QUEEN ELIZABETH HOSPITAL
NHS TRUST

ANNUAL REPORT & ACCOUNTS 2008/09

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INTRODUCTION – SOUTH LONDON HEALTHCARE NHS TRUST

On 1 April 2009 a new NHS Trust came into existence in South London. South London Healthcare NHS Trust was the product of the merger of three smaller hospital trusts. Queen Mary's Sidcup NHS Trust (QMS), Queen Elizabeth Hospital NHS Trust (QEH) and Bromley Hospitals NHS Trust (BHT) merged to create a single hospital on several sites.

The merger took place after much discussion within the local health community about how we might create the best organisation for delivering top quality health services to local residents in the early part of the 21st century.

This was a very positive development. It offered tremendous benefits for patients, local residents and NHS staff. In the months and years ahead:

- A new, larger organisation will provide the critical mass that enables the NHS to develop sustainable and resilient clinical services.
- With an income of over £400m a year the new trust will be approaching the size of organisations such as King's College Hospital. It will be a major new health organisation for London and beyond.
- It will help develop financial stability in the local health community and will enable us to rationalise common functions such as human resources and finance; and
- It will mean the NHS in south east London can develop, recruit and retain the leaders and the clinicians it needs to provide world class health services for local people.

As soon as the new Trust was created there was evidence that talented people were positively seeking to join the new hospital Trust because they can see that the merger spells a bright future and a better way of working.

South London Healthcare NHS Trust came into existence on 1 April 2009 but, of course, not everything changed immediately. There is a new board with a new chairman (Mr. George Jenkins) and a new chief executive (Dr Chris Streather). A transitional executive management team was appointed and the recruitment of a permanent executive team began.

Within the new Trust change will be gradual and incremental – evolutionary rather than revolutionary. It will be a rolling process. Staff, patients and local communities will all need to embrace and adopt new ways of working and new ways of using our local health services.

Staff can be proud of the fact that all three of the former trusts have a track record of providing good health care for local people. This record is reflected in support from the public and other stakeholders but uncertainty about the future was straining clinical services. The new, larger, combined Trust will be in a far stronger position to ensure the continuing provision of the very best healthcare for local communities.

South London Healthcare NHS Trust will be setting its sights high. The new Trust will aim to be "best in class" in all it does. It will be looking to recruit the best and the brightest people. It will be defining standards of care, levels of staffing and clinical cover, governance structures and financial and operational targets which will place the new Trust at the forefront of patient care and clinical excellence.

The people of London and beyond can look forward to a hospital trust in which they can take renewed pride, and which will inspire their loyalty and trust. Our staff can look forward to working for a vibrant and successful health organisation that is nothing less than top class.

QUEEN ELIZABETH HOSPITAL – REVIEW OF THE YEAR

2008/09 was another extremely busy year 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 PCTs and other NHS Trusts in outer south east London to move forward plans for the future shape of local health care. The Trust also undertook its share of the work to successfully complete the process of creating South London Healthcare NHS Trust.

Apart from these two major pieces of work, our priorities continued to be to provide the highest standard of care to our patients whilst seeking to move towards financial stability.

In financial terms we succeeded in achieving our planned deficit of £5.5 million. In 2007/08 the deficit was £3.1 million. To achieve this position we have continued to place tight controls on expenditure throughout the organisation. Much credit for this should go to our former Director of Finance David Wragg and his team.

We have done well in meeting the majority of our targets for the year although we did not achieve our 18 week target for admitted patients in December 2008. Through the hard work of many of our staff the backlog of cases has now been cleared and the target achieved from April 2009.

The Trust achieved a sharp reduction in MRSA cases to 6, well below the trajectory target of 16, which was in itself challenging. This is a tremendous achievement and reflects the hard work and dedication of all staff, but in particular, former Director of Nursing, Terina Riches, our Matrons, the infection control team and our ISS Mediclean partners.

Having had 41 cases in 2004/05, we managed to reduce this to 23 cases in 2005/06 and 17 in 2006/07 and 19 cases last year. During the past 12 months there have been a number of months when we have recorded no MRSA bacteraemia cases at all.

Our efforts to reduce Clostridium Difficile have continued to be successful and have won praise from the SHA and Department of Health. We ended the year with 58 cases recorded which was significantly below another challenging trajectory of 71.

In the pages that follow, we describe more about the hospital's achievements and challenges in 2008/9.

OPERATING & FINANCIAL REVIEW

History and background to the Trust

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

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

From 1 April 2009 the Secretary of State for Health approved the merger of Queen Elizabeth Hospital NHS Trust with Bromley Hospitals NHS Trust and Queen Mary's Sidcup NHS Trust to form South London Healthcare NHS Trust.

Population

Greenwich is one of 12 inner London boroughs. It has a population of around 230,000, 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 has pockets of extreme deprivation and a number of wards are amongst the 10% most deprived 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 has been reflected in the increased number of births -, which have risen from 3,021 in 2001/02, when QEH first opened, to 4,190 in 2008/09.

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.

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 population makes a particularly high demand on the Trust's genito-urinary services. Telemedicine technology has been developed to provide some services to this section of the population.

The services we provide

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

Activity Review

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

The tables below show that in 2008/09 the hospital remains as busy as ever. Please note that the apparent drop in non-elective activity reflects a reclassification of some of that activity into outpatient attendances and does not represent an activity reduction.

A&E Attendances

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
75,149	73,638	85,223	94,298	100,831	99,700	99,534	98,224

Non-Elective Admissions (spells)
(excluding obstetrics)

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
13,355	14,854	16,584	16,879	16,882	17,669	17,757	14,421*

* see note in text above

Elective Admissions (spells)

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
18,586	20,946	21,116	21,155	23,497	24,622	23,648	24,369

Outpatient Attendances

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
155,000	169,808	168,234	158,221	169,560	190,077	193,502	210,279

Births

2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
3,021	3,264	3,487	3,753	3,950	4,182	4,263	4,190

The environment in which we operate

Along with all NHS trusts, QEH operates within a financial, competitive and regulatory environment determined by government. This regulation includes an annual health check, by the Care Quality Commission (CQC) and a number of inspections and accreditations from a 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.

The CQC 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. As with last year, QEH was rated as *'Good'* for quality of services and '*Weak'* for use of resources based on performance during 2007/08. We had anticipated a poor use of resources rating because of the financial challenges we face, and we were pleased to have again been assessed as 'Good' for the quality of our services.

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 previous Chairman of the Patients' Forum is 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 a 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 – the move towards merger

We make reference later in this report 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 three acute trusts - Queen Elizabeth, Queen Mary's, Bromley Hospitals - recognised the need for new management arrangements to enable a faster more transparent solution to developments aimed at improving the financial position of the trusts. During the year, under the auspices of the Joint Committee, a three month TUPE consultation process, together with stakeholder engagement was carried out by the three Trusts to discuss the proposal to merge. It has recently been announced that the 'A Picture of Health' reconfiguration proposals have been approved by the Secretary of State. The merged Trust can now work with its commissioners on addressing the provision of services in the local health economy. .

Trust Executive Committee

The QEH Board has 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. 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 £3.5M in 2008/09, £7.8M in 2007/08, £10.9M in 2006/7 and £4.5M in 2005/6.

In parallel with these internal performance management arrangements, regular meetings between senior Trust personnel and those of Greenwich Teaching Primary Care Trust and Bexley Care Trust also take place to review performance against the respective Service Level Agreements, 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.

The Trust's key long term risks are:-

- The Trust's ability to implement a plan to achieve financial balance within the planned timescale, with expenditure being contained within income earned.

- The Trust's requirement to standardise key Information Technology systems across its sites and the capacity to deploy the new national Care Records System given the financial position and probable impact of A Picture of Health on staff time and resources. The full benefits of Connecting for Health may not be realised by the Trust.

- Clinical services may suffer from less than optimum organisational arrangements until proposals from A Picture of Health are implemented.

- The Trust's ability to meet national targets for waiting times and the 4 hour accident and emergency target may potentially affect patient care, and may damage the good reputation of the Trust.

The Department of Health requires trusts to disclose serious untoward incidents involving data loss or confidentiality breaches in the format below

Date of Incident	Nature of Incident	Nature of data involved	Number of People potentially affected	Grade	Notification Steps
February 2009	Fax sent to a wrong number	Names, Addresses, Hospital Number and Clinical Details	6	2	Contacted and informed by telephone
Further action	The incident has been investigated and the policy for sending faxes reviewed. We will continue to monitor and assess risks associated with breach of confidentiality.				

How we performed in 2008/09

2008/09 National Targets

The Trust's performance against the national performance targets, is summarised in the following table.

Indicator	Measure	Target	Trust Position 2008/09	√ 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%	97.67%	x

Indicator	Measure	Target	Trust Position 2008/09	√ or x
18 Week Referral to Treatment Target (RTT)	Data completeness of the referral to treatment data	Between 90 and 110%	Within thresholds	√
	By December 2008, 90% of admitted patients to be treated within 18 weeks	90%	70%	x
	By December 2008, 95% of non-admitted patients to be treated within 18 weeks	95%	97%	√
Diagnostic Tests	Proportion of patients receiving specific diagnostic test in 6 weeks or less	100%	100%	√
Cancer – 2 week rule	Proportion of patients seen within 2 weeks of urgent GP referral for suspected cancer to first outpatient appointment	98%	98.9%	√
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%	98.6%	√
Cancelled Operations	*Part 1* - % of elective admissions cancelled on the day of, or after, admission for non-clinical reasons	0.8%	0.78%	√
	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	16	6	√
Clostridium difficile	Local target for Clostridium difficile infections agreed with PCTs and in place by March 2008,	71	58	√
Delayed transfers of care	% of patients whose transfer of care was delayed	3.5%	1.76%	√
Number of inpatients or day cases waiting longer than the	% of patients waiting 26 weeks or more for an elective admission	0%	0%	√

Indicator	Measure	Target	Trust Position 2008/09	√ or x
standard				
Number of outpatients waiting longer than the standard	% of patients waiting 13 weeks or more for a first outpatient appointment following a GP referral	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%	98.7%	√
Waiting times for GUM clinic	Improvement in access to GUM clinics within 48 hours	Awaiting confirmation by the CQC	99.2%	√
Data quality on ethnic group	% of patient admissions for whom a valid 2001 census coding for ethnic category is recorded	85%	93.4%	√
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 Part 2 - Number of mothers known to have initiated breastfeeding within 48 hours compared to 2005/06	< previous year > previous year	12.7% 81.5%	x √

Action with regard to targets not met

SLHT recognises that sustained delivery of the key access targets - 18 week Referral to Treatment Time (RTT) target and 4-hour A&E - will be critical to its success and we have developed a model for performance improvement that enables a structured approach to delivery against these and all targets.

18 Weeks Delivery

The SLHT model for delivery is based on the successful turnaround in performance achieved on the QMS site during 2008/09. The model combines performance management and improvement techniques that have been used successfully at Bromley hospitals and Queen Mary's Sidcup.

4-Hour A&E Delivery

A similarly structured approach is now being applied to A&E performance improvement to ensure sustained achievement of the 4-hour target. A weekly performance board has been established, which will provide the coordinating hub, and a dedicated project manager has been appointed to focus on short-term performance and sustainability, in particular during a period of significant change during APOH implementation. Details of the approach are provided in Appendix 3.2.

