	20-25	0	0	20-25	0	0
Daphne Barnett*°	0-5	0	0	5-10	0	0
Lady Ann Jenkins*°	5-10	0	0	5-10	0	0
Dr Allan McNaught*°	0-5	0	0	5-10	0	0
John Pelly*	145-150	0	0	140-145	0	0
Sylvia Perrins*°	5-10	0	0	5-10	0	0
Terina Riches	80-85	0	0	75-80	0	0
Dr David Robson	45-50	145-150	0	45-50	150-155	0
Lynn Saunders	85-90	0	0	75-80	0	0
Elisa Steele	75-80	0	0	75-80	0	0
Sally Storey	65-70	0	0	60-65	0	0
Ruth Russell	80-85	0	0	30-35	0	0
Gary Kent*°	5-10	0	0	0-5	0	0
Susan Walker	-	-	-	0-5	0	0
David Wragg	95-100	0	0	85-90	0	0

\*Member of the Remuneration and Terms of Service Committee.

°Member of the Audit and Assurance Committee

Total Directors' Emoluments were £842K in 2007/08 (2006/07, £813K)

### Changes in executive directors 2007/08

- David Robson's term started as Chief Executive on the 1 April 2008
- David Robson's term ended as Medical Director on the 31 March 2008
- David Sulch's term started as Medical Director on the 1 April 2008
- John Pelly's term as Chief Executive ended on the 31 March 2008.

### Changes in non-executive directors 2007/08

- Daphne Barnett's term of office as a non-executive director ended on 31 October 2007.
- Allan MacNaught resigned on 30 April 2007.

### 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 as non-executive director from 1 January 2007.

## Pension Benefits

Name and title	Real increase in pension and related lump sum at 31 March 2008 (bands of £2.500) £000	Total accrued pension and related lump sum at 31 March 2008 (bands of £2.500) £000	Cash Equivalent Transfer Value at 31 March 2007 £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest
Ruth Russell	17.5-20	80-85	198	270	21	-
John Pelly	5-7.5	100-105	395	443	27	-
Terina Riches	7.5-10	125-130	419	474	31	-
Dr David Robson	7.5-10	340-345	0	0	0	-
Lynn Saunders	10-12.5	60-65	189	241	33	-
Elisa Steele	2.5-5	80-85	254	281	14	-
Sally Storey	5-7.5	85-90	304	342	21	-
David Wragg	10-12.5	75-80	210	256	29	-

- 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 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.

# SERVICES PROVIDED AT QUEEN ELIZABETH HOSPITAL

## Appendix 1

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

\* Service provided by Lewisham Hospital NHS Trust

\*\*Service provided by Queen Mary's Sidcup NHS Trust

\*\*\* Service provided by Bexley and Greenwich Cottage Hospice

\*\*\*\*Service provided by Guy's and St Thomas' Hospital NHS Foundation Trust

## DIRECTORS' BIOGRAPHIES for the year 2007/08

### Appendix 2

#### **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. He is an elected Local Government Councillor for Bexley where he lives. 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 was the Trust's Champion for Older People and chaired the Joint Staff Committee. *Term of office ended 31 October 2007.*

#### **Gary Kent - Non-Executive Director**



Gary 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. *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 chaired the Trust Executive Committee. *Resigned 31 March 2008.*

#### ***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. *Appointed Chief Executive 1 April 2008.*

#### ***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 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.

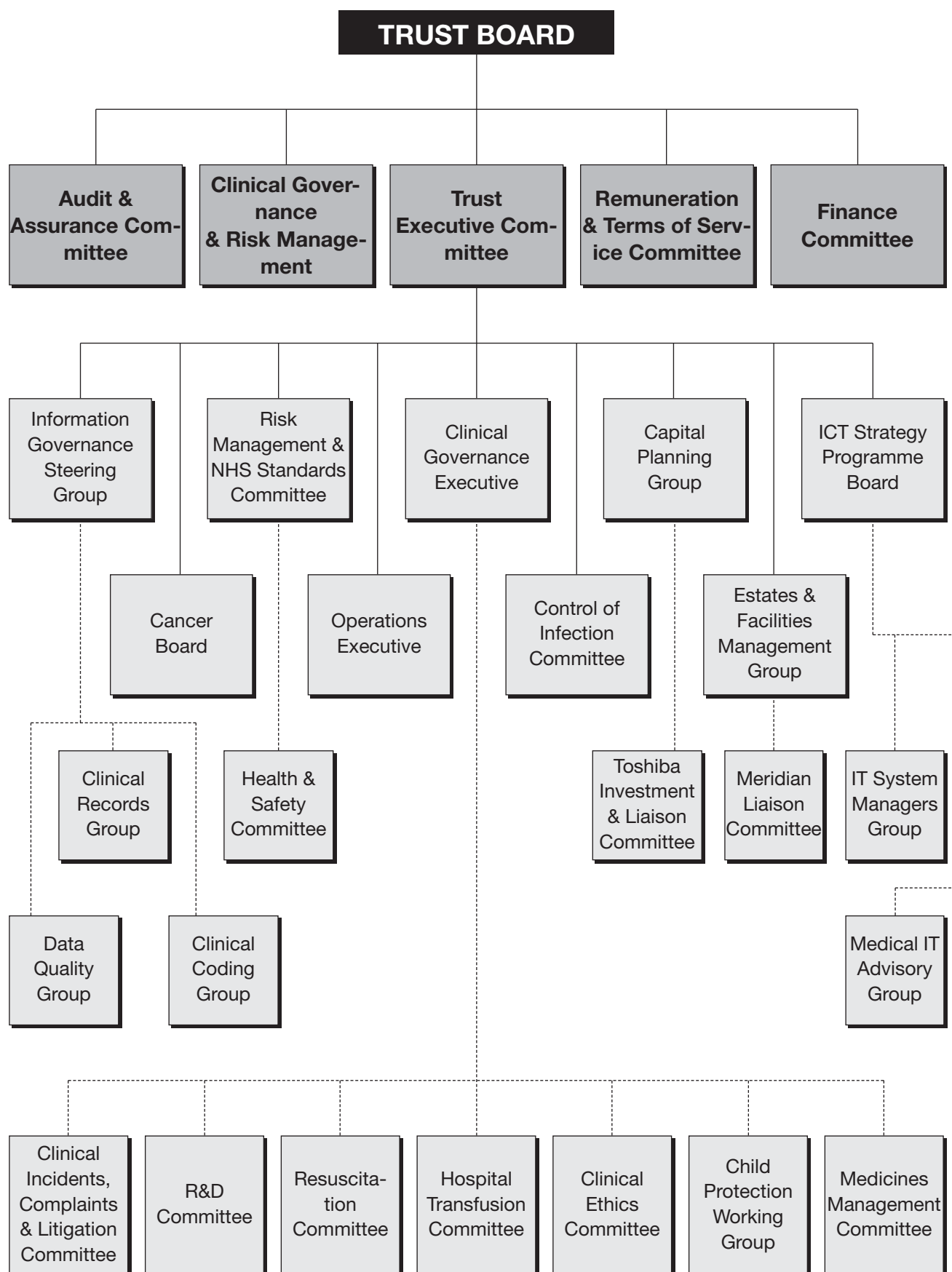
#### ***Sally Storey - Director of Human Resources & Organisational Development***



