Kingston Hospital NHS
NHS Trust

Annual Accounts 2009/10

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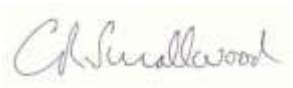
Chairman's Foreword

After my first full year as Chairman of the Trust, I remain as impressed with the dedication and commitment to patient care shown by all the staff here at Kingston Hospital as I was in January 2009 when I joined.

I would like to thank all the people who took part in our Foundation Trust (FT) public consultation last year and for the support they continue to show. Being an FT will give local people more say on the services we offer to our community and will give us far greater autonomy to develop the hospital in line with local needs. We expect to relaunch our application to become an FT when the current review of healthcare provision in South West London is concluded.

However, becoming an FT is just one part of the vision we have for Kingston Hospital. The hospital staff and everyone associated with it are proud of the hospital's reputation as one of the country's leading district general hospitals; indeed the best district general hospital in London according to the recent independent Dr Foster report. We plan to continue to provide consultant delivered Accident and Emergency (A&E), emergency services and planned surgery and maternity care for our local population, always striving to improve standards.

As well as thanking all of the hardworking staff at Kingston Hospital who put patient care at the forefront of all they do, there is also a huge number of supporters and staff from other organisations who I'd like to thank for their commitment. I would like to thank our Non-Executive Directors who help advise and support the hospital, our ISS colleagues who maintain the cleanliness and security of the site, our partners from The Royal Marsden Hospital and Macmillan Cancer Support who help us to deliver cancer services, and our colleagues at Queen Mary's Hospital Roehampton (QMR) and BMI Healthcare (BMI) who help us to treat ever greater numbers of patients. Finally, I would like to extend my thanks to the volunteers of the hospital for their continued dedication and their invaluable support to our patients and staff.



Christopher Smallwood
Chairman

Statement from the Chief Executive

As we conclude this financial year, and as my first full year as Chief Executive, I have been reflecting on the hospital's achievements – and am delighted to say that they are many.

Being named as the best district general hospital in London by Dr Foster, and as the 15th best hospital in the whole country, was a real boon and has focussed our minds on achieving even more in the coming year.

Kingston Hospital's Accident and Emergency (A&E) Department remains one of the biggest in South West London. In 2009/10 we saw over 109,870 emergency attendances annually. Our staff also attended to 20,078 patients at the Teddington walk in centre. Our Maternity Unit is the second largest in London and in 2009/10 there were 5,881 births in the unit and these numbers continue to grow. We are also very proud of our high quality estate and are continuing to invest to improve the hospital environment for our patients and staff.

This year we continued to tighten our grip on MRSA and Clostridium Difficile **(**C Diff) after a real clamp down on hygiene, which continues to this day. We fought hard to win funding from the renowned King's Fund to help the team develop new best practice initiatives to share across the country in maternity and we secured all A1 care standards for Stroke Care in our Stroke Unit. Where things don't go to plan, we have made a real effort to learn from them and to ensure we improve the care we provide to our patients.

Our Care Records Service (CRS) was introduced at the end of 2009 and whilst not without its challenges, we've been told it is the most successful introduction of the service in the country so far. Investment in training and support for our staff was a major key to this success, and knowing that it would be challenging made it easier to manage when issues raised their heads.

A reorganisation into clinically led divisions has helped each team really focus on what they can achieve and how they can improve. That team spirit has helped Kingston Hospital achieve such a great deal in 2009/10.

We've developed good partnership working over the year, not just with our established partners such as The Royal Marsden Hospital and Macmillan, but with new partners such as BMI on the hospital's private wing. We are continuing to develop wider relationships with our commissioners and clinical colleagues, such as local GPs and with other hospitals, to ensure that we can continue to grow and develop the services we offer a widening community.

I'd like to add my thanks the Chairman and everyone in the hospital who has helped make the last year such a success.

In this tough economic climate and with the review of hospitals taking place across South West London, there are of course many challenges that will be faced by the hospital. Kingston Hospital, however, continues to plan for the future and deliver excellent services for our patients and our local community.

Kate Grimes
Chief Executive

2. About Kingston Hospital NHS Trust

Kingston Hospital is a single-site district general hospital based approximately 12 miles from London. The hospital supports approximately 320,000 people in the surrounding area, including the boroughs of Kingston, Richmond, Elmbridge and parts of Wandsworth (Roehampton and Putney).

In the Dr Foster's 2009 Hospital Guide, Kingston Hospital was rated London's top District General Hospital and the Trust lies 15th nationally. The hospital was also awarded the CHKS Data Quality Award, which recognises the Trust's accurate recording of clinical data and excellence in clinical coding. The hospital was also named in the CHKS Top 40 Hospitals for the 9th year running.

The Trust believes 'Taking Care' is an essential responsibility that it strives to maintain and which underlines everything done across the hospital. By doing so, it benefits the health and wellbeing of all patients, staff and visitors – from the moment they arrive to the time they leave, every day throughout the year.

With the support of 2820 invaluable staff, supported by 403 ISS Mediclean, OSL and Sunlight colleagues and over 300 volunteers.

A full range of diagnostic and treatment services is provided at the hospital, which has a national reputation for innovative developments in healthcare, particularly maternity services, and day surgery.

Clinical services are managed through four divisions:

- Acute Medicine (including Accident & Emergency, Medical Assessment Centre, Care of Elderly and Stroke, Cardiology, Respiratory and Gastroenterology)
- Ambulatory Care (Pathology, Cancer, Radiology, Pharmacy and Medical Specialities)
- Surgery and Critical Care (Urology, Orthopaedics, Ophthalmology, Intensive Care, General Surgery, Anaesthetics, Oral and Maxillofacial)
- Women and Children (Gynaecology, Obstetrics, Paediatrics).

3. Our Performance - key achievements against last year's priorities

19,264 patients were able to go home on the same day as their planned operation.

4,335 planned procedures requiring patients to stay in hospital were carried out, with a further 19,565 patients requiring non-planned treatment.

109,870 people attended the A&E Department and Royal Eye Unit casualty department.

There were 236,286 attendances to our Outpatient Department. This excludes outpatient attendances for Maternity and the Wolverton Centre.

There were 5,881 births at Kingston Hospital's Maternity Unit.

The Wolverton Centre for Sexual Health saw 16,046 attendances.

15,510 children have been treated by Kingston Hospital's Paediatrics Department (inpatient and outpatients).

Summary of performance 2009/10

2009/10 was another successful year for the Trust.

Against the key national access targets and standards the Trust performed well again.

18 weeks

The Trust delivered its commitment to ensure a maximum waiting time of 18 weeks from referral to start of treatment across all specialties for 90% of admitted patients and 95% of non-admitted patients.

A&E four-hour wait

Performance against the A&E 4-hour wait standard remained strong. The Trust ensured 98.4%* of patients were met in this timeframe.

Delayed Transfers of Care (DToCs)

DToCs continued to be high throughout the year relative to other organisations, but a joint programme of work is in place with NHS Kingston and the Royal Borough of Kingston to improve the discharge planning process has started to have a positive impact and this will continue through 2010/11 to further reduce unnecessary delays.

Cancer Waits

Performance against all cancer targets remained strong, including the two-week target, introduced in January for all breast symptomatic patients.

Stroke

The stroke unit was externally assessed on 23 March 2010 and successfully passed the A1 Healthcare for London stroke standard. This is a set of criteria that give an assurance about the quality of care that is being delivered on the unit and includes ensuring that more than 70% of stroke patients spend more than 90% of their admission on the dedicated unit. Assessment against the higher level A2 criteria will take place in the summer, with all but one of these higher criteria currently being met.

Cancelled Operations

The Trust continued to reduce the number of elective operations cancelled on the day of or after admission to hospital to below 0.8% and is currently rebooking 93% of patients for readmission within 28 days.

* A&E performance includes an approved proportion of Teddington Walk In Centre activity.

Hospital and Community Acquired Infections

A total of 13 MRSA bacteraemia were reported in the Trust, nine of which were acquired in the community.

Hospital Standardised Mortality Rates (HSMRs)

Relative to other acute hospitals in the country, the Trust has again performed extremely well in terms of HSMRs. The ratio of the actual number of deaths to the expected number of deaths, (where 100 is the national average) for the year (April to December 2009) was 85.5.

Care Records Service (CRS)

The Trust deployed the national CRS across Kingston Hospital at the end of November 2009. Over the last four months, Trust staff have been working alongside BT, Cerner & London Programme for IT (LPfIT) colleagues to bed-in the system.

As a result of very significant efforts of the Trust staff and partners, the majority of the Trust is now back to operating at business-as-usual levels and this is starting to deliver some real benefits for the hospital, GPs and patients, including the opportunity to roll out the electronic transfer of discharge summaries, which will not only be available faster, but can be imported into GPs' own systems.

Staff have been given additional training and data correction is being undertaken by a combination of clinical and back office staff. Whilst overall the Trust continues to meet the 18 week waiting standards for both admitted and non-admitted patients at Trust level. From 1 January 2010 the DH introduced new targets of achieving 18 week waiting standards across all specialities and the Trust is still working towards achieving this.

Some issues have had a negative impact on a small number of GPs and patients, mainly around the booking of clinics and significant effort has gone into work with GPs and patients to apologise for the impact this has had and to keep them informed of the actions taken. Most of these issues have now been resolved.

Overall, this substantial change programme has been successfully delivered and the organisation is well placed to benefit from the improvements that adopting CRS will bring.

4. Delivering clinical and professional excellence (operational highlights of the year)

a) Acute Medicine

Stroke Unit

Kingston Hospital's Stroke Unit has successfully passed all A1 care standards in a Healthcare for London assessment. The unit was assessed by a team of experts as part of the reconfiguration of stroke services across London. This included assessment of staffing levels, documentation, length of stay in the unit, amount of therapy input available, patient and carer information and training for the team.

The Unit has also achieved the top quartile (25%) for Stroke Care Performance in the 6th National Sentinel Audit in 2008 having been around the median in 2006. The next cycle occurs later this year.

Accident and Emergency (A&E)

In the A&E Department a new observation bay has been opened to enable the extended treatment of patients and ensure safe and timely discharge, as well as relieve the pressure on ward beds.

Kingston's A&E Department continues to produce more research papers for publications than the majority of A&Es across London and the breadth of research has attracted national and international media exposure on topics as diverse as trampolining and drug abuse.

Cardiopulmonary Testing Machine

A new Cardiopulmonary Exercise Testing Machine is now being used at Kingston Hospital to identify those patients who are more at risk of heart complications during and after surgery. The new equipment has helped ensure that appropriate actions are taken for patients on admission and during their post operative care.

New Endoscopy Unit

In May 2009, the Trust opened a new and refurbished Gastro Intestinal (GI) Investigations Unit with a state of the art automated reprocessor for endoscopes and a dedicated recovery area for patients. The larger unit has also enabled the hospital to see more patients, as well as ease the flow of patients visiting the unit, which in turn has helped improve infection control.

Medical GP Unit (MGPU)

Since opening in May 2008, the unit has gone from strength to strength with plans to expand and diversify the unit later in 2010.

The Deep Vein Thrombosis Service (DVT) has seen a total of 1,309 patients, which has helped identify the need for a specialist DVT nurse-led service, due to start in May 2010. This will ensure patients have a faster and more efficient service.

The Transient Ischaemic Attack (TIA) Clinic has had 326 patients, the majority of which have been seen within 24 hours of referral with the added bonus of same day Computed tomography (CT) scans and dopplers provided by the X-ray department for quick and efficient diagnosis.

The new Emergency Outpatient Antibiotic program has also been an enormous success, with 50 patients avoiding the minimum of a three day stay as an inpatient.

Medical Assessment centre (MAC)

Because of the high turnover of patients involved in admissions and transfers, a patient coordinator was employed to be responsible for taking patient referrals from the Advanced Nurse Practitioners and handing over the patient to the wards. This means that senior nursing staff have been released from an essentially administrative duty to provide clinical care to the patients and support to the staff. The role also allows for a centralising of patient information regarding admission, real time data input for CRS and someone to support the four hour standard from an inpatient area.

b) Ambulatory Care

Wolverton Centre

The Trust's sexual health clinic, The Wolverton Centre, is leading on the development of sexual health provision across Kingston through the new Managed Clinical Network for Sexual Health. The network is a partnership covering the hospital, GPs, community contraceptive services, school health, public health, social services and voluntary organisations. The network will be collectively responsible for improving and integrating sexual health services across the borough. This includes developing patient focused sexual health care pathways, which are responsive to the sexual health needs of local communities, improving sexual health promotion and improving coordinated training in sexual health.

Opening of Willow Room

In August a dedicated room was officially opened for relatives and carers of patients who are approaching the end of their life. It provides a welcome private space for the family to be together, away from the clinical area and a more private space for clinical staff to talk to families.

Palliative Care: End of Life Care Strategy

In partnership with NHS Kingston and the Royal Borough of Kingston, Kingston Hospital has been successfully nominated as one of three Healthcare for London pilots for end of life care. The focus of the local project will look at a cross-organisational approach to end of life care, with an aim to support people to pass away in their place of choice, improve the care for people who die in hospital and develop highly flexible approach to the use of resources for patients.

The aim of Kingston Hospital's End of Life Care Strategy Group is to identify the priority actions that will support the Trust to achieve the National and London-wide End of Life Care Quality Markers and, by so doing, improve the care provided to patients who are either dying in Kingston Hospital or who are being discharged to their preferred place.

Radiology

In September, digital dictation and voice recognition were successfully implemented into the Trust's Radiology Department. Digital dictation has helped ensure expensive dictaphone machines have become obsolete. The benefits mean that all the workloads for patients' reports can be viewed on a single screen. Dictation can be batched into groups of work such as GPs, inpatients and outpatients, but equally they can also be batched and sent to an individual secretary of choice. Dictation can now be prioritised as urgent, ensuring the next available medical secretary can type the most urgent diagnostic report on behalf of the whole department.

Voice recognition means a clinician can dictate a report using a hand held device and the software will type the information directly into the report screen for them. Clinicians can check the quality of the report before authorising, freeing up medical secretaries.

The introduction of CRS into the department has seen electronic diagnostic reports introduced which gives faster data back to the referring clinician. The technology sees the end of manual printing of hard copy Radiology Diagnostic reports and a streamlining of clerical processes, meaning less scanning-in of request forms and pending processes.

Cancer

This year the Trust has been developing its Laparoscopic services, with two dedicated surgeons leading the work resulting in larger numbers of patients with renal and colorectal cancers having their operations through keyhole surgery. This means that patients can be discharged faster and return to normal activity more rapidly.

Pharmacy

In 2009 Kingston Hospital's Pharmacy Department gained accreditation for training Pharmacists to Diploma levels. In addition to the training of pre-registration Pharmacists and Pharmacy Technicians, the department also provides short placements for Pharmacy Undergraduates from Kingston University.

The department has also successfully implemented a new Medicines Management Policy to ensure the clinical, cost effective and safe use of medicines and ensure patients get the maximum benefit from the medicines. An Intravenous Medicine Administration Policy and Guide for Adults has also been developed to support practitioners in ensuring safe administration of medicines intravenously.

Pathology Accreditation

Following a two day on-site national assessment by the United Kingdom Accreditation Service through Clinical Pathology Accreditation (UK) Ltd (CPA), Kingston's Pathology Laboratory Department demonstrated good compliance against standards and the quality of services delivered were recognised as being very high.

New Technology

Major projects have been undertaken across Pathology to introduce new technology and improve efficiency, streamline workflow and reduce running costs. The new equipment introduced into Haematology is the first in the United Kingdom and one of the first in Europe. Major analysers in both Clinical Biochemistry and Haematology, which measure the majority of routine requested investigations have been replaced and new systems have been delivered and are being evaluated prior to introduction in April 2010.

Microbiology

The Microbiology laboratory has replaced its analytical platforms to detect Chlamydia and Neisseria Gonorrhoea, which has resulted in efficiencies. The laboratory is now able to extend both the number of samples it can accommodate and the collection of in-house testing.

Cytology and Blood Transfusion

The London Regional Quality Assurance Reference Centre (QARC) visited the Trust in June 2009 to review the quality of the cervical cytology services and, overall, reported a high quality diagnostic service with strong links to commissioners. In addition, Kingston Hospital's Blood Transfusion Service was subject to annual review against the requirements of the Blood Safety and Quality Regulations, undertaken by Medical and Healthcare Products Regulatory Agency (MHRA). MHRA found the hospital's services to be of a high quality.

c) Surgery and Critical Care

Wet Age-related Macular Degeneration (AMD)

The Wet AMD service continues to expand and innovate and is now offering patients Lucentis treatments on four week days a week, including Monday mornings, when patients attend for their very first outpatient appointment, thereby minimising any delay in starting treatment.

The wet AMD service is also in the process of getting a brand new fundus camera for retinal imaging to help improve the efficiency and comfort for patients, as the innovative camera utilises low attenuated laser imaging, rather than bright light to capture images. Technicians have been trained to operate the camera, releasing a senior ophthalmologist from this duty providing an extra clinic doctor to examine patients.

The service is aiming to be 'kite' quality marked by the Royal College of Ophthalmologists for their wet AMD Service in 2010 and continues to work with the Local Optical Committee to raise awareness of the Fast Track Service available for patients at the Royal Eye Hospital amongst optometrists and opticians.

Intensive Care Unit (ICU) & High Dependency Unit (HDU)

Over the past year new assessments for patients before complex abdominal surgery has been introduced by some of the ICU Anaesthetic Consultants. Selected patients due for this surgery are seen in a pre-assessment clinic and undergo cardiopulmonary exercise testing (CPX). The CPX test shows which patients might benefit from intensive post-operative therapy to enhance oxygen delivery. This work with high risk surgical patients has led to a significant increase in patients' life expectancy and also sees a reduction in their length of stay and the costs incurred in treatment.

Therapeutic hypothermia (active cooling) for patients who have suffered a cardiac arrest is now practiced within the ICU using specific cooling devices. This treatment benefits unconscious adults who have poor circulation and have had a heart attack. It decreases their chances of suffering brain damage and increases post-operative life expectancy.

Trauma and Orthopaedic Department

The Orthopaedic Department at Kingston Hospital has been rapidly improving its services and in the last year has achieved significant improvements in standards of care for patients with fractured hips. These include:

- average time to operations is currently 38.6 hours (compared to the London average of 41 hours and national average of 44 hours)
- average length of stay ranging from 13 to 18.8 days (compared to the London average of 21 days and national average of 20 days)

- pre-operative assessments by specialist Geriatricians in 80% of patients (compared to London levels of 66% and national levels of 55%)
- bone protection and prevention of further fractures in 69% of patients (compared to the London levels of 66% and national levels of 53%). The unit has demonstrated a 25% improvement in the last four months
- falls assessments performed in 75% of patients (compared to the London levels of 55% and national levels of 52%). Again, the unit has demonstrated a 25% improvement in the last four months
- geriatrician led, multi-disciplinary rehabilitation and discharge planning for every patient.

In the coming year, a 'fast-track' hip fracture pathway is planned for every relevant patient admitted, and a robust multi-disciplinary educational programme will be established.

Development of Laparoscopic Renal Surgery at Kingston Hospital

The Trust has developed renal laparoscopy at the hospital which has allowed the majority of patients with renal pathology to have their surgery using laparoscopic techniques. This has led to patients' rapid recovery when compared to open surgery. These techniques are now also being used on patients who need adrenal surgery and Kingston Hospital aims to become a local centre of excellence in laparoscopic surgery, not only for urology, but other surgical specialities.

Collaborative working and Outreach Clinics

Kingston Hospital has strong links with GPs working within Surrey and South West London and has done a lot of work in the last 12 months to enhance the local provision of outpatient services in that locality. This has included increases in the number of consultant-led clinics held at Molesey Hospital and the introduction of clinics in specific GP surgeries. This has benefited local patients and has also enhanced the working relationships between GPs and consultants. In surgery and critical care, services provided include orthopaedics, urology, ophthalmology. Work is currently taking place to extend this to upper GI in 2010/11. Any patient seen in the community is then referred to Kingston Hospital in the event that they need surgery.

Endoscopy services

During the last 12 months, the inpatient endoscopy services have been upgraded to include a recovery area and new decontamination facilities. This has increased the turnaround of patients and has enabled an increased number of patients to be seen in this facility. The management of this has transferred to the Surgery and Critical Care division enabling the staff to rotate between the day surgery and inpatient facilities, and to share their expertise.

d) Women and Children

Maternity services - New national initiative

Following a rigorous selection process, Kingston Hospital's Maternity Unit is part of a ground-breaking national initiative launched by the King's Fund to help maternity units in England. The hospital's team will join a network of 12 maternity units chosen from 50 applicants that will have access to external expertise and support. The team will have the opportunity to develop new initiatives, learn from the other teams' experiences and to share their learning with maternity services throughout England, the aim of which is to develop best practice for maternity across the country.

Maternity Matters

Maternity Matters, the Maternity Services Improvement Programme, commenced in April 2009. A programme of service transformation has been defined and is being delivered to achieve the national imperatives specifically around choice, early access to maternity care and strengthened continuity of care.

A key component has been the change of service delivery model and workforce redesign. Integrated teams will work to smaller and more defined geographical areas with close alignments to children centre clusters and associated GP practices, providing care across the whole continuum - antenatal, intrapartum and postnatal care.

In order to achieve this, the Unit required an additional 30 Midwives and 40 Maternity Support Workers above its 2008/09 establishment. This will take the ratio of Midwives to deliveries to 1:34. A recruitment strategy was developed with an associated advertising campaign and microsite established, and ongoing recruitment is in progress, which has already seen 23 Midwives and 32 Maternity Support Workers successfully recruited. In February 2010 a further round of recruitment was undertaken and was a great success. Subsequently offers have been made to 23.92 whole time equivalent (WTE). As a result, three integrated teams have been rolled out, with more due to be rolled out in 2010/11.

Additional progress to date also includes:

- the development of shared care guidelines and pathways for women, which have been distributed to GPs and are being used by NHS London as an exemplar
- the introduction of an electronic maternity referral form, which has been made available to all GP Practices with a bespoke email account to receive the referrals
- increased engagement with service users through providing increased opportunities to provide feedback, the undertaking of a postnatal survey and meetings with women in the local community
- further work to increase the number of women who have their booking assessment appointment with a Midwife by 12 weeks and six days of pregnancy.

New Maternity Website

A bespoke maternity website has been launched to provide a wealth of information about the care women can expect to receive and the facilities available if they choose to have their baby at Kingston Hospital. It also provides answers to many frequently asked questions and links to other useful sites. Women will be able to use the website to self-refer themselves to Kingston Hospital's Maternity Unit, instead of their GP referring them. This is a brand new initiative as a result of Maternity Matters, the Government's plan to improve the quality and accessibility of maternity care for women and their families.

The website also offers the opportunity for Kingston Hospital to share feedback with women. This may be via information on the Patient Experience Tracker, minutes of the Maternity Services Liaison Committee, comments from the recently introduced comment cards or survey results from the one to one care survey. It will be a new way in which the hospital can listen to women's views and as a result make improvements to the maternity care provided.

Women's feedback

Each quarter the Maternity Unit undertakes a one to one care in labour survey. In October 2009 95% of women surveyed confirmed they had received one to one care in established labour. Each quarter all the results are taken and shared with staff and women. During July to September 2009 the Trust undertook a postnatal survey, similar to the survey undertaken in 2007. Findings demonstrated that 70% of women rated their postnatal care as excellent or good compared to 53% in 2007.

In addition to this, new comment cards have been launched in all Maternity inpatient areas to deliver instant feedback from women on their experiences in the Maternity Unit.