*Reduction in the number of women known to be smokers at the time of de*livery

All women who book to deliver their babies at Queen Elizabeth are asked whether or not they smoke. Those that do, are offered a referral to the Smoking Cessation Team, where a midwife member can work with them to give up smoking.

Reducing healthcare acquired infection

We have been very pleased with our overall performance against the national targets, this year achieving a reduction in the number of MRSA (methicillin-resistant staphylococcus aureus) bacteraemia (bloodstream infections). 16 MRSA bacteraemias during 2008/9 was considered a challenging target set for our organisation and much lower than many other London hospitals. A concerted effort was made by all staff across the organisation, which culminated with the organisation achieving a total of 6 MRSA bacteraemias during 2008/9. Of these 6 three were pre 48 hours and therefore considered community acquired (1 was in a patient who travelled directly to Woolwich from Ireland and therefore not a local resident. The other 3 were associated with the hospital 1 surgical 1 medical and 1 maternity (this is the first bacteraemia we have seen in relation to maternity patients).
(This figure compares against 19 MRSA bacteraemias during 2007/08). 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.

Infection control continues to have an extremely high profile within our organisation and this view was supported by the Healthcare Commission in their feedback to us following their unannounced spot-check visit in August 2008. There was only one area where action was required and this was in relation to the Trust not displaying the ward specific cleaning schedules. This requirement was instituted and cleaning schedules are now displayed on the ward walls and included in each patient's bedside folder.

Our work during the year has also focused on reducing other healthcare acquired infections, in particular Clostridium Difficile (C. Diff). During 2008/09 the Trust is pleased to report a reduction in the number of cases to 58, beating its Department of Health target of no more than 71.

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 gradual improvement in compliance; The trust is compliant with the NPSA Alert published in September 2008 regarding the use and positioning of alcohol hand gels. We have recently removed alcohol hand gels from the main hospital corridors. (This was as a result of the thefts and ingestion of alcohol gel by unknown persons across some London Hospitals). Clear notices continue to be placed across the organisation reminding the need to use the gel at point of care from supplies located on the wards and at the patients' bedsides.

- 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;

- Enhanced chlorine cleaning was introduced in 2007/08, and has gradually been rolled out to the majority of wards;

- Antibiotic protocols were reviewed and re-issued, with every junior doctor receiving a pocket guide.

In addition, during 2008/09 QEH successfully bid for resources from Greenwich PCT. The funding included monies for the: -

- Increase in Microbiology laboratory staff to support the increase in screening specimens

- Funding for the appointment for an Infection Control Data Analyst

- Funding for 5 WTE Infection Control Administrative Support

Achievements during the year

During the year, the Trust focused on service developments that would contribute towards the provision of more local services, consolidating the Trust's position as the local hospital of choice. These developments were cost neutral or cost saving to commissioners. For the most part, our plans to develop these services looked to maximise the use of existing skills and resources and provide local choice for the first time. The aim has been to broaden QEH's catchment base and, in time, when services are well established, to enable some work to be repatriated from the tertiary centres.

Breast reconstruction surgery
The Trust introduced simultaneous reconstruction surgery for women requiring mastectomy for breast cancer. A plastic surgeon from Guy's and St Thomas' supports this service, which provides a monthly operating list at the moment, providing the instruction and clinical supervision that the development of such a service requires. The development of this surgical technique has augmented the service so that the Breast unit at QEH can care for all women requiring surgery for this condition regardless of their treatment choice. The development provides a local choice and avoids unnecessary travel into tertiary centres for women who chose simultaneous breast reconstruction with mastectomy.

Non invasive detection of early liver disease
The Trust has invested in a Fibroscan machine, which optimises the quality of patient care by detecting early liver disease using non invasive scanning. This procedure is provided in a one-stop clinic stetting and reduces the need to use radiological scanning and liver biopsies. The Fibroscan is a standalone portable machine and is used in the gastroenterology outpatient clinics providing, for the first time, a local non-invasive scanning service for patients with potential liver disease.

Ano rectal physiology assessments
The Trust has invested in an anal endo-sonography machine which enables QEH to undertake ano rectal physiology assessments locally. This investigative method is a simple rapid and accurate method of screening patients to determine whether surgical repair might be appropriate and is also invaluable in the investigation of anal pain and sepsis. Until now the Trust has had to refer outside of the area for this investigation, which is inconvenient for the patients concerned and has a detrimental impact on 18 week pathway achievement.

End of life care
During the year, the Trust consulted on merging the management of Specialist Palliative care under the umbrella of Greenwich and Bexley Hospice (GBCH) and this merger has been successfully implemented.
This service change has united the services previously managed separately by QEH and the GBCH in a 'hub and spoke' model under the management of GBCH, but with medical staff contracts remaining with QEH. The newly merged service provides a more seamless service for patients as well as achieving 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. The new service configuration also includes the service delivery changes necessary to meet NICE guidance on supportive and palliative care for adults with cancer.

Clinical skills laboratory
In April 2008, the Trust opened a new multi-disciplinary clinical skills laboratory, supported by SIFT funding. In Phase 1, the lab is delivering medical student skills training as set out in the Guy's, King's and St Thomas' curriculum, Royal College of surgeons accredited base surgical skills course, laparoscopic gynaecology courses, MRCOG courses, and resuscitation courses. This facility provides all staff with the opportunity to learn and practice clinical techniques, based upon the best evidence, in a non-threatening environment. It also allows both pre and post registration practical skills to be honed prior to attempting the chosen skill on a patient, without compromising patient care. The laboratory provides a range of anatomical models and mannequins/simulators together with audiovisual equipment and video camera facilities simulated consultations and team based patient scenarios. This allows effective feedback to participants during scenarios and addresses both verbal and non-verbal communication in a more realistic environment. Since opening, the Trust has successfully completed two Royal College of Surgeons approved basic surgical skills courses together with other courses that include laparoscopic skills for gynaecologists, a hysterectomy master-class and various life support and resuscitation courses. Further developments will include multi-professional skills courses, advanced endoscopic training courses with a video link to theatres allowing live demonstrations of laparoscopic and endoscopic skills.

Arts Programme

Another eventful year for the Elixir Arts programme at QEH saw the completion of the Artists in Residence programme. At the end of their year-long project involving consultations with patients and staff, residency artists Rachel Wingfield and Mathias Gmachl of Loop.ph presented several proposals for site-specific projects.

These included a Roof Garden, Living Canopy –innovative lightweight tree-like structures supporting climbing plants and Reflections of the Familiar - a window design to filter out sunlight and heat from corridors. The Living Canopy project was chosen to be taken forward and was installed in the main Courtyard garden during the summer. Fourteen climbing plants will provide

a focus of interest and colour in the garden throughout the year. The Residency was supported by the Leverhulme Trust.

Patients on Wards 3 and 4 enjoyed regular visits by musicians playing in the ward bays, during 2008. Music ranged from European classics to Flamenco, Senegalese to Pop hits of the 50s and 60s. Frequently a party atmosphere developed on the wards and patients, visitors and staff joined in at times, singing and even dancing by their beds! The funding from Tesco Charity Trust also provided regular crafts sessions for Ward 4 patients during the autumn and a programme of visiting speakers, including a special reminiscence session to mark the NHS60 celebrations.

The long-awaited Elixir Gallery was launched in December 2008, with a Staff Open Exhibition. Visitors were delighted and impressed by the very high standard of work submitted which included photographs, digital design, drawings and pastels. The Gallery, located between the West Entrance and the Just EAT Restaurant, will show a regularly changing programme of artwork by professional artists, local schools and staff, over future years.

Patient Experience

The Picker Institute was commissioned by the Trust to undertake the 2008 Inpatient Survey. In total 829 patients were eligible for the survey, 379 (45.7%) returned a completed questionnaire. The results showed that, compared to the previous year, we were:

- significantly better on 2 questions regarding enough privacy when discussing condition or treatment and receiving copies of letters sent between hospital doctors and GPs at the time of discharge;

- significantly worse on 2 questions regarding having to wait a long time to get to bed on admission and discharge being delayed by 1 hour or more;

- showed no significant difference on 57 questions;

Compared to other trusts we were disappointingly:

- significantly better on 1 question regarding the receiving copies of letters sent between hospital doctors and GPs at the time of discharge;

- significantly worse than average on 38 questions regarding waiting times, single sex accommodation , food choices, doctors / nurses behaviour / attitude, patient involvement and discharge;

- average on 25 questions.

These results show that we still have a considerable way to go to attain the levels of patient satisfaction that other hospital trusts are achieving on a year by year basis. The Getting it Right for Patients strategy, launched in July 2007, has continued to tackle the areas of concern to ensure that changes are implemented successfully, and the following key improvements have been made:

- New standards of behaviour have been introduced to ensure that staff and patients are fully aware of what is expected of them in terms of attitude and behaviour. They have

been developed with the help of patient representatives and are shared with all who come to the Trust.

- We have introduced Patient Experience Trackers (PET), which allow patients to give us instant feedback on the quality of their care. PET is an electronic surveying computer which, at the touch of a button, allows patients to rate various services, such as the quality of care, the quality of their food and the attitude of staff. The trackers have been introduced in several areas of the hospital and will allow up to date information to be collected, enabling us to react immediately to people's concerns and to feedback to our patients the improvements we introduce as a result.

- The Matrons have been leading a drive in 2008 to improve nutrition, diet and refreshments for patients, as part of the Getting it Right for Patients strategy and also a key part of the national Essence of Care programme for setting benchmarks for good practice for nursing in the NHS. Protected mealtimes protocols have been introduced to wards and guidelines for staff focusing on the importance of food and drink for patients have been introduced together with the trialling of a new hydration system using water bottles on the wards.

- A four-week awareness campaign highlighted the importance of nutrition and the wider context in which it fits, with an emphasis on the broad range of nutritional issues that affect the hospital population, including both patients and staff. NICE Guidelines were incorporated in the four major themes of the campaign:

    - Fluids and hydration;
    - Healthy snacks
    - the Malnutrition Universal Screening Tool (MUST) – all patients are screened within 48 hours and weekly thereafter;
    - diabetes, which focused on healthy eating to reduce and prevent the long-term complication of diabetes.

- A team of volunteers has been providing support to patients coming into the accident & emergency department by staffing a helpdesk to advise patients if they are in the right place and redirecting where necessary.

Our priorities for 2009/10

The merged Trust's plans for 2009/10 were approved by the South London Healthcare NHS Trust Board on 29 April. They are centred around seven core objectives:

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

OBJECTIVE 1

Our patients. We will put patients at the centre of everything that we do. We will ensure that all patients experience care that is safe, maintains their dignity, treats them with respect and leads to agreed outcomes.

Actions and Outcomes

1.1 Work in partnership with local commissioners to implement systems that respond to the views and experiences of patients and improve the patient experience of services.

1.2 Work with our local commissioners to deliver substantial and meaningful reductions in the number of patients in our hospitals who report that they share sleeping or sanitary accommodation with members of the opposite sex.

1.3 We will ensure a system wide focus on quality through ensuring that:

- our patients are safe – that care is provided in a clean and safe environment. There will be a clear and systematic approach to improving patient safety;

- that care is effective from a patient perspective, measured through patient reported outcome measures (PROMS)* and other local patient survey mechanisms;

- that we deliver quality, personalised care focusing on the compassion, dignity and respect with which patients are treated and how easy it is for patients to access services, taking account of the need to promote equality for minority groups.

