Kingston Hospital NHS
NHS Trust

Annual Report and Accounts 2010-11

Kingston Hospital NHS Trust, Galsworthy Road,
Kingston upon Thames, Surrey KT2 7QB.
E: enquiries@kingstonHospital.nhs.uk
W: www.kingstonHospital.nhs.uk
T: 020 8546 7711

Contents

1. Chairman's Foreword

It has been a busy and challenging year for Kingston Hospital. In the current tough economic climate and with many changes taking place across the NHS, we have continued to deliver excellent services for our patients and the local community.

The Trust is again moving ahead with its plans to become an NHS Foundation Trust (FT). We have already submitted an early draft of our Integrated Business Plan (IBP) and Long Term Financial Model (LTFM) to NHS London in January 2011, and we are currently carrying out a formal consultation with our members, stakeholders and staff about our future plans; this will finish later on in the summer. We have also signed up to an agreed timetable which enables us to achieve FT status by autumn 2012. We strongly believe that becoming an FT will make services better for local people and will play an important role in future developments at the Hospital.

Looking to the future, our vision, for the next five years, is 'to be the Hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff.'

In order to achieve this, we have identified 5 key priorities (or service development plans), a number of which will involve working with partners in health (other acute Trusts, primary care and commissioners) and social care.

The five key priorities are:

- To expand our maternity services so that no woman who wishes to use us is turned away;
- To strengthen further our services for the acutely unwell, ensuring appropriate treatment 24/7;
- To support GPs to shift care out of Hospital into the community where appropriate;
- To improve the experience of our patients and GPs;
- To work with partners to make savings and improve care for patients.

Over the year we have continued to work closely with our partners such as The Royal Marsden and Macmillan Cancer Support. We are developing other key relationships with our commissioners and clinical colleagues, such as local GPs and other Hospitals such as Queen Mary's, St George's and Teddington Memorial.

And finally, I would like to thank all the staff working at the Trust for their continued dedication – so essential for the running of the Hospital – as well as the many partner organisations, volunteers and fundraisers for their invaluable support, which helps us to provide a high quality service for our patients of which we should all be proud.

Christopher Smallwood
Chairman

Statement from the Chief Executive

This year at Kingston Hospital there has been a real focus on patient safety and improving the quality of our services, as well as the patient experience. This is reflected in our many achievements.

In March 2011, the Trust won a prestigious national award in the Board Leadership Category of the Nursing Times and Health Service Journal Patient Safety Awards. The Hospital was highlighted as having the best practice for putting patient safety first and was specifically praised for the senior changes in the board that enabled a refocus on patient safety, including reducing mortality rates and minimising preventable harm to patients.

The Hospital continues to have a good reputation for its services and has been performing well against the key national access targets and standards. We have reduced even further our already very low MRSA and Clostridium Difficile rates to ensure that we provide a safe environment for our patients to be treated in.

In May 2010, the Trust was one of five Hospitals across the country to be named as a Top Hospital for the tenth year running and was also awarded second place in the 2010 CHKS Data Quality Award for England, which celebrates excellence in patient safety, quality of care and data quality.

Our maternity unit is the second biggest single site in London and in December 2010, mothers rated us as the best unit in London, in a survey carried out on behalf of the Care Quality Commission, (CQC). In addition to this, our Stroke Unit is continuing to make real strides in service provision and is achieving 100% of the targets set by the Stroke Network. The Accident and Emergency (A&E) Department remains one of the biggest and busiest in South West London and has seen growth of 12% over the last 5 years with attendances now reaching 110,000 a year.

In January 2011, the Hospital opened a new Cardiac Catheterisation Laboratory to provide an on-site diagnostic service for patients. This has helped us improve patient experience, by reducing Outpatient waiting times and giving patients a choice of appointment. Inpatients can now receive treatment promptly as they no longer need to wait for a bed at a specialist Hospital to receive a diagnosis, which helps reduce their length of stay in Hospital and improves their overall experience.

Our staff have worked incredibly hard this year. In particular, we were very busy over winter due to a combination of the heavy snow and also an increase in the number of patients we saw with seasonal and swine flu. Although there was increased demand on our services, the Trust responded well. We had a number of very busy weeks and I was particularly impressed with the way our staff rose to the challenge, many of them working additional shifts and longer hours to ensure that our patients received the care they needed during this busy time.

Kate Grimes
Chief Executive

2. About Kingston Hospital NHS Trust

Kingston Hospital NHS Trust (KHT) is a single site, medium sized District General Hospital, located within Kingston-Upon-Thames. We provide a full range of diagnostic and treatment services to approximately 320,000 people locally on behalf of our commissioners within South West London and North Surrey.