Productive Ward

Kingston Hospital's Worcester Ward has successfully implemented The Productive Ward, an innovation which, when implemented, releases time for Midwives and other staff to directly care for women and which has delivered positive results for patients and the hospital. Key highlights include:

- Patient At a Glance board, an acronym free board which uses strong colours and easily recognisable indicators, to provide all information staff require without having to interrupt women. As a result, interruptions have reduced from nine per hour to four – a 50% reduction per shift
- Well Organised Ward – a 'welcome' folder for women and their families has been introduced to assist them with key information to help them find their way around. There are now photographs on cupboards and transfers on the floor, so it is very visible where equipment and stock needs to be stored. The two-bin system has led to improved control of stock levels and reduction in wastage. Changes to the storage of linen by introducing a linen trolley at each end of the ward will save 18 shifts per year.

The Productive Ward programme will now be rolled out across other areas of the Maternity Unit.

Paediatrics

The Moor Lane Centre

In September 2009 the Community Paediatric service, which was previously based at Maple Children's Centre on the Kingston Hospital site, was relocated to the Moor Lane Centre in Chessington. It is a fit for purpose centre, which will provide higher quality facilities to children and their families. The new centre now provides an integrated service for children with disabilities and complex health needs, encompassing both health and social care. It will include all of the community services that were delivered through the Maple Children's Centre, and the Disabled Children's Team at Beaconsfield Children's Resource Centre.

Dedicated Adolescent Bay

A dedicated adolescent bay has been created on Sunshine Children's Ward in recognition of the different needs of adolescents and to provide a suitable environment for adolescents to be cared for. This enables adolescents to be located alongside others of a similar age to encourage social interaction, as well as making it easier for staff to meet their needs for education, entertainment and additional privacy, which are different in older children and meets the National Service Framework for Children, which highlights the importance of age-appropriate environments.

Paediatric Nurse-Led Services

The range of Nurse-Led Services has been enhanced to include a nurse-led prolonged neonatal jaundice clinic, as well as administration of chemotherapy by nursing staff and nurse-led Paediatric Assessment Unit algorithm-led discharges.

Training Developments

Training developments for staff have included: Membership of Royal College of Paediatrics and Child Health (MRCPCH) examination training programme, developed as a commercial venture and open to external candidates; a local Neonatal Advanced Life Support (NALS) course; and the training of Physicians' Assistants in partnership with St George's Hospital.

Gynaecology

In September 2009 the Colposcopy service which had been run at QMR transferred to Kingston Hospital. This enabled the consolidation of the service and means improved governance arrangements. In line with quality assurance recommendations there is now greater nursing support in clinics, this is done with the aim of supporting women and improving their patient experience.

5. Our future

In planning for 2010/11 there are a number of externally driven strategic developments that the Trust has taken in to account. The exact details are unknown and have potentially significant implications on service delivery in 2010/11 and beyond. Key developments include:

- the outcomes of the Healthcare for South West London Review
- the economic downturn and associated efficiency requirements.

Specific priorities identified for the next year are identified in the Trust's corporate objectives and are noted below.

Corporate Objectives

Six high level corporate objectives have been identified for 2010/11. These represent a combination of national, local and internal priorities and encompass strategic, quality, operational, financial and workforce objectives. The objectives are:

- to deliver quality services with an excellent reputation
- delivering care by staff that feel valued, working in effective and supportive teams
- working through partnerships to consolidate and strengthen services delivered on the Kingston Hospital site
- to engage in polysystems and community models of care
- to deliver services that are value for money for the tax payer
- to ensure the Trust is well governed and managed so that it is fit for FT status (or its successor) - once approval to proceed with the application is granted

A work plan has been developed to support delivery of the corporate objectives, highlighting the key deliverables and success criteria, with Directors accountable for delivery and the monitoring approach for each objective.

Service Development Plans

The Trust will be pursuing a number of specific service developments in 2009/10 to support delivery of its overall objectives, a number of which will involve working with partners in health (other acute trusts, primary care and commissioners) and social care.

The four key priorities are:

- Maternity Expansion – delivery of Maternity Matters and the integrated model of midwifery and plans for expansion of the service
- Emergency Services (Initial 48 hours) – focus on the initial 48 hours and a service redesign of the model within the Trust and across the local health and social care system. This will ensure the most appropriate services are provided by the most appropriate person, at the right time, in the right place

- Improving communication and access with GPs and patients - ensuring Kingston Hospital is the hospital of choice for patients and GPs
- Enhancing and improving elective services – maximising the use of the Trust's existing surgical facilities and consolidating activity on site.

A programme management approach is being adopted both internally and across the local health and social care economy to ensure delivery of many of these priorities.

2010/11 will also see the expansion of the Clinical Quality Indicators (CQUIN) scheme introduced in 2009/10. 1.5% of the Trust's income will only be paid by commissioners to the hospital on the achievement of specific quality improvements agreed with the sector and local commissioners. In 2010/11, initiatives will be implemented in the following areas, some of which are new for 2010/11 and some of which build on previous CQUINs:

- Venous Thromboembolism assessment (VTE) and action
- improving patient experience
- improving patient safety (IHI Global trigger tool and enhanced recovery programme developments)
- improving the timeliness and quality of discharges and associated information
- implementation of the London dementia services framework
- reducing emergency readmissions further
- improving the maternity services and experience
- increasing smoking cessation.

Foundation Trust Application

The Trust is continuing to prepare for Foundation Trust (FT) status. The Trust's strategic and financial plans need to be aligned to the conclusions drawn from the Integrated Strategic Plan for London which was published in January 2010. Consultation on proposals emerging from this plan for London are being considered for the Autumn and the Trust thus needed to review its schedule for formal FT application in line with this timetable.

The Trust is however continuing with a programme of work that ensures it is able to meet the standards set down by Monitor, the regulatory body for Foundation Trusts. Areas of particular focus ensuring that the hospital:

- is well managed and governed, with an active and effective membership
- has a clear and defined five year vision and strategic direction, supported by defined and measurable strategic objectives
- has a defined service strategy delivered through a number of distinct service development plans

- has a set of enabling strategies, such as a workforce strategy and estates strategy that facilitate delivery of the above
- has an overarching five year business plan, capturing the above.

Kingston Hospital undertook a formal consultation between 24 June and 16 September 2009 on the business strategy, approach to membership and governance arrangements that would apply on achievement of Foundation Trust status. During this time there were 12 public meetings with 70 attendees. Additionally the hospital was invited to present to Kingston and Elmbridge Overview and Scrutiny Committees. A full copy of the report following the consultation that went to Trust Board in November 2009 is available on the website.

Sustainability/Caring for the environment

Kingston Hospital is committed to reducing its carbon footprint and is determined to ensure that it is working towards becoming a medical centre of excellence, as well as benefiting from the savings associated with an environmentally friendly site. The Trust Board has approved an Outline Sustainability Plan with a full strategy to be developed in 2010/11.

The Trust has commissioned a specialist firm to help develop a carbon strategy for the Trust, which will not only help reduce the hospital's utility consumption and costs, but also look at transport alternatives, internal procurement processes and carbon neutral ways of disposing of waste.

The refurbished boiler house and new, modern Combined Heat and Power (CHP) plant installed in 2006/7 continues to bring savings to the annual energy costs and significantly reduce the amount of CO_2 emitted by the hospital.

Healthy Travel Plan

As part of Kingston Hospital's Healthy Transport Plan, the Trust encourages staff to cycle, walk or run to work where possible by providing showers, changing facilities and lockers around the site. In addition to this, interest free loans are available for staff to purchase season tickets for public transport and a tax efficient cycle purchase scheme has been introduced this year. Car sharing is in place and used by many staff, and the Trust holds regular meetings to discuss proposals for improving local public transport, particularly for those travelling early in the morning and late in the evening.

The National Bike Week is a hugely popular event at the hospital and staff bring their cycles in for free 'Dr Bike' checks and police security marking. The week also sees hospital staff being offered a number of other cycle-friendly events such as electric cycle promotions, giveaways and raffles.

A travel survey has recently been commissioned in partnership with Kingston Council to identify preferred and current modes of transport for visitors, patients and staff of the hospital. The Trust is

also currently reviewing car parking facilities on the site to ensure fair access to all groups using the hospital facilities and to encourage and promote alternative methods of travelling.

Travel information is also sent to patients with appointments, suggesting alternative means of getting to the hospital, rather than travelling by car. This information is also easily accessible on the hospital's website for visitors and links to the Transport for London site. A local cycle map is currently being worked upon with the local council and the 'Getting to Kingston Hospital' leaflet produced by Transport for London has also been updated by the Trust.

Refurbishment and Improvement Works

Kingston Hospital is the largest single site district hospital in South West London and over the last two years significant investment has been made to ensure a high quality estate. As part of the ongoing Estates programme this year, the Trust has invested a total of £2 million for maintenance and refurbishments across the hospital site to help improve the patient experience. This includes improved accessibility for disabled patients in the Outpatients Department and two ward renovations to include new shower/washroom facilities.

The Cardiology Unit has also been refurbished to include two exercise tolerance rooms, an echocardiogram suite, two multi-purpose rooms for patients requiring Electrocardiograms (ECGs), a pacing clinic room and areas in which diagnostics results can be analysed. More than 50 clinical wash hand basins have been replaced across the hospital in ward areas to meet new infection control standards and 450 old mattresses have been replaced with new ones.

Estates Strategy

The Trust has developed an up-to-date estates strategy to provide a framework for all future site developments and to ensure their proper integration into the hospital's overall business plans. This was approved by the Trust Board in March 2010. The strategy takes into consideration how the current estate is performing, how space is utilised, the functional suitability of buildings, costs of running the estate, and will help inform any future decision making about how buildings can be made suitable for key clinical developments. It seeks to support the Trust's overall business plans and key service developments and will ensure financial provision for new service developments and guarantee that existing buildings are well maintained and provide fit-for-purpose patient environments.

Communication

The Trust has invested in updating its website and will develop news ways of engaging with staff, patients and stakeholders. This will include moving some paper-based communications to digital communications and ezines. It has engaged with contemporary forms of new media, with 2,189 members on its 'I was born at Kingston Hospital' Facebook page and 139 Twitter followers.

6. Valuing our staff

Our Staff

The Trust currently employs 2,820 permanent staff across all groups including nursing and midwifery, medical and dental, administrative and clerical ancillary and management. Staff work together to provide the best possible services for patients. The 2009 annual staff survey demonstrated that the Trust is doing well overall but has highlighted areas for improvement.

Staff Survey

The results of this year's annual national staff survey were generally positive. Overall, scores were either better or the same when compared to other similar trusts in the country. Kingston Hospital scored higher than other trusts on three indicators: supporting staff to do a good job; providing the opportunity for feedback through appraisals: and supporting the health, safety and welfare of staff. The Trust was similar to other trusts in five other key areas:

- work-life balance
- staff views about their job
- errors, near misses and incidents
- harassment, bullying and violence
- a worthwhile job and the chance to develop.

However, staff also said that they would like to see improved access to training and communications. The Trust has taken note of these comments and will be focussing on these areas during the coming year.

Recognition - Staff Excellence Awards

The Trust has performed well this year, due to the tremendous commitment and contributions of all its staff. This was reflected this in the Staff Excellence Awards, which recognise outstanding contributions in areas of patient care, innovation, cost improvement and team work. Awards were made to the following outstanding teams and individuals:

- **Team Work award** - Blood Transfusion Team; Peter Struik, Transfusion Specialist; Vince Michael, Biomedical Scientists Lesley Buggy and Tim Noel
- **Cost Improvement award** - Administrative Manager A&E; Christine Cantello
- **Patient Care award** - Paediatric Diabetes Team; Dr Vinayak Pai, Consultant Paediatrician; Jane Gwynne, Diabetes Liaison Nurse; Emily Cavell-Clarke, Outreach Nurse and Sue Thomas, Specialist Dietician
- **Innovation award** - Falls Group; Cindy David, Occupational Therapist and Anne Jones; Clinical Audit Manager.

Organisational Change

In 2009, the Trust reviewed its organisational arrangements and implemented a new divisional structure with the aim to enhance the involvement of clinicians as leaders and to improve clinical engagement.

Following a consultation in October, four new divisions were established: Acute Medicine, Surgery and Critical Care, Ambulatory Care and Women and Children. As a result of these key changes, good progress has been made in strengthening clinical leadership and all four new Divisional Directors are clinicians. Furthermore, with the change of roles and responsibilities, the new clinical leaders have clearer accountability to make key decisions within their respective divisions, as well as working more collaboratively.

Education, Learning and Development

The Trust provides and enables training and professional development for staff through its Education Centre, and from Kingston University via the Professional Development Coordinator. During 2009 the focus of the Education Centre was to ensure that all staff were up to date in the knowledge and practical skills training they require to meet mandatory and statutory obligations and to support implementation of the new CRS. Training modules to cover the major elements of mandatory training were delivered through a mix of in class, practical and online training and CRS training was delivered to all staff in clinical services.

The Clinical Skills team continues to ensure provision of a broad range of practical skills training, working in conjunction with the Professional Development Coordinator. A major initiative to improve the induction training of new Health Care Assistants (HCAs) has proved successful, and this is has led to improved retention over the last six months. With the aid of funding through the Joint Investment Fund the Trust has sponsored experienced HCAs to achieve NVQ Levels two and three in Health and Social Care and to provide courses for first line supervisory and management diplomas, delivered on-site by Kingston College of Further Education. Both qualifications have been proved popular. Internally soft skills training modules have been delivered across areas including communication and managing employee relations.

Staff Benefits and Work Life Balance

The Trust continues to provide good benefits for staff, including childcare and carer support - just one of the many services offered for staff and their families. There is a dedicated Childcare and Carer Support Manager who offers advice and support to parents, carers and managers to help staff better balance their home and work commitments. A holiday play-scheme called the Honey Pot & Hive Club is run during school holidays and is in great demand, especially during the summer holidays. The staff nursery, the Busy Bees, provides care for children aged one to five years which is very much valued by staff, and there is currently a waiting list for places at the on site nursery. Staff can also reduce their costs and increase the tax efficiency on childcare payments by using the Busy Bee Voucher Scheme.

The excellent quality of care provided was reflected in both Busy Bees and the Honey Pot and Hive Club receiving good OFSTED reports this year.

European Working Time Directive (EWTD) Compliance

Kingston Hospital achieved 100% EWTD compliant rotas in August 2009 and is continuing to monitor compliance.

Equality and Diversity

This is an important agenda for the Trust, staff and patients alike. In ensuring that this is at the heart of everything the Trust does, the agenda is now being led directly by the Chief Executive. There have been a number of significant achievements this year: a refreshed equality and diversity strategy and a Single Equality Scheme (SES) action plan was built on the work undertaken last year. There is also a considerably strengthened link to a range of community partners, including the Kingston Centre for Independent Living (KCIL), the Kingston Racial Equality Council and the Patient and Public Involvement Forum and other partners who continue to play a vital role in quality assuring, challenging and supporting the hospital to continuously improve services for patients, visitors and carers.

Occupational Health & Well Being at Work

The Occupational Health Department hosted a health promotion event for all staff to promote wellbeing at work. This event was very well attended and highlights of the event included free taster sessions of complementary therapies, such as clinical hypnotherapy, Qigong Chinese massage and information on acupuncture. Staff were able to have free blood pressure checks, cholesterol tests and get diet and fitness advice. The current staff survey information shows that this service is valued by staff and overall staff are more positive about wellbeing at work, than in other similar trusts.

Sickness Absence Rate

Having a healthy workforce is important to the Trust and the support provided by the hospital's Occupational Health service for staff is therefore vitally important. Sickness absence data has been centrally compiled and the Trust has an average number of days sickness per full time equivalent of 7.4%, this is below the NHS average of 9.8%.

Volunteering

Kingston Hospital has a well established team of volunteers who devote much spare time to carrying out voluntary work within the hospital and the Trust would like to thank them for their continued support. Many volunteers come in the first place because they wish to give something back in return for the service received when relatives or friends have been patients. They are valued and appreciated for the help given and are an important part of our hospital. A walk around the hospital will reveal volunteers undertaking a wide range of tasks including taking people to hospital departments or pointing them in the right direction, visiting patients, operating tea trolleys, doing administrative and reception work, contributing to the hospital radio and helping in many other vital areas of hospital life.

7. Listening to our patients

Patient Advice and Liaison Service (PALS)

Between 1 April 2009 and 31 March 2010, over 3,600 PALS contacts were dealt with. This is an increase of (44%) on the numbers received during 2008/09. Of these, the majority (72%) were concerns raised by patients and the public, although many requests for information and advice (20%), and expressions of gratitude were also received.

The most common concerns raised through PALS this year were:

- appointment-related issues such as incorrect appointment letters, clinic cancellations, inability to contact the appointment booking staff
- communication problems such as difficulties contacting departments within the Trust
- waiting times, for example for follow up appointments
- treatment.

A further 650 concerns were received which directly related to appointment issues. These are dealt with via a dedicated team and were resolved within an average of five working days.

The percentage of patients who proceeded to a formal complaint (ie they were not happy either with the way the PALS service managed their concern, or felt that the issue needed to be raised again through the formal process) was just over 3%. This reflects the comprehensive way that concerns brought to the PALS service are responded to. It is encouraging that the majority of concerns are dealt with promptly and conclusively without escalation.

Complaints

Over the course of 2009/10, the Trust received 459 formal complaints, which is an increase of about 5**%** on the 439 received in 2008/09. The main issues complained about were:

- poor communication – failure to notify of cancellations or changes to appointments; lack of information about clinic delays; calls not returned; poor information regarding discharge arrangements; lack of information about diagnosis and treatment of patients; inability to contact medical staff.
- treatment – misdiagnosis; changes in treatment plan; lack of clarity about the care of patients; poor clinical care.
- poor attitude of staff.

The Trust's complaints performance and response times are monitored by the Risk Management Committee, which reports to the Trust Board via the Compliance and Risk Scrutiny Committee.

Next Stage of Complaints

The Health Care Commission (HCC) ceased to exist from 31 March 2009 and, as of 1 April 2009, trusts became responsible for providing independent reviews in cases where complaints remain unresolved following local resolution. There have been no independent reviews to date for 2009/10.

Once local resolution has been exhausted, complainants can refer any outstanding issues to the Health Service Ombudsman, where an assessor will review the complaint investigation and the subject of the complaint. There have been eleven referrals to the Ombudsman since April 2009. To date, the Ombudsman has declined to take on four of these cases, and is considering seven.

Learning from comments and compliments

The Trust's complaints performance and response times are monitored by the Trust's risk management structure which reports to the Board.

Through close working between the PALS team and the clinical divisions, the Trust aims to resolve issues at an early stage whenever possible. The Trust's staff work hard to ensure that complaint investigations are thorough and that the outcomes reflect the seriousness of the issues that patients and their relatives or carers have raised. Some examples of actions taken as a result of complaints are:

- a new policy for the disposal of unused drugs in the A&E Department
- five new wheelchairs purchased for A&E
- soft gauze to be used with oxygen masks to prevent pressure sores
- a mouth care plan form to be added to the routine nursing documentation.

Principles for Remedy

As per the Ombudsman's Principles for Remedy, trusts must provide remedies to those who have suffered injustice or hardship as a result of maladministration or poor service.

All forms of remedy should be considered, such as an apology, an explanation, remedial action or financial compensation. The remedy must be fair and proportionate to the complainant's injustice or hardship. This system is now incorporated into the Trust's complaints process.

Freedom of Information (FOI)

In 2009/10 the Trust received 234 Freedom of Information Requests. However, the complexity of some of these requests have increased and overall 48% have been answered within 20 working days. This compares with 57% of the 233 requests in 2008/09.

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

The Trust has published a list of frequently asked Freedom of Information questions on the hospital's website.

Overall since the Act came fully into force in January 2005, the Trust has received 770 requests and over 80% of these have received all of the information, or the nearest alternative held.

Patient information

There is now a standard procedure for collating patient leaflets and aim to ensure that the information is clear, accurate and up-to-date.

8. Working with our stakeholders

Kingston Hospital members

The Trust has a membership base of 2,918 people. Steps continue to be taken to encourage growth of the membership and there is a programme of activities to involve them in the hospital. Where members are actively engaged in individual services, the benefits are appreciated by staff and patients.

Members are being invited to sit on membership focus groups to give patient/public perspective in relation to patient information and provision of services. Some examples of these are:

- Members/Patient Group at Royal Eye Unit
- Focus Group created in Audiology
- Diversity – Equality Impact Assessment Training
- Diversity – Diversity Workshop – single equality policy
- Readers Group – Communications Team
- Steering Group – Productive Ward – Sycamore Ward
- Clinical Ethics Group.

During the last year a number of "Medicine for Members" events based on topics of interests to members have been held. These events give the Trust the opportunity to share useful information and enable members to find out about services and interact with staff. Events held to date include:

- 18 weeks and the Royal Eye Unit
- Infection Control
- Summer Sun
- Keep Warm Keep Well.

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Joint working with our consultants and local GPs

The Trust continues to work with all GPs from Kingston, Richmond and Twickenham, Surrey and Putney through the quarterly GP and Consultant Clinical Forum.

The forums provide a valuable opportunity for all hospital clinicians and GPs to come together to discuss a wide ranging number of issues, from enabling easy and effective communication between clinical colleagues to joint development of services and pathways across primary and secondary care.

Each forum sees attendance of around five clinicians, usually with an even split between those attending from primary and secondary care.

During 2009/10 the forums covered many subjects including:

- models of care associated with emerging polyclinics
- 2009/10 Commissioning for Quality and Innovation Scheme (CQUIN) targets – identification of targets and how performance against targets will be measured
- surgical services at Kingston Hospital - looking ahead at developments within surgical services at Kingston Hospital, in particular the launch of a Surgical Assessment Unit
- remodelling of the Trust's website and health professionals site, with the introduction of a password protected area for GPs
- facilitating communication between clinical colleagues across primary and secondary care
- introduction of electronic notification of discharge
- introduction of CRS.

Each forum also results in a number of suggested actions, which are then explored further by the Trust and PCTs. Examples of these include:

Electronic Notification of Discharge

In response to GPs, the Trust is now seeking a solution to enable new electronic discharge summaries in a format where they can upload the information directly into their patient records. It is hoped that this will be in place by summer 2010.

Dedicated email address for GPs

The Trust has also introduced a dedicated email address for GPs to use for queries associated with discharge summaries.

Trust website and electronic news

Through discussions, GPs have been able to shape the development of the new website. GPs have also expressed an interest in receiving their newsletter as an ezine, which the Trust will be trialling this year.

Hospital Switchboard

Through discussions with GPs, the Trust became aware that the current switchboard contract did not cope well with peaks of calls from GPs at the end of surgery, during lunchtime and in the evenings. As a result, the Trust is working with the service provider to review this service so that it better matches peaks of GP calls. A fast-track route for GPs calling the hospital has been introduced.

Care Record Service (CRS)

In response to GPs' comments, the Trust has introduced a dedicated email address for GPs to send through any issues associated with the new system.

Involving our patients

The Trust is committed to putting patients at the centre of everything it does and recognises the value of listening to patient views. It believes that talking to patients, their relatives and carers will help to make effective changes which improve patient care and the overall experience of being in hospital.

Patient Environment Inspection (PEAT)

In February 2010, the Trust undertook its annual Patient Environment Inspection. Members of staff from Estates and Facilities, Nursing, Infection Control, Prime and ISS Mediclean undertook an inspection and scored patient facilities throughout the hospital in respect of environmental issues such as cleaning, food, maintenance and finding their way around the hospital. The Trust scored well on the day and a final score from the Department of Health is eagerly awaited.

In addition, the Trust undertakes a "matrons' walkabout" every Wednesday morning to maintain the momentum of the PEAT inspections throughout the year. This supplements the 'walkabouts' undertaken by Directors which includes a commode cleanliness check.