1.4 Implement the new national complaints system, Making Experiences Count.

1.5 Develop active and mutually supportive relationships with Local Involvement Networks (LINks) and local projects that provide feedback from local groups and communities.

*** Operating Framework – PROMs**:
. short questionnaires used to measure patients' assessments of their own health and well-being – will play an important role in measuring the effectiveness of care, and contribute to the Commission for Quality and Innovation (CQUIN) payment framework.

. PROMs put patients at the centre of determining the quality of services and will be introduced under the standard NHS contract for acute services.

. From April 2009 they will cover patients undergoing elective hip and knee replacements, varicose veins and groin hernia surgery.

OBJECTIVE 2

Financial viability. We will develop and commence implementation of a strategy to achieve and sustain financial viability in readiness for a future foundation trust application, ensuring that our services are provided within available financial resources and that we get paid for the services we provide.

Actions and Outcomes

2.1 Maintain excellent health care services whilst ensuring that expenditure is contained within the income earned and provide value for money.

2.2 Develop a financial plan that delivers run-rate balance within the 24 month timetable agreed by the Board within the Medium term financial Strategy (MTFS).

2.3 Implement a detailed programme of work to ensure that all activity undertaken is recorded, coded and charged appropriately, maximising the income available to the Trust over the next two years.

2.4 Develop, implement and deliver a robust Cost Releasing Efficiency Savings (CRES) programme to ensure that the year end control total is met.

OBJECTIVE 3

Leadership and workforce. We will provide positive leadership and effective management and engagement of staff at all levels and in all disciplines in the transition to the new organisation to ensure a safe and supportive working environment. We will develop 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.

Actions and Outcomes

3.1 Provide positive leadership in the transition to the new organisation, communicating well with our staff to ensure a safe and supportive working environment.

3.2 Build upon existing levels of staff empowerment and engagement, which are crucial to ensuring improved quality of care and effective implementation of the local clinical visions at the heart of High Quality Care for All.

3.3 Staff satisfaction will be improved through our commitment to provide good workplaces and rewarding jobs for all of our staff.

3.4 Ensure that we are a learning and nurturing organisation, providing appropriate levels of training, learning and development for all of our staff ensuring they have the skills they need to improve patient care.

3.5 Develop and improve the performance appraisal process based on the knowledge skills framework.

OBJECTIVE 4

High Quality Clinical Care. We will deliver 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.

Actions and Outcomes

4.1 Achieve compliance with all of the core standards within Standards for Better Health, through effective arrangements for the collection of evidence, periodic monitoring of compliance with them and prompt action where lapses are identified in respect of them.

4.2 Ensure the existence of strong clinical governance arrangement within Divisions, including the introduction of appropriate performance indicators for clinical quality and safety at specialty level.

4.3 Ensure systematic organisation-wide processes for the review of compliance with NSF standards, NICE guidance and all relevant national regulatory bodies

OBJECTIVE 5

Healthcare acquired infections. We will continue to drive forward improvements in reducing health care acquired infections, to ensure that patients receive safe care that conforms to nationally agreed best practice and which leads to reductions in the incidents of Clostridium Difficile infections and MRSA.

Actions and Outcomes

5.1 Maintain compliance with the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infection to ensure that patients receive safe care that conforms to nationally agreed best infection control practice, ensuring specifically:

- meeting national targets for MRSA;
- reduction in the rates of Clostridium Difficile;
- raising levels of cleanliness across all our sites as measured by the PEAT scores; and
- compliance with the Hygiene Code.

OBJECTIVE 6

National and Local Priorities: We will demonstrate that the Trust is providing high quality cost effective services through achieving the national priorities highlighted in the Operating Framework and through the achievement of a high level of performance in the measures included within the Annual Health Check (or Care Quality Commission equivalent), including the Auditor's Local Evaluation Assessments.

Actions and Outcomes

6.1 Improve performance to 'Good' for the Quality of Service element of the Annual Health Check (or Care Quality Commission equivalent), which will require achievement of the performance standards set for the new and existing national targets as well as achievement of the core standards within Standards for Better Health.

6.2 Deliver the key access targets:

- 18 week referral to treatment target (RTT);
- 4-hour A&E treatment target;

- All cancer targets – 2 week; 31 day and 62 day targets

6.3 Deliver our commitments for keeping adults and children well, specifically:

- Deliver the Cancer Reform Strategy;
- Implement the Stroke Strategy;
- Improve maternity care, through delivering the requirements of Maternity Matters

6.4 Work with PCTs and other local organisations to ensure robust plans are in place to enable an effective response to major incidents and to pandemic influenza. During 2009/10 and beyond, these plans will be tested, reviewed and improved, as appropriate, to take account of lessons learned and of developments in the national arrangements for pandemic influenza preparedness.

6.5 Work with PCTs to deliver local key priorities, specifically the (KPIs) key performance indicators and the Commissioning for Quality and Innovation (CQUINS) measures identified within the Service Level Agreements, developing local improvements plans and delivering improved patient pathways as necessary.

6.6 Achieve level 3 (good) on those elements of the Auditor's Local Evaluation (ALE) that are not dependent on setting a balanced budget, namely financial reporting, internal control, value for money, and financial management. (Financial standing will be scored at level 1 (poor) whilst the Trust is in deficit.)

OBJECTIVE 7

Services and facilities fit for the future. We will work closely with partners in primary and social care to develop new and improved services to benefit our local population, with particular emphasis on the quality of care within improved patient pathways. We will ensure that our buildings, equipment and infrastructure are fit for purpose and capable of accommodating service change.

Actions and Outcomes

7.1 Work closely with PCT partners to contribute fully to the implementation of the APOH strategy, ensuring that the service changes agreed are developed into robust, deliverable and timely project plans.

7.2 Ensure that a communications strategy is developed, which supports the service change agreed within the APOH plans.

7.3 As a part of 7.1 above, produce Development Control Plans for each of the hospital sites, which deliver buildings and infrastructure that are capable of accommodating the agreed service changes.

7.4 Ensure that service transformation plans are developed and implemented to enable the Trust to achieve the productivity improvements required by the APOH strategy, specifically in the areas of length of stay, day case rates and theatre utilisation.

7.5 Engage with patients, our staff and the public to ensure safe, high quality and affordable services and work actively with all of our key partners to plan a viable future for our services and our organisation.

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 numbers of factors including, in the past, operating inefficiencies and the high costs of our PFI scheme. The 'excess' costs of the PFI scheme – the costs that the Trust is unable to recover through the income it receives under the payment by results system of funding hospitals – have been assessed by independent consultants Tribal Consulting, and validated by Cambridge Economic Policy Associates, at approximately £8M per annum. The consequence of this history is that the Trust's balance sheet at 31 March 2009 contains a negative income and expenditure reserve of £51M.

The full accounts for the year ending 31 March 2009 are included within this document from page 41 onwards. 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 2008/09 was designed to produce a deficit of £5.5M. This required us to plan and implement savings measures amounting to almost £9M in the year. The Trust was successful in achieving the deficit planned at the start of the year. A shortfall on planned savings was offset by higher than budgeted income.

The table below compares the main elements of our income and expenditure account in 2007/08 and 2008/09 and comments on the main changes between the two.

Income and Expenditure

	2007/08 (£ million)	**2008/09 (£ million)**	**Comment**
Income			
Income from activities	141.3	145.9	Income from activities increased by 3.26% in 2008/09 from additional income for reduction in elective waiting times and improved recording of income from Overseas patients,
Education, training and research	5.1	5.7	There was an increase in-year for Education and Training Funding for both Medical (post-graduation) & Nursing staff groups.
Other operating income	5.7	6.0	Small increase in income above inflation relating to increased recovery of charges.

Total income	**152.1**	**157.6**	
Expenditure			
Pay	-92.1	-97.8	A reduction in the number of permanent employees required a higher usage of agency staff than in the previous year.
Non-pay	-62.6	-65.2	The increase in non-pay arises from contractual increases in PFI payments and higher drug usage, in addition to annual cost inflation
Total expenditure	**-154.7**	**-163.0**	
Interest receivable	0.6	0.4	
Dividends payable	-0.6	-0.2	
Asset Write Off	-0.5	-0.1	
Surplus/(deficit)	**-3.1**	**-5.5**	

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 £1.7M in 22 capital schemes. The table below summarises our capital expenditure for the year.

Capital Expenditure

	2008/09 (£ Million)	**Description**
IT Network and Equipment	0.7	Network and equipment to support our IT systems and Relocation of the Data Centre to the Hospital Site
Surgical Equipment	0.3	Purchase of an Endosonography machine and other required surgical equipment
Imaging	0.3	Enabling works and contribution to the replacement of the Cardiac Angiography Suite
Other	0.4	Other clinical / IT equipment and enabling works
Total	1.7	

From 2007/08 the system of allocating capital resources to NHS trusts was 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 needs 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 2008/09, and we have been restricted to investing the sum set aside for depreciation and amortisation of, approximately £1.7M.

The Trust urgently needs to upgrade the electricity power supply to the hospital and plan to carry out the work in 2009/10. An application for funding has been submitted to NHS London. The capital costs are expected to be £4.5M.

Cash

The Trust had an External Financing Limit (EFL) of £5,302k, which it undershot by £232k. The Trust had a cash balance of £3,406k at the year-end.

As at last year-end the Trust has cumulative cash borrowings of £65.4m, relating to historic borrowing received by the Trust to fund past deficits. These borrowings have not increased during the year ended 31 March 2009.

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 6 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. Annual spend on the Meridian contract was £24M.

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 £4.0M.

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 NHS London 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, accounting and payroll 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

From the 1 April 2008 the Trust was required to account for Financial Instruments under the provisions of FRS 25, FRS 26 and FRS29. The Trust's accounting policies have been amended to reflect this change.

Pension liabilities

Information about the accounting treatment of pension liabilities is provided in note 1.14 of the 2008/09 accounts.

Auditors

The Trust's auditors are PricewaterhouseCoopers LLP (PwC), who have been appointed by the Audit Commission as our external statutory auditor. In addition to the statutory audit carried out by PwC in 2008/09, at a cost of £216,000, additional work reviewing the Trust's readiness for the implementation of International Financial Reporting Standards (IFRS) was done at a cost of £15,000.

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 2008/09, as directed by the Secretary of State in accordance with Reporting Standard 1.

How we are addressing our environmental, social and community responsibilities

Whilst the Trust continues to take its responsibility for the reduction of its carbon footprint and its commitment to achieve the 2050 national carbon reduction targets seriously, the ability to move ahead with further initiatives has been delayed by the merger of Queen Elizabeth NHS Trust with Bromley Hospitals NHS Trust and Queen Mary's NHS Trust. However, following the merger and the reorganisation of the Estates and Facilities Directorate, it is envisaged that the responsibility for carbon management across the new organisation will be managed centrally under the auspices of the new Estates & Facilities Director.

The Trust has continued however with its recycling initiative and extended recent trials to Ward levels with the intention to rollout the programme across the entire site during the forthcoming year.