For centuries, the town of Kingston-Upon-Thames has served as the regional centre for the surrounding population. Residents from areas such as Wimbledon, Richmond, Epsom and Esher have historically travelled to Kingston for business, shopping, legal affairs at the courts and for their Hospital care. Kingston also has two universities drawing people in from further afield and a vibrant night time economy. There are excellent travel links and most importantly, historic flows mean that people from the surrounding area look at Kingston as their regional centre.

Although generally our catchment is fairly affluent, we do serve more deprived populations. We also serve a mix of ethnic groups including large Korean and Tamil communities around Kingston. We have therefore developed our services to be responsive to the challenges this population profile presents.

Our flagship services include maternity, paediatrics, accident & emergency, stroke and cancer. Kingston is a popular local Hospital and our services have a very good reputation. These include:

- Our **maternity service** which is recognised locally, nationally and internationally as offering a very high standard of care. We have the largest unit in south west London and we are the second biggest single site unit in London, expecting close to 5,900 deliveries this year. The service is very popular with local women and in December 2010 we were rated as the best Hospital in London for maternity services by mothers in a survey carried out on behalf of the CQC;
- Our **Accident & Emergency Department** which is in the top 10% in the country seeing over 100,000 attendances per year. We have relatively low admission rates and our performance against the 4 hour wait target is the best in south west London and in the top quartile across London;
- Our **paediatric service** which supports our maternity and A&E services. We run shared care cancer services with The Royal Marsden and Great Ormond Street Hospitals. We are increasingly being asked to increase our shared care capacity for patients from other local areas;
- **Our stroke unit** which was awarded the A2 standard for our stroke care in December 2010. The standard has protocols and policies, which promote a multi disciplinary approach to care, including increased nursing and therapy input to enable early patient discharge into community care;

- **Our day surgery services** are provided from a purpose built unit, which was opened in 1996. We started performing day surgery as early as 1978 and in 2004 we were the first day surgery unit in Europe to be accredited by the Health Quality Service. We regularly host Hospitals from around the world who want to see how we have designed and use our purpose built facility;
- Our **cancer services,** which are provided from a dedicated facility built in 2008 and in partnership with the Royal Marsden Hospital and Macmillan Cancer Support.

Our main Hospital facilities include:

- 559 inpatient beds;
- An accident and emergency department with supporting medical and surgical assessment units;
- A maternity unit including a midwifery led unit;
- A dedicated day surgery unit;
- Seven main operating theatres, four day surgery operating theatres, one eye unit operating theatre, and two maternity operating theatres;
- A cardiac catheter laboratory;
- A surgical centre opened in 2007;
- An education centre opened in 2007;
- A cancer unit opened in 2008 in partnership with the Royal Marsden Hospital; and,
- A private patient facility operated by BMI Healthcare since 2009.

We have demonstrated consistently strong performance in operational delivery, clinical quality and financial management. We have very low levels of Health Care Acquired Infections (HCAIs), such as MRSA and particularly Clostridium Difficile, compared with other local Hospitals. Our mortality rates are also extremely low.

We work closely with, and respond to the needs of our local community, by delivering care closer to home. Our clinicians provide and/or support care in outpatient and day surgery facilities at a number of community locations including Queen Mary's Hospital Roehampton, Teddington Memorial Hospital, Molesey Hospital, Cobham Day Surgery Unit and Emberbrook Community Centre. We have strong links with tertiary and specialist Hospitals, particularly St George's Hospital and the Royal Marsden Hospital. We also have close links with Kingston University and St George's Medical School. We are a partner in the Elective Orthopaedic Centre based at Epsom Hospital.

Our 2,403 (working time equivalent) staff are the Trust's most valuable asset. Our success is down to their hard work, commitment and dedication along with our 300 volunteers and supported by 350 contract workers who help us with cleaning, catering and laundry.

Key facts:

Category	Historic 2009-10	Current 2010-11	Plan 2011-12
Activity:			
A&E (attendances) inc. Royal Eye Unit Casualty Department	109,870	109,728	109,660
Outpatient (attendances) *	318,938	374,838	376,539
Inpatient (spells)	61,392	63,605	62,753
Income	£195.7m	£200.1m	£195.1m
Overall Income & Expenditure Position	£1.2m	£2.0m	£2.1m

* counting change implemented in 2010/11 in relation to physiotherapy and maternity episodes (54,732).

3. Our Performance

109,728 people attended our A&E department (including attendances to our Royal Eye Unit Casualty) with **17,244** needing emergency admission to the Hospital.

There were **374,838** attendances to our Outpatient Department. This includes outpatient attendances for Maternity (40,995) and the Wolverton Centre (17,399).

21,792 patients were able to go home on the same day as their planned treatment or operation.

4,531 planned procedures requiring patients to stay in hospital were carried out, with a further ***22,539*** patients requiring non-planned treatment.

Our maternity unit delivered **5,929** babies.

14,136 children have been treated by our Paediatrics Department (inpatient and outpatients).