Inpatient Survey 2010

In January 2010 the CQC released the results of an inpatient survey of adult inpatients at the hospital and highlighted areas where the Trust could make improvements.

The CQC Outpatients survey was conducted over the period of March to May 2009 and released in February 2010, by which time the Trust had already put measures in place to address the issues raised. This included improvement works in Outpatients where the downstairs reception area has been redeveloped to include a low level counter to improve accessibility for all patients and the corridor flooring.

The Trust is currently reviewing the CQC annual patient survey and is developing an action plan to quickly put improvements in place where necessary to ensure that excellent patient care and patient experience remains a top priority.

Patient Experience Tracker

The Patient Experience Tracker, developed by Dr Foster Intelligence, has been introduced on ten wards across The Trust. This electronic surveying tool invites patients to comment on five questions related to their experience during this particular episode of care received at Kingston Hospital. The device has created opportunities for wards/departments to obtain 'real time patient feedback' and initiate actions to make improvements to the patient experience of their care.

Partnership working

Royal Marsden and Macmillan Cancer Support

In June 2009 Kingston Hospital celebrated the first anniversary of the opening of the SWR Unit. The Unit was funded from a £3 million donation from the Kingston Can appeal and a £1.4 million donation from the Royal Marsden Trustees and £630,000 from Macmillan Cancer Support.

Working in partnership with the Royal Marsden and Macmillan Cancer Support, it provides patients with cancer with the best medical facilities locally as well as being the source of high quality information and advice.

Staff from The Royal Marsden and Macmillan Cancer Support joined Kingston Hospital staff to celebrate the anniversary of the SWR Unit.

The partnership was described as 'a positive experience' by staff and it has also been welcomed by patients who say that the bright and spacious environment enhances the quality of care patients receive and that they appreciate being able to have their chemotherapy and treatments close to home which reduces travel time.

Queen Mary's Hospital, Roehampton

Kingston Hospital has been running services at QMR for many years. In 2009/2010, Kingston Hospital signed a Memorandum of Understanding (MoU) with Community Services Wandsworth and NHS Wandsworth to continue offering commissioned work and direct services to patients. Additionally, new service provision will be explored over the duration of the MoU for the years 2010/11 and 2011/2012.

BMI Healthcare Limited (BMI) Coombe Wing

On 1 October 2009, Kingston Hospital successfully entered into a contractual relationship with BMI Healthcare Limited for the latter to deliver private patient services at the Kingston Hospital site. BMI is the largest independent provider of acute surgical services in the UK and is owned by its parent company, General Healthcare Group Limited.

South West London Elective Orthopaedic Centre (SWLEOC)

SWLEOC is the UK's largest dedicated hip and knee service providing world class orthopaedic care. The centre is managed in partnership by the four acute Trusts in South West London (Kingston Hospital, St George's, Mayday and Epsom & St Helier).

The 11,000 hip and knee replacements carried out each year provides a vast amount of clinical outcomes data, which allows clinical leaders to refine clinical pathways in the pursuit of providing a high quality efficient service.

The benefits are many and include patients having a knee replacement at SWLEOC spending on average just 4.78 days as an inpatient. This compares with the London average of 8.05 days for a knee replacement. (Data from www.drfosterhealth.co.uk).

Orthopaedics have one of the biggest challenges in the NHS. They are expected to have 90% of admitted patients receiving treatment within 18 weeks of their GP referral. The SWLEOC partnership not only successfully achieved, but sustained the target in 2008/09 and has now put in place a stretch internal target of 95% to further improve the service offered to Kingston Hospital's patients.

Further improvements for patients include steps to provide healthcare closer to home through the one-stop clinics. Patients are assessed for their fitness for surgery at the clinics via outpatient appointments. This reduces the need for further attendance at hospital. The service is already provided at some of the Kingston consultant outreach clinics and will continue to expand. Additionally a six week follow up service has been introduced, which sees patients visited by an SWLEOC nurse in their own home.

Improving Safety

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

The Safer Neighbourhood Team also holds regular bike marking events and cycle security advice clinics at the hospital to help staff keep their cycles safe.

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

A successful Security Awareness Month was held in November where advice, leaflets and information was shared between the hospital staff and the police.

9. Clinical governance

Annual Health Check

The Trust received satisfactory outcomes against external assessments.

In the Care Quality Commission's (CQC) Annual Health Check, the Trust achieved a 'fair' performance rating for its quality of services and a 'good' performance rating for its use of resources for 2008/9 (published in October 2009). Disappointingly these ratings were down from "good" and "excellent" in 2007/8. Clear objectives have been put in place across the Trust, which is already making a difference to its performance.

Performance was rated against

- 44 national core standards in areas that really matter to patients, such as; safety, quality of care and how responsive a trust is to patients
- eight existing national targets, which are mainly concerned with waiting times and access to services
- 13 new national priorities, designed to promote improvement in health outcomes, such as; smoking, sexual health, health inequalities and reduction in death rates for cancer, stroke and heart disease.

Care Quality Commission

The Trust successfully registered with the CQC against their code of practice for the prevention and control of healthcare associate infections**.** From 1 April 2010 in order to continue to operate, all trusts needed to be registered with the CQC against 16 essential standards of quality and safety. All trusts submitted their applications for registration to the CQC in January 2010 and Kingston Hospital has been registered without condition as at March 2010.

Kingston Hospital top District General Hospital in London and 15th nationally

In the Dr Foster's 2009 Hospital Guide, the Trust was rated London's top District General Hospital and was just a few points away from being in the top banding as one of the best performing hospitals in England for patient safety. Out of the top six London trusts, Kingston is the only District General Hospital; the others are teaching hospitals. Overall, the hospital lies 15th nationally.

CHKS "Top 40" Hospital for nine years running

In 2009 Kingston Hospital won the CHKS Data Quality Award which recognises the importance of accurate recording of clinical data and excellence in clinical coding. Kingston Hospital is one of only five trusts to have been a CHKS 'Top 40' Hospital for nine years running. Winning this award for the 9th consecutive year is an outstanding achievement and one which demonstrates the hospital's commitment to provide high quality, safe care to its patients.

Healthcare associated infections

The Trust has continued to make significant progress in reducing hospital acquired infections during 2009/10 and is the best performing hospital in the South West London region.

MRSA bacteraemia rates remained constant with four hospital acquired and nine community acquired cases between April 2009 and March 2010. The trajectory of three MRSA bacteraemias (set by the Department of Health) gave an upper limit of 12 to incorporate community-acquired infections; therefore the Trust is just above trajectory for the year and has not seen a reduction in MRSA bacteraemias. Mechanisms for reporting community acquired and hospital acquired cases will change in 2010 with the trajectory for the Trust no longer reflecting community acquired infections.

C Diff figures were markedly reduced with 25 hospital acquired cases between April 2009 and March 2010, a reduction of 44% from the 45 cases in the same period last year.

In December 2009 the CQC performed an unannounced spot check on the Trust and visited three medical areas: Astor, MAC and Kennet. Their exception audit reported failures against two of The Health and Social Care Act 2008's criteria – environment and equipment. Subsequently a plan was drawn up to replace curtains and to address the commode cleaning issues. Daily commode audits throughout January and February saw a marked improvement and a second unannounced spot check on 4 February 2010 recognised that significant improvements had been made.

Infection prevention and control remains a top priority for the Trust. In the last year MRSA screening for all elective admissions has been rolled out and the team is preparing to implement MRSA screening for all emergency admissions in March 2011. Monthly hand hygiene audits continue and the latest phase of the national 'clean your hands' campaign 'Five Moments for Hand Hygiene' will be implemented this year. Saving Lives audit activity continues and will be extended in 2010 – 2011 to incorporate equipment cleaning audits.

Reports on infection prevention and control are routinely presented at divisional governance meetings, the Patient Safety Group and to the Trust Board. Key performance indicators are reported from each Division to the Trust Board.

Nursing Performance indicators

Nursing indicators that focus on patient experience and patient safety were implemented across the Trust. Matrons report these measures and analyse them monthly.

Productive Ward

The Productive Ward showcase Ward was recently featured in a publication by the NHS institute for Innovation and Improvement. Systems have been refined leading to an increase in the time released

to care for patients. Overall, there has been an improvement in patient experience. The initiative will be implemented in other areas across the organisation during the next year.

Learning Disabilities

Kingston Hospital has successfully implemented a passport for people with learning disabilities. The passport was developed in collaboration with other acute and primary care organisations across South West London and is used during admission to personalise care for each patient.

Staff from Kingston Hospital participated in workshops coordinated by NHS London. Patients with learning disabilities, representatives from local care homes and NHS Richmond identified areas to improve services for patients with Learning Disabilities and their Carers in 2010/2011.

Throughout the year, the Trust has worked to implement plans that improve access to hospital services for patients with disabilities. Dedicated training courses were delivered to Matrons and Ward Sisters across the organisation and there are plans to extend this training to other staff groups next year.

Patient Safety

The Trust is committed to providing safe and effective care for patients and has undertaken a number of activities during the year that positively contribute to this.

Kingston Hospital took an active part in the national Patient Safety Week in September. There were regular walk rounds of wards and other clinical areas by Executive Director s, 'Check the Meds', 'Check the Observations' audits, as well as patient safety poster displays and stands near the restaurant and at the front entrance to the hospital. Throughout the hospital, commodes are regularly checked to ensure that they remain clean and safe for patient use.

The hospital also has a process in place to check all patients admitted to the hospital for risk of Deep Vein Thrombosis (DVT) and provide preventative treatment if necessary. In February this year, the Trust also took part in National Dignity Action Day to promote patient privacy and dignity.

Safe Surgery Checklist

During the year, the Trust responded to guidance from the National Patient Safety Agency about the implementation of a new form of surgical checklist to help reduce the risk of errors in identification of correct surgical procedures and patients. The checklist was originally developed by the World Health Organisation (WHO) and a team of the Trust's senior clinicians were gathered together to see how the Trust could integrate this international good practice in its surgical services. There was great enthusiasm for using the checklist and the new process has now been rolled out to all surgical areas across the Trust.

Identification of the deteriorating patient

The Trust has reviewed and updated its process for speedy identification of deterioration in patients and how to escalate this appropriately. A revised observation chart and training of all staff has been completed. A regular audit of its use is being continuously monitored to ensure it becomes well embedded in everyday practices.

Response to national alerts on patient safety

The Trust regularly receives national alerts on patient safety issues and performance of medical equipment. During 2009/10, 114 alerts were issued, of which 94 were relevant to the services or equipment provided by the Trust. For these 94 alerts, the Trust completed the actions recommended in each alert within the required timescale in 97% of cases.

As part of its system for identifying learning from external sources of patient safety information, the Trust has also considered the recommendations outlined in the Care Quality Commission report on Milton Keynes NHS Foundation Trust Maternity Services and the Francis Inquiry Report into Mid Staffordshire Hospitals NHS Foundation Trust. Action plans to disseminate the lessons identified in these reports have been developed and are being implemented across the Trust.

Kingston Hospital's Same Sex Accommodation declaration

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. Kingston Hospital's Trust Board is committed to providing every patient with same sex accommodation, as it believes this safeguards patients' privacy and dignity when they are often at their most vulnerable.

Mixed sex accommodation has been virtually eliminated across the Trust. Sharing accommodation with members of the opposite sex will only happen by exception, based on clinical need; for example where patients require specialist equipment and interventions. At Kingston Hospital this will include areas such as ICU, CCU/ Step-down and the Stroke Unit, or when patients choose to share.

Privacy and Dignity

Kingston Hospital has invested in improvement works to clinical areas to meet new privacy and dignity guidelines issued by the Department of Health. The funding was made available centrally. These works included remodelling all Esher Level Seven patient shower/toilets and installing panels to create cubicles in the Day Surgery Unit in March 2010. The panels create a more private area for patients.

Swine Flu

During the swine flu pandemic, the Trust worked closely with colleagues at NHS Kingston, Department of Health (DH) and the Health Protection Agency (HPA) to ensure that a comprehensive plan for the healthcare of the local community was in place and consistent messages were being sent out to staff

and patients. In September the hospital invited all health, social services and local council partners to a table top exercise called, 'cold play' designed by the DH to test the cohesiveness of local plans.

Kingston Hospital faced considerable activity pressures during the early months (May and June 2009) of the swine flu pandemic. The first patient to be affected within the local area was a pupil at a school in early May. As a result several schools had to be closed and hundreds of individuals were given doses of antivirals. This affected daily attendances at the A&E Department at Kingston, which rose from an average of 274 in May 2008 to 303 in May 2009 and monthly range broadened from 216 – 351 to 281 – 387.

The number of in-patient cases peaked in June. These patients were isolated within two bays on the Medical Assessment Centre. Many attendees only required reassurance, which complemented the information already provided on the Trust's website and the various pamphlets and posters distributed throughout the hospital. Local radio was also used as a medium for getting the message to everyone to contact their GP rather than attend A&E.

During June the first antiviral collection points opened. Pharmacy staff from Kingston Hospital assisted in staffing these collection points.

During the summer holidays the Kingston area saw a reduction in the number of swine flu cases, which enabled the Trust to prepare for the peak of the pandemic scheduled for September when children returned to school. The reduction in the number of attendances at A&E was helped by the opening of the National Pandemic Flu Helpline.

The first patient with swine flu in the Hospital's Critical Care area was in November. In December Kingston Hospital had its first death from swine flu, a patient with a long-term underlying condition, but there has been very few other cases during the winter period.

The swine flu vaccination programme for staff commenced on 26 October 2009. Occupational Health staff visited the clinical areas over a three week period, initially prioritising staff working in high risk areas. This was followed up with open 'drop in' sessions in Occupational Health, which are ongoing. To date, 44% of front line staff have been vaccinated.

During and after the pandemic a number of lessons were learnt, which the Trust will be reviewing to ensure readiness and resilience for any future pandemics.

Major incident plan compliance

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

Kate Grimes, Chief Executive, Kingston Hospital NHS Trust

10. Fundraising

Kingston Can

Kingston Can is the charity that was set up to raise funds to help build the SWR Unit. Although the major fundraising effort for Kingston Can is complete and the SWR Unit has been open for some time, nevertheless donations continue to be received on a regular basis from the hospital's supporters.

Over £100,000 has been donated during the financial year, from a tremendous variety of sources, and people remain keen to provide ongoing support to the unit. Some of the money raised has helped fund equipment at the SWR Unit.

Born Too Soon

Kingston Hospital's Born Too Soon is celebrating its 25th Anniversary this year. The charity was established in 1985 by parents and staff to offer information and support to parents who have a baby or babies being cared for on the Neonatal Unit at Kingston Hospital. The charity offers the invaluable little 'extras' that the NHS cannot provide, including instant photographs, baby clothes, blankets as well as Christmas Day and Mother's Day presents and cards. Born Too Soon has been chosen by Sainsbury's as their charity for 2009/2010.

In the last year alone, the charity has raised over £100,000 through various fundraising events and has helped purchase resuscitation stations, foetal heart monitors, phototherapy units (light units for treating jaundice), giraffe incubators, bereavement support, vital signs monitors and new furniture in the Neonatal Unit.

The charity also helps provide funding towards a weekly parents support group (Welcare) for families and a twice-yearly memorial services organised in conjunction with the Chaplaincy and the Maternity Unit.

Momentum

Momentum was established as an independent charity in 2004 and supports children with cancer and life-limiting conditions in Surrey and South West London. In 2009 Momentum raised funds for a 'quiet room' in the Paediatric Department where medical staff can have confidential talks to patients and where bereaved parents, or parents of very sick children, can have private time alone. In order to make the best use of space, the room will also have a dual purpose as a 'sensory room', so that children who are unable to see or hear, or have a learning disability, can use sensory equipment in a peaceful, relaxing environment.

Last year Momentum also bought a log cabin in Dorset, which they had previously been renting. This will help continue to send families (whose children are patients of Kingston Hospital) away on holidays. The log cabin has also been available to Paediatric nursing staff. For Christmas 2009,

Momentum set up a wonderful Santa's Grotto in the Momentum Children's garden, which all the oncology and other seriously ill children were invited to visit.

Momentum furthermore supports children and their families on an individual basis and pays for special treats and outings, or for expensive items such as wigs for teenagers who have lost their hair during chemotherapy treatment.

Friends of Kingston Hospital

The Friends continue to support the Trust by raising funds in a number of ways. In the past twelve months almost £40,000 has been contributed to a variety of different areas affecting and improving the lives of patients, staff, and visitors.

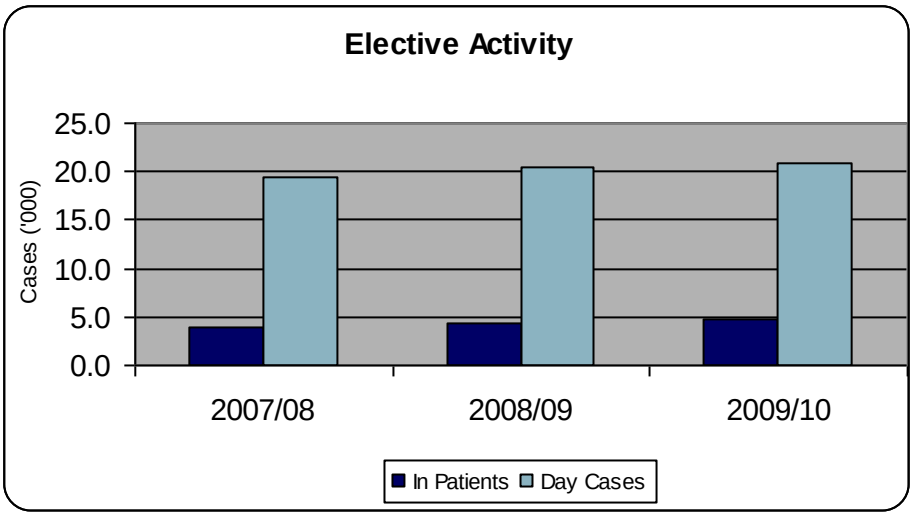
Together with Hospital Radio, which provides an invaluable service to patients in the hospital, the Friends have almost 100 unpaid volunteers, holding raffles, tombolas, bazaars and book sales throughout the year.

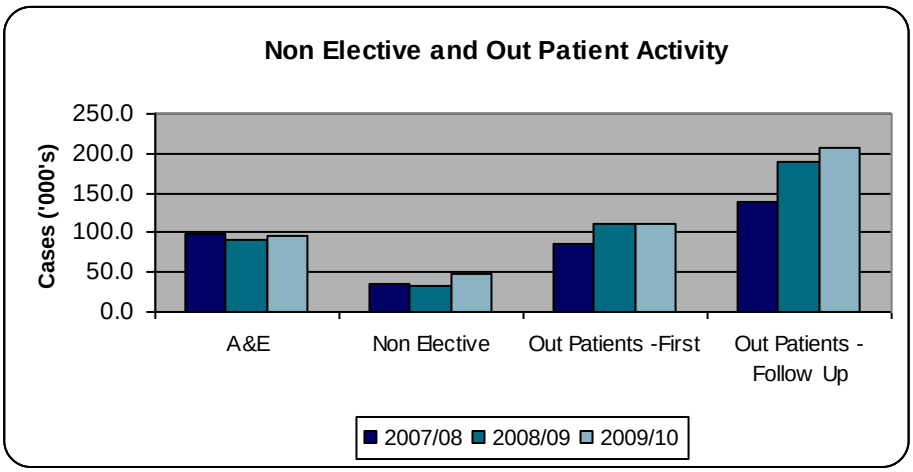
11. Operating and financial review

In this section of the Annual Report we bring together a summary of the Trust's performance in the year and review prospects for the new financial year.

Operational Performance

In 2009/10 the Trust's clinical activity increased by 6% over 2008/09. The majority of the increase was in outpatients (20,000 appointments, 6.7%) and includes the transfer of women's services from QMR. Increases were also seen in elective activity (4%), non elective activity (9.9%) and A&E attendances (4%).





The Trust has continued to perform well in 2009/10 as measured by the NHS performance management system, delivering on the majority of key targets. The table below summarises performance against those key indicators.

In the CQC Annual Health Check, the Trust achieved a ‘fair’ performance rating for its quality of services and a ‘good’ performance rating for its use of resources for 2008/9 (published in October 2009). Disappointingly these ratings were down from ‘good’ and ‘excellent’ in 2007/8. Clear objectives have been put in place across the Trust, which is already making a difference to its performance.

Annual Performance Rating

The Trust’s own assessment of its performance against the indicators that will be used for 2009/10 Performance rating is shown below:

Performance Indicators		Target 2009/10	Position for 2009/10
Speed of treatment for cancer patients:			
All patients will be seen within two weeks from an urgent GP referral for suspected cancer to their first outpatient appointment		93%	94.06%
All patients will be seen within one month of diagnosis (decision to treat) to treatment		98%	98.44%
Cancer Diagnosis to Treatment Waiting Times - 31 day second or subsequent treatment (surgery)		94%	90.91%
Cancer Diagnosis to Treatment Waiting Times - 31 day second or subsequent treatment (drug)		98%	100%
All patients with suspected cancers will be seen within two months of urgent referral to treatment		85%	85.85%
Cancer Urgent referral to treatment Times - 62 day referral to treatment from screening		90%	90.24%
Cancer Urgent referral to treatment Times - 62 day referral to treatment from hospital specialist		85%	98.04%
Speed of treatment for inpatients and outpatients			
Number of patients waiting longer than the 26 week standard for inpatient admission		0.03%	0.00%
Number of outpatients waiting longer than the 13 week standard for outpatient appointments		0.03%	0.008%
18 weeks Referral To Treatment	Admitted Patients	90%	94%
	Non Admitted Patients	95%	96.3%
Speed of treatment in A&E			
Total Time in A&E: four hours or less		98%	98.4%
Speed of treatment for cardiac patients			
Number of patients seen within two weeks of being referred to the rapid access chest pain clinic		100%	100%
Reduction in healthcare acquired infection			
Achieve a 60% reduction of numbers of MRSA Bacteraemia on 2003/04 figures baseline		12	13
Reduction of number of C.diff positive cases - achieve 30% reduction by 2010/11 on the 2007/08 (Trust Apportioned)		45	25
Quality of Stroke Care - Proportion of Stroke Patients spending>90% of their time on Stroke Unit		70%	59.3%
Smoking during Pregnancy and Breastfeeding initiation rates - Breastfeeding		86.5%	89.2%
Smoking during Pregnancy and Breastfeeding initiation rates - Smoking		4.3%	4.3%
The % of first attendances at a GUM service offered an appointment < 48hrs		98%	100%
Proportion of patients whose operation was cancelled, by the hospital, for non clinical reasons, on the day or after the admission		0.8%	0.74%
Delayed transfer of Care		3.5%	4.9%

Information Governance Assurance

There were no serious untoward incidents involving personal data during 2009/10.

Summary of other personal data related incidents in 2009/10	
Nature of Incident	**Total**
Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	0
Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	0
Insecure disposal of inadequately protected electronic equipment, devices or paper documents.	0
Unauthorised disclosure.	3
Other.	0

Financial Standing and Results

The Trust planned to deliver a £1.9m surplus in 2009/10. This target was revised in year to £1.2m, reflecting an impairment charge (£0.7m) the Trust had to make to its financial position, as a result of the downturn in property valuation. Similar adjustments have been common across the NHS.

During the year the Trust incurred additional costs relating to the flu pandemic (equipment and consumables), staff training (CRS) and increased activity levels. These were offset by additional income due to over-performance, particularly in the later part of the year.

On 1 October 2009, Kingston Hospital successfully entered into a contractual relationship with BMI Healthcare Limited for the latter to deliver private patient services at the Kingston Hospital site. Although the service is in its infancy it has already started to generate increased revenue for the Trust.