We are continuing to monitor the reduction of our waste output related to both clinical and domestic waste despite continued increases in patient activity. We have had a number of discussions with energy consultants including Waterman Energy, Environment and Design who have indicated their ability to work with the Trust in order to facilitate carbon reduction initiatives and a request for further references have been sought with a view of creating a commercial partnership.

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 a communications exercise during 2008. The next live rehearsal will be held in 2009/10.

The role of the Emergency Planning Officer has been combined with the role of the Head of Nursing for the Clinical Site Management Team and a new Emergency Preparedness Working Group has been established under the chairmanship of the Director of Operations. The working group are responsible for the development and implementation of the site'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 2008/09 we planned to have an average 2,185 whole time equivalent (WTE) staff over the course of the year, comprising both permanent and temporary staff. The number of substantive staff in post reduced during the year and staffing levels were maintained through increased use of temporary staff.

Key achievements

- As a key part of the Trust's *Getting it Right for Patients* strategy we published robust standards of behaviour, developed and rolled-out *A Positive Experience Every Time*, the Trust's customer care and diversity awareness programme, and introduced Dr Foster Patient Experience Trackers (PET) in to 10 wards or departments to capture patient experience.

- The Trust launched its Mediation framework, having trained 30 staff at all levels and in all disciplines to provide an internal resource, to reduce the increasing amount of time spent by managers and staff in formal and often confrontational grievance processes by addressing issues speedily and informally.

- We partnered with Kings College Hospital in a ground breaking *Thought Leadership* programme to stimulate innovative thinking in senior nurse leaders.

- Successfully outsourced payroll administration to NHS Shared Business Services.

- Enhanced the Queen Elizabeth Hospital as a state of the art teaching facility with the commissioning and opening of a SIFT funded Clinical Skills Laboratory. This facility provides all staff with the opportunity to learn and practice clinical techniques, in a high tech simulated environment, without compromising patient care.

- Introduced an electronic bank booking system to improve efficiency and release maximum resources for patient care.

- Agreed a full business case for the introduction of e-rostering which will automate systems of time, attendance, rostering and sickness reporting and management.

- Successfully tendered to Occupational Health Services and awarded the contract to Royal Marsden NHS Foundation Trust for commencement in 2009/10.

- Made significant progress towards EWTD compliance in August 2009.

- Appointed an Associate Director of Medical Education to take forward the Trust's plans for medical education.

- The August intake of doctors in training was successfully managed, with the majority of the Trust's posts filled with Deanery appointments.

- Consulted with staff on the proposed merger with Bromley Hospitals NHS Trust and Queen Mary's Sidcup NHS Trust.

Key workforce metrics

- Workforce actual against plan

Workforce whole time equivalent (w.t.e.) actual remained between 2% and 3% below plan throughout the year, although the year closed on plan. Vacancy levels increased during the year from 9% to 11%, peaking at 14% mid year. Bank staff employed flexibly made up the gap, though difficulty in recruiting sufficient bank staff led to an increased use of agency staff from less than 2% to over 8% of the monthly pay bill. Vacancy levels rose particularly for trained and specialist staff, with all clinical services experiencing a shortage. The majority of services were maintained, but the impact was most noticeable in areas where clinical activity had increased, where uncertainty in relation to *A Picture of Health* was highest, and where levels of maternity absence were high. (Source: Workforce Information Management System (WIMS) March 09).

- Staff survey results

The Trust's scores in the annual staff survey showed an improvement in areas which had been of previous concern including job satisfaction and the intention to leave, the availability of counselling services and awareness in relation to infection control. The key indicator where the Trust continued to fall below average related to the provision of annual appraisal/Knowledge and Skills Framework reviews.

- Ethnicity

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 a rich 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 the action plans, reporting annually to our Board and executive.

- 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. However an significant increase in demand for temporary staff, and reduced availability, has led to a significant increase in the use of agency staff, in spite of action in the early part of the year to increase pay rates (Source: WIMS March 09).

- Staff turnover

Staff turnover has been higher this year, at around 13%, though there was a peak at 14% mid year. Uncertainty in relation to organisational and service change has had a significant impact, though the difficulty in some areas is in recruiting replacements for normal turnover rather than higher turnover itself. (Source ESR December 2008).

- Sickness absence

Levels of sickness absence have been managed at around 4.5% (Source: WIMS March 09)

- European Working Time Directive (EWTD) compliance

The hospital is confident of compliance with the European Working Time Directive (EWTD) from August 1st 2009. Of those rotas that were non compliant, three require recruitment of extra non training staff. The remainder require some adjustment but do not require additional recruitment.

- Standards for Better Health compliance

Following a declaration in 2007/08 based on staff survey evidence of 'insufficient assurance' for Standard C7e -*"Healthcare organisations challenge discrimination, promote equality and respect human rights*" an extensive diversity training programme commenced in September 2008 and rolled-out across the Trust to reflect both our new Standards of Behaviour for staff and enable the Trust to declare full compliance by year end.

- Staff involvement and consultation

Our Joint Staff Council (JSC) has met regularly, involving itself in all aspects of the Trust's business and receiving regular reports on the Trust's performance. The proposed merger with 2 local hospital Trusts rose to the top of the agenda as the year progressed, and the Trust worked hard with local staff representatives to keep staff engaged and involved, both internally and through the local Partnership Committee set up to oversee staffing issues across outer south east London.

Communication with staff continued through clinical directorates, through both regular and merger specific briefings and regular Open Forums hosted by the Chief Executive and Director colleagues.

- Learning and Development

In conjunction with staff at the Nightingale School at King's College London (KCL), a Thought Leadership programme was designed to meet the specific needs of the Trust in regard to encouraging a culture of continuous improvement and innovation.

The first cohort of staff graduated in January 2009 and several of the participants have opted to convert their participation into academic credit; at least one is planning to join the M.Sc. in Leadership that is offered at KCL. All participants undertook a service improvement project as a means of putting Thought Leadership into practice. The programme will run again in September 2009.

A learning intervention that covered issues of improving service-user experience and addressing diversity was designed so that it might be run over two hours in workplace-based team meetings. Delivery was undertaken in each Directorate by the respective HR Manager.

Feedback from these events was extremely positive, with staff clearly enjoying and feeling that they benefited from attendance.

Over 30 staff across Queen Elizabeth Hospital went through a four-day training course in workplace mediation, delivered on behalf of the Trust by ACAS. A mediation scheme has been running in pilot form since Jan 2009; the scheme will be formally launched in June 2009.

- Knowledge Services

Knowledge Services continued to support evidence based practice through the provision of access to an increasing range of electronic resources supported by tailored group and individual training sessions and supplementary search services. The Healthcare Library now enjoys a regular slot on Trust inductions enabling the promotion of resources and services to staff at all levels of the organisation.

The Healthcare Library recently participated in the South East London Regional Library survey enabling the benchmarking of user satisfaction with other regional Health Libraries. Over 85% of respondents found the overall service to be good or excellent, slightly higher than the regional average. Respondents made most frequent use of the library's print and electronic collections of journals and books while a significant percentage of Trust staff used the Healthcare Library services to assist with their Continuing Professional Development (38%) and made use of the literature search facilities (42%) and document delivery services (30%).

- Spiritual and pastoral care

Chaplaincy Services at QE have continued to provide a range of pastoral and spiritual support to patients and staff, provided by a small paid team and a wide range of volunteers from many faiths. The team provides a focal point for the Trust's multi-faith endeavours, in particular:

- A part-time Muslim bank chaplain has been appointed and is now undertaking regular weekly visitation of Muslim patients as well as providing guidance to colleagues, whilst teaching at Friday Prayers continues to be provided from Woolwich Mosque.
- A national Sikh initiative to have a week of prayer for healthcare has motivated the Sikh community to hold monthly Sikh prayers in our Prayer Room, a new development.
- Chaplaincy has been instrumental in the establishment of a Trust-wide mediation scheme for staff, enabling them to settle differences without recourse to formal and often adversarial procedures. This is linked to the work of contact officers, already facilitated by chaplaincy.
- Spiritual care links have been set up across all clinical areas and regular quarterly meetings are getting established, to enable greater staff awareness of the ‘how’ of spiritual and cultural care.
- The Hospice Outreach Team development has led to closer working between the hospice and the QE chaplaincy.

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.

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.

Executive director salaries were increased by 2.75% with effect from 1 April 2008, following an assessment of satisfactory performance.

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 (audited element of remuneration report)

	2008/09			2007/08		
Name and Title ◊	Salary (bands of £5000) £0	Other Remuneration (bands of £5000) £0	Benefits in Kind Rounded to the nearest £000	Salary (bands of £5000) £0	Other Remuneration (bands of £5000) £0	Benefits in Kind Rounded to the nearest £000
Colin Campbell*	20-25		0	20-25		0
Lady Ann Jenkins*□	5-10		0	5-10		0
Sylvia Perrins*□	5-10		0	5-10		0
Gary Kent*□	5-10		0	5-10		0
Raoul Pinnell*□	5-10		0			
John Ballard*□	5-10		0			
Terina Riches	70-75		0	80-85		0

Dr David Robson	125-130	35-40	0	45-50	145-150	0
Lynn Saunders	90-95		0	85-90		0
Elisa Steele	80-85		0	75-80		0
Sally Storey	65-70		0	65-70		0
Ruth Russell	85-90		0	80-85		0
David Sulch	30-35	105-110	0			
David Wragg	100-105		0	95-100		0

◊ See Appendix 2 for titles

* Member of the Remuneration and Terms of Service Committee.

 Member of the Audit and Assurance Committee

Changes in executive directors 2008/09

- Dr David Sulch became the Trust's Medical Director from April 2008.
- Terina Riches left the Trust in February 2009.
- David Wragg, Director of Finance left the Trust on 31 March 2009.

Changes in non-executive directors 2008/09

- John Ballard and Raoul Pinnell both joined the Trust as non-executive directors in May 2008.

Pension Benefits (audited element of remuneration report)

Name and title	Real increase in pension and related lump sum at 31 March 2009 (bands of £2500) £000	Total accrued pension and related lump sum at 31 March 2009 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2008 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Ruth Russell	0-2.5	100-105	270	354	54	-
Terina Riches	2.5-5	135-140	474	649	114	-
Dr David Robson	5-7.5	340-345	0	0	0	-
Dr David Sulch	-12.5 - -15	100-105	366	422	33	-
Lynn Saunders	5-7.5	65-70	241	350	72	-
Elisa Steele	2.5-5	85-90	281	378	63	-
Sally Storey	5-7.5	95-100	342	478	88	-
David Wragg	2.5-5	80-85	256	347	59	-

- 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 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.

Dr Chris Streather
Chief Executive

10.6.09

Appendix 1

SERVICES PROVIDED AT QUEEN ELIZABETH HOSPITAL

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 Laboratory and 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
Gastroenterology	Social Services
General Medicine	Special Care Baby Unit
General Radiology	Speech and Language Therapy
General Surgery	Stroke Unit
Genitourinary Medicine	Surgical Appliances
Gynaecology	
	Trauma Surgery
Haematology	
Histopathology	Ultrasound
	Upper Gastrointestinal Surgery
Imaging	Urology

Immunology	
Infection Control	Virology
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*

Appendix 2

DIRECTOR BIOGRAPHIES

Colin Campbell - Chairman

Colin is a former technology director with a global accounting and financial services firm and is now a director of a number of small companies. He has been involved with the NHS since the late 1980's. He is an elected Local Government Councillor for Bexley where he lives.