Best Clinical Outcomes

At the start of 2011, the Trust started publishing clinical outcomes to give more information about the performance of the Hospital and to be more open and transparent to its patients. Publishing these figures is part of the Hospital's work to become a top performing Trust and help identify areas for improvement. The outcomes are now reported to the Trust Board on a bi-monthly basis through the Medical Director's Quality and Safety Report.

Some of the Hospital's best clinical outcomes include, 84% of operations at the Hospital are now performed as day surgery, this is higher than other similar Trusts. In addition to this, 94% of breast lump removals are being performed as day surgery compared to 74% in other similar Trusts and 68% of laparoscopic hernia repairs are day cases compared to 36% in other similar Trusts.

The Trust is also doing particularly well in reducing the length of stay of patients who have had surgery down to 14 days, which is well below the national average. Following the introduction of the Enhanced Recovery Programme in surgery, the length of stay for bowel surgery patients has reduced by three days compared to 2009 figures. The programme has also helped reduced Hospital stay for urological surgery patients by two to three days, depending on the procedure. Reducing the length of stay in Orthopaedic surgery has also seen significant benefits for elderly patients who undergo hip operations, as they are now able to go home sooner, hence reducing the risk of them developing other medical conditions.

In 2010-11 the Trust performed well against the key national access targets and standards.

A&E Four-Hour Wait

The Trust's performance against the A&E 4-hour wait standard remained strong through the year and above 98.1%.

In 2011-12 eight new clinical quality indicators will be introduced to replace the four hour standard. Performance against these is currently being monitored weekly.

Stroke

The Hospital's Stroke Unit was externally assessed on 23 March 2010 and successfully passed the A1 Healthcare for London stroke standard for achieving 100% of its targets. This criteria gives assurance about the quality of care that is being delivered on the unit. The proportion of patients spending more than 90% of their time on the Stroke Unit is currently 77.1%, which is slightly below the expected target. The Trust has an action plan in place to improve this.

18 Week Performance

The Trust is committed to ensuring 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.

Since December, the Trust's admitted performance has been below target. A comprehensive plan has been developed to resolve this issue and an interim senior manager appointed to oversee this work.

Delayed Transfers of Care (DToCs)

A joint programme of work with NHS Kingston and the Royal Borough of Kingston at the start of the year to improve the discharge process has meant DTOCs have been low in 2010-11 averaging 2.1% compared to 4.9% in 2009-10.

Cancer Waits

The Trust's performance against the 31 day diagnosis to treatment and 31 day subsequent treatment (surgery) was below expected. A short term solution has been implemented to resolve the issue. Performance against the other six cancer targets has been very good.

Hospital Standardised Mortality Rates (HSMRs)

Compared to other acute Hospitals in the country, the Trust has again performed 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 Feb 2010 to Jan 2011 = 69.9.

Performance Indicators	Target 2010/11	Position for 2010/11
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%	98.7%
Breast Sympton Two Week Wait (New Indicator)	93%	97.0%
All patients will be seen within one month of diagnosis (decision to treat) to treatment	96%	95.7%
Cancer Diagnosis to Treatment Waiting Times - 31 day second or subsequent treatment (surgery)	94%	93.1%
Cancer Diagnosis to Treatment Waiting Times - 31 day second or subsequent treatment (drug)	98%	100.0%
All patients with suspected cancers will be seen within two months of urgent referral to treatment	85%	86.55%
Cancer Urgent Referral to Treatment Times - 62 day referral to treatment from screening	90%	93.33%
Cancer Urgent Referral to Treatment Times - 62 day referral to treatment from hospital specialist	90%	100.00%
Speed of treatment for inpatients and outpatients		
18 Weeks Referral To Treatment - Admitted Patients	90%	89.3%
18 Weeks Referral To Treatment - Non Admitted Patients	95%	96.8%
Speed of treatment in A&E		
Total Time in A&E: four hours or less	98%	98.1%
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 by 2008/09 (Trust Apportioned)	3	3
Reduction in number of C. diff positive cases – achieve 30% reduction by 2010/11 on the 2007/08 (Trust Apportioned)	25	17
Quality of Stroke Care - Proportion of Stroke Patients spending > 90% of their time on Stroke Unit	80%	77.00%
Smoking During Pregnancy and Breastfeeding Inititation Rates - Breastfeeding	86.5%	86.3%
Smoking During Pregnancy and Breastfeeding Inititation Rates - Smoking	4.3%	4.5%
The % of first attendances at a GUM service offered an appo	98%	100%
Proprtion of patients whose operation was cancelled, by the	0.80%	0.60%
Delayed Transfers of Care	3.50%	2.15%

*** Figures correct as of 18 April 2011.**

4. Our Achievements

Accident and Emergency (A&E)

The Hospital's A&E Department has seen growth of 12% over the last 5 years with attendances now reaching 110,000 a year. The department has been acknowledged by the College of Emergency Medicine as good practice, for its proactive work with Primary Care colleagues to establish modern and first class urgent care service, whilst reducing costs.