The Trust successfully managed to deliver £6m of efficiency savings in year and looks to build on this position in 2010/11.

Financial Targets

Each year the financial performance of the Trust is judged externally against a range of financial duties and targets. A summary of the Trust's duties is detailed in the table below. The full set of accounts can be found at Chapter 18.

	Plan	**Actual**	**Achieved**
Financial Balance before impairments	£1.9m surplus	£1.9m surplus	✓
External Financing Limit	-£0.2m	-£0.2m	✓
Capital Resource Limit	£7.0m	£7.0m	✓
Capital Cost Absorption	3.50%	3.50%	✓

Changes in accounting policies

Financial reporting requirements have changed, with a new set of standards being introduced on 1 April 2009. The Trust is required to comply with the new rules called International Financial Reporting Standards (IFRS). These standards have been used in private sector reporting for a number of years, to provide consistency and comparability between financial reports in the global economy.

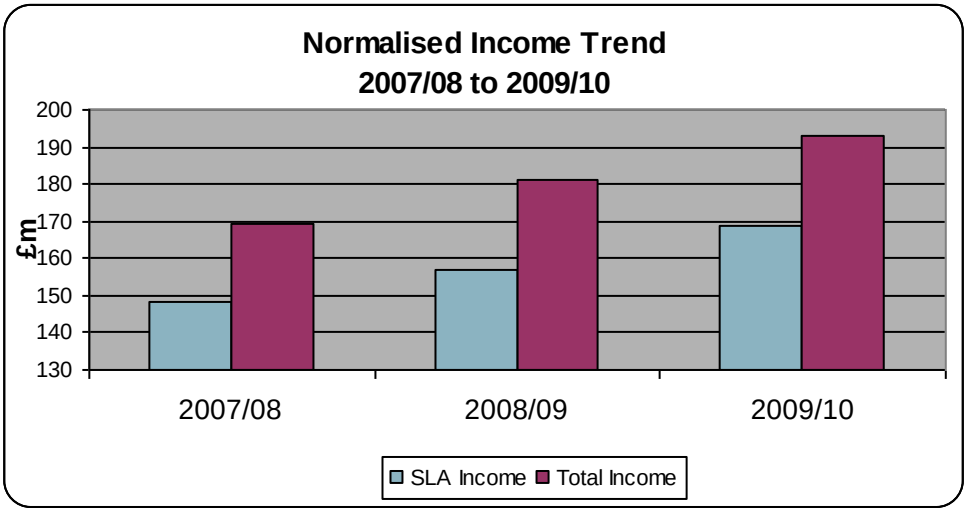
The annual accounts in section 18 are present under the IFRS format; with the 2008/09 accounts restated under IFRS rules to enable a comparison. The main changes to the Trust's accounts are:

- new terminology within the financial statements
- re-classification of leases – changes in rules to classify types of lease
- finance leases, including PFI contracts, to be identified as a Trust asset.

Revenue

In 2009/10 the Trust received £195.7m income. This is an overall increase of 6.8% on the income received in 2008/09.

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



Income can be classified as following:

- direct patient treatment 88%
- private income 1%
- training and education 4%
- other income 7%

Income relating to direct patient care increased by £9.7m in 2009/10. These changes can be attributed to an increased number of patients treated by the Trust (£5.0m) and price changes through

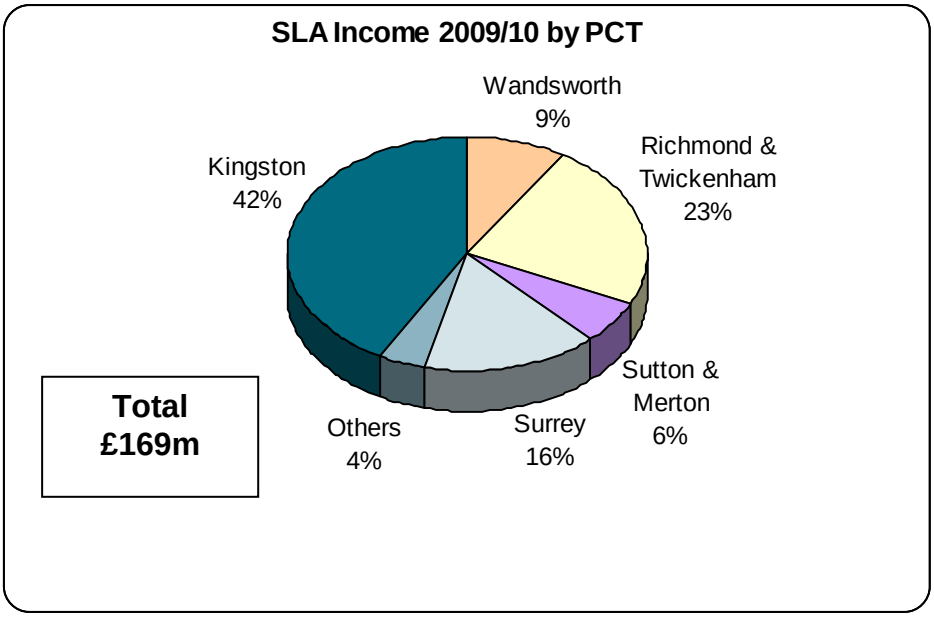
the introduction of the new tariff system (HRG4) in 2009/10 (£4.7m). This tariff system was updated to better reflect the actual costs incurred by trusts by redistributing funding more accurately. Further to this, some tariffs were increased to enable investment in service to improve quality eg maternity services.

The key changes are detailed below:

Service	**Income Increase**	
Maternity	£3.5m	Increased number of births and increased tariff to reflect the investment in maternity service improvement programme
Ophthalmology (Wet AMD)	£1.5m	This service continues to expand since NICE approved the treatment in August 2008
Orthopaedics	£1.2m	Increased number of patients treated plus increased funding through HRG4

During 2009/10 the Trust worked in partnership with other providers (eg QMR) to deliver patient care on their sites. This activity and its associated tariff income is not included within the Trust's financial position.

The Trust's patient care income was commissioned by five main PCTs. The split of income is detailed below:



Expenditure

From 1 April 2009 the Trust was required to produce its financial statement under International Financial Reporting Standards (IFRS). This has increased the costs charged in the accounts for this financial year by £0.9m. The majority of this increase relates to the PFI schemes being identified on the Trust's Statement of Financial Position (also known as moving the assets onto the balance sheet).

The total cost incurred in 2009/10 was £194.5m. This can be summarised in the following categories:

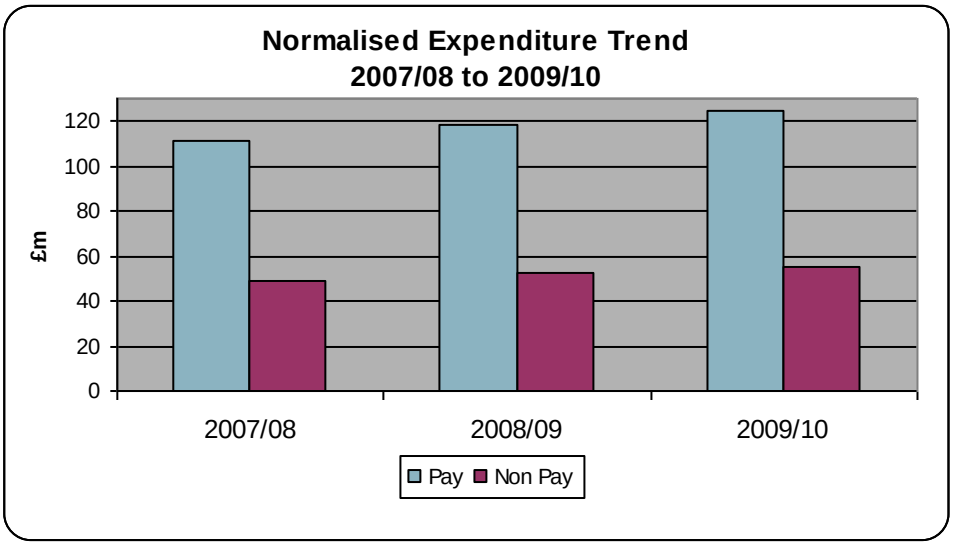
- pay £125.5m
- non pay £63.9m
- finance costs (PFI) £2.1m
- public dividend payable £3.0m

Pay costs increased by £7.2m (6%). This can be attributed to pay awards and increments £5.1m (5%); staffing to deliver increased levels of activity £1.3m; and additional resource to support CRS deployment £0.8m.

Non-pay costs increased by £4.1m (7%). The main increases are due to:

- clinical insurance premiums increased across the NHS in 2009/10 and the impact on the Trust was £2m
- due to the current financial climate, the interest relating to cash held at bank reduced by £0.4m
- the Trust invested in further supplies due to the swine flu pandemic (£0.2m)
- drug spend increased by £1.4m (50% increase on 2008/09 costs) due to expansion of the wet AMD service and increase prices.

The finance costs incurred by the Trust are in line with those for 2008/09 (as restated under IFRS) and relate to the lease contracts now reported on the Statement of Financial Position eg PFI



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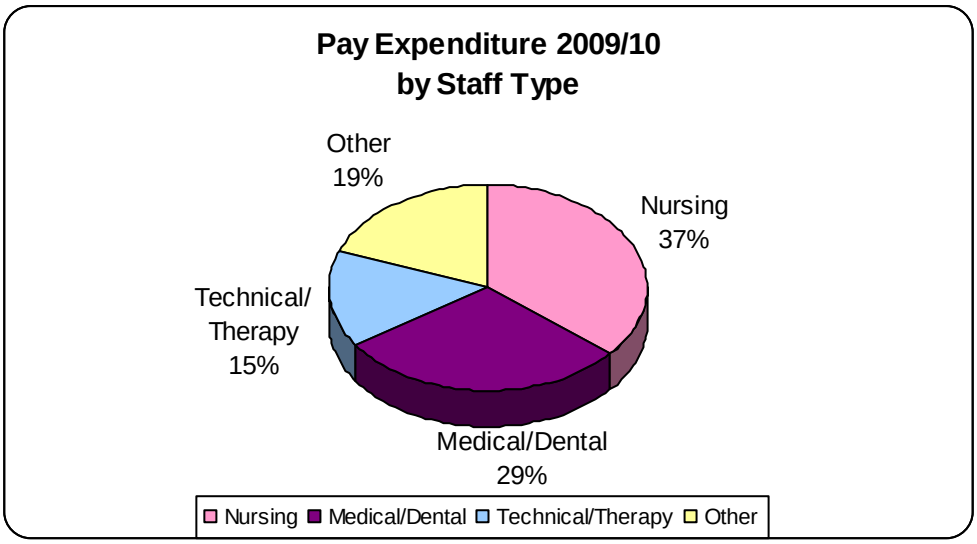
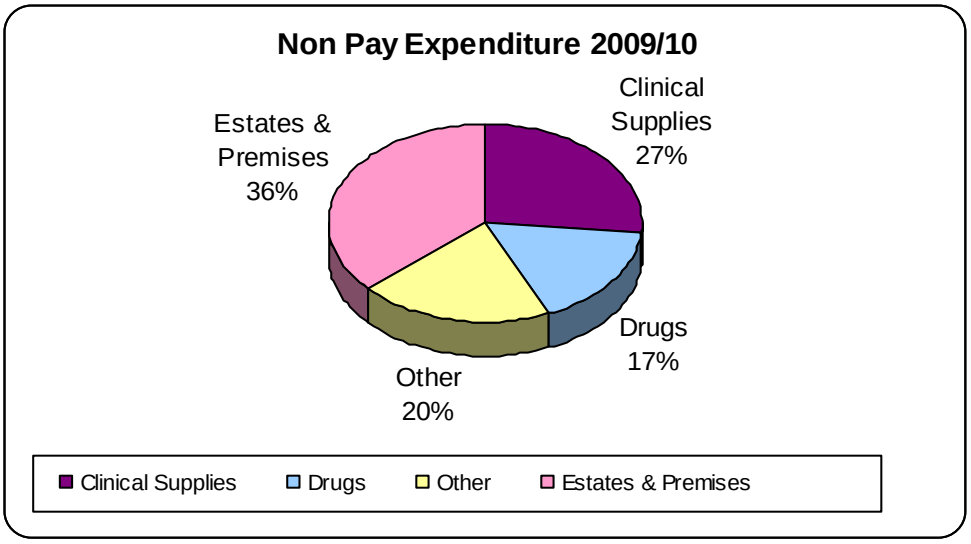




Capital investment, return on assets, capital structure, cash and the External Financing Limit

The Trust had an approved capital expenditure of £6.973m for 2009/10. This is known as the Capital Resource Limit (CRL). The main expenditure programme can be divided into three areas:

- estates
- medical Equipment
- IM&T

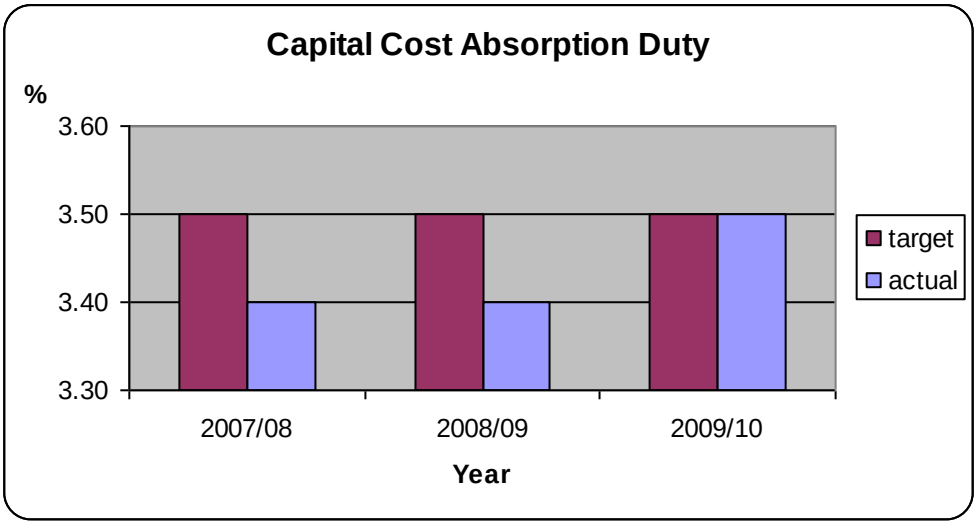
The key project delivered in 2009/10 was the deployment of CRS, in November 2009. The Trust spent £3.4m (49%) on the development and implementation of the IT solution in year.

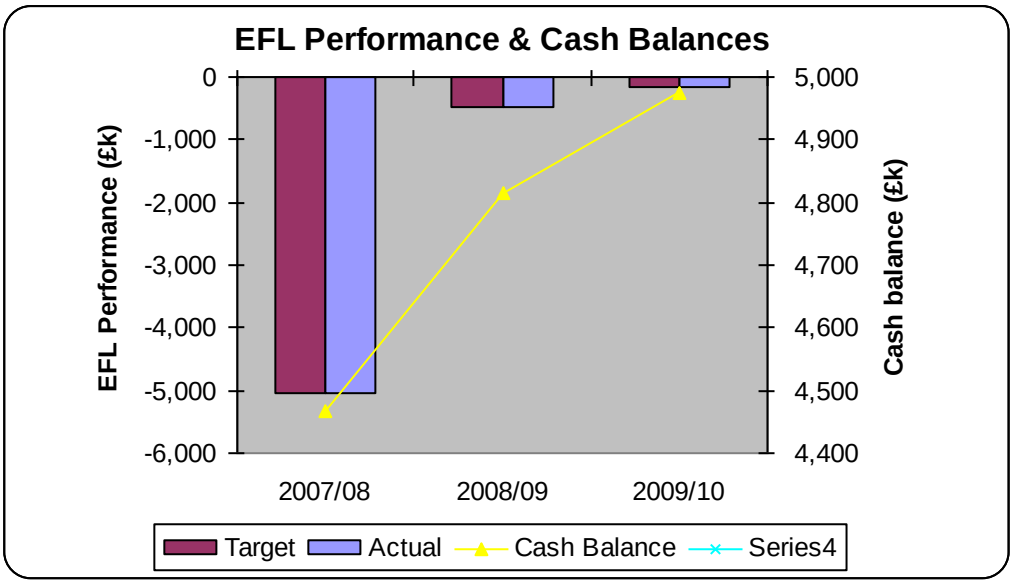
The Trust continued to maintain and update its estate (£2.0m. 28%) and clinical equipment (£1.4m, 23%). This included improving the ward environment, single sex facilities and investing in additional equipment to support clinical services such as the maternity improvement programme.

During 2009/10 the Trust was required to have its land and buildings re-valued. This has resulted in a reduction in the value of the assets, which is in part due to the current economic climate. The asset values have decreased by £28.2m (over 21%) of which £9.5m relates to land. Where available, the fall in value has been funded using the revaluation reserve. The remaining cost has been charged to the revenue account as an impairment (£0.7m). The affect of reduction in asset value has led to a reduction in the public dividend payable to the Treasury (£1m less than 2008/09).

Planned capital expenditure for 2010/11 is £7.2m of which 49% relates to estates, 25% to IM&T and 14% to clinical equipment. The remainder is a contingency for emergency capital items in year.

NHS trusts must plan to achieve a 3.5% Capital Cost Absorption Duty (CCAD), which reflects the Trust Debt Remuneration (dividends) as a percentage of net assets. This recognises that there is a financing cost associated with the capital base and the Trust is therefore required to absorb the capital costs in full through the public dividend payable to the Treasury. In contrast to previous years the 2009/10 dividend was required to be calculated on the actual average net book value of the assets over the year. This target was achieved by the Trust.





The Trust's financial performance is monitored against the duty to meet its External Financing Limit (EFL). The EFL is a control on net cash flows of NHS trusts. It sets a limit on the level of cash that an NHS trust may draw from external sources or its own cash reserves (which would be a positive EFL) or increase cash reserves (a negative EFL). The Trust met its planned increase in cash reserves (a negative EFL of £0.2m) and has consistently met this target.

Efficiency

The Trust continues to work in partnership to deliver effective and efficient services to the local health economy. This is demonstrated through a below average national reference cost index (ie 100) of 96 in 2008/09.

Recognising the future slowdown in public sector spending the Trust continues to develop its service line reporting system. This has enabled the examination of efficiencies, informed service strategies and played a key role in identifying savings programmes for 2010/11.

Financial Outlook

The Trust has developed a financial plan for 2010/11 recognising public spending is required to reduce. This is a significant change from the recent environment of above inflation increases granted to the NHS. This has made the planning cycle a challenging process for both providers and commissioners.

Whilst recognising the financial challenges ahead, the Trust has developed a plan showing a £1.9m (1%) surplus. It is important that this funding is saved for future years to ensure the estate and equipment can be maintained and updated as well as investing service development.

The level of savings required to attain this surplus whilst continuing to invest in quality of care is £11.6m. This is a challenging target and developing schemes to deliver the savings has been a key part of the planning process for 2010/11. Efficiency targets have been developed using service line reporting information or each department. This has enabled clinical engagement and appropriate levels of savings to be identified in all service. During 2010/11 back office functions will benchmark themselves against similar providers to ensure value for money and that the maximum funding is direct towards front line services.

2010/11 will see the expansion of the clinical quality indicators (CQUINs). Achievement of the agreed quality standards will enable the Trust to earn £2.5m clinical income. This is a key priority for the Trust and processes are being developed to ensure delivery of the indicators and receipt of the funds.

During 2010/11 the Trust will continue to work with the commissioners to develop patient pathways which will ensure patients are seen by the right person, at the right time, in the right place. This will support the delivery of Healthcare for London, efficiently delivering quality care closer to home.

Employees

The Trust is committed to employment policies which follow best practice based on equal opportunities for all employees, irrespective of sex, race, national origin, religion, colour, disability, sexual orientation, age or marital status.

Employees are kept closely involved in major changes affecting them through such measures as team briefings and internal communications. There are well-established procedures to ensure that the views of the employees are taken into account in reaching decisions.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days or receipt of goods or a valid invoice, whichever is later. Further to this the Trust continued to pay non NHS creditors within 10 days, where possible.

In 2009/10 the Trust paid 96% by value and 92% by number for non-NHS trade invoices.

The Prompt Payment Code

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

Approved signatories undertake to:

- pay suppliers on time
- give clear guidance to suppliers and resolve disputes as quickly as possible
- encourage suppliers and customers to sign up to the code.

Each May and November the Trust will be reassessed to ensure we are still paying promptly.

External Auditors

The Trust's external auditors for the financial year 2009/10 were the Audit Commission. Their fees amounted to £126,100 (2008/09 £160,000), which was for services provided to conduct the statutory audit and related services.

Late Payment of Commercial Debts

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

Management Costs

The Trust's management costs are subject to public and DH scrutiny, as defined by the Audit Commission, and for 2009/10 were 6.6% of income (net of training income) received in the year.

Pension Liabilities

Treatment of pension liabilities can be found in note 12 of the annual accounts.

Directors and Directors' Interests

During the year none of the Trust's Directors or senior management staff, or parties related to them, has undertaken any material transactions with Kingston Hospital NHS Trust except for the matter noted below:

During 2009/10, the Trust paid for £139,200 of legal services from Morgan Cole, one of whose partners is the spouse of Andrew Seddon who was, the Trust's Director of Finance and Information (for the period to 31 January 2010). This interest was properly disclosed in the Trust's register of interests.

Gren Collings, the Trust's Associate Director currently holds the position of Property Advisor to South West London & St Georges Mental Health Trust. During 200910, The Trust has procured products and services from this NHS body totalling £92,626.80, and provided products and services to the same to them of £701,428.48. The interest is properly disclosed in the Trust's register of interests

Corporate Governance

Much of the legislative basis for NHS powers is provided by the National Health Service Act 1977 and the NHS & Community Care Act 1990. This is supplemented by Statutory Instruments and Directions from the Secretary of State. The Chief Executive is the Accountable Officer of the Trust.

The Trust operates a sub-committee and working group structure that reflects the need of the Trust Board to fulfil its governance obligations. The Compliance and Risk Scrutiny Committee monitors and reviews the operation of risk, control and governance processes which have been established in the organisation.

The Trust's Internal Auditors, Deloitte & Touche, regularly report to the Audit Committee on a work programme derived from a risk assessment of Trust activities and reviews the Assurance Framework, which supports the Statement of Internal Control. Under these arrangements the auditors have reported that the Trust is compliant with the prescribed criteria for assessing the Assurance Framework. In addition, the Trust's external auditors, the Audit Commission, have reported to the Audit Committee on the financial aspects of corporate governance. There have been no matters identified by either the internal or external auditors that have required reporting to the Trust Board.

As far as the Board is aware there is no relevant audit information of which the Trust's auditors are unaware. The Board has taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of that information.

12. Trust Board

Kingston Hospital is managed by a Trust Board, made up of the Chairman, the Chief Executive, full-time Executive Directors and part-time Non-Executive Directors.

The role of the Trust Board is to:

- set the overall strategic direction of the Trust
- provide effective financial control
- ensure high standards of corporate governance
- ensure the Trust provides high quality, effective and patient-centred care.

Trust Board meetings are held in public every month (except August and December) at the hospital site on Galsworthy Road, Kingston upon Thames. From April 2010, Trust Board meetings will move to being every second month instead of monthly. Dates of future meetings and minutes of previous meetings can be found at www.kingstonhospital.nhs.uk

Trust Board profiles

Christopher Smallwood - Chairman

Christopher Smallwood was appointed Chairman of Kingston Hospital in December 2008.

Prior to this he was Chair of NHS Hounslow (Hounslow Primary Care Trust and was appointed in January 2007) and Policy Adviser to The Prince's Charities.