John Ballard – Non-Executive Director

John was appointed as a Non-Executive Director on 1 May 2008. He has a long career at senior levels in a number of Government departments, including latterly, as the Finance Director for the Department of Environment, Transport and the Regions. He is currently a Non-Executive Director and Chair of the Audit Committee for Northern Ireland Water and has similar roles with the Marine and Fisheries Agency. He has also been a Trustee of the Great Ormond Street Children's Hospital Charity since 2000. John chaired the Audit and Assurance Committee from November 2008. John continues with the new Trust as Non-Executive Director.

William Bruce – Associate Director

William was appointed Associate Director in April 2008, but had been closely involved with the Trust since 2003 when he first represented patients on the Board. As a patient himself, he is a firm believer in a patient-led NHS and works closely with many people throughout the hospital to ensure this is a reality. William chairs the QEH Patients' Group – the successor to the Patients' Forum. He is a retired journalist and lives locally.

Janet Grant – Director of Nursing and Patient care

Jan joined the Trust as Interim Director of Nursing and Patient Care in February 2009. She is a trained Children's and General Nurse, qualified midwife and has nursing experience in Primary Care. Prior to her appointment as Interim Director she has held a wide range of senior appointments including Deputy Director of Nursing at Oxford Radcliffe Hospitals, Director of Clinical Services and Quality at South East and South West Oxfordshire PCT and Lead Nurse at Thames Valley Strategic Health Authority. Jan is passionate about nursing. Her interests focus on professional development, public and patient involvement and organisational development. Jan continues with the new Trust as Associate Director of Nursing, Woolwich.

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 Chair 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.

Gary Kent - Non-Executive Director

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

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 was Chair of the the Audit and Assurance Committee until November 2008.

Raoul Pinnell – Non-Executive Director

Raoul was appointed as a Non-Executive Director on 1 May 2008. He has extensive business experience, gained in the Fast Moving Consumer Goods sector, with: H.J.Heinz, and Nestle; in Financial Services, with Prudential and NatWest; and in the Oil and Retail sector, where he became Chairman of Shell Brands International. He now has a portfolio of activities, including Trustee of Leonard Cheshire Disability.

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. Lynn continues with the new Trust as Transitional Director of Strategy and Business Development.

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. Terina left the Trust in February 2009.

Dr David Robson – Chief Executive

David was appointed Chief Executive in April 2008. Prior to this he had served on the Trust Board first as Director for IM&T and since 2004, as Medical Director. David became a Consultant Physician in 1978 and until his appointment as Chief Executive worked in Intensive Care and Cardiology.

Dr David Sulch – Medical Director

David was appointed Medical Director in April 2008. Beginning his medical career in the Midlands, moving to SE London in 1993. In 2001 he was appointment a Consultant Physician at Queen Elizabeth Hospital and from 2004, until becoming Medical Director, was Clinical Director of Acute Medicine. As Medical Director his key concerns are the quality and organisation of the clinical services, together with the clinical governance arrangements of the Trust. David continues with the new Trust as Transitional Medical Director.

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

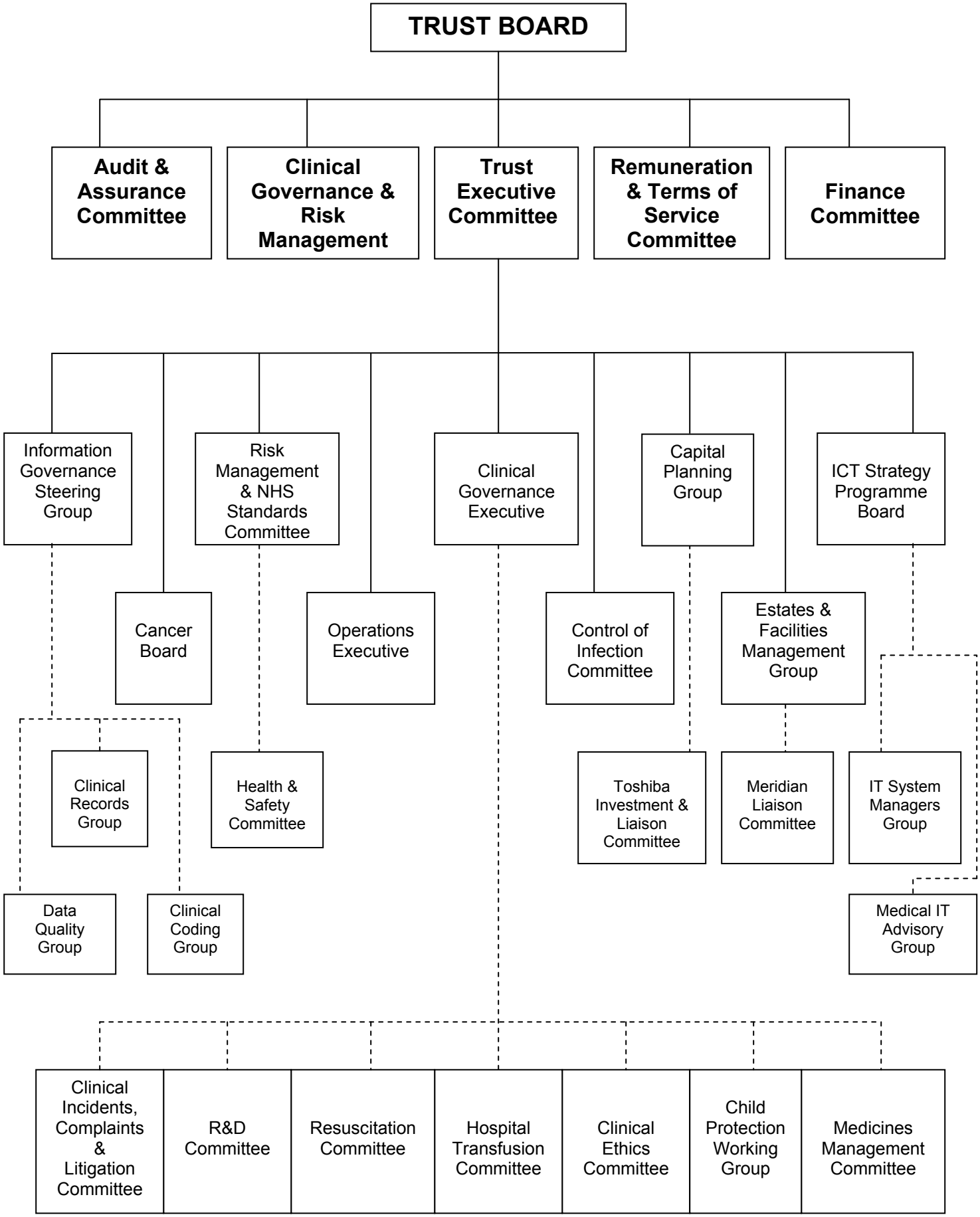
company set up by the NHS and the private sector to deliver financial services to NHS clients).

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 25 years including positions at the South East Regional Health Authority and in the private sector. Her outside interests include acting as a volunteer telephone counsellor for a national charity. Elisa continues with the new Trust as Transitional Director of Information Management &Technology.

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. Sally continues with the new Trust as Associate Director of Human Resources, Woolwich.

COMMITTEE STRUCTURE



Appendix 4

CLINICAL DIRECTORATE STRUCTURE

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	
Cardiology (including cardiac diagnostics	Neurology	Anticoagulation Service
Cancer Team	Dermatology	Outpatient Services
Palliative Care	Genito-Urinary Medicine	Medical Records

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
2008/09

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 are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

- value for money is achieved from the resources available to the trust;

- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

- effective and sound financial management systems are in place; and

- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an accountable officer.

Signed...Dr Chris Steather.....Chief Executive

Date...10.6.09

STATEMENT ON INTERNAL CONTROL

1. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, the Chief Executive of this Board had responsibility for maintaining a sound system of internal control that supported the achievement of the organisation's policies, aims and objectives. The Chief Executive for Queen Elizabeth Hospital NHS Trust for 2008/09 was Dr. David Robson.

He also had responsibility for safeguarding the public funds and the organisation's assets for which they were personally responsible as set out in the Accountable Officer Memorandum. As Chief Executive they reported to the Chairman of the Trust and ensured appropriate systems existed to support the work of the Trust and the Board. They managed the executive team who had clear accountabilities and annual objectives, drawn from the annual plan of the Trust.

He was also accountable to the NHS Chief Executive and Parliament through the provision of a wide range of information to the Department of Health, and through the formal monitoring of the Trust's performance by NHS London.

The Trust worked in partnership with other health and social care organisations in South-East London and surrounding areas; principally Greenwich Teaching Primary Care Trust and Bexley Care Trust. During this year there had also been considerable input to the A Picture of Health Project Board on the redesign of services for Outer South East London (OSEL), and the Joint Transitional Committee on the proposed management merger of Queen Elizabeth Hospital NHS Trust, Queen Mary's Sidcup NHS Trust and Bromley Hospitals NHS Trust to form South London Healthcare NHS Trust from April 2009.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level and cannot eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control was in place in Queen Elizabeth Hospital NHS Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Queen Elizabeth Hospital NHS Trust's capacity to handle risk was based around a clear Board approved Risk Management Strategy, effective leadership of the risk management process and staff trained and equipped to manage risk in a way appropriate to their authority.

The key elements of the Trust's capacity to handle risk were as follows:

- A formal Board committee structure was in place to oversee the Trust's risk management activities and performance. There was a Non-Executive Clinical Governance and Risk Management Committee reporting to the Board. Executive management of risk was co-ordinated through the Trust Executive Committee, which reported to the Board, and was 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 managed clinical risk through the coordination of eight specific sub-committees. The Audit and Assurance Committee was a Non-Executive committee which monitored the delivery of elements of the risk agenda.

- The Director of Finance was identified as the Board lead for non-clinical risk management, and the Medical Director and Director of Nursing & Patient Care were the joint Board leads for clinical governance and clinical risk management.

- The Trust invested in staff and systems resources to support these Directors in carrying out their risk management roles. The Head of Clinical Governance attended the Clinical Governance and Risk Management Committee as well as the Risk Management and NHS Standards Committee.

- The Trust provided risk management training for staff, which included 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, took place in a wide variety of ways, both at corporate and departmental level. These included 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

Risk, or change in risk was identified, evaluated and controlled as described in the Trust's Risk Management Strategy and policy which were updated and approved by the Board in 2007/08. This described the overall approach and methodology for managing risks, and identified corporate and departmental responsibilities. It also included guidance on risk identification and assessment processes using a matrix-based model. Key risks were entered on to the Trust's risk register and were reported to the Trust Board or its sub-committees.

Risks and policies relating to data security and information governance were managed by the Information Governance Group and ICT Strategy Board, with both reporting to the Board via the Trust Executive Committee. Reports were routinely received identifying risks and issues by the Audit Committee and IT Project Boards. The Trust completed the annual self-assessment of the Information Governance Toolkit to assess the policies and procedures in place to manage information. The Trust had 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, were a responsibility of line managers. In the course of 2008/09, 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 remained at Level 1.

The Trust had 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 were actively monitored and managed in line with Department of Health recommendations.