Seeing over 100,000 patients per year means that the department is now in the top 10% of departments' nationally in terms of workload, with the national average for A&E attendances being just over 65,000.

The A&E at Kingston Hospital plays an active role in the South West London and Surrey Regional Trauma Network as part of NHS London service reconfiguration. The department continues to work closely with local PCTs and the members of the planned pathfinder GP consortia to establish new pathways for patients to access unscheduled care services and to ensure they are provided with the best possible care in the appropriate clinical setting.

Care Quality Commission (CQC) Maternity Survey

Kingston Hospital was rated the best Hospital in London for maternity services by mothers who gave birth in February 2010. The findings, which were recently released by national health watchdog the CQC, were gathered through a survey carried out on 25,000 mothers across England. Only four out of 22 Hospital Trusts in London were rated better than the national average, of which Kingston Hospital fared the best, with 86 per cent of women rating the overall care received during labour and birth as either "excellent" or "very good" – the highest rating in London.

Clinical Negligence Scheme for Trusts (CNST) Assessment

In a level one CNST assessment in January 2011, the Hospital's Maternity Unit passed with the highest possible score – an excellent 100% against 50 set standards including clinical care, communication as well as postnatal and newborn care. The work the Trust is doing to meet these standards ensures the Hospital's services are safer for patients and highlights any areas of concern which help reduce the number and severity of incidents and cost of claims.

UNICEF Accreditation

In December 2010, UNICEF awarded the Trust's Maternity Unit with the UNICEF Baby Friendly Stage One Accreditation. The accreditation means that the unit has met strict international standards involving almost three years of operational and procedural changes. Achieving a Stage One also demonstrates that the Trust has the right mechanisms in place to enable best practice standards in infant feeding.

Labour Ward Upgrade

In 2010, the Hospital's Maternity Unit has increased the number of fully equipped birthing rooms from eight to ten which has allowed more flexibility in caring for women in labour and helped reduce delays in the induction and labour process. There is also a 24 hour triage service and a dedicated area for the women coming to the unit to ensure they are seen quickly and are admitted to the most appropriate area without delay.

Staffing in Maternity

The staffing of the Maternity Unit has been reviewed to ensure that there are the right number of staff with the right skills in different areas and sufficient numbers of Midwives to provide 1:1 care for women in labour. The unit operates within an integrated model of care, which promotes normality for low risk women via a skilled community midwifery team and a birthing unit, ensuring those women who require more input from an obstetrician are cared for by staff with the necessary skills.

Kingston is one of the first Hospital's in the country to increase consultant presence on the unit from 60 hours per week to 98 hours per week from September 2010. This is to ensure there is senior medical supervision for women in labour in the maternity unit from 8am until 10:30pm with a Consultant on call from home outside these hours. A midwifery manager's on-call rota has also been introduced in July 2010 to provide an out of hours senior management overview of workload and staffing in the unit and if required, managers will attend the unit to oversee the prioritisation at peak times. A daily multi-disciplinary meeting involving Consultant Obstetrician, Anaesthetists, Paediatricians, Midwives, Neonatal staff and the Midwifery Management Team has also been implemented. This provides a real-time overview of the women currently in the Maternity Unit and allows joint decision making, and the allocation of staff and beds appropriately.

Baby Boom

In October 2010, the Hospital's Maternity Unit had a baby boom with over 500 babies being delivered at the unit. To prepare for the expected surge in births the unit recruited an extra 19 new midwives and a new consultant, as well as increasing consultants' hours and introducing a Midwifery Managers on-call rota to help provide greater support to staff.

Stroke Unit Standards

The Trust's Stroke Unit is continuing to make real strides in service provision. The unit has now successfully passed all A2 care standards set by the Stroke Network for achieving 100% of its targets. This is a big improvement from 2009 when the Stroke Unit was awarded A1 standards for hitting 70% of its targets.

During the healthcare for London Assessment, the unit was inspected by a team of experts. The assessment included the timeliness of admissions to ensure that they were direct to the Stroke Unit. A notes review was undertaken which confirmed that all patients received timely therapy, medical,

nursing and swallowing/nutrition assessments. Evidence was also provided on the multidisciplinary education/training programme for all staff members.

Paediatrics Revamped

Kingston Hospital's Paediatrics Department, with the help of the charity Momentum, has created a new purpose-designed clinical area devoted to the safe and efficient administration of cancer chemotherapy.

The new area includes a reception and waiting area and two new rooms which will help protect children receiving chemotherapy from the risk of catching infections from other children, as well as streamline their visit to the Hospital for treatment.