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 Companion 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.

# COMMITTEE STRUCTURE

Appendix 3



# CLINICAL DIRECTORATE STRUCTURE

From June 2007

Appendix 4

## Director of Clinical Services

- Clinical Site Management Team (including Emergency Planning)
- Pharmacy

### Directorate of Acute Medicine

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

### Directorate of Pathology

Haematology (including Blood Transfusion)	Microbiology (including the Infection Control Team)	Histopathology (including the Bereavement Service)
Biochemistry	Virology	Cytopathology
Immunology		

### Directorate of Specialist Medicine

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

### Directorate of Surgery

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

### Directorate of Women's and Children's Services

Paediatrics (including dedicated outpatient facility)	Community Paediatric Nursing	Gynaecology
	Maternity Services	

QUEEN ELIZABETH HOSPITAL  
NHS TRUST

ANNUAL ACCOUNTS  
2007/08

## 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.

David Robson  
Chief Executive

19.6.08

# STATEMENT ON INTERNAL CONTROL 2007/08

## QUEEN ELIZABETH HOSPITAL NHS TRUST

### **1. Scope of responsibility**

The Board is accountable for internal control. Having taken up post in April 2008 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; and
- 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 2008 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 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 2007/08. 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.

Risks and policies relating to data security and information governance are managed by the Information Governance Group and ICT Strategy Board, with both reporting to the Board via the Trust Executive Committee. Reports are routinely received identifying risks and issues by the Audit Committee and IT Project Boards. The Trust annually completes the Information Governance Toolkit to assess the policies and procedures in place to manage information, and has taken part in the Information Governance Assurance Programme (IGAP), which is a national review of data flows and security. The Trust has a number of policies relating to data security, sharing and access.

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 2007/08, the Trust maintained its CNST accreditation in maternity services at Level 2, this score having improved in 2006/07. 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.

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.

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.

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. It should be noted that there is the potential to lose the Trust Chairman and two experienced NEDs (Vice Chair and Audit Chair) during late 2008, at the end of their second term of office.

## **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;
- Reports from the Healthcare Commission;
- The results of the Clinical Negligence Scheme for Trusts (CNST) assessment;
- The PBR Assurance Framework and Clinical Coding audit report;
- 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 2007/08; and
- 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's Standards for Better Health declaration included two core standards for which the Board believes there was insufficient assurance as to whether the standard had been met throughout the year:

- Standard C7e: Healthcare organisations challenge discrimination, promote equality and respect human rights. Although the Trust has the required policies and procedures in place, some responses from the Trust staff survey related to training and development meant that the Trust prudently assessed itself as not having adequate assurance; and
- Standard C16: Information made available to patients and public was self assessed as not fully met throughout the year, but met by year-end. This was following the provision of an improved range and quality of patient information.

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

- The Trust had an underlying financial deficit in 2007/08, of approximately £2m per annum. The actual reported deficit was £3.1m in 2007/08, of which £0.6m relates to asset disposals, while the remainder relates to other non-recurrent items. The underlying deficit in 2008/09 has increased to approximately £14m 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 approximately £9m in 2008/09 has been approved by the Board, leaving a planned deficit of £5.5m., which has been agreed by the London Health Authority

- Because of the Trust's financial deficit in 2007/08 the Trust's external auditors, PricewaterhouseCoopers LLP, following the Code of Audit Practice, have concluded adversely that:
  - o The Trust has not put in place arrangements to ensure that its spending matches its available resources; and
  - o 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.
- Under Section 19 of the Audit Commission Act 1998, the Trust external auditors are considering writing to The Secretary of State for Health noting that the Trust will not meet its statutory break even duty over a rolling three year period, under paragraph 2(1) of Schedule 5 to the National Health Service Act 2006. The report to the Secretary of State recognises the significant cost saving programmes achieved by the Trust over recent years of £4.5m in 2004/05, £4.5m in 2005/06 and £10.8m in 2006/07.
- The Trust is unlikely to generate material surpluses that will enable it to recover historic deficits without a reconfiguration 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 among the four Outer South East London Hospitals. Consultation on this finished in May 2008.
- The Auditors Local Evaluation (ALE) to be reported as part of the Healthcare Commission's Annual Healthcheck for 2007/08, will award the Trust a score of 1 for Use of Resources. This is the lowest score available and is automatically awarded based on the Trust's financial standing being a deficit position. The Trust has performed well on the individual elements of the ALE review and are expecting a 2 for Financial Management, 3 for Internal Control, 3 for Value for Money and 2 for Financial Reporting.
- The Trust has failed to reduce its MRSA (methicillin-resistant staphylococcus aureus) infections to the targeted level of 12 in 2007/08. Although we missed our target, with 19 cases for the year, we have continued to invest considerable effort into improving infection control and have secured a reduction in MRSA bacteraemia of some 14% over last year, which follows a 46% reduction over the previous two years. (Please see page 16 of the Annual Report for further details).
- Results of the PBR Assurance and Clinical Coding audit have identified inaccuracies in the Trusts clinical coding, which affect the amount the Trust is paid for patients treated. The report identifies the potential for increased income if accuracy is improved and in response the Trust put in place an action plan from October 2007 and expects to achieve increased income levels from more accurate coding in 2008/09.