The Assurance Framework embodied 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 described 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 identified where there were areas of poor control, or where a lack of assurance existed. This, together with other key processes, was used to provide the Board with assurance that an effective system of internal control was in place for the Trust.

The Trust engaged 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 were clearly linked to the priorities of other partners and the wider community. The Trust engaged formally with a range of statutory and voluntary sector partners to reflect the diverse needs of the catchment population.

The Trust was not fully compliant with two of the core Standards for Better Health for the full year but was fully compliant by 31st March 2009. The detail is described in section 5 under significant control issues.

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

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

5. Review of effectiveness

As Accountable Officer, of the successor body 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 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 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 2008/09; 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 reference to the work of the Board, the Audit & Assurance Committee, the Clinical Governance and Risk Management Committee, and the Trust Executive Committee.

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 received monthly financial and performance management reports, which set out performance against the key plans and targets. The Board also reviewed 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 was established and an annual plan of Internal Audit activity was approved and monitored by the Audit and Assurance Committee. The committee also reviewed any incidence of fraud. Minutes of the Audit and Assurance Committee were reported to the Board.

The Clinical Governance and Risk Management Committee scrutinized the Trust's actions and performance on all clinical risk and governance matters. Minutes of this committee were reported to the Board.

Significant Control Issues

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

- The Trust had an underlying financial deficit in 2008/09, of approximately £2m per annum. The actual reported deficit was £5.5m in 2008/09, of which £0.14m relates to asset disposals, while the remainder relates to other non-recurrent items.

- The Trust was unlikely to generate material surpluses that will enable it to recover historic deficits without a reconfiguration of clinical services within SE London. It therefore actively engaged in a project, known as 'A Picture of Health', which considered options for achieving this. The decision was held over into 2009/10 as it was subject to review by an Independent Review Panel. It is planned that the Trust will merge with the other two outer South East London Hospitals to form the South London Healthcare NHS Trust in April 2009.

- Results of the internal audit review of waiting list data quality highlighted issues with the data accuracy in relation to the 18 week referral to treatment targets. Many of these issues have already been resolved and appropriate remedial action is also included within the Trust's 18 week Action Plan. The Trust did not achieve the 18 week target for admitted patients but a plan has been developed to ensure that the target is fully achieved from April 2009.

- The Trust failed to achieve the A&E 4 hour target with 97.67% of patients waiting 4 hours or less rather than the 98% required by the national target. The Trust has developed a model for performance improvement to enable a structured approach to delivering this target.

- The Trust was fully compliant with the core standards for better health for the full year apart from the following:

  Core standard C2, "Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations", the Trust had insufficient assurance for compliance with this standard as it did not have a named doctor for safeguarding children for the whole year. The Trust was compliant by the end of the financial year.

  Core standard C7e, "Healthcare organisations challenge discrimination, promote equality, and respect human rights", the Trust reported that it had insufficient assurance for compliance with this standard but was compliant by April 2009. Last year some responses from the Trust staff survey related to training and development meant that the Trust prudently assessed itself as not having adequate assurance. During 2008/09 the Trust developed and rolled out a

programme entitled “A positive experience every time” covering diversity awareness and customer care.

- The Trust reported two incidents during 2008/09 where there was a breach of data security, both involving patient identifiable data being faxed to the wrong fax address.

A plan to address weaknesses and ensure continuous improvement of the system is in place.

Signed…Dr Chris Streather…… Chief Executive

Date…10.6.09

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, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of 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

10.6.09.....Date...Dr Chris Streather……Chief Executive

10.6.09.....Date...Mr Robert Kirton.....Interim Finance Director

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 2009 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 financial statements and the part of the Remuneration Report to be audited have 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 Operational 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 set out in "Guidance on Completing the Statement on Internal Control 2008/09", issued on 25 February 2009. We report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' Statement on Internal Control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only the Foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Operating and Financial Review and Staffing report. 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

In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2009 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 and Staffing Report, included within the Annual Report, is consistent with the financial statements.

PricewaterhouseCoopers LLP
London

11 June 2009

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

Directors' Responsibilities

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

Auditor's Responsibilities

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

Adverse Conclusion

We have undertaken our audit in accordance with the Code of Audit Practice. In so doing, we identified the following:

- The NHS trust failed to ensure that its spending matched available resources in year;
- The Trust's financial strategy does not address the statutory requirement to ensure that spending matches available resources year on year.

For the reasons set out above and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, we are not satisfied that, in all significant respects, Queen Elizabeth Hospital NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2009, in that it did not put in place:

- a medium-term financial strategy, budgets and a capital programme that are soundly based and designed to deliver its strategic priorities; and
- arrangements to ensure that its spending matches its available resources.

Auditors' responsibilities

Referral to the Secretary of State under s19 of the Audit Commission Act 1998

We have a duty under the Audit Commission Act 1998 to refer the matter to the Secretary of State if we have a reason to believe that the body, or an officer of the body, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

In July 2008, we referred a matter to the Secretary of State under section 19 of the Audit Commission Act 1998. This concerned the Trust's inability to meet its break-even duty within the extended five year financial recovery period. This referral reported that the Trust was projecting a deficit for the 2008/09 financial year.

Certificate

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

PricewaterhouseCoopers LLP
London

11 June 2009

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2009

	NOTE	2008/09 £000	2007/08 £000
Income from activities	2	**145,870**	141,302
Other operating income	3	**11,697**	10,819
Operating expenses	4-5	**(163,082)**	(154,670)
OPERATING DEFICIT		**(5,515)**	(2,549)
Loss on disposal of fixed assets	7	**(135)**	(516)
DEFICIT BEFORE INTEREST		**(5,650)**	(3,065)
Interest receivable	8	**381**	632
Other finance costs - unwinding of discount	14	**(61)**	(70)
DEFICIT FOR THE FINANCIAL YEAR		**(5,330)**	(2,503)
Public dividend capital dividends payable		**(151)**	(622)
RETAINED DEFICIT FOR THE YEAR		**(5,481)**	(3,125)

The notes on pages 5 to 34 form part of these accounts.
All income and expenditure is derived from continuing operations.

BALANCE SHEET AS AT 31 March 2009

	NOTE	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS			
Intangible assets	9	**1,055**	1,355
Tangible assets	10	**73,548**	66,698
TOTAL FIXED ASSETS		**74,603**	68,053
CURRENT ASSETS			
Stocks and work in progress	11	**1,835**	1,663
Debtors	12	**26,541**	27,240
Cash at bank and in hand	16.3	**3,406**	6,485
TOTAL CURRENT ASSETS		**31,782**	35,388
CREDITORS: Amounts falling due within one year	13.1	**(10,093)**	(7,812)
NET CURRENT ASSETS		**21,689**	**27,576**
TOTAL ASSETS LESS CURRENT LIABILITIES		**96,292**	**95,629**
CREDITORS: Amounts falling due after more than one year	13.1	**(575)**	(603)
PROVISIONS FOR LIABILITIES AND CHARGES	14	**(3,712)**	(3,600)
TOTAL ASSETS EMPLOYED		**92,005**	91,426
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	20	**90,348**	88,348
Revaluation reserve	15	**51,929**	48,268
Donated asset reserve	15	**315**	381
Income and expenditure reserve	15	**(50,587)**	(45,571)
TOTAL TAXPAYERS' EQUITY		**92,005**	91,426

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 34 were approved by the Board on [date] and signed on its behalf by:

Signed: …Dr Chris Streather……(Chief Executive) Date: …10.6.09

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2009

	2008/09	2007/08
	£000	£000
Deficit for the financial year before dividend payments	**(5,330)**	(2,503)
Unrealised surplus on fixed asset revaluations/indexation	**4,136**	3,442
Increases in the donated asset and government grant reserve due to receipt of donated and government grant financed assets	**20**	156
Total gains and losses recognised in the financial year	**(1,174)**	**1,095**

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2009

	NOTE	2008/09 £000	2007/08 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	16.1	**(1,693)**	29,025
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**382**	632
Net cash inflow from returns on investments and servicing of finance		**382**	632
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed assets		**(3,538)**	(1,415)
(Payments) to acquire intangible assets		**(79)**	(487)
Net cash outflow from capital expenditure		**(3,617)**	(1,902)
DIVIDENDS PAID		**(151)**	(622)
Net cash inflow/(outflow) before management of liquid resources and financing		**(5,079)**	**27,133**
MANAGEMENT OF LIQUID RESOURCES			
Sale of financial assets with the Department of Health		**0**	6,000
Net cash inflow/(outflow) from management of liquid resources		**0**	6,000
Net cash inflow/(outflow) before financing		**(5,079)**	**33,133**
FINANCING			
Public dividend capital received		**2,000**	2,097
Public dividend capital repaid		**0**	(29,225)
Net cash inflow/(outflow) from financing		**2,000**	(27,128)
Increase/(decrease) in cash		**(3,079)**	6,005

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 2008/09 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 Intangible fixed assets

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

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

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

1.4 Tangible fixed assets

Capitalisation

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

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

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

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

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.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. 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. The land was revalued as at 1st April 2008 on a Modern Equivalent Asset (MEA) basis. Subsequently the land value has been re-valued downwards based on the residential building land values reported in the Property Market Report published by the Valuation Office.

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 land and buildings indexation is based on the indices issued by HM Treasury and permitted by FReM 5.2.7 (PES (2009)02) issued on 19th February 2009.

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

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.

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.

Gains arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. Downward adjustments are made against the revaluation reserve to the extent that previous revaluations are available. 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.

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.

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.

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.

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.

1.5 Donated fixed assets

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

1.6 Private Finance Initiative (PFI) transactions

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

1.7 Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods in intermediate stages of production. Partially completed contracts for patient services are not accounted for as work-in-progress.

1.8 Research and development

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

- there is a clearly defined project;
- the outcome of the project has been assessed with reasonable certainty as to:
- its technical feasibility;
- its resulting in a product or service which will eventually be brought into use;
- adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.

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

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

1.9 Provisions

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 14.

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 2008/09 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.10 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at 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.

March 2006 (the latest midpoint) updated to 31 March 2009 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 2009
The scheme is a 'final salary' scheme. 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. From 1 April 2008 a voluntary additional pension facility becomes available, under which members may purchase up to £5,000 per annum of additional pension at a cost determined by the actuary from time-to-time.

Early payment of a pension 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.

Existing members at 1 April 2008
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. From 1 April 2008 there is the opportunity of giving up some of the pension to increase the retirement lump sum. 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 or eligible unmarried partner.

New entrants from 1 April 2008
Annual pensions for new entrants from 1 April 2008 will be based on 1/60th of the best three-year average of pensionable earnings in the ten years before retirement. Members wishing to obtain a retirement lump sum may give up some of this pension to obtain a retirement lump of up to 25% of the total value of their retirement benefits. Survivor pensions will be available to married and unmarried partners and will be equal to 37.5% of the member's pension.

1.11 Liquid resources

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

1.12 Value Added Tax

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

1.13 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 25 to the accounts.

1.14 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.

1.15 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.

1.16 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 27 is compiled directly from the losses and compensations register which is prepared on an accruals basis for 2007/08.

1.17 Financial Instruments

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of nonfinancial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are classified as 'Loans and receivables'. Financial liabilities are classified as 'Other financial liabilities'.

1.17 Financial Instruments (cont)

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash at bank and in hand, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the income and expenditure account.