Other isolation rooms in the department have been remodelled and revamped. Local artist Amanda Leggatt, transformed the rooms into an African Safari with images of animals, the sea as well as ferris wheels and sticks of candy floss on the walls. The isolation rooms are used by children who are vulnerable to infection, including children with cancer or those requiring isolation because they need treatment for infectious diseases.

New Cardiac Catheterisation Laboratory

In January 2011, the Hospital opened a new Cardiac Catheterisation Laboratory to provide on-site diagnostic service for patients. The laboratory has been very beneficial in reducing Outpatient waiting times and with four lists running a week, patients now have a choice of appointment compared to previously, when the mobile laboratory was only available once a week. Inpatients can now receive treatment promptly as they no longer need to wait for a bed at a specialist Hospital to receive a diagnosis, which helps reduce the patients' length of stay in Hospital and improves their overall experience of the Hospital. The new facility will also save money for our commissioners, as they will no longer have to pay for admissions to two different Hospitals.

End of Life Care Project

One of the Trust's wards is taking part in a national pilot for the Gold Standards Framework (GSF) Project for acute Hospitals. The project aims to improve the experience and coordination of care across organisations in the last year of life, before, during and after Hospital visits and reduces Hospitalisation, length of stay, by rapid discharges and avoiding admissions.

Macmillan Quality Environment Mark (QEM)

The Macmillan Information and Support Centre at the Hospital's Sir William Rous Unit is one of the first in the country to be awarded the new Macmillan Quality Environment Mark (QEM), for successfully meeting standards required by people living with cancer.

The QEM It is the first assessment tool of its kind in the UK and is a detailed framework for assessing facilities. The assessment has been developed in collaboration with over 400 people living with

cancer and stakeholders including the Department of Health. The scheme has assessed and awarded the Macmillan QEM to only 14 beacon sites across the country. Having reached the standard is a testament of the high quality of care the Hospital offers to its cancer patients.

Audiology Upgrade

With the help of funding from the Friends of Kingston Hospital, the Trust has upgraded two adult sound Booths in the Audiology Department. The refurbishments have improved the setting for adult patients having hearing tests and the clinical setting for staff which has led to increased patient satisfaction and experience.

Healthcare Quality Improvement Partnership (HQIP) Award

In April 2010, the Trust won the HQIP national clinical audit award in the creating or improving efficiencies category, for a clinical audit jointly carried out by the Biochemistry and the Obstetrics Department. The audit focused on the tests that should be performed when women present with the possibility of an ectopic pregnancy and led to an improvement in processes that have now become embedded in clinical practice. As a result, patients now avoid undergoing unnecessary tests.

New Computed Tomography (CT) Scanners

In 2010, two new CT scanners have been installed at the Trust to enable state of the art imaging at the Hospital. The Trust signed a contract with independent equipment supplier Asteral, to help provide CT scanning services to Kingston Hospital for the next seven years. As part of the deal, Asteral have worked with the Hospital's Radiology Department to reconfigure the building in which CT is provided and the team have changed their ways of working to maximise usage of the new equipment.

Wolverton Sexual Health Centre Website

The sexual health centre at the Hospital launched its website in August 2010 and contains a wealth of knowledge about STIs, HIV, and even has an automated comparison table to compare the different contraception options. The website also has dedicated sections on a wide range of specialist information for young people, men, women, gay or bi-sexual men and HIV positive patients, as well as information on what to do in case of an emergency.

Wolverton Sexual Health Centre Open Day

To celebrate its one year anniversary, the Wolverton Centre held an Open Day in September for medical practitioners, which was a huge success. The centre team provided a vast array of safe sex information, an introduction to how the Wolverton Centre can be used by young people to access safe sex and contraceptive advice, STI screening and HIV tests.

Acute Care Physicians in Medical Assessment Centre

In January 2011, the Trust introduced Acute Care Physicians in its Medical Assessment Centre. By doing this, the Hospital has almost doubled the number of consultants in the centre and will ensure

that all patients get seen by a consultant on the same day of admission (within 12 hours during the day). The increased presence of consultants and their input will help improve the outcomes for acutely ill medical patients and ensure better continuity of care.

Enhanced Recovery Programme (ERP)

In 2010, the Enhanced Recovery Programme was rolled out in surgery at the Hospital, focusing on colorectal patients. The programme aims to prepare patients for surgery by helping reduce the physical impact of surgery and decrease patients' recovery time, as well as help make patients active participants in their recovery. This is achieved by educating patients when they attend their first clinic appointment and throughout the journey including pre-op assessment, on the day of admission, through to their discharge. Benefits of the programme include early discharge and reduced Hospital stay.