David Robson  
*Chief Executive*

19.6.08

# 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 judgements 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

David Robson  
*Chief Executive*

19.6.08

David Wragg  
*Finance Director*

19.6.08

# Independent auditors' report to the Directors of the Board of 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 2008 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 in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as 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 report to you whether, in our opinion, the information which comprises the commentary on the financial performance included within the Operating and Financial Review, included in the Annual Report, is consistent with the financial statements.

We review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements "Statement on Internal Control 2007/08 – Disclosures", issued on 7 April 2008 and 20 May 2008. 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 unaudited part of the Remuneration Report, the Message from the Chairman, the Chief Executive's Summary, the Staffing Report and the remaining elements of 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 are free from material misstatement, whether caused by fraud or other irregularity or error; and the financial statements and the part of the Remuneration Report to be audited have been properly prepared. 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***

As stated in our audit report for the year ended 31 March 2008 issued on 20 June 2008:

- 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 2008 and of its income and expenditure for the year then ended;
- the financial statements 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; and
- information which comprises commentary on the financial performance included within the Operating and Financial Review, included within the Annual Report, is consistent with the financial statements.

***Emphasis of matter – liquidity***

Without qualifying our opinion, we draw attention to note 22 in the financial statements which indicates that the Trust has £65 million cash in PDC which it will be required to repay in 2008/09. Repayment terms have not been negotiated with the Department of Health. These conditions indicate the existence of a material uncertainty which may cast significant doubt about the Trust's liquidity.

PricewaterhouseCoopers LLP  
80 Strand  
London  
WC2R 0AF

23 July 2008

## INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2008

		2007/08 £000	Restated * 2006/07 £000
	NOTE		
Income from activities	3	141,302	134,362
Other operating income	4	10,819	11,736
Operating expenses	5	(154,670)	(151,579)
<b>OPERATING DEFICIT</b>		<b>(2,549)</b>	<b>(5,481)</b>
Loss on disposal of fixed assets	8	(516)	0
<b>DEFICIT BEFORE INTEREST</b>		<b>(3,065)</b>	<b>(5,481)</b>
Interest receivable		632	288
Other finance costs - unwinding of discount	16	(70)	(66)
<b>DEFICIT FOR THE FINANCIAL YEAR</b>		<b>(2,503)</b>	<b>(5,259)</b>
Public Dividend Capital dividends payable		(622)	(1,985)
<b>RETAINED DEFICIT FOR THE YEAR</b>		<b>(3,125)</b>	<b>(7,244)</b>

The notes on pages 5 to 36 form part of these accounts.

All income and expenditure is derived from continuing operations.

\* See note 1.3 for details of the prior year restatement

# BALANCE SHEET AS AT 31 March 2008

		31 March 2008 £000	31 March 2007 £000
	NOTE		
<b>FIXED ASSETS</b>			
Intangible assets	10	1,355	1,090
Tangible assets	11	66,698	61,387
		<u>68,053</u>	<u>62,477</u>
<b>CURRENT ASSETS</b>			
Stocks and work in progress	12	1,663	1,636
Debtors	13	27,240	60,842
Investments	14.2	0	6,000
Cash at bank and in hand	18.3	6,485	480
		<u>35,388</u>	<u>68,958</u>
<b>CREDITORS: Amounts falling due within one year</b>	15	<u>(7,812)</u>	<u>(8,753)</u>
<b>NET CURRENT ASSETS</b>		<u>27,576</u>	<u>60,205</u>
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>		<b>95,629</b>	<b>122,682</b>
CREDITORS: Amounts falling due after more than one year	15	(603)	(632)
<b>PROVISIONS FOR LIABILITIES AND CHARGES</b>	16	<b>(3,600)</b>	<b>(3,770)</b>
<b>TOTAL ASSETS EMPLOYED</b>		<u><b>91,426</b></u>	<u><b>118,280</b></u>
<b>FINANCED BY:</b>			
<b>TAXPAYERS' EQUITY</b>			
Public dividend capital	22	88,348	115,476
Revaluation reserve	17	48,268	44,876
Donated asset reserve	17	381	416
Income and expenditure reserve	17	(45,571)	(42,488)
<b>TOTAL TAXPAYERS' EQUITY</b>		<u><b>91,426</b></u>	<u><b>118,280</b></u>

Included within Public Dividend Capital are cash borrowings to the value of £65.4m, repayable to the Department of Health. These monies have been allocated to the Trust in the past to fund historic deficits.

The financial statements on pages 1 to 36 were approved by the Board on 5 June 2008 and signed on its behalf by:

David Robson

Chief Executive

19.6.08

## STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2008

	2007/08 £000	2006/07 £000
Deficit for the financial year before dividend payments	<b>(2,503)</b>	(5,259)
Unrealised surplus on fixed asset indexation	<b>3,442</b>	3,200
Increases in the donated asset and government grant reserve due to receipt of donated assets	<b>156</b>	87
<b>Total gains and losses recognised in the financial year</b>	<b>1,095</b>	(1,972)

# CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
<b>OPERATING ACTIVITIES</b>			
Net cash inflow/(outflow) from operating activities	18.1	29,025	(36,337)
<b>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:</b>			
Interest received		632	288
Net cash inflow/(outflow) from returns on investments and servicing of finance		632	288
<b>CAPITAL EXPENDITURE</b>			
(Payments) to acquire tangible fixed assets		(1,415)	(3,816)
(Payments) to acquire intangible assets		(487)	(72)
Net cash inflow/(outflow) from capital expenditure		(1,902)	(3,888)
<b>DIVIDENDS PAID</b>			
		(622)	(1,985)
Net cash inflow/(outflow) before management of liquid resources and financing		27,133	(41,922)
<b>MANAGEMENT OF LIQUID RESOURCES</b>			
(Purchase) of investments with DH		0	(6,000)
Sale of investments with DH		6,000	0
Net cash inflow/(outflow) from management of liquid resources		6,000	(6,000)
Net cash inflow/(outflow) before financing		33,133	(47,922)
<b>FINANCING</b>			
Public dividend capital received		2,097	66,832
Public dividend capital repaid (not previously accrued)		(29,225)	(18,842)
Net cash inflow/(outflow) from financing		(27,128)	47,990
Increase in cash		6,005	68

# 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 2007/08 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow UK generally accepted accounting practice 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 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 specific activity which is to be delivered in the following financial year, that income is deferred.