Impairment of Financial Assets

At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

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

2. Income from Activities

	2008/09	2007/08
	£000	£000
Primary Care Trusts	**126,157**	121,365
Department of Health	**18,707**	19,130
Non NHS:		
- Private patients	**83**	105
- Overseas patients (non-reciprocal)	**557**	331
- Injury cost recovery	**348**	371
- Other	**18**	0
	145,870	**141,302**

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.

3. Other Operating Income

	2008/09	2007/08
Education, training and research	**5,720**	5,140
Transfers from Donated Asset Reserve	**96**	199
Non-patient care services to other bodies	**3,162**	3,290
Income generation	**568**	627
Other income	**2,151**	1,563
	11,697	10,819

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

	£000	£000
Oxleas SLA (This SLA is not activity related, it relates to the occupation of a Trust owned building by Oxleas NHS Foundation Trust).	1,684	1,646
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.	0	367
Greenwich Teaching PCT non-patient SLA for payroll and human resources services .	620	600

4. Operating Expenses

4.1 Operating expenses comprise:

	2008/09	2007/08
	£000	£000
Services from other NHS Trusts	**1,151**	835
Services from other NHS bodies	**559**	1,089
Directors' costs	**873**	842
Staff costs	**96,978**	91,284
Supplies and services - clinical	**25,574**	24,295
Supplies and services - general	**7,716**	7,190
Consultancy services	**1,012**	673
Establishment	**1,417**	1,364
Transport	**507**	555
Premises	**21,057**	19,705
Impairment of debtors	**287**	271
Depreciation	**855**	876
Amortisation	**449**	421
Audit fees	**216**	218
Clinical negligence	**2,142**	2,259
Redundancy costs	**237**	20
Other	**2,052**	2,773
	163,082	154,670

Other Expenditure includes the amortisation of the Trust Deferred Asset of £1,025k (2007/08 £1,025k).

4.2 Operating leases

4.2/1 Operating expenses include:

	2008/09	Restated 2007/08
	£000	£000
Other operating lease rentals	**108**	103
	108	103

4.2/2 Annual commitments under non - cancellable operating leases are:

	Land and buildings	
	2008/09	Restated 2007/08
	£000	£000
Operating leases which expire:		
Between 1 and 5 years	**10**	6
After 5 years	**98**	97
	108	103

5. Staff costs and numbers

5.1 Staff costs

	2008/09			2007/08
	Total	**Permanently Employed**	**Other**	
	£000	**£000**	**£000**	£000
Salaries and wages	**82,839**	69,945	12,894	77,111
Social Security Costs	**6,431**	5,922	509	6,692
Employer contributions to NHS BSA - Pensions Division	**8,526**	8,331	195	8,276
	97,796	**84,198**	**13,598**	92,079

5.2 Average number of persons employed

	2008/09			Restated 2007/08
	Total	**Permanently Employed**	**Other**	
	Number	**Number**	**Number**	Number
Medical and dental	**388**	281	107	361
Administration and estates	**463**	394	69	464
Healthcare assistants and other support staff	**467**	334	133	399
Nursing, midwifery and health visiting staff	**866**	706	160	850
Nursing, midwifery and health visiting learners	**16**	16	0	22
Scientific, therapeutic and technical staff	**304**	211	93	272
Other	**11**	2	9	3
Total	**2,515**	**1,944**	**571**	**2,371**

The 2007/08 number of staff has been restated to include agency staff.

5.3 Employee benefits

There were no employee benefits in 2008/09 (2007/08 £0).

5.4 Management costs

	2008/09	(Restated) 2007/08
	£000	£000
Management costs	**6,306**	5,643
Income	**157,567**	152,121

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en. Management costs for 2007/08 have been restated to include £315k for internal and external audit costs.

5.5 Retirements due to ill-health

During 2008/09 there were 6 (2007/08, 6) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £292k (2007/08: £333k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

6. Better Payment Practice Code

6.1 Better Payment Practice Code - measure of compliance

	2008/09		**2007/08**	
	Number	**£000**	**Number**	**£000**
Total Non-NHS trade invoices paid in the year	**37,613**	**67,359**	**32,213**	**61,377**
Total Non NHS trade invoices paid within target	**28,456**	**55,846**	**24,070**	**56,313**
Percentage of Non-NHS trade invoices paid within target	**76%**	**83%**	**75%**	**92%**
Total NHS trade invoices paid in the year	**1,473**	**9,626**	**1,297**	**12,299**
Total NHS trade invoices paid within target	**761**	**6,492**	**948**	**11,852**
Percentage of NHS trade invoices paid within target	**52%**	**67%**	**73%**	**96%**

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 to measure compliance correctly. This has the effect of worsening the Trust's reported performance against this target.

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

During 2008/09 the Trust paid no interest arising from claims under this legislation (2007/08 £0), and paid no compensation to cover debt recovery under this legislation (2007/08 £0).

7. Losses on Disposal of Fixed Assets

	2008/09	2007/08
	£000	£000
(Loss) on disposal of intangible fixed assets	**(4)**	(66)
(Loss) on disposal of land and buildings	**(49)**	(11)
(Loss) on disposal of plant and IT equipment	**(82)**	(439)
	(135)	(516)

8. Interest receivable

	2008/09	2007/08
	£000	£000
Interest receivable	**381**	632
TOTAL	**381**	**632**

9. Intangible Fixed Assets

	Software licences	Total
	£000	£000
Gross cost at 1 April 2008	2,572	2,572
Reclassifications	74	74
Additions purchased	79	79
Disposals	(12)	(12)
Gross cost at 31 March 2009	**2,713**	**2,713**
Amortisation at 1 April 2008	1,217	1,217
Charged during the year	449	449
Disposals	(8)	(8)
Amortisation at 31 March 2009	**1,658**	**1,658**
Net book value		
- Purchased at 1 April 2008	1,333	1,333
- Donated at 1 April 2008	22	22
- Total at 1 April 2008	**1,355**	**1,355**
- Purchased at 31 March 2009	**1,051**	**1,051**
- Donated at 31 March 2009	**4**	**4**
- Total at 31 March 2009	**1,055**	**1,055**

Following a review of asset accounting a number of re-classifications have occurred between tangible assets and intangible assets.

10. Tangible Fixed Assets

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

	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	50,310	1,417	11,954	2,857	40	2,753	126	69,457
Additions purchased	0	890	2,141	445	0	279	0	3,755
Additions donated	0	20	0	0	0	0	0	20
Reclassifications	0	260	(558)	88	0	125	11	(74)
Indexation	(23,826)	(119)	(650)	77	1		3	(24,514)
Revaluation	28,690	0	0	0	0	0	0	28,690
Disposals	0	(93)	0	(128)	0	(653)	0	(874)
Cost or Valuation at 31 March 2009	**55,174**	**2,375**	**12,887**	**3,339**	**41**	**2,504**	**140**	**76,460**
Depreciation at 1 April 2008	0	0	0	1,530	24	1,185	20	2,759
Charged during the year	0	92	0	320	6	413	24	855
Indexation	0	0	0	40	0		0	40
Disposals	0	(44)	0	(83)	0	(615)	0	(742)
Depreciation at 31 March 2009	**0**	**48**	**0**	**1,807**	**30**	**983**	**44**	**2,912**
Net book value								
- Purchased at 1 April 2008	50,310	1,399	11,954	1,029	0	1,565	82	66,339
- Donated at 1 April 2008	0	18	0	298	16	3	24	359
- Total at 1 April 2008	**50,310**	**1,417**	**11,954**	**1,327**	**16**	**1,568**	**106**	**66,698**
- Purchased at 31 March 2009	55,174	2,289	12,887	1,291	0	1,520	76	73,237
- Donated at 31 March 2009	0	38	0	241	11	1	20	311
- Total at 31 March 2009	**55,174**	**2,327**	**12,887**	**1,532**	**11**	**1,521**	**96**	**73,548**

Following a review of asset accounting a number of re-classifications have occurred between asset categories and between tangible assets and intangible assets.

There were no fixed assets held under finance lease at the balance sheet date (2007/08 £0). Of the totals at 31 March 2009, the Trust had no assets held at open market valuation (2007/08 £0). The reversionary interest in the hospital is shown in assets under construction at a value of £12.9m (2007/08 £11.8m).

The land was re-valued by the District Valuer (MRICS) as at 1 April 2008 to £79m on an Modern Equivalent Asset (MEA) basis.

10. Tangible Fixed Assets (contd)

10.2 Asset Financing

	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
Net book value 31 March 2009								
Owned	**55,174**	**2,327**	**0**	**1,532**	**11**	**1,521**	**96**	**60,661**
PFI residual interests	**0**	**0**	**12,887**	**0**	**0**	**0**	**0**	**12,887**
Total 31 March 2009	**55,174**	**2,327**	**12,887**	**1,532**	**11**	**1,521**	**96**	**73,548**
Net book value 1 April 2008								
Owned	50,310	1,417	0	1,327	16	1,568	106	**54,744**
PFI residual interests	0	0	11,954	0	0	0	0	**11,954**
Total 1 April 2008	**50,310**	**1,417**	**11,954**	**1,327**	**16**	**1,568**	**106**	**66,698**

10.3 The net book value of land, buildings and dwellings at 31 March 2009 comprises:

	2008/09	2007/08
	£000	£000
Freehold	**57,501**	51,727
TOTAL	**57,501**	**51,727**

11. Stocks and Work in Progress

	31 March 2009 £000	31 March 2008 £000
Raw materials and consumables	**1,835**	1,663
TOTAL	**1,835**	1,663

12. Debtors

12.1 Debtors at the balance sheet date are made up of:

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
NHS debtors	**2,010**	2,360
Provision for impairment of debtors	**(1,742)**	(1,674)
Other prepayments and accrued income	**2,438**	2,780
Other debtors	**4,546**	3,430
Sub Total: falling due within one year	**7,252**	6,896
Amounts falling due after more than one year:		
Other prepayments and accrued income	**19,289**	20,344
Sub Total: falling due after more than one year	**19,289**	20,344
TOTAL	**26,541**	27,240

Within Other prepayments and accrued income greater than one year is the PFI Deferred Asset value of the Hospital.

12.2 Provision for impairment of debtors	31 March 2009 £000
Balance at 1 April	**1,674**
Amount written off during the year	**(219)**
Amount recovered during the year	**(183)**
Increase in debtors impaired	**470**
Balance at 31 March	**1,742**

12.3 Debtors past due date but not impaired:	31 March 2009 £000
By up to 3 months	**1,073**
By 3 to 6 months	**284**
By more than 6 months	**1,117**
	2,474

13. Creditors

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

	31 March 2009 £000	31 March 2008 £000
Amounts falling due within one year:		
Payments received on account	**1**	81
NHS creditors	**2,059**	1,280
Non - NHS trade creditors - revenue	**2,747**	716
Non - NHS trade creditors - capital	**378**	508
Tax	**138**	90
Other creditors	**33**	246
Accruals and deferred income	**4,737**	4,891
Sub Total: amounts falling due within one year	**10,093**	7,812
Amounts falling due after more than one year:		
Other	**575**	603
Sub Total: amounts falling due in more than one year	**575**	603
TOTAL	**10,668**	8,415

Other creditors falling due after one year of £575k 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 2009 (31 March 2008 £0).