Until 2005, he was Chief Economic Adviser to Barclays Plc, following several years as a partner at the City consultancy Makinson Cowell. He was formerly Strategic Development Director and Chief Economist at TSB Group. He was also Economics Editor of The Sunday Times and Chief Economist and Head of Financial Strategy and Planning for BP. He has been an Economic Adviser to HM Treasury and a Special Adviser at the Cabinet Office. He is also currently a member of the Competition Commission.

Christopher is Chairman of the Finance & Investment and Remuneration Committees.

Kate Grimes - Chief Executive

Kate joined Kingston Hospital as Chief Executive on 1 December 2008.

Prior to starting her career in the NHS, Kate spent a year in the Sudan teaching English after graduating in Biology. Her first job in the NHS was as a porter, followed by various roles managing a range of clinical and non clinical services.

After gaining a distinction in her Masters in Health Services Management, Kate specialised in service improvement and redesigning services with patients, managing a major change programme at King's College Hospital, which pioneered new techniques in service design and delivery.

In 2002, Kate joined the South East London Strategic Health Authority as Director of Development before being appointed Deputy Chief Executive in 2004. Kate was appointed Chief Executive of Queen Mary's Sidcup in October 2005 and successfully managed the hospital through a challenging period, working with partners to secure its strategic future.

Andrew Seddon - Director of Finance and Information (to January 2010)

Andrew was appointed to the Board of Kingston Hospital as Director of Finance and Information in June 2006. Andrew joined the NHS in October 2002, and since then has worked for Sutton and Merton PCT where he was Chief Operating Officer and previously Director of Finance and Commissioning. Prior to that Andrew had 20 years' experience in the private sector, most recently as the European Chief Financial Officer for a major US asset financing company. Andrew is a Chartered Accountant. He trained originally with Price Waterhouse Coopers in London.

Candace Imison - Non-Executive Director (from December 2009)

Candace Imison was appointed Non-Executive Director of the Trust on 1 December 2009. Candace has had a long career in the NHS where she has held a number of board level and senior management roles. Between 2000 and 2006 Candace was a senior strategy advisor at the Department of Health. In 2007 Candace began working at The King's Fund and took on the role of Deputy Director of Policy at the Fund from January 2009. Candace is a member of several committees including the Compliance & Risk Scrutiny Committee, Finance & Investment Committee, as well as the Remuneration Committee.

Charles Carter - Non-Executive Director

Charles was appointed as Non-Executive Director of the Trust in June 2006. He is currently self-employed in various consulting and non-executive roles. Prior to this, he was a partner with Accenture Ltd (formerly Andersen Consulting), a global management consulting and technology services company. While there he specialised in working with clients to improve their customer service and also held a number of internal positions, including leadership of the company's UK strategy practice. Charles is also Chairman of Rokeby Educational Trust Ltd, an independent school for boys in Kingston. He is a member of the Audit, Finance & Investment and Remuneration Committees and chairs the Charitable Funds Committee.

Cherill Scott - Non-Executive Director

Cherill was appointed as a Non Executive Director of the Trust in August 2005. Cherill is a Registered Nurse who has held academic research posts in the Department of Epidemiology, London School of Hygiene and Tropical Medicine (University of London) and the Royal College of Nursing Institute. She

has recently taken up the post of Senior Research Fellow in the School of Health and Social Care, University of Greenwich. Cherill is a member of the Trust's Remuneration and Compliance & Risk Scrutiny Committees.

Dr Colin Todd - Medical Director (to June 2009)

Colin was appointed Medical Director of Kingston Hospital in June 2006. He joined the hospital in 1998 as Consultant Radiologist. Colin was the Trust's Lead Clinician in Radiology from 2002 - 2006 and Clinical Director for the Clinical Services CMG from 2003 - 2006. Prior to this he was at QMR, where he was appointed Consultant Radiologist in 1991.

Gren Collings – Non-Executive Director

Gren joined as an Associate Director of the Trust in July 2004. Gren is a fellow of the Royal Institute of Chartered Surveyors, is Chairman of Kingston University and a non-executive Strategic Property Advisor to South West London and St. George's Mental Health Trust. Gren is a member of the Charitable Trust Funds Committee and Remuneration Committee.

Helen Dirilen – Director of Nursing and Quality

Helen was appointed as Deputy Director of Nursing at Kingston Hospital in October 2002 and was appointed as Director of Nursing and Quality in October 2007.Helen stated her career in nursing in 1978 as an ophthalmic student, qualifying as a General Nurse in 1985 in Liverpool. She moved to London in 1987 to take up her first Ward Sister post and since then has been both a Senior Nurse and Transformational Lead.

John Charlick – Non Executive Director

John joined the Trust on 1 December 2007. He was a partner with KPMG (major accountancy and advisory firm) for over 20 years, where he specialised in corporate finance, mergers and acquisitions. During his KPMG career, he gained significant international management experience and spent extended periods based in London, Chicago and Toronto. Subsequently, he was based in the Caribbean where he served as chief executive officer of a privately owned financial services group. John is a chartered accountant, a member of the Institute of Directors and a member of the Board of Governors of Farnborough College of Technology. John is Chairman of the Audit Committee and a member of the Remuneration Committee.

Lance McCarthy - Chief Operating Officer (from January 2010)

Lance joined Kingston Hospital as Chief Operating Officer in January 2010. Lance has worked in the NHS since 1994 in a variety of general management roles across a range of acute providers in London. Directly prior to joining Kingston, Lance was the Head of Operations for one of the Clinical Programme Groups at Imperial College Healthcare and prior to that the Associate Director for Performance at Hammersmith Hospitals. Lance is an economics graduate and has an MBA.

Mark Ogden-Meade - Chief Operating Officer (to December 2009)

Mark Ogden-Meade joined Kingston Hospital in April 2009 as Interim Chief Operating Officer to undertake a nine month contract to support the Trust through a period of change. Mark is an experienced NHS Senior Manager who specialises in interim executive work in acute hospitals. Mark has held a number of Board level posts over the last 15 years, including a spell as Chief Executive. In the last five years Mark has worked with a number of trusts in the south of England including Brighton University Trust, Maidstone & Tunbridge Wells and the Queen Victoria Foundation Trust where he held executive Director posts responsible for ensuring high levels of performance. Mark has a MBA from Warwick University in 1991.

Miss Jane Wilson - Medical Director (from August 2009)

Jane was appointed Medical Director of Kingston Hospital in July 2009. Jane has 16 years experience at Kingston Hospital as Consultant Obstetrician and Gynaecologist. Jane has held a number of leadership roles within the Trust, both in clinical management roles in the Women and Children Division, and most recently as the Trust's Director of Education from 2002 – 2009.

Peter Thomas - Non-Executive Director

Peter was appointed as a Non Executive Director of the Trust on 1 January 2005. Between 1970 and 2003, Peter held a number of senior management positions at Reuters, the global news and financial services company, including postings in the UK, Europe and North America.

Since leaving Reuters in 2003 Peter has worked as a consultant for a number of private companies and charities in the area of public and media relations. Peter is a member of the Remuneration & Audit Committees and Chair of the Compliance & Risk Scrutiny Committees.

Simon Ellen – Non-Executive Director and Deputy Chairman (to November 2009)

Simon joined the Trust on 1 April 2002. He has extensive experience in the financial services sector and was previously a Non-Executive Director of Homerton University Hospital NHS Trust. In addition to a number of Non Executive roles, Simon is an External Advisor to the Royal College of Physicians and to the Royal College of Nursing. Simon was a member of the Audit, Remuneration and Governance Committees and chaired the Finance and Contracting Committee. Simon completed his term of office in November 2009.

Simon Milligan - Director of Finance and Information (from February 2010)

Simon joined Kingston Hospital as Director of Finance and Information in February 2010. Simon joined us from Commissioning Support for London (formerly Healthcare for London) where he was the Senior Finance Lead working across London's 31 PCTs to implement Lord Darzi's report, 'A Framework for Action'. Before that, he worked as Director of Finance at Winchester and Eastleigh NHS Trust and in finance teams at Hammersmith Hospital Trust, St Mary's Hospital, S. Durham Health Care NHS Trust and the Northern Regional Health Authority. He started his accountancy career at KPMG.

As at March 2010 the interests declared by Board Directors are as follows:

Name	Board Position	Current Declared Interest
Christopher Smallwood	Chairman	Nothing to Declare
Kate Grimes	Chief Executive	Nothing to Declare
Candace Imison	Non-Executive Director	Deputy Director of Policy at the King's Fund
Charles Carter	Non Executive Director	Chairman Rokeby Educational Trust Ltd., Partner, Orion Partners LLP
Cherill Scott	Non Executive Director	Spouse of Vice Chancellor Kingston University
Gren Collings	Associate Director	Chair of Board, Kingston University Strategic Property Advisor, South West London & St Georges Mental Health Trust
Helen Dirilen	Director of Nursing and Quality	Nothing to Declare
John Charlick	Non-Executive Director	Nothing to Declare
Lance McCarthy	Chief Operating Officer	Nothing to Declare
Jane Wilson	Medical Director	Nothing to Declare
Peter Thomas	Non-Executive Director	Nothing to Declare
Simon Milligan	Director of Finance & Information	Nothing to Declare

13. Remuneration report

The Remuneration Committee is a permanent body which determines the contractual terms, conditions and benefits, including salaries, of Trust Executive Directors including the Chief Executive.

Membership of the Committee comprises:

- The Trust Chairman
- All Non-Executive Directors

The Chief Executive, the Director of Human Resources & Organisation Development and the Board Secretary attend meetings by invitation only.

The objectives of the Committee are:

- to receive updates on national pay initiatives
- to receive and review senior pay comparator data
- to determine Executive pay strategy for the Trust
- to determine the remuneration of the Chief Executive and anyone who reports to the Chief Executive
- to address other tasks as determined by the Committee or referred to the Committee by the Board.

The Committee meets at least once a year, or ad hoc as required, to determine pay policies or to address other tasks referred to it by the Board.

Executive Directors (excluding interims) hold permanent contracts of employment and are subject to three months' notice. All contracts are made and terminated in accordance with best practice and employment law.

The framework for remuneration of Executive Directors is guided by benchmarking within and outside the NHS to determine appropriate levels. Interim pay rates are agreed by the Remuneration Committee.

Executive Director Posts may be reviewed individually in the light of changes in their responsibilities, in market factors, pay relativities or other relevant circumstances. Each Executive Director is appraised annually against objectives set at the start of the financial year, which reflect the corporate objectives agreed by the Board. Pay is not performance related.

26 May 2010 Chief Executive

Salaries and Allowances

Name and Title	2009-10			2008-09		
	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind (Rounded to the nearest)	Salary (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind (Rounded to the nearest)
	£000	£000	£000	£000	£000	£000
Christopher Smallwood *Chairman (from 01 January 2009)*	20-25	0	0	5-10	0	0
Claudette Asgill *Interim Director of Workforce & Organisation Development (from 4th January 2010 - 19th March 2010)*	45-50*	0	0	n/a	n/a	n/a
Rachel Benton *Commercial Director (from 1st March 2010)*	5-10	0	0	n/a	n/a	n/a
Anthony Brewer *IT Director*	100-105	0	0	90-95	0	0
Stuart Butt *Director of Planning*	95-100	0	0	90-95	0	0
Charles Carter *Non Executive Director*	5-10	0	0	5-10	0	0
John Charlick *Non Executive Director*	5-10	0	0	5-10	0	0
Gren Collings *Associate Director*	5-10	0	0	5-10	0	0
Helen Dirilen *Director of Nursing & Quality*	95-100	0	0	85-90	0	0
Simon Ellen *Non Executive Director & Deputy Chairman (to 30th November 2009)*	0-5	0	0	5-10	0	0
David Grantham *Director of Workforce & Organisation Development (from 22nd March 2010)*	0-5	0	0	n/a	n/a	n/a

Name and Title	2009-10			2008-09		
	Salary (bands of £5000)	**Other Remuneration (bands of £5000)**	**Benefits in Kind (Rounded to the nearest)**	**Salary (bands of £5000)**	**Other Remuneration (bands of £5000)**	**Benefits in Kind (Rounded to the nearest)**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Kate Grimes, *Chief Executive (from 10th December 2008)*	145-150	0	0	40-45	0	0
Candace Imison *Non Executive Director (from 1st December 2009)*	0-5	0	0	n/a	n/a	n/a
Sylvia Kennedy *Director of Strategy (to 3rd January 2010)*	75-80	0	0	95-100	0	0
Ruth Lewis, *Director of Workforce & Organisation Development (to 26th January 2010)*	80-85	0	0	95-100	0	0
Lance McCarthy *Chief Operating Officer (from 7th January 2010)*	25-30	0	0	n/a	n/a	n/a
Simon Milligan *Director of Finance & Information (from 1st February 2010)*	15-20	0	0	n/a	n/a	n/a
Mark Ogden-Meade *Interim Chief Operating Officer (to 24th January 2010)*	220-225*	0	0	n/a	n/a	n/a
Cherill Scott *Non Executive Director*	5-10	0	0	5-10	0	0
Andrew Seddon *Director of Finance & Information (to 7th February 2010)*	90-95	0	0	105-110	0	0
Peter Thomas *Non Executive Director*	5-10	0	0	5-10	0	0
Colin Todd *Medical Director (to 1st July 2009)*	15-20	35-40	0	60-65	135-140	0
Jane Wilson *Medical Director (from 3rd August 2009)*	15-20	90-95	0	n/a	n/a	n/a

*The remuneration for Mark Ogden Meade and Claudette Asgill was paid by their employing organisations. The salary reflected above comprises the charges for their services from the employing organisation (including employer on costs) and VAT.

Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2010	Cash Equivalent Transfer Value at 31 March 2009	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Rachel Benton	0-2.5	0-2.5	5-10	20-25	106	82	2
Anthony Brewer	0-2.5	5-7.5	45-50	140-145	1147	986	112
Stuart Butt	0-2.5	5-7.5	25-30	75-80	442	372	50
Helen Dirilen	2.5-5	7.5-10	25-30	80-85	503	411	71
David Grantham	0-2.5	0-2.5	7.5-10	20-25	119	84	1
Kate Grimes	2.5-5	12.5-15	35-40	115-120	653	526	100
Sylvia Kennedy	0-2.5	0-2.5	30-35	90-95	546	491	23
Ruth Lewis	0-2.5	0-2.5	0-5	10-15	100	76	17
Lance McCarthy	0-2.5	0-2.5	15-20	55-60	258	200	11
Simon Milligan	n/a	n/a	20-25	60-65	335	n/a	n/a
Andrew Seddon	0-2.5	2.5-5	10-15	30-35	215	165	35
Colin Todd	0-2.5	0-2.5	50-55	155-160	1212	1069	23
Jane Wilson	2.5-5	12.5-15	50-55	150-155	1006	786	119

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

The period of notice for the termination of employment of Senior Managers appointed at Agenda for Change Band 7 and above is three months notice on either side.

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 disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

There may be a significant difference when this year's CETV values are compared with last year's. This is due to a change in the factors used to calculate the CETVs, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine cash equivalent transfer values (CETV) from Public Sector Pension Schemes came into force on 13 October 2008.

Note: The relevant tables and narrative within the Remuneration Report have been subject to audit.

14. Statement of internal control 2009/10

Scope of responsibility

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

As Chief Executive I report to the Trust Chairman. I manage the Executive Team who have clear personal accountabilities and objectives to ensure the delivery of the Trust's Business Plan.

The Trust continually strives to improve patient care and part of this approach is to work closely with partner organisations. The Trust works in partnership with other health and social care organisations in the South West London sector. The Trust has a partnership arrangement with the Royal Marsden Hospital delivering cancer services for local patients in the SWR unit at the Trust and is a partner in the South West London Elective Orthopaedic Centre. The Trust also has close links with local PCTs, local authorities and the other acute trusts within the sector. I attend the Royal Borough of Kingston (RBK) Health Overview and Scrutiny Committee to account for the performance of the Trust to the local community.

I also account to NHS London for the performance of the Trust in regular meetings and through the provision of regular returns on financial and governance performance.

The purpose of the system of internal control

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

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

The system of internal control has been in place in the Trust for the year ended 31 March 2010 and up to the date of the approval of the annual report and accounts.

Capacity to handle risk

The Trust is committed to providing high quality services in a safe and secure environment. The Trust offers leadership on risk management through a clear risk management strategy and risk

management policy. There have been significant changes to the Executive Team in 2009-10 including the appointment of a new Medical Director, new Chief Operating Officer and a new Director of Finance and Information. A new Non Executive Director has also been appointed to the Board. The management of the Trust has continued to function well during this period.

As Chief Executive I have overall responsibility for risk, with day-to-day responsibility being delegated to the Director of Nursing and Quality, who is the lead for Clinical Governance and Quality at Board level and who works closely with the Medical Director and the Head of Corporate Affairs on risk management. The Chief Operating Officer is the Executive Director who is responsible for the estate and related risks. The remit of the Director of Finance and Information includes the formal role of Senior Information Risk Officer (SIRO) as well as being the lead for financial risk management.

The Trust employs a range of specialists to lead on the implementation of risk management strategies covering both clinical and non-clinical risks. These include the Head of Risk and Safety, the Health and Safety Advisor and specialists in information governance, fire, waste, infection control and tissue viability.

The responsibility for risk management is identified across all levels in the Trust; from Board members, through Divisional Directors and Divisional Managers to all staff and managers. Named Executive Directors have specific responsibilities and accountability for risk, and these are laid out in the Risk Management Strategy, which was reviewed by the Board in March 2010.

To support these accountabilities, the Trust implemented a revised governance structure in September 2009. A Compliance and Risk Scrutiny Committee has been established as a sub-committee of the Board. This committee is chaired by a Non-Executive Director and one of the three Non Executive Directors on the committee is a member of the Audit Committee. The Compliance and Risk Scrutiny Committee has responsibility for monitoring and reviewing the operation of the risk, control and governance processes which have been established in the organisation. The Audit Committee continues to have primary responsibility for financial risk and associated controls, corporate governance and assurance.

At operational level a Risk Management Committee has been established, chaired by the Chief Executive. The Risk Management Committee receives reports and monitors action plans from seven subgroups covering the main areas of risk: health and safety, patient safety, audit and clinical effectiveness, patient experience, outcomes, information governance and equality and diversity. The Risk Management Committee reports up to the Compliance and Risk Scrutiny Committee.

Staff and management responsibilities for risk are clearly identified within the Risk Management Strategy, covering both clinical and non-clinical risks. Staff are trained appropriately within that framework, the key elements being the use of root cause analysis techniques for the investigation of

serious incidents and the identification, preparation and evaluation of risks for the Risk Register. The Trust is committed to a robust induction process, and this includes the basic elements of risk management. Training and education of staff in good practice in managing risks of all kinds is provided both in house from the Trust's specialist advisory team for risk and safety and from external providers, such as fire safety. A range of formal training sessions on matters relating to risk is co-ordinated centrally.

The Trust is committed to learning from good practice, and works closely with its internal auditors and bodies such as the National Patient Safety Agency (NPSA), the Medicines and Healthcare Regulatory Products Regulatory Agency and Royal Colleges. The Trust regularly submits electronic reports of patient incidents to the NPSA.

Untoward Incidents and near misses are reported electronically and recorded on a central database, from which trends are analysed and performance reports produced at Trust and Divisional levels. All Serious Untoward Incidents at Level 2 or above are reported to the Board, the Strategic Health Authority and relevant Primary Care Trust, and are subject to a detailed investigation, reporting and action planning process. Learning from serious incidents is shared across the Trust through the Divisional Risk Performance Reports and risk newsletters.

The risk and control framework

Risk management is embedded in the activity of the organisation through:

- the Risk Management Strategy and supporting policies and procedures
- the committee structure described above
- management processes eg using a risk-based approach to help prioritise the Capital Programme
- the Board's Assurance Framework
- compliance with NHSLA risk management standards – Level 1
- compliance with core standards (Standards for Better Health), the Essential Standards for Quality and Safety (Care Quality Commission), key lines of enquiry from ALE (Auditors Local Evaluation) and the NHS Information Governance Toolkit
- the Risk and Safety Team working with divisions
- risk management skills training including both clinical risk assessments of various types and the mandatory and statutory training programme
- an active counter fraud culture.

The key elements of the Trust's Risk Management Strategy are designed to identify and control risks whether strategic, financial, reputational or relating to compliance, health and safety or clinical safety. The Risk Management Strategy is reviewed annually, the reviews taking place in March 2009 and March 2010. The 2009 strategy continued to build on the milestones and targets identified in the 2008 strategy with two additions:

- to ensure that events identified in the NPSA 'Never Events' programme for commissioners are actively prevented from occurring within the Trust
- to further develop key indicators in management of incidents and ensure that performance is, at least, in line with benchmarks.

The Trust's Risk Management Strategy focuses on a fair blame approach, seeking to identify improvements and learning from lessons highlighted through risk assessment, adverse events, near misses and patient and public feedback. The Trust employs a standardised methodology for supporting investigations and in the application of risk grading criteria, which helps to ensure a consistent approach to the prioritisation of risks and the effective targeting of resources. As a result risk management is an important element of the Trust's Business Planning processes.

The Trust has adopted a bottom up approach to the generation of its risk register with each Division preparing its own risk register that then feeds into the overall Trust Register. During 2009/10 each of the Divisions and Corporate Departments has continued to undertake regular reviews of their risks. The Risk Management Policy sets the framework for the escalation of risk. Risks rated as 12 or more on initial assessment must be supported by a timeframed action plan and recorded on the Trust Risk Register. These risks and their action plans are reviewed by the Risk Management Committee on a quarterly basis and those with a score of 15 or more are reported to the Compliance and Risk Scrutiny Committee and the Board bi-annually. The process outlined in the Risk Management Policy requires regular review of individual risk assessments.

The Risk and Safety team support the Divisions by providing specialist advice on identifying and assessing risks and work with them to facilitate risk mitigation plans through training, education and other individual support.

In addition, the Trust Board agrees the strategic risks that relate to its principle objectives. This forms the assurance framework. The Assurance Framework has been embedded into the Trust since 2004. It is based on the Trust's corporate objectives as agreed by the Trust Board and is a high level document covering all the Trust's functions. The Assurance Framework is linked to the Standards for Better Health and the Trust's Annual Business Plan.

The Assurance Framework for 2009-10 covered the following areas:

- compliance with the Care Quality Commission requirements to maintain licence to practice (with respect to the Hygiene Code)
- sustainable delivery of national access standards and targets relating to patient waiting times
- development and production of the Trust's first Quality Accounts
- delivery of Maternity Matters by December 2009
- achievement of NHSLA risk management standards for maternity
- achievement of targets for MRSA screening

- compliance with core standards
- compliance with best practice and legislation on child protection
- best practice with regard to vulnerable adults
- to have a positive reputation in the local community
- implement the single equality scheme
- robust information governance arrangements
- delivery of agreed 2009/10 financial plan
- delivery of the “planning our future” programme
- development of a refreshed long-term financial plan for the Trust
- strong financial governance of the Trust
- further development of clinical divisions, structures, processes, systems and teams to enable them to operate successfully in the current NHS environment
- all staff have clear objectives, regular appraisals and a personal development plan
- a revised approach to performance management across the Trusts
- achievement of EWTD compliance by August 2009
- a clearly defined Trust vision and future strategic direction informed by an understanding of the external risks and opportunities facing the Trust
- an understanding of what the Trust strategy means for existing services and models of care
- a review of the value to the Trust of existing partnerships and agreements revised or discontinued as appropriate
- conclusion of the IS procurement and implement any decisions made
- revised and refreshed estates strategy and a carbon reduction strategy and sustainable development outline plan
- provide a safe environment for staff and patients
- revised and refreshed workforce strategy
- programme of work across the health community to deliver change
- established programme of work to deliver Foundation Trust status in 2010
- manage the risk and maximise opportunities of the Trust’s place in the National CRS implementation plan
- successful deployment of CRS across the Trust if deployment is agreed by the Board.