### 1.3 Prior Year Restatement

Income and expenditure for the year ended 31 March 2007 has been restated to exclude recharges in line with the Manual for Accounts. Changes have been made to several lines within notes 3 and 4, and primarily staff costs within note 5. This has had no effect on the Trust in year or prior year reported deficit.

### 1.4 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.

## **1.5 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.
- 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 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 Her Majesty's Revenue and Customs. 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 31 March 2005.

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

Specialised operational NHS assets are 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; and

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 nonoperational 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; and
- No adjustments are made to reflect hypothetical flooding of the market.

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.

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 scheduled for imminent closure and subsequent disposal.

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

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. 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.

All impairments resulting from price changes are charged to the Statement of Total Recognised Gains and Losses for the year.

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 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:

	Years
Medical equipment and engineering plant and equipment	5 to 15
Furniture	10
Mainframe information technology installations	8
Soft furnishings	7
Office and information technology equipment	5
Set-up costs in new buildings	10

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, 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.

## **1.6 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.

## **1.7 Private Finance Initiative (PFI) transactions**

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides practical 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 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.

## **1.8 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.

## **1.9 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.

## **1.10 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 2007/08 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.

## 1.11 Pension costs

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

The Scheme is subject to a full actuarial valuation every four years (until 2004, based on a five year valuation cycle), and a FRS17 accounting valuation every year. An outline of these follows:

### **a) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

### **b) FRS17 Accounting valuation**

In accordance with FRS17, a valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the balance sheet date by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account,

published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

#### **Scheme provisions as at 31 March 2008**

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. 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 year’s pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member’s final year’s pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (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.

#### **Scheme provisions from 1 April 2008**

From 1 April 2008 changes have been made to the NHS Pension Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website.

### **1.12 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.

### **1.13 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.

### **1.14 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.

### **1.15 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 27 to the accounts.

### **1.16 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.

### **1.17 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.

### **1.18 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 29 is compiled directly from the losses and compensations register which is prepared on an accruals basis for 2007/08. However, the 2006/07 comparatives are prepared on a cash basis and are therefore not a like for like comparative.

## **1.19 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.

The Trust will only enter into finance leases where these represent better value for money than purchasing or other leasing arrangements.

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 Analysis

The Trust only provides healthcare, therefore no segmental analysis is required

## 3. Income from Activities

	2007/08	Restated *
	£000	2006/07
		£000
Primary Care Trusts	121,345	114,437
Department of Health	19,130	19,137
Non NHS:		
- Private patients	105	92
- Overseas patients (non-reciprocal)	331	241
- Injury cost recovery	371	455
	<u>141,302</u>	<u>134,362</u>

Injury cost recovery income is subject to a provision for doubtful debts of 50% of the current outstanding debt to reflect expected rates of collection (30% in 2006/07).

\* See note 1.3 for details of the prior year restatement

## 4. Other Operating Income

	2007/08	Restated *
	£000	2006/07
		£000
Education, training and research	5,140	4,493
Transfers from donated asset reserve	199	184
Non-patient care services to other bodies	3,290	4,368
Income Generation	627	632
Other income	1,563	2,059
	<u>10,819</u>	<u>11,736</u>
	£000	£000

Included within Non-Patient care services to other bodies are the following significant items:

Oxleas SLA (This SLA is not activity related, it relates to the occupation of a Trust owned building by Oxleas NHS Foundation Trust).

1,646	1,665
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PFI smoothing monies from the Department of Health. This income has been received as the Trust were one of the first to enter a PFI partnership.

367	713
-----	-----

Greenwich Teaching PCT non-patient SLA for payroll and human resources services .

600	560
-----	-----

\* See note 1.3 for details of the prior year restatement

## 5. Operating Expenses

### 5.1 Operating expenses comprise:

	2007/08	Restated * 2006/07
	£000	£000
Services from other NHS Trusts	835	838
Services from other NHS bodies	1,089	962
Directors' costs	842	813
Staff costs	91,284	90,660
Supplies and services - clinical	24,295	23,124
Supplies and services - general	7,190	6,941
Consultancy services	673	516
Establishment	1,364	1,613
Transport	555	515
Premises	19,705	18,780
Bad debts	271	563
Depreciation	876	939
Amortisation	421	378
Audit fees	218	218
Clinical negligence	2,259	2,400
Redundancy costs	20	464
Other	2,773	1,855
	<b>154,670</b>	<b>151,579</b>

Other Expenditure includes the amortisation of the Trust Deferred Asset of £1,025k (2006/07 £1,025k).

\* See note 1.3 for details of the prior year restatement

2006/07 operating expenses have been restated to separately disclose consultancy services in line with the manual for accounts. This has resulted in a restated figure for "Staff Costs" for 2006/07.

### 5.2 Operating leases

#### 5.2/1 Operating expenses include:

	2007/08	2006/07
	£000	£000
Other operating lease rentals	41	32
	<b>41</b>	<b>32</b>

**5.2/2 Annual commitments under non - cancellable operating leases are:**

	<b>Land and buildings</b>	
	<b>2007/08 £000</b>	<b>2006/07 £000</b>
Operating leases which expire:		
After 5 years	<b>41</b>	<b>38</b>
	<u><b>41</b></u>	<u><b>38</b></u>

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**

	<b>Total</b>	<b>2007/08 Permanently</b>	<b>Other Employed</b>	<b>2006/07</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Salaries and wages	<b>77,111</b>	69,211	7,900	78,302
Social Security Costs	<b>6,692</b>	6,210	482	6,880
Employer contributions to NHS Pension Scheme	<b>8,276</b>	8,092	184	8,184
	<u><b>92,079</b></u>	<u><b>83,513</b></u>	<u><b>8,566</b></u>	<u><b>93,366</b></u>

The total employer pension contributions payable in 2007/ 08 were £8,092,000 (2006/07 £8,016,000).