13.2 Loans and other long-term financial liabilities

The Trust has no loans outstanding as at 31 March 2009 (£0 as at 31 March 2008).

13.3 Finance lease obligations

Queen Elizabeth Hospital NHS trust has no finance lease obligation (2007/08 £0).

14. Provisions for liabilities and charges

	Pensions relating to other staff	Legal claims	Other	**Total**
	£000	£000	£000	**£000**
At 1 April 2008	3,236	302	62	**3,600**
Arising during the year	26	652	0	**678**
Utilised during the year	(254)	(77)	0	**(331)**
Reversed unused	(227)	(7)	(62)	**(296)**
Unwinding of discount	61	0	0	**61**
At 31 March 2009	**2,842**	**870**	**0**	**3,712**
Expected timing of cashflows:				
Within one year	254	735	0	**989**
Between one and five years	2,588	135	0	**2,723**

Pension provisions relate to staff under early retirement arrangements. The timing of cashflows has been based on payments made during 2008/09. The value of the provision is based on estimated lifespan of individuals, and final salaries at the date of retirement.

Legal claims includes amounts that the Trust is legally or constructively liable for at the balance sheet date. Other 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.

£24,451k is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of the NHS Trust (31 March 2008 £14,176k).

15. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Income and Expenditure Reserve £000	**Total £000**
At 1 April 2008 as previously stated	48,268	381	(45,571)	**3,078**
Transfer from the income and expenditure account			(5,481)	**(5,481)**
Surplus on other revaluations/indexation of fixed/current assets	4,126	10		**4,136**
Receipt of donated/government granted assets		20		**20**
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/government granted assets		(96)		**(96)**
Other transfers between reserves	(465)	0	465	**0**
At 31 March 2009	**51,929**	**315**	**(50,587)**	**1,657**

16. Notes to the cash flow Statement

16. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2008/09	2007/08
	£000	£000
Total operating deficit	**(5,515)**	(2,549)
Depreciation and amortisation charge	**1,304**	1,297
Transfer from Donated Asset Reserve	**(96)**	(199)
Increase in stocks	**(172)**	(27)
Decrease in debtors	**699**	31,534
Increase/(decrease) in creditors	**2,036**	(791)
Increase/(decrease) in provisions	**51**	(240)
Net cash inflow from operating activities	**(1,693)**	29,025

16.2 Reconciliation of net cash flow to movement in net debt

	2008/09	2007/08
	£000	£000
Increase/(decrease) in cash in the period	**(3,079)**	6,005
Cash (inflow)/outflow from (decrease)/increase in liquid resources	**0**	(6,000)
Change in net debt resulting from cash flows	**(3,079)**	5
Net debt at 1 April 2008	**6,485**	6,480
Net debt at 31 March 2009	**3,406**	6,485

16.3 Analysis of changes in net debt

	At 1 April 2008	Other cash changes in year	**At 31 March 2009**
	£000	£000	**£000**
OPG cash at bank	6,478	(3,079)	**3,399**
Cash in hand	7	0	**7**
	6,485	**(3,079)**	**3,406**

17. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2009 were £360k (31 March 2008 £508k).

18. Post Balance Sheet Events

On 1st April 2009 Queen Elizabeth Hospital NHS Trust merged with Bromley Hospitals NHS Trust and Queen Mary's Hospital Sidcup NHS Trust to form South London Healthcare NHS Trust.

19. Contingencies

	2008/09	2007/08
	£000	£000
Contingent liabilities	**(662)**	(644)
Net value of contingent liabiliies	**(662)**	(644)

Of the total contingent liabilities of £662k, £644k relates to the possible compensation on termination of a contract between Macillan Cancer Relief and the Queen Elizabeth Hospital NHS Trust for contribution towards the Oncology Unit at the Queen Elizabeth Hospital, and £18k relates to legal cases.

The compensation on termination clause is activated in the event that the agreement is terminated at any time in the period of the 10 years from the completion of the hospital (2008/09 represents year 8 of the 10 year period).

20. Movement in Public Dividend Capital

	2008/09	2007/08
	£000	£000
Public Dividend Capital as at 1 April 2008	**88,348**	115,476
New Public Dividend Capital received (including transfers from dissolved NHS Trusts)	**2,000**	2,097
Public Dividend Capital repaid in year	**0**	(29,225)
Public Dividend Capital as at 31 March 2009	**90,348**	**88,348**

Cash

To maintain liquidity the Trust had 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. Repayment terms have not yet been negotiated with the Department of Health.

21. Financial Performance Targets

21.1 Breakeven Performance

The trust's breakeven performance for 2008/09 is as follows:

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
	£000	£000	£000	£000	£000	£000
Turnover	125,436	130,090	132,983	147,525	152,121	157,567
Retained surplus/(deficit) for the year	917	(9,186)	(19,289)	(7,244)	(3,125)	(5,481)
Adjustment for:						
- 2005/06 Prior Period Adjustment (relating to 1997/98 to 2004/05)	(4,417)	(136)	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)	(5,481)
Break-even cumulative position	(4,173)	(13,495)	(32,584)	(39,828)	(42,953)	(48,434)
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%	-4.91%	-2.05%	-3.48%
- Break-even cumulative position as a percentage of turnover	-3.33%	-10.37%	-24.50%	-27.00%	-28.24%	-30.74%

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

The Trust's break-even performance is compared to a materiallity 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.

21.2 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 £0.15m, bears to the average relevant net assets of £87m, that is 0.2%.

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 2008/09 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 2008/09 causing the absorption rate to drop below the allowed 3% threshold.

21.3 External financing

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

	£000	**2008/09 £000**	2007/08 £000
External financing limit		**5,302**	(27,128)
Cash flow financing	5,079		(27,133)
External financing requirement		**5,079**	(27,133)
Undershoot		**223**	5

21.4 Capital Resource Limit

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

	2008/09 £000	2007/08 £000
Gross capital expenditure	**3,854**	3,948
Less: book value of assets disposed of	**(136)**	(517)
Less: donations towards the acquisition of fixed assets	**(20)**	(156)
Charge against the capital resource limit	**3,698**	3,275
Capital resource limit	**3,718**	3,823
Underspend against the capital resource limit	**20**	548

22. 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 number of significant 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	
	2008/09 £000s	2007/08 £000s	2008/09 £000s	2007/08 £000s	2008/09 £000s	2007/08 £000s	2008/09 £000s	2007/08 £000s
Greenwich PCT	0	760	0	33	98,373	98,633	0	56
Bexley PCT	541	463	0	32	21,836	19,007	17	29
The NHS London	88	86	0	0	6,175	5,610	5	44
The NHS litigation Authority	0	0	2	0	0	0	2,234	2,373
Lewisham PCT	49	41	2	2	2,660	2,387	10	8
London Ambulance Service NHS Trust	0	0	13	14	0	0	851	887
NHS Blood and Transplant	0	0	31	0	0	0	1,168	1,235
NHS Purchasing and Supply Agency	0	0	171	204	0	0	0	2,413
Greenwich Council	0	40	0	2	5	40	2,759	1,586
Department of Health	1	0	1,124	0	18,746	19,130	0	137

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 £20,125 worth of capital donations during 2008/09 (in 2007/08 £156k).

David Wragg, the Trust Finance Director was 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 received 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.

23. Private Finance Transactions

23.1 PFI schemes deemed to be off-balance sheet

	2008/09	2007/08
	£000	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**26,957**	26,316
Amortisation of PFI deferred asset	**(1,025)**	(1,025)
Net charge to operating expenses	**25,932**	25,291

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

PFI scheme which expires;		
6th to 10th years (inclusive)	**3,952**	3,924
21st to 25th years (inclusive)	**25,057**	23,446

	£000	£000
Estimated capital value of the PFI scheme	116,153	116,153
Contract Start date:	01/01/2001	
Contract End date:	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 headlease to Meridian Hospital Company Plc for a period of 125 years.

The Trust has assessed the lease agreement under SSAP 21 and FRS 5 and determined that the land should be accounted for on balance sheet. The net book value of this land (disclosed in note 10.1) is £55.17 million.

Toshiba Managed Equipment

	2008/09	2007/08
	£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.

24. Financial Instruments

FRS 25, 26 and 29, 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.

The NHS Trust is not exposed to significant financial risk factors arising from financial instruments. Because of the continuing service provider relationship that the Trust has with local primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market risk

Market risk is the possibility that financial loss might arise as a result of changes in such measures as interest rates and stock market movements. Market risk comprises three types of risk, where the fair value or future cash flows could fluctuate because of movements in the underlying Interest rate risk, Currency risk; and Price risk.

Interest rate risk

The Trust does not hold any investments. Other than the cash balance, the Trust's financial assets and liabilities carry nil or fixed rates of interest and the Trust's income and operating cash-flows are substantially independent of changes in market interest rates.

Currency risk

The Trust's transactions are almost all undertaken in sterling and so it is not exposed to foreign exchange risk.

Price risk

The Trust has a number of contractual arrangements which are linked to the UK Retail Price Index (RPI), for example the PFI contracts (Note 23) , therefore the Trust is exposed to price risk in line with movements in the UK economy.

Credit risk

Credit risk is the possibility that other parties might fail to pay amounts due to the Trust. Credit risk arises from deposits with banks as well as credit exposures to the Trust's commissioners and other debtors. The Trust's cash assets are held with the Office of the Post Master General only. The Trust does not have surplus amounts of operational cash to invest. The Trust's net operating costs are incurred largely under annual service agreements with local primary care trusts, which are financed from resources voted annually by Parliament. An analysis of the ageing of debtors and provision for impairment can be found at Note 12 "Debtors".

Liquidity risk

Liquidity risk is the possibility that the Trust might not have the funds available to meet its commitments to make payments. Prudent liquidity risk management includes maintaining sufficient cash and the availability of funding from an adequate amount of committed credit facilities.

24.1 Financial Assets

	Loans and receivables £000	Total £000
NHS debtors	2,010	**2,010**
Non NHS debtors	2,206	**2,206**
Cash at bank and in hand	3,408	**3,408**
Total at 31 March 2009	**7,624**	**7,624**

24.2 Financial Liabilities

	Other £000	Total £000
NHS creditors	2,059	**2,059**
Non NHS creditors	7,429	**7,429**
Total at 31 March 2009	**9,488**	**9,488**

25. Third Party Assets

The Trust held £9k cash at bank and in hand at 31 March 2009 (£7k - at 31 March 2008) 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.

26. 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 more than one year
	£000	**£000**	**£000**	**£000**
Balances with other Central Government Bodies	1,407	0	1,592	0
Balances with NHS Trusts and Foundation Trusts	603	0	637	0
Balances with Public Corporations and Trading Funds	0	0	31	0
Intra Government balances	2,010	0	2,260	0
Balances with bodies external to Government	5,242	19,289	7,833	575
At 31 March 2009	**7,252**	**19,289**	**10,093**	**575**
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
Intra Government balances	2,543	0	1,053	0
Balances with bodies external to Government	4,353	20,344	6,759	603
At 31 March 2008	**6,896**	**20,344**	**7,812**	**603**

27. Losses and Special Payments

There were 38 cases of losses and special payments (2007/08: 578 cases) totalling £140,000 (2007/08: £459,000) during 2008/09.