Breast Cancer Peer Review

The Breast Cancer Team was visited by a team of experts in May 2010 and were found to be running an extremely efficient service, with the majority of patients receiving a one-stop clinic approach to diagnosis. In particular, the team were complimented for the range of service user surveys and the lymphoedema service provided for patients with mild to moderate breast related lymphoedeam. The review also showed significant changes in breast care provision, including a new consultant oncoplastic breast surgeon, development of the breast reconstruction service on the Hospital site, nipple tattooing, digital mammography, sentinel lymph node biopsy service, the development of complementary therapies and provision of new Macmillan workshops to support patients living with cancer.

5. Our Future

Mission and Vision

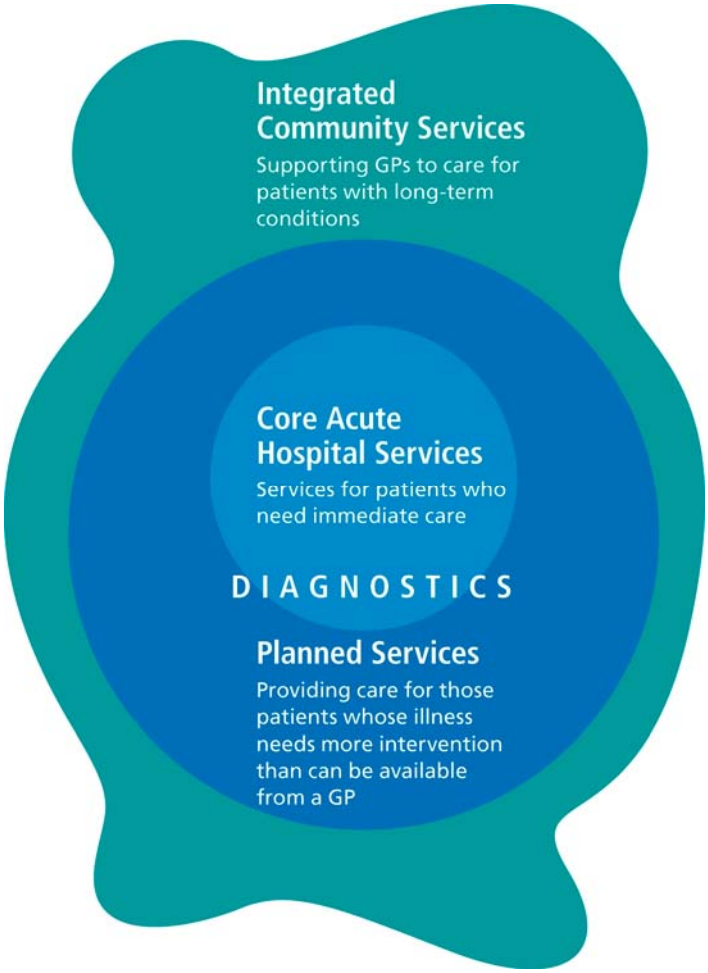
The Trust's mission, which sets out our fundamental purpose, is:

- 'To improve the health and well being of our community through the provision of high quality, patient focussed healthcare.

Our Vision, which sets out our goals for the next five years, is:

- 'To be the Hospital of choice for our local community, recognised for excellent and innovative emergency, surgical, acute medicine and maternity services, delivered by caring and valued staff.'

Our vision is visually represented and described further, in the diagram below:



Strategic Objectives 2011-16:

There are five strategic objectives which have been set by the Trust for the next five years and are underpinned by the corporate objectives and a number of success criteria which will be reflected in personal objectives and development plans for staff:

- Delivering quality, patient centred healthcare services with an excellent reputation;

- Delivering care by competent and caring staff working in effective and supportive teams who feel valued by the Trust;
- Working with partners to consolidate and strengthen the healthcare we deliver to our local community;
- Working with GPs and other providers to support the delivery of more care in primary and community settings;
- Delivering well managed, quality services which are value for money for the tax payer.

Service Development Plans

The Trust will be pursuing a number of specific service developments plans in the next few years to support the 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 five key priorities are:

- To expand our maternity services so that no woman who wishes to use us is turned away;
- To strengthen further our services for the acutely unwell, ensuring appropriate treatment 24/7;
- To support GPs to shift care out of Hospital into the community where appropriate;
- To improve the experience of our patients and GPs;
- To work with partners to make savings and improve care for patients.

Foundation Trust (FT) Application

During 2010-11 the Trust has made good progress with its FT application. Since the Hospital recommenced its application in September 2010, it has had well over 70 meetings with GPs, PCTs, patients, patient groups, staff, local authorities and the plans within the Trust's five year IBP have been built around their priorities. An early draft of our IBP and LTFM was submitted to NHS London in January 2011. Feedback received from NHS London described the submission as 'a very high quality document, with the IBP being well written and the content good'. The Trust has received letters of support for our application from its top four commissioners, covering about 90% of our activity. The Tripartite agreement, which sets out the Trust's timetable for the application going forward, has been signed between the DH, NHS London and the South West London Cluster. If all key milestones set out in the agreement are met the Trust envisages becoming an FT by autumn 2012.