## 6.2 Average number of persons employed

	Total	2007/08 Permanently Employed Number	Other	2006/07
	Number	Number	Number	Number
Medical and dental	326	303	23	317
Ambulance staff	0	0	0	0
Administration and estates	439	419	20	452
Healthcare assistants and other support staff	386	305	81	386
Nursing, midwifery and health visiting staff	839	712	127	855
Nursing, midwifery and health visiting learners	22	22	0	22
Scientific, therapeutic and technical staff	229	219	10	247
Social care staff	0	0	0	0
Other	2	2	0	2
Total	<b>2,243</b>	<b>1,982</b>	<b>261</b>	<b>2,281</b>

\*2006/07 figures have been restated in line with changes in classification introduced in 2007/08 to provide consistency between the two financial years.

## 6.3 Employee benefits

There were no employee benefits in 2007/08 (2006/07 £0)

## 6.4 Management costs

	2007/08 £000	2006/07 £000
Management costs	5,328	5,160
Income	152,121	146,098

Management costs are defined as those on the management costs website at [www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSMangementCosts/fs/en](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSMangementCosts/fs/en)

## 6.5 Retirements due to ill-health

During 2007/08 there were six (2006/07 seven) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £333K (2006/07 £242K). 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

	2007/08 Number	£000	2006/07 Number	£000
Total Non-NHS trade invoices paid in the year	32,213	61,377	32,533	58,667
Total Non NHS trade invoices paid within target	24,070	56,313	25,201	48,453
Percentage of Non-NHS trade invoices paid within target	75%	92%	77%	83%
Total NHS trade invoices paid in the year	1,297	12,299	1,252	39,657
Total NHS trade invoices paid within target	948	11,852	732	37,554
Percentage of NHS trade invoices paid within target	73%	96%	58%	95%

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.

The statistics include some payments which were disputed but were not able to be recorded as such. These relate to the Trust pharmacy system where there is insufficient data available to measure compliance correctly. This has the effect of worsening the Trust's reported performance against this target.

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

2007/08 £000	2006/07 £000
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Amounts included within Interest Payable (Note 9) arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

## 8. Loss on Disposal of Fixed Assets

Loss on the disposal of fixed assets is made up as follows:

	2007/08	2006/07
	£000	£000
Loss on disposal of intangible fixed assets	(66)	0
Loss on disposal of land and buildings	(11)	0
Loss on disposal of plant and equipment	(439)	0
	<u>(516)</u>	<u>0</u>

The Trust has undertaken a full review of fixed assets purchased in prior financial periods during the financial year resulting in £0.5m of assets no longer in use being written off to expenditure.

## 9. Interest Payable

There was no interest payable in 2007/08 (2006/07 £0)

## 10. Intangible Fixed Assets

	Software licences
	£000
Gross cost at 1 April 2007	2,561
Indexation	0
Impairments	0
Reclassifications	265
Revaluation	0
Additions purchased	487
Additions donated	0
Additions government granted	0
Disposals	(741)
<b>Gross cost at 31 March 2008</b>	<b><u>2,572</u></b>
Amortisation at 1 April 2007	1,471
Indexation	0
Impairments	0
Reversal of impairments	0
Reclassifications	0
Revaluation	0
Charged during the year	421
Disposals	(675)
<b>Amortisation at 31 March 2008</b>	<b><u>1,217</u></b>
Net book value	
- Purchased at 1 April 2007	1,049
- Donated at 1 April 2007	41
<b>- Total at 1 April 2007</b>	<b><u>1,090</u></b>
- Purchased at 31 March 2008	1,333
- Donated at 31 March 2008	22
<b>- Total at 31 March 2008</b>	<b><u>1,355</u></b>

Following a full asset verification exercise and full review of asset accounting, a number of re-classifications have occurred between asset categories.

## 11. Tangible Fixed Assets

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

	Land	Buildings excluding dwellings	Assets under construction and payments on account*	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2007	47,730	1,128	8,999	2,310	91	7,173	47	67,478
Additions purchased	0	169	2,263	405	0	388	80	3,305
Additions donated	0	0	0	156	0	0	0	156
Additions government granted	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0
Reclassifications	0	100	(44)	(29)	0	(292)	0	(265)
Indexation	2,580	134	736	63	2	0	1	3,516
Revaluation	0	0	0	0	0	0	0	0
Disposals	0	(448)	0	(48)	(53)	(4,516)	(2)	(5,067)
<b>Cost or Valuation at 31 March 2008</b>	<b>50,310</b>	<b>1,083</b>	<b>11,954</b>	<b>2,857</b>	<b>40</b>	<b>2,753</b>	<b>126</b>	<b>69,123</b>
Depreciation at 1 April 2007	0	0	0	1,189	69	4,817	16	6,091
Charged during the year	0	63	0	344	6	457	6	876
Impairments	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Indexation	0	40	0	32	2	0	0	74
Revaluation	0	0	0	0	0	0	0	0
Disposals	0	(437)	0	(35)	(53)	(4,089)	(2)	(4,616)
<b>Depreciation at 31 March 2008</b>	<b>0</b>	<b>(334)</b>	<b>0</b>	<b>1,530</b>	<b>24</b>	<b>1,185</b>	<b>20</b>	<b>2,425</b>
<b>Net book value</b>								
- Purchased at 1 April 2007	47,730	1,110	8,999	818	0	2,351	4	61,012
- Donated at 1 April 2007	0	18	0	303	22	5	27	375
- Total at 1 April 2007	<b>47,730</b>	<b>1,128</b>	<b>8,999</b>	<b>1,121</b>	<b>22</b>	<b>2,356</b>	<b>31</b>	<b>61,387</b>
- Purchased at 31 March 2008	50,310	1,399	11,954	1,029	0	1,565	82	66,339
- Donated at 31 March 2008	0	18	0	298	16	3	24	359
- Total at 31 March 2008	<b>50,310</b>	<b>1,417</b>	<b>11,954</b>	<b>1,327</b>	<b>16</b>	<b>1,568</b>	<b>106</b>	<b>66,698</b>

Following a full asset verification exercise and full review of asset accounting, a number of reclassifications have occurred between asset categories.