The Assurance Framework is cross referenced to the Core Standards, the Risk Register and the Business Plan.

Public stakeholders have been involved where appropriate in managing risks which impact on them. The Trust has been extremely fortunate to be able to involve dedicated local residents in several of its Steering Groups. A long standing local resident has been involved with the Car Park Steering Group since its inception earlier this year, bringing his knowledge of the local area to the group and ensuring that the concerns of local residents are appreciated. The Nutritional Steering

Group also has public representation and associations with Kingston LINks, which has previously attended the PEAT inspections and has been happy to offer its help in assisting the Trust in carrying out audits. Extensive consultation has taken place with patients and carers about the Healthcare for London proposals for stroke health.

The Trust has been increasing its membership in anticipation of achieving Foundation Status. Members are key to the Trust's public and patient engagement and have been involved in focus groups working with the Royal Eye Unit and the Audiology department to assist in surveys, feedback on service and signage. Members have also advised on the content of patient information and on communications. The Trust has a group of Members who are trained in equality impact assessment who will work with the Patient Experience Manager to impact assess Trust policies and procedures. Two Members sit on the Trust's Clinical Ethics Forum. Existing Trust members are also involved in the recruitment of new members through member get member campaigns.

A number of minor gaps in controls and/or assurance were identified in reviewing and agreeing the Assurance Framework. The action plans for these areas have been monitored as appropriate within the committee structure.

Key areas of risk relating to the Assurance Framework have been:

- aspects of performance targets including delayed transfers of care. An action plan has been put in place within the Trust to reduce delayed transfers of care and a joint health improvement programme has been set up to address delayed transfer of care issues that cross organisational boundaries. There were significant improvements in performance during March 2010.
- achievement of Foundation Trust status is delayed while the Trust awaits the outcome of the review of Healthcare in South West London. The timetable for the review means that it is unlikely that Foundation Trust status will be achieved during 2010. The Trust is continuing to progress those areas of the application that it can whilst while awaiting the outcome of the review.
- compliance with the Hygiene Code. A number of breaches were identified by the Care Quality Commission in a spot check visit in December 2009. However, a follow up Care Quality Commission visit in February 2010 indicated that the breaches had been addressed
- implementation of CRS. CRS was deployed across the Trust on 30 November 2009. In general the implementation has been successful but there are some outstanding issues relating to data quality which are being addressed. There is a stabilisation programme in place covering 7 workstreams. Most have returned to business as usual. Dedicated teams are working on resolving some date quality issues and this is being tracked and monitored weekly by members of the Executive Team and regularly by the trust Board.

- achievement of CNST Level 2 in maternity. The Trust achieved CNST Level 1 in maternity in January 2010 against the revised standards. A recovery plan is in place which will see the Trust secure Level 2 in Maternity in 2012.
- a revised workforce strategy is not yet in place but will be presented to the Board for approval in July 2010.

All of these matters have been the subject of regular Board attention.

The Board is aware of the importance of maintaining high standards of information governance and securing the confidentiality of patient's information. It ensures delivery of this objective via the Senior Information Risk Officer (SIRO) who chairs the Information Governance Committee. The SIRO is supported by an Information Governance Manager and the Trust has a range of policies, procedures and training material to make sure that information governance principles are well known by all staff and embedded into everyday practice across the Trust. The Board has appointed the Director of Finance and Information as the Senior Information Risk Officer (SIRO).

The Information Governance Committee oversees completion of the Information Governance Toolkit and also receives information on any information security incidents.

The Core Standards for Better Health have formed a significant part of the overall process of risk management and the Trust's assurance framework. However, the Trust is not fully compliant with the core standards for better health. The Trust's Mid Year Declaration for 2009/10 declared a lack of assurance against one standard, core standard C11b) - Ensuring staff participate in mandatory training programmes. A robust action plan has been developed to ensure delivery and sustainability of compliance during 2010/11. During an inspection in December 2009 the CQC found that the Trust had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare associated infection. A warning notice was not issued. An action plan was instituted by the Trust and a follow up inspection by the CQC in February 2010 found that the Trust was compliant with the regulation. The Trust has remained compliant with all other core standards for the period 1 April 2009 to 31 March 2010.

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

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

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of effectiveness

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

- external and internal audit reports
- assurance Framework (in operation at the beginning of the Financial Year and reviewed by Internal Audit in March 2010)
- NHSLA General Accreditation Level 1 March 2009
- self assessment of core standards for 2009-10
- successful achievement of Care Quality Commission registration without compliance conditions with effect from 1 April 2010
- level 3 ALE in 2008-9.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Audit Committee, Governance Committee (until September 2009), Compliance and Risk Scrutiny Committee (since January 2010) and the Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The following information highlights some of the key methods that the Board uses to be assured its system of internal control is effective:

The Board

The Board has reviewed the Assurance Framework and also received regular information from the Audit Committee and Governance Committee (until September 2009). In addition, the Board has received regular reports on incidents and complaint trends, and has reviewed various significant policies including the Risk Management Strategy and Policy.

The Audit Committee

The Annual Internal Audit Plan enables the Board to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. It has reviewed internal and external audit reports, and reviewed progress on meeting the requirements of the Assurance Framework.

Compliance and Risk Scrutiny Committee

This committee monitors and reviews the operation of the risk, control and governance processes which have been established in the organisation

Executive Managers

Executive Managers have clear responsibilities for risk management within their areas of control. They also have corporate responsibility as Board members.

Internal Audit

The Trust has Deloitte and Touche Public Sector Internal Audit Ltd as the providers of internal audit services. The contract and associated Quality Plan specify that the delivery of the internal audit function will continue to be in compliance with the NHS Internal Audit Standards and those of the Institute of Internal Auditors (UK). The Internal Audit team conducted a review of the Assurance Framework in March 2010. An audit opinion of substantial assurance was given indicating that while there was a basically sound system there were weaknesses which put some of the control objectives at risk. Action plans are being put in place to address the recommendations made in the internal audit report.

Accreditation

The Trust has successfully achieved the A1 in Standards for Stroke Care as defined by Healthcare for London and has achieved Clinical Pathology Accreditation in Haematology, Cellular Pathology, Microbiology and Biochemistry.

Care Quality Commission Registration

The Trust has been registered with the Care Quality Commission since 1 April 2009 and will be registered as a healthcare provider by the Care Quality Commission without compliance conditions from 1 April 2010.

During preparation of this Statement, the Trust has considered carefully whether there were any significant internal weaknesses as defined by the Department of Health. As stated in section 4 above, the Trust is not compliant with Core Standard C11b) and the steps to rectify this are given below:

C11b) Ensure staff participate in mandatory training programmes = lack of assurance
The Trust does provide a comprehensive range of mandatory training. However, the Trust has not yet successfully established a comprehensive call and recall system for all relevant aspects of mandatory training. The Trust also declared lack of assurance with this standard in 2009/10.
The action plan to achieve this core standard has been refocused to ensure cost effective provision of high quality statutory and mandatory training that is targeted and monitored. Specific actions are as follows: • development of a comprehensive Training Matrix • an organisational wide Training Needs Analysis • development of a structured Training Plan and Mandatory Training Prospectus • improving access and attendance by using blended learning approaches including e-learning, work-based assessment and simulation, as well as classroom -based delivery • improving recording and reporting by refreshing and extending use of the ESR Oracle Learning Management system. Compliance is expected to be achieved by the end of Quarter 1 2010/11.

The Board was extremely pleased that the Trust performed very strongly against key national targets. Nevertheless, there were some areas of performance, such as delayed transfers of care, where performance was less strong.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that the Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Kate Grimes
Chief Executive

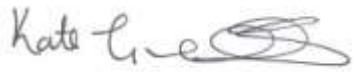
26 May 2010

15. Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place
- 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.



Kate Grimes
Chief Executive

26 May 2010

16. Statement of Director s' 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.

17. Independent auditor's report to the Board of Directors of Kingston Hospital NHS Trust

Opinion on the financial statements

I have audited the financial statements of Kingston Hospital Trust for the year ended 31 March 2010 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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 within them.

I have also audited the information in the Remuneration Report that is described as having been audited within the Annual Report.

This report is made solely to the Board of Directors of Kingston Hospital Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 49 of the Statement of Responsibilities of Auditors and of Audited Bodies published by the Audit Commission in April 2008.

Respective responsibilities of directors and auditor

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

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).
I report to you my opinion as to whether 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. I report whether the financial statements and the part of the Remuneration Report 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. I also report to you whether, in my 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.

I 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 2009/10' issued in February 2010. I 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 I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Annual Report except for the commentary on Operational and Financial Review and the audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and 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. 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.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me 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 have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report audited.

Opinion

In my 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 2010 and of its income and expenditure for the year then ended;
- the financial statements and the part of the Remuneration Report 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; and
- information which comprises the commentary on the financial performance included within the Operational and Financial Review, included within the Annual Report, is consistent with the financial statements.

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

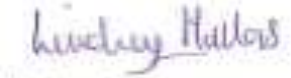
I am required by the Audit Commission Act 1998 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion in relation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

Conclusion

I have undertaken my audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, I am satisfied that, in all significant respects, Kingston Hospital Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2010.

Certificate

I certify that I 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.



Lindsey Mallors

Officer of the Audit Commission

Audit Commission,

1st Floor, Millbank Tower,

Millbank, London, SW1P 4HQ

8th June 2010

18. Annual accounts

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	4	**173,271**	163,527
Other operating revenue	5	**22,424**	19,815
Operating expenses	7	**(189,355)**	(178,499)
Operating surplus (deficit)		**6,340**	4,843
Finance costs:			
Investment revenue	13	**21**	386
Other gains and (losses)	14	**(99)**	0
Finance costs	15	**(2,114)**	(2,087)
Surplus/(deficit) for the financial year		**4,148**	3,142
Public dividend capital dividends payable		**(2,982)**	(4,008)
Retained surplus/(deficit) for the year		**1,166**	**(866)**
Other comprehensive income			
Impairments and reversals		(30,537)	(19,579)
Gains on revaluations		2,994	0
Receipt of donated/government granted assets		187	1,195
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)		0	0
Net gains/(losses) on available for sale financial assets		0	0
Reclassification adjustments:		0	
- Transfers from donated and government grant reserves		(513)	(399)
- On disposal of available for sale financial assets		0	0
Total comprehensive income for the year		**(26,703)**	**(19,649)**

The notes on pages 7 to 50 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010

	NOTE	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	16	**117,425**	147,529	166,578
Intangible assets	17	**4,779**	1,965	2,193
Investment property		**0**	0	0
Other financial assets	22	**0**	0	0
Trade and other receivables	21	**427**	479	531
Total non-current assets		**122,631**	149,973	169,302
Current assets				
Inventories	20	**1,346**	1,009	1,008
Trade and other receivables	21	**11,116**	11,355	10,626
Other financial assets	22	**0**	0	0
Other current assets	23	**0**	0	0
Cash and cash equivalents	24	**4,974**	4,816	4,466
		17,436	17,180	16,100
Non-current assets held for sale	25	**0**	0	0
Total current assets		**17,436**	17,180	16,100
Total assets		**140,067**	167,153	185,402
Current liabilities				
Trade and other payables	26	**(21,471)**	(20,401)	(18,516)
Other liabilities	28	**0**	0	0
DH Working capital loan		**0**	0	0
DH Capital loan		**0**	0	0
Borrowings	27	**(653)**	(620)	(574)
Other financial liabilities	33	**0**	0	0
Provisions	34	**(354)**	(1,000)	(297)
Net current assets/(liabilities)		**(5,042)**	(4,841)	(3,287)
Total assets less current liabilities		**117,589**	145,132	166,015
Non-current liabilities				
Borrowings	27	**(33,795)**	(34,479)	(35,284)
DH Working capital loan		**0**	0	0
DH Capital loan		**0**	0	0
Trade and other payables	26	**(108)**	(215)	(322)
Other financial liabilities	33	**0**	0	0
Provisions	34	**(1,464)**	(1,513)	(1,835)
Other liabilities	28	**0**	0	0
Total assets employed		**82,222**	108,925	128,574
Financed by taxpayers' equity:				
Public dividend capital		**57,131**	57,131	57,131
Retained earnings		**(144)**	(2,267)	(2,710)
Revaluation reserve		**19,584**	47,883	67,933
Donated asset reserve		**5,268**	5,764	5,775
Government grant reserve		**383**	414	445
Other reserves		**0**	0	0
Total Taxpayers' Equity		**82,222**	108,925	128,574

The financial statements on pages 1 to 50 were approved by the Board on [date] and signed on its behalf by:

Signed: ……(Chief Executive) Date: 26 May 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2008							
As previously stated	57,131	(2,710)	67,933	5,775	445	0	128,574
Prior Period Adjustment	0	0	0	0	0	0	0
Restated balance	57,131	(2,710)	67,933	5,775	445	0	128,574
Changes in taxpayers' equity for 2008/09							
Total Comprehensive Income for the year:							
Retained surplus/(deficit) for the year	0	(866)	0	0	0	0	(866)
Transfers between reserves	0	1,309	(1,309)	0	0	0	0
Impairments and reversals	0	0	(18,741)	(838)	0	0	(19,579)
Net gain on revaluation of property, plant, equipment	0	0	0	0	0	0	0
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	1,195	0	0	1,195
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(368)	(31)	0	(399)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	0	0	0	0	0	0	0
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2009	57,131	(2,267)	47,883	5,764	414	0	108,925

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2009/10							
Balance at 1 April 2009	57,131	(2,267)	47,883	5,764	414	0	108,925
Total Comprehensive Income for the year							
Retained surplus/(deficit) for the year	0	1,166	0	0	0	0	1,166
Transfers between reserves	0	957	(957)	0	0	0	0
Impairments and reversals	0	0	(29,899)	(638)	0	0	(30,537)
Net gain on revaluation of property, plant, equipment	0	0	2,557	437	0	0	2,994
Net gain on revaluation of intangible assets	0	0	0	0	0	0	0
Net gain on revaluation of financial assets	0	0	0	0	0	0	0
Net gain on revaluation of non current assets held for sale	0	0	0	0	0	0	0
Receipt of donated/government granted assets	0	0	0	187	0	0	187
Net gain/loss on other reserves (e.g. defined benefit pension scheme)	0	0	0	0	0	0	0
Movements in other reserves	0	0	0	0	0	0	0
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(482)	(31)	0	(513)
- on disposal of available for sale financial assets	0	0	0	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0	0	0	0
Originating capital for Trust establishment in year	0	0	0	0	0	0	0
New PDC received	0	0	0	0	0	0	0
PDC repaid in year	0	0	0	0	0	0	0
PDC written off	0	0	0	0	0	0	0
Other movements in PDC in year	0	0	0	0	0	0	0
Balance at 31 March 2010	57,131	(144)	19,584	5,268	383	0	82,222

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**6,340**	4,843
Depreciation and amortisation		**6,134**	5,717
Impairments and reversals		**748**	1,136
Net foreign exchange gains/(losses)		**0**	0
Transfer from donated asset reserve		**(482)**	(368)
Transfer from government grant reserve		**(31)**	(31)
Interest paid		**(2,074)**	(2,044)
Dividends paid		**(3,050)**	(4,008)
(Increase)/decrease in inventories		**(337)**	(1)
(Increase)/decrease in trade and other receivables		**359**	(677)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables		**1,652**	1,395
Increase/(decrease) in other current liabilities		**0**	(139)
Increase/(decrease) in provisions	34	**(735)**	338
Net cash inflow/(outflow) from operating activities		**8,524**	6,161
Cash flows from investing activities			
Interest received		**21**	386
(Payments) for property, plant and equipment	16	**(4,544)**	(5,412)
Proceeds from disposal of plant, property and equipment		**0**	0
(Payments) for intangible assets	17	**(3,190)**	(26)
Proceeds from disposal of intangible assets		**0**	0
(Payments) for investments with DH		**0**	0
(Payments) for other investments		**0**	0
Proceeds from disposal of investments with DH		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Revenue rental income		**0**	0
Net cash inflow/(outflow) from investing activities		**(7,713)**	**(5,052)**
Net cash inflow/(outflow) before financing		**811**	1,109
Cash flows from financing activities			
Public dividend capital received		**0**	0
Public dividend capital repaid		**0**	0
Loans received from the DH		**0**	0
Other loans received		**0**	0
Loans repaid to the DH		**0**	0
Other loans repaid		**0**	0
Other capital receipts		**0**	0
Capital element of finance leases and PFI		**(653)**	(620)
Cash transferred to NHS Foundation Trusts		**0**	0
Net cash inflow/(outflow) from financing		**(653)**	(620)
Net increase/(decrease) in cash and cash equivalents		**158**	489
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**4,816**	4,327
Effect of exchange rate changes on the balance of cash held in foreign currencies		**0**	0
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	24	**4,974**	4,816

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS Trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

a) The Trust has undertaken a review of all its leases and management have determined that the Huntleigh Healthcare Ltd beds lease is a finance lease, due to the Trust receiving significantly all of the risks and rewards. The initial cost of the lease is £772k and it is a 10 year lease starting in March 2005.

b) The Trust has two PFI schemes both of which have been accounted for under IFRIC 12 and are on balance sheet under IFRS.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

a) £85k is included in provisions relating to NHS Litigation Authority member provisions. These provisions are subject to the future outcome of litigation in progress. The probabilities provided by the NHS Litigation Authority have been used to calculate the provision.

b) £1,666k relates to pension provisions for staff and directors. The provision is calculated based on life expectancies of each individual. Life expectancy tables are used and these are obtained from the GAD website (up to 2006) and more recently from the Office for National Statistics.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the Accounts - 1. Accounting Policies (Continued)

Retirement benefit costs

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

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

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

● it is held for use in delivering services or for administrative purposes;
● it is probable that future economic benefits will flow to, or service potential will be supplied to, the
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● the item has cost of at least £5,000; or
● Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent

Notes to the Accounts - 1. Accounting Policies (Continued)

accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS Trusts must apply these new valuation requirements by 1 April 2010 at the latest. The Trust has had all land and buildings assets valued by an independent valuer, Gerald Eve, using the MEAV valuation method as at the 31st December 2009, and details of this can be found in note 16.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

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

1.8 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

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

Notes to the Accounts - 1. Accounting Policies (Continued)

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

If there has been an impairment loss, the asset is written down to its recoverable amount, with the loss charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Donated assets

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

1.11 Government grants

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

The Trust has one government grant of £455k which was received in July 2007 from the Energy Saving Trust This was given to the Trust as a lump sum to be used for funding the Dalkia boiler project and is released to income over the life of the PFI lease.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Non-current assets held for sale

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

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

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

1.13 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

Notes to the Accounts - 1. Accounting Policies (Continued)

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Notes to the Accounts - 1. Accounting Policies (Continued)

Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the *first-in first-out* cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks. Partially completed spells for patient services are not accounted for as work in progress.

1.16 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Notes to the Accounts - 1. Accounting Policies (Continued)

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. 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 35.

1.19 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.

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

Notes to the Accounts - 1. Accounting Policies (Continued)

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition. The Trust does not currently have any available for sale financial assets.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

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

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

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

Notes to the Accounts - 1. Accounting Policies (Continued)

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.22 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.23 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.

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust’s surplus/deficit in the period in which they arise.

1.25 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 40 to the accounts.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and 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. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.27 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, the note on losses and special payments is compiled directly from the losses and special payments register, which reports amounts on an accruals basis, with the exception of provisions for future losses.

1.28 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2009/10, in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate Trustee.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Accounting standards that have been issued but have not yet been adopted

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. None of them are expected to impact upon the Trust financial statements.

IAS 27 (Revised) Consolidated and separate financial statements

Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues

Amendment to IAS 39 Eligible hedged items

IFRS 3 (Revised) Business combinations

IFRIC 17 Distributions of Non-cash Assets to Owners

IFRIC 18 Transfer of assets from customers

1.30 Accounting standards issued that have been adopted early

The amendment to IFRS 8 Operating segments that was included in the April 2009 Improvements to IFRS has been adopted early. As a result, total assets are not reported by operating segment.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

2. Operating segments

Kingston Hospital NHS Trust has only one segment, Healthcare.

The income from external customers in year was £195,695k

The following four customers contributed more than 10% of total income:

Kingston PCT	£72,627k
Richmond & Twickenham PCT	£40,019k
Surrey PCT	£27,291k
Wandsworth PCT	£19,456k

3. Income generation activities

The Trust does not undertake any income generation activities that has full costs in excess of £1m.

4. Revenue from patient care activities

	2009/10 £000	2008/09 £000
Strategic health authorities	**4**	140
NHS Trusts	**329**	952
Primary care Trusts	**169,413**	158,157
Foundation Trusts	**111**	191
Local authorities	**100**	0
Department of Health	**0**	65
NHS other	**0**	0
Non-NHS:		
Private patients	**1,764**	3,324
Overseas patients (non-reciprocal)	**137**	224
Injury costs recovery	**617**	474
Other	**796**	0
	173,271	**163,527**

Injury cost recovery income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

5. Other Operating Revenue

	2009/10 £000	2008/09 £000
Patient transport services	**0**	0
Education, training and research	**8,153**	9,252
Charitable and other contributions to expenditure	**0**	0
Transfers from Donated Asset Reserve	**482**	368
Transfers from Government Grant Reserve	**31**	31
Non-patient care services to other bodies	**7,781**	6,689
Income generation	**1,399**	1,386
Rental revenue	**529**	240
Other revenue	**4,049**	1,849
	22,424	19,815

Other revenue includes £529k of PFI transitional relief income, £85k merit award income, £85k for a VAT reclaim, £33k from the Trust's charitable trust fund for administration overheads and £68k from pharmacy prescriptions.

6. Revenue

	2009/10 £000	2008/09 £000
From rendering of services	**195,695**	183,342
From sale of goods	**0**	0

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating Expenses

	2009/10 £000	2008/09 £000
Services from other NHS Trusts	**118**	263
Services from PCTs	**1,017**	490
Services from other NHS bodies	**0**	0
Services from Foundation Trusts	**0**	0
Purchase of healthcare from non NHS bodies	**537**	929
Directors' costs	**583**	648
Other Employee Benefits	**124,939**	117,644
Supplies and services - clinical	**26,326**	24,299
Supplies and services - general	**10,692**	11,037
Consultancy services	**1,505**	1,481
Establishment	**1,740**	1,764
Transport	**1,140**	1,229
Premises	**7,686**	7,282
Provision for impairment of receivables	**13**	184
Inventories write offs	**7**	0
Depreciation	**5,602**	5,466
Amortisation	**532**	251
Impairments and reversals of property, plant and equipment	**748**	1,136
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets [by class]	**0**	0
Impairments and Reversals for Non Current Assets held for sale	**0**	0
Audit fees	**153**	160
Other auditor's remuneration	**90**	95
Clinical negligence	**4,220**	2,229
Research and development	**0**	0
Education and Training	**1,614**	646
Other	**93**	1,266
	189,355	178,499

Other auditors remuneration includes £33k for Counter Fraud services and £57k for Internal Audit services provided to the Trust.

8. Operating leases

8.1 As lessee

Operating lease expenses in year include cars and vans £13k, rental of buildings £397k, equipment leases £129k, and £21k photocopier leases.

Payments recognised as an expense	**2009/10 £000**	2008/09 £000
Minimum lease payments	**560**	421
Contingent rents	**0**	0
Sub-lease payments	**0**	0
	560	421

Total future minimum lease payments	**2009/10 £000**	2008/09 £000
Payable:		
Not later than one year	**554**	345
Between one and five years	**1,129**	833
After 5 years	**0**	177
Total	**1,683**	1,355

8.2 As lessor

Rental revenue includes £121k for the rental of floor space in the Sir William Rous Unit, £124k for the lease of roof space for telecomms masts, £16k rental of floor space for the hospital shop and £269k for the rental of floor space to BMI.