Information Technology and Care Records Service (CRS) Update

During 2010-11 the Trust approved a new Information Technology Strategy to guide future developments over the next few years. The strategy sets outs how the Hospital will improve patient safety and increase productivity through the use of IT, including the development of CRS.

The Trust's successful CRS deployment in November 2009 was recognised when the Hospital was shortlisted for the e-Health Insider Award in the major healthcare project of the year category. Although the Trust did not win, being shortlisted was a very good achievement for the Hospital and reflects the huge amount of teamwork that has contributed to its success.

Following The Trust's CRS deployment, the Hospital returned to business as usual. The work in 2010-11 has focussed on three main areas:

- Stabilisation - to resolve operational issues around Maternity and 18 weeks reporting, mainly around improving the quality of data input through either changes to the system and/or changes to processes and/or re-training;
- Optimisation – building in new functionality, albeit on a limited basis. As a result, we can now send discharge summaries electronically direct to our GPs from CRS;
- Road-mapping – defining a strategic development path and outline business case for investment in CRS across the Trust, commencing with a number of upgrades and then deployment of medicines management (electronic prescribing) and clinical documentation.

Other developments this year include implementing a system to share digital images such as x-rays with other Trusts, connecting a variety of new diagnostic equipment to our Pathology system, upgrading various clinical systems, providing the ability to access our systems remotely (e.g. from other Hospital sites) and providing links into clinical systems run by other Hospitals. We have also procured a system to enable our GPs to order diagnostic tests electronically. This will also provide test results to them, not only on their orders, but also when their patients have had tests ordered by our Consultants. We are currently in the process of procuring for electronic staff rostering and for patient level costing systems to help the Trust become more efficient in 2011-12. Alongside all of this the Trust has maintained the usual maintenance programme to ensure that our IT network and associated equipment and systems remain robust and fit for purpose.

Sustainability and Caring for the Environment

Kingston Hospital is committed to reducing its carbon footprint and 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 has a Carbon Management Plan which sets out how it plans to meet mandatory targets and comply with environmental legislative requirements. The plan also sets out how the Hospital will achieve excellent environmental standards through the sustainable design and implementation for all new builds and refurbishment works, as well as a reduction in the consumption of natural resources by minimising energy and water usage and also promoting energy and environmental awareness through education and communication. These will all help achieve our goal of a 10% carbon emission reduction from our operations by 2014-15.

The refurbished boiler house and new, modern Combined Heat and Power (CHP) plant installed in 2006-07 continues to bring savings to the annual energy costs and significantly reduce the amount of CO_2 emitted by the Hospital. The Trust also ensures that Display Energy Certificates are updated annually to indicate the amount of energy being used and demonstrate how energy efficient each individual building is.

This year, as part of the Sustainable Waste Action Plan, the Trust successfully introduced a new orange bag waste disposal system to try and ensure healthcare waste is segregated correctly and disposed of in an environmentally friendly manner. The Trust also carried out a 'Waste Awareness Day' to raise more awareness on correct waste segregation and waste minimisation. By implementing the system across the Hospital, it is anticipated that two thirds of the waste collected can be treated in a more environmentally friendly way and save the Trust over £30,000 annually.

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 and provides 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 also 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.

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 offers electric cycle promotions, giveaways and raffles.

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 (TfL) site.

Car Parking Changes

This year, the Trust has made changes to the car parking on site, to improve the number of parking spaces available for patients and visitors, and introduce new criteria for staff parking permits to reduce overcrowding. These changes took place in October 2010 and have resulted in a 25% increase in patient car parking spaces and helped keep queues in the car park to a minimum. The Trust has also taken steps to implement criteria to control the number of staff parking on site. This has encouraged people to use public transport. The Trust is continuing to look at the balance and layout of spaces and will be making further improvements in the near future. The Hospital remains committed to finding a long term solution to the parking problems on site and moving to a more user friendly payment system for patients and visitors in the future.

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 the Trust has 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 to help improve the patient experience. This includes two ward refurbishments to replace carpets, the toilet and washing facilities, new nurse call systems, new utilities, nurse stations and replacement of lighting. The Outpatients Department has also been

refurbished to include a new reception counter, ceiling, floor and waiting area. The Trust's Day Surgery Unit has had a new facility installed to clean and store endoscopes. This involved new plant rooms, utility rooms, installation of water treatment systems and new ventilation.

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. 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. The strategy seeks to support the Trust's overall business plans and key service developments. It will ensure financial provision for new service developments and ensure that existing buildings are well maintained and provide fit-for-purpose patient environments, as well as being a good neighbour to those living and working close by.

6. Listening to our Patients

Patient Experience

The Trust is committed to involving patients and the public in the development and improvement of the Hospital's services. As part of this, the Trust introduced a new Patient Experience and Public Involvement Strategy in January 2011. The strategy has been developed to change the culture of the organisation so that the patient's perspective drives delivery of care, governance and the decision making of the Trust, and so that the Hospital teams can deliver a caring, respectful, safe and high quality experience all of the time.