There were no fixed assets held under finance lease at the balance sheet date (2006/07 £0). Of the totals at 31 March 2008, the Trust had no assets held at open market valuation (2006/07 £0). The Reversionary Interest in the hospital is shown under assets under construction at a value of £11.8m (2006/07 £8.2m).

## 11.2 The net book value of land, buildings and dwellings at 31 March 2008 comprises:

	31 March 2008 £000	31 March 2007 £000
Freehold	51,727	48,858
<b>TOTAL</b>	<b>51,727</b>	<b>48,858</b>

## 12. Stocks and Work in Progress

	31 March 2008 £000	31 March 2007 £000
Raw materials and consumables	1,663	1,636
<b>TOTAL</b>	<b>1,663</b>	<b>1,636</b>

## 13. Debtors

### Amounts falling due within one year:

NHS debtors	2,360	35,566
Provision for irrecoverable debts	(1,674)	(1,502)
Other prepayments and accrued income	2,780	1,262
Other debtors	3,430	4,120
<b>Sub Total</b>	<b>6,896</b>	<b>39,446</b>

### Amounts falling due after more than one year:

Provision for irrecoverable debts	0	0
Other prepayments and accrued income	20,344	21,396
Other debtors	0	0
<b>Sub Total</b>	<b>20,344</b>	<b>21,396</b>
<b>TOTAL</b>	<b>27,240</b>	<b>60,842</b>

Other Debtors include no prepaid pension contributions at 31 March 2008 (none at 31 March 2007).

Within the Other Prepayments and Accrued Income greater than one year is the PFI Deferred Asset value of the Hospital.

Included within NHS Debtors in 2006/07 is an amount of £29.2m in relation to the reversal of the NHS RAB system.

Other prepayments and accrued income falling due within one year includes £1.1m paid to the Trust PFI partner, Meridian Hospital Company, and £1.2m paid to Greenwich Council. These amounts relate to future accounting periods.

## 14. Investments

### 14.1 Fixed Asset Investments

The Trust has no fixed asset investments (2006/07 £0).

### 14.2 Current Asset Investments

	Department of Health £000
Balance at 1 April 2007	6,000
Additions	0
Disposals	(6,000)
Revaluations	0
	<hr/>
Balance at 31 March 2008	0

The Trust had £6m of deposit with the National Loan Fund as at 31 March 2007; the deposit was £0 as at 31 March 2008.

## 15. Creditors

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

	31 March 2008 £000	31 March 2007 £000
<b>Amounts falling due within one year:</b>		
Payments received on account	81	0
NHS creditors	1,280	3,836
Non - NHS trade creditors - revenue	716	0
Non - NHS trade creditors - capital	508	687
Tax	90	0
Other creditors	246	1,893
Accruals and deferred income	4,891	2,337
<b>Sub Total</b>	<hr/> <b>7,812</b>	<hr/> <b>8,753</b>
 <b>Amounts falling due after more than one year:</b>		
Other	603	632
<b>Sub Total</b>	<hr/> <b>603</b>	<hr/> <b>632</b>
 <b>TOTAL</b>	<hr/> <b>8,415</b>	<hr/> <b>9,385</b>

Other creditors falling due after more than one year of £603k relates to the contract between Oxleas NHS Foundation Trust, Meridian and Queen Elizabeth Hospital NHS Trust for building improvement works.

There were no outstanding pensions contributions at 31 March 2008 (none at 31 March 2007).

## **15.2 Loans**

The Trust has no loans outstanding as at 31 March 2008 (£0 as at 31 March 2007).

## **15.3 Finance lease obligations**

Queen Elizabeth Hospital NHS Trust has no finance lease obligation (2006/07 £0).

## **15.4 Finance lease commitments**

Queen Elizabeth Hospital NHS Trust has no finance lease commitments (2006/07 £0).

## 16. Provisions for liabilities and charges

	Pensions	Legal claim relating to other staff	Restructurings	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2007					
Arising during the year	3,238	68	464	0	3,770
Utilised during the year	1,390	290	0	62	1,742
Reversed unused	(288)	(24)	(444)	0	(756)
Unwinding of discount	(1,174)	(32)	(20)	0	(1,226)
	70	0	0	0	70
At 31 March 2008	3,236	302	0	62	3,600

### Expected timing of cashflows:

Within one year	288	274	0	62	624
Between one and five years	2,948	28	0	0	2,976
After five years	0	0	0	0	0

£14,176k is included in the provision of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the Trust (31 March 2007 £8,638k).

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 2007/08. 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 value of the provision is based on information provided by the NHS Litigation Authority on a case by case basis.

Included within other provisions are amounts considered to become liabilities in future financial periods for which the Trust is either legally or constructively liable at the balance sheet date.