Rental Revenue	**2009/10 £000**	2008/09 £000
Contingent rent	**0**	0
Other	**529**	240
Total rental revenue	**529**	240

Total future minimum lease payments	**2009/10 £000**	2008/09 £000
Receivable:		
Not later than one year	**404**	114
Between one and five years	**1,403**	331
After 5 years	**855**	45
Total	**2,662**	490

9. Employee costs and numbers

9.1 Employee costs

	2009/10			2008/09		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**106,340**	**89,915**	**16,425**	99,513	85,261	14,252
Social Security Costs	**7,755**	**7,056**	**699**	7,369	6,599	770
Employer contributions to NHS Pension scheme	**11,890**	**11,406**	**484**	11,351	10,807	544
Other pension costs	**0**	**0**	**0**	0	0	0
Other post-employment benefits	**0**	**0**	**0**	0	0	0
Other employment benefits	**0**	**0**	**0**	0	0	0
Termination benefits	**0**	**0**	**0**	0	0	0
Employee benefits expense	**125,985**	**108,377**	**17,608**	118,233	102,667	15,566
Of the total above:						
Charged to capital	523			224		
Employee benefits charged to revenue	125,462			118,009		
	125,985			**118,233**		

9.2 Average number of people employed

	2009/10			2008/09		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**398**	**358**	**40**	384	346	38
Ambulance staff	**0**	**0**	**0**	0	0	0
Administration and estates	**541**	**472**	**69**	618	542	76
Healthcare assistants and other support staff	**362**	**222**	**140**	281	176	105
Nursing, midwifery and health visiting staff	**833**	**718**	**115**	864	732	132
Nursing, midwifery and health visiting learners	**17**	**17**	**0**	28	28	0
Scientific, therapeutic and technical staff	**447**	**426**	**21**	442	419	23
Social care staff	**0**	**0**	**0**	0	0	0
Other	**119**	**115**	**4**	27	23	4
Total	**2,717**	**2,328**	**389**	2,644	2,266	**378**
Of the above:						
Number of staff (WTE) engaged on capital projects	**11**			**4**		

9.3 Staff sickness absence*

* in relation to the 2009 calendar year	**2009/10 Number**
Days lost (long term)	17,149
Days lost (short term)	0
Total days lost	**17,149**
Total staff years	**2,330**
Average working days lost	7.36
Total staff employed in period (headcount)	
Total staff employed in period with no absence (headcount)	
Percentage staff with no sick leave	

9.4 Management Costs

	2009/10 £000	**2008/09 £000**
Management costs	12,331	12,394
Income	187,599	174,173

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, every five years) and an 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.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

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

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 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.

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

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.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

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

Preserved Benefits

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

Compensation for Early Retirement

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

11. Retirements due to ill-health

During 2009/10 there were 5 (2008/09, 2) 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 £102k (2008/09: £66k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

12. Better Payment Practice Code

12.1 Better Payment Practice Code - measure of compliance	2009/10 Number	2009/10 £000	2008/09 Number	2008/09 £000
Total Non-NHS trade invoices paid in the year	**59,854**	**77,907**	58,479	73,042
Total Non NHS trade invoices paid within target	**55,200**	**74,599**	49,257	64,354
Percentage of Non-NHS trade invoices paid within target	**92%**	**96%**	84%	88%
Total NHS trade invoices paid in the year	**7,177**	**12,174**	7,740	9,140
Total NHS trade invoices paid within target	**6,797**	**10,886**	7,046	7,966
Percentage of NHS trade invoices paid within target	**95%**	**89%**	91%	87%

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.

12.2 The Late Payment of Commercial Debts (Interest) Act 1998	2009/10 £000	2008/09 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	**0**

13. Investment revenue	**2009/10 £000**	2008/09 £000
Rental revenue:		
PFI finance lease revenue:		
planned	0	0
contingent	0	0
Other finance lease revenue	0	0
Interest revenue:		
Bank accounts	21	286
Other loans and receivables	0	100
Impaired financial assets	0	0
Other financial assets	0	0
Total	21	386

14. Other gains and losses	**2009/10 £000**	2008/09 £000
Gain/(loss) on disposal of property, plant and equipment	**(99)**	0
Gain/(loss) on disposal of intangible assets	**0**	0
Gain/(loss) on disposal of financial assets	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through profit and loss	**0**	0
Change in fair value of financial liabilities carried at fair value through profit and loss	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets available for sale	**0**	0
Total	**(99)**	0

15. Finance Costs	**2009/10 £000**	2008/09 £000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**28**	32
Interest on obligations under PFI contracts:		
- main finance cost	**1,886**	1,915
- contingent finance cost	**160**	97
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**2,074**	2,044
Other finance costs	**40**	43
Total	**2,114**	**2,087**

16. Property, plant and equipment

2009/10:	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construct £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2009	37,473	94,941	0	464	21,644	0	6,458	2,499	163,479
Additions purchased	0	2,004	0	(78)	1,527	0	279	(31)	3,701
Additions donated	0	110	0	0	77	0	0	0	187
Additions government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	250	0	(318)	0	0	68	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(765)	0	0	(14)	(779)
Revaluation/indexation gains	0	2,994	0	0	0	0	0	0	2,994
Impairments	(9,473)	(21,064)	0	0	0	0	0	0	(30,537)
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0
At 31 March 2010	**28,000**	**79,235**	**0**	**68**	**22,483**	**0**	**6,805**	**2,454**	**139,045**
Depreciation at 1 April 2009	0	0	0	0	11,865	0	2,792	1,293	15,950
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(666)	0	0	(14)	(680)
Revaluation/indexation gains	0	0	0	0	0	0	0	0	0
Impairments	0	748	0	0	0	0	0	0	748
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	3,147	0	0	1,399	0	876	180	5,602
Transfer to Foundation Trust	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2010	**0**	**3,895**	**0**	**0**	**12,598**	**0**	**3,668**	**1,459**	**21,620**
Net book value									
Purchased	28,000	71,565	0	68	8,259	0	2,903	995	111,790
Donated	0	3,775	0	0	1,243	0	234	0	5,252
Government granted	0	0	0	0	383	0	0	0	383
Total at 31 March 2010	**28,000**	**75,340**	**0**	**68**	**9,885**	**0**	**3,137**	**995**	**117,425**
Asset financing									
Owned	**28,000**	**54,059**	**0**	**68**	**7,542**	**0**	**3,137**	**614**	**93,420**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**381**	**381**
Private finance initiative	**0**	**21,281**	**0**	**0**	**2,343**	**0**	**0**	**0**	**23,624**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total 31 March 2010	**28,000**	**75,340**	**0**	**68**	**9,885**	**0**	**3,137**	**995**	**117,425**

Economic Lives of Non-Current Assets	Maincode 01 Min Life Years	Maincode 02 Max Life Years
Intangible Assets		
Software Licences	0	15
Licences and Trademarks	0	0
Patents	0	0
Development Expenditure	0	0
Property, Plant and Equipment		
Buildings exc Dwellings	0	80
Dwellings	0	0
Plant & Machinery	0	28
Transport Equipment	0	0
Information Technology	0	14
Furniture and Fittings	0	24

Prior year:

2008/09:	Land £000	Buildings excluding Dwellings £000	£000	Assets under construct £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2008	52,773	95,754	0	4,862	20,732	0	4,451	2,469	181,041
Additions purchased	0	3,406	0	(428)	904	0	1,944	134	5,960
Additions donated	0	405	0	0	700	0	67	0	1,172
Additions government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	3,970	0	(3,970)	0	0	(4)	(10)	(14)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(692)	0	0	(94)	(786)
Revaluation/indexation gains	0	0	0	0	0	0	0	0	0
Impairments	(15,300)	(4,279)	0	0	0	0	0	0	(19,579)
Reversal of impairments	0	0	0	0	0	0	0	0	0
At 31 March 2009	**37,473**	**99,256**	**0**	**464**	**21,644**	**0**	**6,458**	**2,499**	**167,794**
Depreciation at 1 April 2008	0	0	0	0	11,212	0	2,049	1,202	14,463
Reclassifications	0	0	0	0	0	0	(4)	(10)	(14)
Reclassified as held for sale	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	(692)	0	0	(94)	(786)
Revaluation/indexation gains	0	0	0	0	0	0	0	0	0
Impairments	0	1,136	0	0	0	0	0	0	1,136
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	3,179	0	0	1,345	0	747	195	5,466
Depreciation at 31 March 2009	**0**	**4,315**	**0**	**0**	**11,865**	**0**	**2,792**	**1,293**	**20,265**
Net book value									
Purchased	37,473	90,965	0	464	7,917	0	3,358	1,197	141,374
Donated	0	3,976	0	0	1,448	0	308	9	5,741
Government granted	0	0	0	0	414	0	0	0	414
Total at 31 March 2009	**37,473**	**94,941**	**0**	**464**	**9,779**	**0**	**3,666**	**1,206**	**147,529**
Asset financing									
Owned	**37,473**	**72,747**	**0**	**464**	**7,353**	**0**	**3,666**	**748**	**122,451**
Finance Leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**458**	**458**
Private finance initiative	**0**	**22,194**	**0**	**0**	**2,426**	**0**	**0**	**0**	**24,620**
PFI residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total 31 March 2009	**37,473**	**94,941**	**0**	**464**	**9,779**	**0**	**3,666**	**1,206**	**147,529**

16. Property, plant and equipment (cont.)

Donations of £110k were received for the construction of the Sir William Rous Unit. Donations were received from the general public, and from The Royal Marsden Foundation Trust Charitable Trust Fund.

£77k of donations were used form the General Charitable Trust fund to purchase 4 items of medical equipment.

The Trust's revaluation reserve has been reviewed to better reflect the composition of the assets. This review updated the individual asset reserve balances by used an estimation technique that fairly reflects the life and value of the Trust's building assets. The total value of the revaluation reserve remained unaffected.

Land and building assets were revalued by an independent valuer, Gerald Eve, on the 31st December 2009. All buildings qualified as specialist properties as per the International Valuation Standards Guidance. The standard requires such properties to be valued on a DRC basis. The International Valuation Standards Guidance Note 8.3.1 defines DRC as "The current cost of replacing an asset with its Modern Equivalent Asset less deduction for physical deteriation and all relevant forms of obsolescence and optimisation. This resulted in land being revalued downwards by £9,473k and buildings revalued downwards by £21,812k. This downward valuation was mainly absorbed within the Trust's revaluation reserve, with a £748k impairment being taken to the Statement of Comprehensive Income.

17. Intangible assets

2009/10:	Computer software - purchased £000	Computer software - internally generated £000	Licences and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2009	2,847	0	0	0	0	2,847
Additions purchased	3,346	0	0	0	0	3,346
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation/indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2010	**6,193**	**0**	**0**	**0**	**0**	**6,193**
Amortisation at 1 April 2009	882	0	0	0	0	882
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	532	0	0	0	0	532
Amortisation at 31 March 2010	**1,414**	**0**	**0**	**0**	**0**	**1,414**
Net book value						
Purchased	4,763	0	0	0	0	4,763
Donated	16	0	0	0	0	16
Government granted	0	0	0	0	0	0
Total at 31 March 2010	**4,779**	**0**	**0**	**0**	**0**	**4,779**

Prior year:

2008/09:	Computer software - purchased £000	Computer software - internally generated £000	Licences and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000
Gross cost at 1 April 2008	2,824	0	0	0	0	2,824
Additions purchased	0	0	0	0	0	0
Additions internally generated	0	0	0	0	0	0
Additions donated	23	0	0	0	0	23
Additions government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation / indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2009	**2,847**	**0**	**0**	**0**	**0**	**2,847**
Amortisation at 1 April 2008	631	0	0	0	0	631
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	251	0	0	0	0	251
Amortisation at 31 March 2009	**882**	**0**	**0**	**0**	**0**	**882**
Net book value						
Purchased	1,942	0	0	0	0	1,942
Donated	23	0	0	0	0	23
Government granted	0	0	0	0	0	0
Total at 31 March 2009	**1,965**	**0**	**0**	**0**	**0**	**1,965**

17. Intangible assets (cont.)

There have been no revaluations of intangible assets in year.

There are no internally generated assets. All intangible assets are software licences with a 5 year life with the exception of the Core PACS Software which has a 10 year life and CRS which has a 15 year life. All assets are amortised on a straight line basis.

17.2 Revaluation reserve balance for intangible assets	**2009/10**	2008/09
	£000	£000
At 1 April	**208**	208
Changes *[itemised]*	**0**	0
At 31 March	**208**	208

18. Impairments

There has been an in year impairment to the Statement of Comprehensive Income of £748k. £377k of this relates to the Kingston Surgical Centre, which is a PFI building asset. The remainder relates to the following buildings:
Substation £325k
Computer Room £2k
Dental Extension £5k
Mortuary £39k

19. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	**195**	197
Intangible assets	**215**	0
Total	**410**	**197**

20. Inventories

20.1. Inventories

	31 March 2010 £000	31 March 2009 £000
Drugs	**1,011**	**918**
Work in progress	**0**	**0**
Consumables	**335**	**91**
Energy	**0**	**0**
Other	**0**	**0**
Total	**1,346**	1,009
Of which held at net realisable value:	0	0

20.2 Inventories recognised in expenses

	31 March 2010 £000	31 March 2009 £000
Inventories recognised as an expense in the period	**13,487**	0
Write-down of inventories (including losses)	**7**	0
Reversal of write-downs that reduced the expense	**0**	0
Total	**13,494**	0

21. Trade and other receivables

21.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
NHS receivables-revenue	**7,314**	8,088	**178**	268
NHS receivables-capital	**0**	0	**0**	0
Non-NHS receivables-revenue	**1,376**	2,525	**249**	211
Non-NHS receivables-capital	**0**	0	**0**	0
Provision for the impairment of receivables	**(284)**	(313)	**0**	0
Accrued income	**1,393**	511	**0**	0
Finance lease Receivables	**0**	0	**0**	0
Operating lease receivables	**42**	0	**0**	0
VAT	**1,119**	544	**0**	0
Other receivables	**156**	0	**0**	0
Total	**11,116**	11,355	**427**	479

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Other trade receivables include private patients, insurance companies and overseas visitors. All overseas visitors have been included in the provision for impairment of receivables and the Trust expects to receive the other outstanding debts in full.

21.2 Receivables past their due date but not impaired

	31 March 2010 £000	31 March 2009 £000
By up to three months	**669**	1,265
By three to six months	**958**	120
By more than six months	**715**	397
Total	**2,342**	**1,782**

21.3 Provision for impairment of receivables	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**(313)**	(155)
Amount written off during the year	**42**	26
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(13)**	(184)
Balance at 31 March	**(284)**	(313)

The receivables impaired include 100% of overseas visitors, 10% of other non nhs receivables between 90-120 days old, and 100% of other non nhs receivables over 120 days old. This is excluding debts outstanding from insurance companies were patients are insured for Private Healthcare provided by the Trust. There is no collateral held by the Trust.

22. Other financial assets	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Embedded derivatives carried at fair value through profit and l	**0**	0	**0**	0
Financial assets carried at fair value through profit and loss	**0**	0	**0**	0
Held to maturity investments at amortised cost	**0**	0	**0**	0
Available for sale financial assets carried at fair value	**0**	0	**0**	0
Loans carried at amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0

23. Other current assets	31 March 2010 £000	31 March 2009 £000
EU Emissions trading scheme allowances	**0**	0
Other assets *[specify]*	**0**	0
Total	**0**	0

24. Cash and cash equivalents	**31 March 2010 £000**	31 March 2009 £000
Balance at 1 April	**4,816**	4,466
Net change in year	**158**	350
Balance at 31 March	**4,974**	4,816
Made up of		
Cash with Office of HM Paymaster General	**4,925**	4,766
Commercial banks and cash in hand	**49**	50
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**4,974**	4,816
Bank overdraft - Office of HM Paymaster General	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**4,974**	4,816

25. Non-current assets held for sale	**Land**	**Buildings, excl dwelling**	**Dwellings**	**Other property, plant and equipment**	**Intangible assets**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Balance brought forward	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	**0**
Less Impairments of assets held for sale	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	**0**
Balance carried forward	0	0	0	0	0	**0**

26. Trade and other payables

	Current		Non-current	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Interest payable	**0**	0		
NHS payables-revenue	**2,352**	2,606	**0**	0
NHS payables-capital	**0**	0	**0**	0
Non NHS trade payables - revenue	**6,092**	3,517	**0**	0
Non NHS trade payables - capital	**637**	1,326	**0**	0
Accruals and deferred income	**7,943**	8,663	**0**	0
Social security costs	**1,178**	2,503		
VAT	**0**	0	**0**	0
Tax	**1,481**	0		
Other	**1,788**	1,786	**108**	215
Total	**21,471**	20,401	**108**	215

Other payables include:
£215k (prior year £67k) for payments due in future years under arrangements to buy out the liability for 1 early retirements over 5 instalments; and £1,553k (prior year £1,487k) outstanding pensions contributions at 31 March 2010.

27. Borrowings

	Current		Non-current	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Bank overdraft - Office of HM Paymaster Gene	**0**	0		
Bank overdraft - Commercial banks	**0**	0		
Loans from:				
Department of Health	**0**	0	**0**	0
Other entities	**0**	0	**0**	0
PFI liabilities	**579**	550	**33,437**	34,043
LIFT	**0**	0	**0**	0
Finance lease liabilities	**74**	70	**358**	436
Other	**0**	0	**0**	0
Total	**653**	620	**33,795**	34,479

Borrowings relate to the following:
Surgical Centre PFI (Current £472k, Non Current £31,301k) relates to a 29 year lease expiring in 2036.
Combined Heat and Power Plant PFI (Current £107k, Non Current £2,136k) relates to a 15 year lease expiring in 2(
Beds lease with Huntleigh Healthcare, finance lease (current £74k, non Current £358k) expiring in 2015.

28. Other liabilities

	Current		Non-current	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
PFI asset – deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**0**	0	**0**	0
Total	**0**	0	**0**	0

29. Finance lease obligations

Kingston Hospital has one finance lease which is a beds lease with Huntleigh Healthcare Ltd.
The lease is for 10 years and is due to expire in Feb 2015.

The future minimum lease payments are calculated by adding the present value of minimum lease payments to the remaining finance lease interest of £69k.

Amounts payable under finance leases:	**Minimum lease payments**		**Present value of minimum lease payments**	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Within one year	**97**	98	**74**	70
Between one and five years	**388**	389	**342**	324
After five years	**16**	116	**16**	112
Less future finance charges	**(69)**	(97)		
Present value of minimum lease payments	**432**	506	**432**	506
Included in:				
Current borrowings			**74**	70
Non-current borrowings			**358**	436
	0	0	**432**	506

30. Finance lease receivables (i.e. as lessor)

Amounts receivable under finance leases Of minimum lease payments	**Gross investments in**		**Present value of minimum**	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Within one year	**0**	0	**0**	**0**
Between one and five years	**0**	0	**0**	**0**
After five years	**0**	0	**0**	**0**
Less future finance income	**0**	0		
Present value of minimum lease payments	**0**	0	**0**	0
Less cumulative provision for uncollectable payments	**0**	0	0	0
Total finance lease receivable recognised in the statement of financial position	**0**	**0**	**0**	**0**
Included in:				
Current borrowings			**0**	0
Non-current borrowings			**0**	0
	0	0	**0**	0

Rental Revenue	**2009/10**	2008/09
	£000	£000
Contingent rent	**0**	0
Other	**0**	0
Total rental revenue	**0**	0

31. Finance lease commitments

The Trust does not have any finance lease commitments.

32. Private Finance Initiative contracts

32.1 PFI schemes off-Statement of Financial Position

The Trust does not have any off-statement PFI schemes.

32.2 PFI schemes on-Statement of Financial Position

The Trust has entered into 2 PFI schemes, these being:

- 29 year lease of the Surgical Centre Building from Prime Care Solutions Ltd, expiring in 2036.
- 15 year lease for a Combined Heat and Power Plant with Dalkia Utilities Services PLC, expiring in 2023.

Surgical Centre

Under IFRIC 12, the Surgical Centre is treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and payments comprise of two elements, imputed finance lease changes and service charges.

Kingston Hospital has the right to use the Surgical Centre for the purposes specified in the project agreement.

The provision of services at Kingston Hospital from the PFI Provider, 'Prime' include a car parking service, a catering service and all other soft facilities management services across the Trust. Prime also provide a hard facilities management service to the Kingston Surgical Centre building.

Prime's obligation was to build the Kingston Surgical Centre and car parking facilities at the Trust.

Kingston Hospital has the right to receive the Surgical Centre building at the end of the contract period.

Under clause 44.6 (replacement of non-performing sub-contractor) prime will put forward proposals for the interim management of the service.

If Prime fail to provide relevant services to the Trust the Trust may perform such services itself or instruct a third party to do so. If Prime then fail to terminate the relevant service the Trust shall be entitled to its option to exercise its rights in accordance with the provisions of Clause 44.5 (remedy provisions).

Force Majeure If in the circumstances referred to in Clause 43 (Force Majeure) the parties have failed to reach agreement on any modification to the project agreement within 6 months of the date on which the party affected serves notice on the other party, either party may at any time afterwards terminate the agreement by written notice.

Voluntary Termination The Trust shall be entitled to terminate the agreement at any

For other rights and obligations please refer to the full project agreement documentation.

There is a 2.5% RPI built into the providers financing model with a base date of 01.04.2002. Actual RPI is calculated on an annual basis.

There have been no changes to the PFI arrangements during the accounting period.

Combined Heat and Power Plant

Dalkia provide and maintain the plant to deliver the combined heat and power to the Trust.

Under IFRIC 12, the Combined Heat and Power Plant is treated as an asset of the Trust. The substance of the contract is that the Trust has a finance lease and payments comprise of two elements, imputed finance lease changes and service charges.

Kingston Hospital has the right to use the Combined Heat and Power Plant for the purposes specified in the project agreement.

Dalkia are obligated to provide the plant and machinery for the boiler house.

On the expiry date of this contract the funded new equipment shall vest in the Trust provided the Trust has paid Dalkia any payment due to it under the project agreement.

Force Majeure The party claiming relief shall be relived of its liability under the project agreement to the extent that by reason of the force majeure it is not able to perform its obligations under this Agreement provided that the Trust shall continue to pay the Operating Element to Dalkia notwithstanding the occurrence of an event of Force Majeure.

On the occurrence of a Dalkia Event of Default referred to in clauses 35.1.2, 35.1.3 (a), 35.1.4, 35.1.5, 35.1.6, 35.1.8 the Trust may terminate the agreement in its entirety by notice in writing having immediate effect.

On the occurrence of a Dalkia Event of Default referred to in clauses 35.1.3(b), 35.1.3 (c), 35.1.3 (d) and 35.1.7, the Trust may serve notice giving Dalkia the option to remedy the default within 20 business days, or put forward a reasonable plan within 20 business days to remedy the default.

In the case of any Event of Default referred to in clause 35.1.7, if Dalkia is awarded one or more warning notices in the following contract month, the Trust can issue notice in writing which terminates the agreement with immediate effect.

Voluntary Termination The Trust is entitled to terminate the project agreement any time on 6 months written notice to Dalkia.

For other rights and obligations please refer to the full project agreement documentation.

There is a 2.5% RPI built into the scheme with a base date of 01.09.2005. Actual RPI is calculated on an annual basis.

There have been no changes to the PFI arrangements during the accounting period.