## 17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation	Donated Asset Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
At 1 April 2007	44,876	416	(42,488)	2,804
Transfer from the income and expenditure account	0	0	(3,125)	(3,125)
Surplus on indexation of fixed assets	3,434	8	0	3,442
Transfer of realised profits/(losses) to the income and expenditure reserve	(42)	0	42	0
Receipt of donated assets	0	156	0	156
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated assets	0	(199)	0	(199)
At 31 March 2008	<u>48,268</u>	<u>381</u>	<u>(45,571)</u>	<u>3,078</u>

## 18. Notes to the cash flow Statement

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

	2007/08 £000	2006/07 £000
Total operating deficit	(2,549)	(5,481)
Depreciation and amortisation charge	1,297	1,317
Transfer from donated asset reserve	(199)	(184)
(Increase)/decrease in stocks	(27)	(116)
(Increase)/decrease in debtors	31,534	(26,773)
Increase/(decrease) in creditors	(791)	(5,430)
Increase/(decrease) in provisions	(240)	330
<b>Net cash inflow from operating activities</b>	<u>29,025</u>	<u>(36,337)</u>

## 18.2 Reconciliation of net cash flow to movement in net debt

	2007/08 £000	2006/07 £000
Increase in cash in the period	6,005	68
Cash (inflow)/outflow from (decrease)/increase in liquid resources	(6,000)	6,000
Change in net debt resulting from cash flows	5	6,068
Net debt at 1 April 2007	6,480	412
<b>Net debt at 31 March 2008</b>	<b>6,485</b>	<b>6,480</b>

## 18.3 Analysis of changes in net debt

	At 1 April 2007 £000	Other cash £000	At 31 March 2008 £000
OPG cash at bank	470	6,008	6,478
Commercial cash at bank and in hand	10	(3)	7
Bank overdraft	0	0	0
Loan from DH due within one year	0	0	0
Other debt due within one year	0	0	0
Loan from DH due after one year	0	0	0
Other debt due after one year	0	0	0
Finance leases	0	0	0
Current asset investments	6,000	(6,000)	0
	<u>6,480</u>	<u>5</u>	<u>6,485</u>

## 19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2008 were £508k (31 March 2007 £643k)

## 20. Post Balance Sheet Events

There are no post balance sheet events.

## 21. Contingencies

	2007/08	2006/07
	£000	£000
Contingent liabilities	(644)	(644)
Amounts recoverable against contingent liabilities	0	0
<b>Net value of contingent liabilities</b>	<b>(644)</b>	<b>(644)</b>
 Contingent Assets	 0	 0

The Contingent liability of £644k relates to the possible compensation on termination of a contract between Macmillan Cancer Relief and the Queen Elizabeth Hospital NHS Trust, for contribution towards the Oncology Unit at the 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 (2007/08 represents year 7 of the 10 year period).

## 22. Movement in Public Dividend Capital

	2007/08	2006/07
	£000	£000
Public Dividend Capital as at 1 April 2007	115,476	67,486
New Public Dividend Capital received (including transfers from dissolved NHS Trusts)	2,097	66,832
Public Dividend Capital repaid in year	(29,225)	(18,842)
Public Dividend Capital written off	0	0
Public Dividend Capital issued as originating capital on new establishment	0	0
Public Dividend Capital transferred to Foundation Trust	0	0
Other movements in Public Dividend Capital in year	0	0
<b>Public Dividend Capital as at 31 March 2008</b>	<b>88,348</b>	<b>115,476</b>

## Cash

To maintain liquidity the Trust has cash borrowings issued as PDC to the value of £65.4m from the Department of Health in 2006/07. This borrowing will require repayment and does not present a permanent solution to the Trust's cash shortfall but repayment terms have not been negotiated with the Department of Health.

### 3. Financial Performance Targets

#### 23.1 Breakeven Performance

The Trust's breakeven performance for 2007/08 is as follows:

	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000	2007/08 £000
Turnover	125,436	130,090	132,983	146,098	152,121
Retained surplus/(deficit) for the year	917	(9,186)	(19,289)	(7,244)	(3,125)
Adjustment for:					
-Timing/non-cash impacting distortions					
-Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0
-2004/05 Prior Period Adjustment (relating to 1997/98 to 2003/04)	0	0	0	0	0
-2005/06 Prior Period Adjustment (relating to 1997/98 to 2004/05)	(4,417)	(136)	0	0	0
-2006/07 Prior Period Adjustment (relating to 1997/98 to 2005/06)	0	0	0	0	0
2007/08 Prior Period Adjustment (relating to 197/98 to 2006/07)	0	0	0	0	0
-Other agreed adjustments	0	0	200	0	0
Break-even in-year position	(3,500)	(9,322)	(19,089)	(7,244)	(3,125)
Break-even cumulative position	(4,173)	(13,495)	(32,584)	(39,828)	(42,953)
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	(2.79%)	(7.17%)	(14.35%)	(4.96%)	(2.05%)
-Break-even cumulative position as a percentage of turnover	(3.33%)	(10.37%)	(24.50%)	(27.26%)	(28.24%)

The Trust received an advance i&e movement £0.2M in 2005/06 relating to RAB system. This movement has been adjusted.

The Trust's breakeven 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.

There is no agreed plan which moves the Trust to a breakeven position. The Trust is actively working with NHS London, neighbouring Trusts and PCTs on 'A Picture of Health', a local consultation on the reconfiguration of clinical services in Outer South East London. The future financial plans are based on the financial modelling completed as part of this process, which has been publicly consulted on. Further details can be found in the Annual Report.

The Trusts plan for 2008/09 includes a £9m savings programme, and a forecast deficit of £5.5m, while future planned deficits are based on the financial modelling arising from 'A Picture 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 £0.6m, bears to the average relevant net assets of £100.9m, that is 0.6%.

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 the estimation process for 2007/08, the Trust recognised a material liability in respect of an expected cash loan with the Department of Health. The Trust was not issued with this loan in 2007/08 causing 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.

	£000	2007/08 £000	2006/07 £000
External financing limit		(27,128)	47,990
Cash flow financing	(27,133)		41,922
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		(27,133)	41,922
<b>Undershoot</b>		<b>5</b>	<b>6,068</b>

## 23.4 Capital Resource Limit

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

	2007/08 £000	2006/07 £000
Gross capital expenditure	3,948	4,323
Less: book value of assets disposed of	(517)	0
Plus: loss on disposal of donated assets	0	0
Less: donations towards the acquisition of fixed assets	(156)	(87)
Charge against the capital resource limit	3,275	4,236
Capital resource limit	3,823	4,585
<b>Underspend against the capital resource limit</b>	<b>548</b>	<b>349</b>

## 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 along with the corresponding amount of debtor and creditor balances recorded at the year end, and amount received and paid during the year:

	Debtor		Creditor		Income		Expenditure	
	2007/08	2006/07	2007/08	2006/07	2007/08	2006/07	2007/08	2006/07
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Greenwich PCT	760	30,292	33	2,916	98,633	93,394	56	16
Bexley PCT	463	339	32	8	19,007	18,005	29	8
The NHS London	86	199	0	0	5,610	4,458	44	3
The NHS Litigation Authority	0	0	0	0	0	0	2,373	2,400
Lewisham PCT	41	306	2	2	2,387	2,322	8	7
London Ambulance Service								
NHS Trust	0	0	14	47	0	0	887	1,010
NHS Blood and Transplant	0	0	0	11	0	0	1,288	1,391
NHS Purchasing and Supply Agency	0	0	204	0	0	0	2,413	1,874
Department of Health	0	0	0	0	19,130	19,200	137	0
Greenwich Council	40	0	2	0	40	0	1,586	1,171

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 £156,000 worth of capital donations during 2007/08 (in 2006/07 £87k).

David Wragg, the Trust Finance Director is a Director of the NHS Shared Business Service, a joint venture between Steria 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

	2007/08 £000	2006/07 £000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	26,316	25,013
Amortisation of PFI deferred asset	(1,025)	(1,025)
Net charge to operating expenses	<u>25,291</u>	<u>23,988</u>

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

PFI scheme which expires;		
Within one year	0	0
2nd to 5th years (inclusive)	0	0
6th to 10th years (inclusive)	3,924	3,754
11th to 15th years (inclusive)	0	0
16th to 20th years (inclusive)	0	0
21st to 25th years (inclusive)	23,446	21,891
	<b>£000</b>	<b>£000</b>
Estimated capital value of the PFI scheme	116,153	116,153
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 to 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 head lease 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 £50.3M.

## Toshiba Managed Equipment

	2007/08	2006/07
	£000	£000
Estimated capital value of the PFI scheme	6,094	6,094
Contract Start date:	27/09/2001	
Contract End date:	14/09/2016	

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) is 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 Trust is not, therefore, exposed to significant liquidity risks.

### Interest-Rate Risk

2.8% of the Trust's financial assets carry nil or fixed rates of interest. Queen Elizabeth Hospital NHS Trust is exposed to interest rate risk to the extent of cash held within the Trust bank account, where the interest varies in line with the Bank of England base rate. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

## 26.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest interest	Fixed rate			Non-interest bearing	
					Weighted average bearing	average period interest rate for which fixed	Years	Weighted average term	Years
	£000	£000	£000	£000	%				
At 31 March 2008									
Sterling	6,485	6,485	0	0	0.00%			0	0
<b>Gross financial assets</b>	<b>6,485</b>	<b>6,485</b>	<b>0</b>	<b>0</b>					
At 31 March 2007									
Sterling	6,480	6,480	0	0	0.00%			0	0
<b>Gross financial assets</b>	<b>6,480</b>	<b>6,480</b>	<b>0</b>	<b>0</b>					
<b>Maturity Profile</b>									
Less Than 1 Year	6,485	6,485	0	0					
Between one and two years	0	0	0	0					
Between two and five years	0	0	0	0					
More than five years	0	0	0	0					

## 26.2 Financial Liabilities

Queen Elizabeth Hospital Trust has no financial liabilities in 2007/08 (2006/07 nil).

2006/07 figures have been restated following further guidance as per the NHS Manual for Accounts.

## 26.3 Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

## 26.4 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 2008. (As restated\*)

	2006/07 Book Value	2006/07 Fair Value	Basis of fair valuation	Book Value	Fair Value
	£000	£000		£000	£000
<b>Financial assets</b>					
Cash	6,485	6,485		480	480
Debtors over 1 year:					
- Agreements with commissioners to cover creditors and provisions	0	0		0	0
Investments	0	0		6,000	6,000
<b>Total</b>	<u>6,485</u>	<u>6,485</u>		<u>6,480</u>	<u>6,480</u>
<b>Financial liabilities</b>					
Overdraft	0	0		0	0
Creditors over 1 year:					
- Finance leases	0	0		0	0
Loans	0	0		0	0
<b>Total</b>	<u>0</u>	<u>0</u>		<u>0</u>	<u>0</u>

\*The value of financial assets for 2006/07 have been restated to include cash, and cash on deposit with the Bank of England in line with the Manual for Accounts. Last year this figure included residual interest and provisions for liabilities and charges.

## 27 Third Party Assets

The Trust held £9k cash at bank and in hand at 31 March 2008 (£7k at 31 March 2007) 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.

## 28 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after one than one
	£000	£000	£000	£000
Balances with other Central Government Bodies	1,956	0	277	0
Balances with Local Authorities	58	0	11	0
Balances with NHS Trusts and Foundation Trusts	529	0	765	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,353	20,344	6,759	603
<b>At 31 March 2008</b>	<b>6,896</b>	<b>20,344</b>	<b>7,812</b>	<b>603</b>
Balances with other Central Government Bodies	32,817	0	2,874	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	2,749	0	950	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,327	21,949	4,929	632
<b>At 31 March 2007</b>	<b>38,893</b>	<b>21,949</b>	<b>8,753</b>	<b>632</b>

## 29 Losses and Special Payments

There were 578 cases of losses and special payments (2006/07: 200 cases) totalling £459,000 (2006/07: £1,040,000) paid during 2007/08.

The Trust has written off £400,431 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 (prior year 0 cases 2006/07).

There were no fraud cases where the net payment exceeded £100,000 (prior year 0 cases 2006/07).

There were no personal injury cases where the net payment exceeded £100,000 (prior year 0 cases 2006/07).

There were no compensation under legal obligation cases where the net payment exceeded £100,000 (prior year 0 cases 2006/07).

There were no fruitless payment cases where the net payment exceeded £100,000 (prior year 0 cases 2006/07).

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.

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.

This note has been prepared on an accruals basis for 2007/08. However, the 2006/07 comparatives are prepared on a cash basis and are therefore not a like for like comparative.