Total obligations for on-statement of financial position PFI contracts due:

	31 March 2010	31 March 2009
	£000	£000
Not later than one year	**2,683**	2,592
Later than one year, not later than five years	**12,025**	11,375
Later than five years	**79,917**	82,166
Sub total	**94,625**	96,133
Less: interest element	**(60,609)**	(61,540)
Total	**34,016**	34,593

32.3 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £7,844k.

The Trust is committed to the following annual charges

	31 March 2010	31 March 2009
	£000	£000
PFI scheme expiry date:		
Not later than one year	**0**	0
Later than one year, not later than five	**0**	0
Later than five years	**266,164**	274,008
Total	**266,164**	274,008

33. Other financial liabilities

	Current		**Non-current**	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Financial liabilities carried at fair value through profit and loss:				
Embedded derivatives	**0**	0	**0**	0
Other financial liabilities	**0**	0	**0**	0
Amortised cost	**0**	0	**0**	0
Total	**0**	0	**0**	0

34. Provisions

	Current		Non-current	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Pensions relating to former directors	**67**	116	**138**	150
Pensions relating to other staff	**135**	198	**1,326**	1,363
Legal claims	**85**	56	**0**	0
Restructurings	**0**	0	**0**	0
Continuing care	**0**	0	**0**	0
Equal pay	**19**	0	**0**	0
Agenda for change	**0**	0	**0**	0
Other (specify)	**48**	630	**0**	0
Total	**354**	1,000	**1,464**	1,513

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Restructurings**	**Continuing care**	**Equal pay**	**Agenda for change**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2008	322	1657	0	0	0	0	0	153	**2,132**
Arising during the year	0	0	56	0	0	0	0	612	**668**
Used during the year	(63)	(132)	0	0	0	0	0	(15)	**(210)**
Reversed unused	0	0	0	0	0	0	0	(120)	**(120)**
Unwinding of discount	7	36	0	0	0	0	0	0	**43**
Transfers in year	0	0	0	0	0	0	0	0	**0**
At 1 April 2009	266	1,561	56	0	0	0	0	630	**2,513**
Arising during the year	0	0	69	0	0	19	0	0	**88**
Used during the year	(67)	(134)	(23)	0	0	0	0	(25)	**(249)**
Reversed unused	0	0	(17)	0	0	0	0	(557)	**(574)**
Unwinding of discount	6	34	0	0	0	0	0	0	**40**
Transfers in year	0	0	0	0	0	0	0	0	**0**
At 31 March 2010	205	1,461	85	0	0	**19**	**0**	48	**1,818**
Expected timing of cash flows:									
In the remainder of the spending review period to 31 March 2011	62	102	85	0	0	19	0	48	**316**
Between 1 April 2011 and 31 March 2016	143	547	0	0	0	0	0	0	**690**
Between 1 April 2016 and 31 March 2021	0	610	0	0	0	0	0	0	**610**
Thereafter	0	202	0	0	0	0	0	0	**202**

Pensions payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided.

Other' includes a provision for redundancy costs of £48k (31 March 2008 £562k). This was calculated on an individual basis, on the probability of redeployment. The remainder relates to potential legal costs relating to Trust property.

£22,673k is included in the provisions of the NHS Litigation Authority at 31/3/2010 in respect of clinical negligence liabilities of the Trust (31/03/09 £20,481k).

35. Contingencies

35.1 Contingent liabilities

	2009/10 £000	2008/09 £000
Equal pay cases	**(6)**	0
Other	**(41)**	(273)
Amounts recoverable against contingent liabilities	**0**	0
Total	**(47)**	(273)

35.2 Contingent assets

The 'Other' contingencies relate to liabilities under the Liability to Third Party Schemes (LTPS) of £36k, and to the balance of the estimated maximum liability for the staff post at risk that is not included in the provision in Note 34 of £5k.

36. Financial Instruments

36.1 Financial assets

	At fair value through profit and loss	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Embedded derivatives	0			**0**
Receivables		11,112		**11,112**
Cash at bank and in hand		4,816		**4,816**
Other financial assets	0	0	0	**0**
Total at 31 March 2009	0	15,928	0	**15,928**
Embedded derivatives	**0**			**0**
Receivables		**10,150**		**10,150**
Cash at bank and in hand		**4,974**		**4,974**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2010	**0**	**15,124**	**0**	**15,124**

36.2 Financial liabilities

	At fair value through profit and loss	Other	Total
	£000	£000	£000
Embedded derivatives	0		0
Payables		20,616	20,616
PFI and finance lease obligations		35,098	35,098
Other borrowings		0	0
Other financial liabilities	0	0	0
Total at 31 March 2009	0	55,714	55,714
Embedded derivatives	**0**		**0**
Payables		**21,576**	**21,576**
PFI and finance lease obligations		**34,448**	**34,448**
Other borrowings		**0**	**0**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2010	**0**	**56,024**	**56,024**

36.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with primary care Trusts and the way those primary care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

36.4 Maturity of financial liabilities

	31 March 2010 £000	31 March 2009 £000
In one year or less	**0**	0
In more than one year but not more than two	**0**	0
In more than two years but not more than five	**0**	0
In more than five years	**0**	0
Total	**0**	0

37. Events after the reporting period

There are no post balance sheet events having a material effect on the accounts.

38. Financial performance targets

The figures given for periods prior to 2009/10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

38.1 Breakeven Performance

	2005/06 £000	2006/07 £000	2007/08 £000	2008/09 £000	2009/10 £000
Turnover	161,677	163,728	171,740	183,311	195,695
Retained surplus/(deficit) for the year	14	1,673	2,713	807	1,166
Adjustment for:					
Timing/non-cash impacting distortions:					
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0				
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0			
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0		
Adjustments for Impairments				0	371
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					875
Other agreed adjustments	0	0	0	0	0
Break-even in-year position	14	1,673	2,713	807	2,412
Break-even cumulative position	495	2,168	4,881	5,688	8,100

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	0%	1%	2%	0%	1%
Break-even cumulative position as a percentage of turnover	0%	1%	3%	3%	4%

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

38.2 Capital cost absorption rate

For 2008/09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £2,982k, bears to the actual average relevant net assets of £85,212, that is 3.5% (prior year 3.4%).

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

38.3 External financing

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

	£000	**2009/10 £000**	2008/09 £000
External financing limit		**(158)**	(489)
Cash flow financing	(811)		(489)
Finance leases taken out in the year	653		0
Other capital receipts	0		0
External financing requirement		**(158)**	(489)
Undershoot/(overshoot)		**0**	0

38.4 Capital Resource Limit

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

	2009/10 £000	2008/09 £000
Gross capital expenditure	**7,234**	7,625
Less: book value of assets disposed of	**(99)**	0
Plus: loss on disposal of donated assets	**8**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(187)**	(1,195)
Charge against the capital resource limit	**6,956**	6,430
Capital resource limit	**6,973**	6,440
(Over)/Underspend against the capital resource limit	**17**	10

39. Related party transactions

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

During the year none of the Trust's directors or senior management staff, or parties related to them, has undertaken any material transactions with Kingston Hospital NHS Trust except for the matters noted below:

During 200910, the Trust has paid £139k for legal services from Morgan Cole, one of whose partners is the spouse of Andrew Seddon, the Trust's Director of Finance and Information until 7th February 2010. The interest is properly disclosed in the Trust's register of interests.

Gren Collings, the Trust's Associate Director currently holds the position of Property Advisor to South West London & St Georges Mental Health Trust. During 2009/10, the Trust has procured products and services from this NHS body totalling £92k, and provided products and services to them of £701k. The interest is properly disclosed in the Trust's register of interests.

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

	Income £'000	Expenditure £'000	Payables outstanding as at 31.03.10 £'000	Receivables outstanding as at 31.03.10 £'000
Department of Health	2,158	0	0	0
London Strategic Health Authority	7,933	21	0	102
Kingston PCT	72,627	417	249	1,312
Richmond and Twickenham PCT	40,019	76	39	1,074
Surrey PCT	27,291	24	13	1,623
Sutton & Merton PCT	10,559			1,062
Wandsworth PCT	19,456	817	833	563
St Georges NHS Trust	274	613	393	564
The Royal Marsden Foundation Trust	223	90	331	291
South West London & St Georges Mental Health NHS Trust	701	93	156	118
NHS Litigation Authority	0	3,915	0	0

In addition, the Trust has had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions have been with HM Revenue and Customs in respect of PAYE, NI contributions and VAT refunds and NHS Pension Scheme in respect of employer superannuation contributions.

The Trust has also received revenue and capital payments from a number of charitable funds, whose corporate Trustee is on the board of Kingston Hospital NHS Trust. The audited accounts for the Charitable Fund held on Trust are available by request from the Trust.

Outstanding balances with the related parties are not secured against any of the Trusts assets and no guarantees have been provided.

There are no expenses recognised in the period in respect of bad or doubtful debts from related parties, and there are no provisions for doubtful debts from related parties in the accounts.

40. Third Party Assets

The Trust held £0 cash and cash equivalents at 31 March 2010 (£0 - at 31 March 2009) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

41. Intra-Government and Other Balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other Central Government Bodies	8,145	427	5,807	0
Balances with Local Authorities	19	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,018	0	650	0
Balances with Public Corporations and Trading Funds	0	0	130	0
Intra Government balances	9,182	427	6,587	0
Balances with bodies external to Government	1,934	0	14,884	108
At 31 March 2010	**11,116**	**427**	**21,471**	**108**
Balances with other Central Government Bodies	7,884	479	4,752	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,416	0	997	0
Balances with Public Corporations and Trading Funds	0	0	103	0
Intra Government balances	9,300	479	5,852	0
Balances with bodies external to Government	2,055	0	14,549	215
At 31 March 2009	11,355	479	20,401	215

42. Losses and Special Payments

There were 290 cases of losses and special payments (2008/09: 104 cases) totalling £103,294 (2008/09: £93,701) accrued during 2009/10.

43. Transition to IFRS

	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve
	£000	£000	£000	£000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**9,258**	**47,870**	**5,764**	**0**
Adjustments for IFRS changes:				
Private finance initiative	(11,477)	13	0	414
Leases	0	0	0	0
Others (specify)	0	0	0	0
Adjustments for:				
Impairments recognised on transition	0	0	0	0
UK GAAP errors	(48)	0	0	0
Taxpayers' equity at 1 April 2009 under IFRS:	**(2,267)**	**47,883**	**5,764**	**414**

	£000
Surplus/(deficit) for 2008/09 under UK GAAP	**807**
Adjustments for:	
Private finance initiative	(1,666)
Leases	0
Others (specify)	(7)
Surplus/(deficit) for 2008/09 under IFRS	**(866)**

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £350k. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

19. Glossary of terms

The following glossary gives an explanation of some of the medical/technical and financial terms used in the report.

Medical/technical glossary of terms

Combined Heat and Power unit (CHP): This is an efficient way to generate electricity and heat simultaneously.

Clostridium Difficile (C Diff): Clostridium Difficile is a bacterium that is present naturally in the gut of around 3% of adults and 66% of children. It does not cause any problems in healthy people. However, some antibiotics that are used to treat other health conditions can interfere with the balance of 'good' bacteria in the gut. When this happens, C Diff bacteria can multiply and cause symptoms such as diarrhoea and fever.

Care Quality Commission (CQC): Care Quality Commission (CQC) is the new independent regulator of health, mental health and adult social care services across England. Its responsibilities include the registration, review and inspection of services and its primary aim is to ensure that quality and safety standards are met on behalf of patients.

Clinical Quality Indicators (CQUINs): National quality indicators, agreed with local commissioners, against which the Trust will be measured. They will cover areas of safety, effectiveness and patient experience.

Care Records Service (CRS): Also known as NHS Care Records Service. This will be an electronic store of over 50 million health and care records which can be accessed by health professionals where and when they are needed. It will also give patients secure Internet access to their own health record.

Department of Health (DH): The Department of Health is a government department that exists to improve the health and wellbeing of people in England. It also sets direction for the NHS, for adult social care and public health.

Foundation Trust (FT): NHS Foundation Trusts are a new type of NHS Trust in England and have been created to devolve decision-making to local organisations and communities so that they are more responsive to the needs and wishes of local people.

Genito-Urinary Medicine (GUM): Genito-urinary medicine clinics deal with sexually transmitted infections and many other genital and sexual problems. These clinics are sometimes called ‘GU clinics’ or GUM for short.

Haemoglobin A1c (HbA1c): HbA1c is a test that measures the amount of haemoglobin in your blood. Glycosylated haemoglobin is a substance in red blood cells formed when blood sugar (glucose) attaches to haemoglobin. The more glucose in the blood, the more haemoglobin A1C or HbA1C will be present in the blood.

Healthcare Associated Infections (HCAI): Healthcare associated infections are infections that are acquired in hospitals or as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

Healthcare for London: Healthcare for London is a 10-year programme to transform healthcare and standards of health in the capital. It is run on behalf of, and funded by, the 31 Primary Care Trusts (PCTs) in London.

High quality care for all: The outcome of the review of the NHS, led by Lord Darzi, to develop a vision of the NHS fit for the 21st century.

Human immunodeficiency virus (HIV): HIV is a virus that is transmitted from person to person through the exchange of body fluids such as blood, semen, breast milk and vaginal secretions. Sexual contact is the most common way to spread HIV, but it can also be transmitted by sharing needles when injecting drugs, or during childbirth and breastfeeding.

Health Protection Agency (HPA): Established as a non-departmental public body. The functions of the Agency are "to protect the community (or any part of the community) against infectious diseases and other dangers to health" (HPA Act 2004).

Independent Sector (IS): Generally taken to mean healthcare providers who are not within the NHS.

Medical Assessment Centre (MAC): A high quality, rapid assessment service to determine if patients need any investigations or care in order to treat or stabilise their medical condition.

Methicillin Resistant Staphylococcus Aureus (MRSA): It is a bacterium from the Staphylococcus aureus family. MRSA bacteria are resistant to some of the antibiotics that are commonly used to treat infection, including methicillin (a type of penicillin originally created to treat Staphylococcus aureus (SA) infections).

NHS London: This is the Strategic Health Authority (SHA) for London, one of the ten strategic health authorities in England established on 1 July 2006.

National Institute for Clinical Excellence (NICE): NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health

Patient Advice and Liaison Service (PALS): The PALS service provides:

- confidential advice and support to families and their carers
- confidential assistance in resolving problems and concerns quickly

explanations of complaints procedures and how to get in touch with someone who can help

Payment by Results (PbR): This is the system by which most acute healthcare is priced and paid for by commissioners (usually Primary Care Trusts).

Primary Care Trusts (PCT): NHS bodies aligned to local government geographic areas which have responsibility for commissioning healthcare on behalf of local residents.

Referral to Treatment (RTT): This is a term used in connection with the 18-week target. By December 2008, all Trusts had to ensure that elective care was delivered within 18 weeks of the initial GP referral. The total time elapsed is the RTT.

Strategic Health Authority (SHA): Strategic Health Authorities manage the NHS locally and are a key link between the Department of Health and the NHS. They hold all local NHS organisations (apart from NHS Foundation Trusts) to account for performance.

"Wet" age-related macular degeneration ("Wet" AMD): Sometimes the delicate cells of the macula become damaged and stop working. There are many different conditions which can cause this. If it occurs later in life, it is called "age-related macular degeneration", also often known as AMD.

"Wet" AMD results in new blood vessels growing behind the retina, this causes bleeding and scarring, which can lead to sight loss. "Wet" AMD can develop quickly and sometimes responds to treatment in the early stages. It accounts for about 10 per cent of all people with AMD.

Financial glossary of terms

Accelerated Deprecation: Where a body has approved a decision to close a property and where the assets value in use is greater than its alternative use value, the asset must be written down to its net realisable value (Value if you were to sell) over the estimated remaining life of the asset. The resulting increase in the annual depreciation charge is known as accelerated depreciation.

Agenda for Change (AfC): Agenda for Change is a national pay structure which all NHS trusts need to use to pay most of their staff, excluding medical staff who are on separate contracts.

Annual Accounts: The annual accounts for the NHS body provide the financial position for the financial year i.e., 1 April to 31 March. The format of the annual accounts is set out in NHS accounts manuals and includes financial statements and notes to the accounts.

Asset impairments: Assets (eg buildings) are held at valuation in the hospital's accounts. All assets are revalued periodically, and the values are changed in the accounts. An impairment is a significant downward change in value of a particular asset that is charged to the income & expenditure account.

Auditors' Local Evaluation (ALE): this is the Audit Commission's assessment framework of the effectiveness of trusts' use of resources and is based on a detailed evaluation and scored judgements on five key areas of financial performance:

- Financial reporting;
- Financial management;
- Financial standing;
- Internal control;
- Value for money.

Audit Report: A final report by an NHS body's auditor on the findings from the audit process.

Average net relevant assets: Relevant net assets are calculated as the total capital and reserves of the NHS trust less the donated asset reserve and cash balances in the Office of the Paymaster General accounts. The average is the average of the opening and closing figures.

Better Payment Practice Code: The target of the Better Payment Practice Code is to pay all NHS and non NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Capital: Capital expenditure is spending on the acquisition of land and premises, and on the provision, adaptation, renewal, replacement or demolition of buildings, items or groups of equipment and vehicles, etc, where the expenditure exceeds £5,000.

Capital charges: The revenue costs associated with fixed assets. This includes elements of depreciation and interest.

Capital cost absorption duty (CCAD): The financial regime of NHS trusts recognises that there is a cost associated with the maintenance of the capital value of the organisation. NHS trusts are required to absorb the cost of capital at a rate of 3.5 per cent of average net relevant assets.

Capital Resource Limit (CRL): An expenditure limit set by the Department of Health for each NHS organisation limiting the amount that may be spent on capital purchases.

Cash Flow: A summary in a prescribed format of the cash received and paid out by an organisation over a defined time period.

Cost Improvement Plans (CIPs): Plans to meet the efficiency savings target levied on NHS bodies by the government.

Depreciation: An accounting adjustment in income and expenditure accounts to represent the use (or wearing out) of assets. It is a non-cash item designed to reflect the fact that when we buy an asset like equipment or buildings, the cash goes out of the bank account immediately but the use of the asset continues over many years. This spreads the cost over the life of the asset rather than just when it was purchased, and effectively creates a fund for the replacement of the asset.

Earnings before Interest, Tax, Depreciation and Amortisation (EBITDA): An increasingly common accounting term, which represents a measure of the profit from operations, before deducting capital and financing items (depreciation, interest, tax). This is a proxy for the cash generated by operations.

External Financing Limit (EFL): The government sets each NHS hospital trust a target for the level of cash movement allowed in year.

European Working Time Directive (EWTD): this is a European Union directive designed to protect the health and safety of workers in the European Union. It lays down minimum requirements in relation to working hours, rest periods, annual leave for all workers and working arrangements for night workers. This has particular relevance for NHS trusts given the extended transitional arrangements for Junior Doctor compliance.

Financial Instruments: A contract that gives rise to a financial asset of one entity and a financial liability or equity instrument of another entity.

Financial Statements: The main statements in the annual accounts of an NHS body. These include: a statement of comprehensive income, statement of financial position, statement in changes in taxpayers equity and statement of cash flow statement. The format of these statements is specified in the NHS accounts manuals.

Forecast Outturn (FOT): Estimated year end position.

Health Care Resource Group (HRG): Healthcare Resource Groups (HRGs) provide a means of categorising the treatment of patients in order to monitor and evaluate the use of resources. The National Tariff uses HRGs.

International Financial Reporting Standards (IFRS): These are the new accounting standards that the NHS has adopted from 1 April 2009.

In Year Financial Performance: Result of income compared with expenditure, ignoring any impact of the previous years' financial results.

Market Forces Factor (MFF): A percentage adjustment, which each NHS trust receives on all Payment by Results income. This Trust currently receives 20.0% uplift, which is intended to reflect the higher cost of living and land values in some areas of the country compared to others.

National Capitation Targets: In order to decide what NHS funding is allocated to commissioners, the government has a resource allocation working group. They set 'capitation' targets that give funding per head of population, adjusted for factors such as age, sex and temporary residents. Because historic allocations were based on location and provision of healthcare rather than population, there is often some distance between the amount of money commissioners receive and their target. Commissioners that are 'over target' receive lower increases in funding; commissioners that are under target receive higher increases in funding each year.

Non-recurrent/recurrent: Recurrent changes are permanent, and non-recurrent changes are temporary and generally they will occur in one year only.

Normalised: Normalised figures are those where the impact of non-recurrent items has been removed, so we can see the ongoing trend.

Outturn: The final financial position, which could be the actual or forecast position.

Payment by Results (PbR): One of the mechanisms which are used to calculate how much money we receive for our patient activity. It means we get an amount of money per patient admitted to hospital which depends on what treatment they receive while they are here. This is calculated using the PbR 'tariff' – a set of prices for each sort of activity. Not all our activity is covered under the PbR mechanism – for example we receive money for some services direct from the PCT, and we receive training money for junior doctors.

Prudential Borrowing Limit (PBL): Loan limit agreed by Department of Health (DH) for spend on Capital. The limit is based on five Balance sheet ratios.

Public Dividend Capital (PDC): When NHS trusts were set up, an organisation was created with ownership of land and buildings. PDC is the amount of taxpayer's equity that is judged to be the taxpayer's stake in that ownership. Each year, we pay a dividend from our income from operations to compensate for the use of this capital.

Primary care trust (PCT): The PCT commissions healthcare services across the local economy. This includes hospital activity, GP services, mental health and ambulance services.

Private Finance Initiative (PFI): The private finance initiative (PFI) provides a way of funding major capital investments, without immediate recourse to the public purse. Private consortia, usually involving large construction firms, are contracted to design, build, and in some cases manage new projects. Contracts typically last for 30 years, during which time the building is leased by a public authority.

Qualified Audit Opinion: When the auditor is of the opinion that there is a problem with the annual accounts of an NHS body, they can issue a qualified report on the accounts. The qualification may be on the truth and fairness of the accounts, the regularity of the transactions or both.

Real / Nominal Rate of Growth: 'Real' growth excludes the effect of inflation, whereas nominal growth includes inflation. The reason we quote both 'real' and 'nominal' growth is that this makes it easier to see the underlying rate of growth when explaining trends over a long period.

Reference Cost Index (RCI): Index value for the cost of a procedure (the average =100) this information informs the value of PbR Tariff in future years.

Remuneration: The money and other benefits paid to people carrying out a job.

Retail Price Index (RPI): Measure of Price inflation comparing year on year movements in price

Retained Surplus: The difference between income earned in a defined period, usually a year, and the associated costs.

Revaluation reserve: A reserve created when an asset is revalued to a higher value than it's historic cost.

Ringfenced: Usually referring to money or other resources where it can only be used for a defined purpose eg to provide cancer care.

Service Level Agreement (SLA): Agreement between two or more parties to deliver a defined service for a defined rate of pay. In the NHS this is usually an agreement between a PCT or Commissioner, and a trust Provider.

Service Line Reporting (SLR): Reporting tool to show the costs and income at a specialty level instead of at Departmental level. Costs will included direct and indirect costs and may include Overheads.

Statement of comprehensive income: This was formally known as the income and expenditure account under UK (GAAP).

Statement of financial position: This was formally known as the balance sheet under UK (GAAP).

Tariff: The value charged for an activity usually known as the National Tariff in the NHS.

True and Fair Opinion: Auditors provide an opinion as to whether an NHS body's accounts have been prepared in accordance with all relevant accounting standards, legislation and guidance.

Unitary Payment: The monthly payment made to the PFI consortia. Payment for services provided including hotel services and building maintenance.

Unqualified Audit Opinion: When auditors of NHS bodies are satisfied with the annual accounts they will issue an unqualified audit opinion.

Working Capital: Working capital is the current assets and liabilities (receivables, inventories, cash and payables) required to facilitate the operation of an organisation.