The Trust is also using patient experience trackers, developed by Doctor Foster [1], across the Hospital to help improve the patient experience. There are currently 26 devices in use across the majority of patient wards and departments including A&E, Maternity, Eye Theatres, Radiology, Dental Wing, Day Surgery and Outpatients to enable the Hospital obtain 'real time' patient feedback. In the near future, feedback reports will be generated monthly and sent to the Director of Nursing and Patient Experience, Heads of Nursing and Midwifery, Matrons and designated leads for each ward or department. The information will then be used to help identify issues for service development and initiate actions to make improvements to the patient experience.

In addition to this, the Trust also has a Patient Experience Committee (PEC) that is chaired by the Director of Nursing and Patient Experience and meets every two months. The committee is made up of the Deputy Director of Nursing, Head of Litigation, Complaints and PALS, LINk manager, Communications Team, Deputy Medical Director, Patient Diversity Manager, Volunteers Manager, Matrons and the lead Chaplin. The committee is responsible for developing, reviewing and implementing changes that will improve our patients experience whilst at the Hospital.

Patient Information Reader Panel

The Trust now has a Patient Information Reader Panel Chaired by the Deputy Director of Nursing, to review all patient leaflets produced by the Hospital. The main aim of the panel is to ensure there is a co-ordinated approach for collating and updating patient leaflets and ensure that the information is clear and accurate. In 2010, 41 patient information leaflets have been updated and produced by the Hospital.

Patient Assembly

The Trust is in the process of establishing a Patient Assembly which will provide a formal way for the views of patients and public to be included in the design and development of the Hospital services and improve patient experience. The Assembly will work closely with the Trust in the development of services to bring patient experience to the heart of decision making. Members of the Patient Assembly

1. Dr Foster is the UK's leading provider of comparative information on health and social care services.
Dr Foster's online tools and consumer guides enable both health and social care users and providers to make better informed decisions. www.drfosterhealth.co.uk

will also be members of other committees and working groups within the Trust which will enable knowledge and experience that patients gain from other committees to be shared with other members of the Assembly.

Patient Bedside Booklets

The Trust has introduced new patient bedside booklets. The new document is placed on every bedside locker and provides information that will be useful throughout the patient's stay in the Hospital though to their discharge. Patients are encouraged to read the booklets during their Hospitalisation.

New Red Uniforms for Matrons

To improve the patient experience, Matrons working across the Hospital now have new visible red uniforms. The new uniform is part of the Trust's drive to improve visibility of the Matrons for patients, relatives and staff, to help promote them as a point of contact and improve the quality of the patient experience. Matrons will increase their accessibility to patients, relatives and staff as their work is scheduled to enable them a daily afternoon presence on wards/departments.

Inpatient Survey 2009

In August 2010, the CQC released the results of the 2009 inpatient survey of adult inpatients at the Hospital.

87% of those who responded rated the care they received at the Hospital as good, very good or excellent and 73% of those who responded said that they were treated with dignity and respect. The Trust has also significantly improved on providing verbal/written information on discharge.

Improvements need to be made in areas such as patient information and staff washing their hands in front of patients. The Trust has reviewed the survey and has developed an action plan to quickly put improvements in place where necessary to ensure that excellent patient care and patient experience remains a top priority.

Some of these actions include:

- Better pain management on admission to wards by introducing pain score charts;
- Ensuring patients and relatives know how to access ward sister and medical teams;
- Increasing the number of hand gel dispensers around the Hospital and explaining to patients were to find them;
- Developing better patient discharge information and actively involving patients in the discharge process.

Patient Advice and Liaison Service (PALS)

The Trust welcomes and encourages feedback on its services provided through our Patient Advice and Liaison Service (PALS).

PALS provide information and discuss options about how a concern or complaint can be resolved. The team aims to sort out problems and concerns in order to avoid them becoming a cause for complaint. The Trust's staff also work hard to ensure that any complaint investigations are thorough and that the outcomes reflect the seriousness of the issues that patients and their relatives or carers have raised. Complaints received from or on behalf of patients in no way prejudice how they are treated and are seen as a valuable way of improving services for patients and carers.

The most common concerns raised through PALS this year were:

- communication problems such as difficulties contacting departments within the Trust and staff not responding to communication requests;
- treatment issues such as delay in treatment or patients unhappy with their treatment plan;
- administration issues such as incorrect appointment letters, patient notes not available for clinic;
- waiting times, for example for follow up appointments or routine procedures.

The percentage of patients who proceeded to a formal complaint (i.e. 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 2010-11, the Trust received 450 formal complaints, which is a decrease of 2% on the 461 received in 2009-10. The main issues complained about were:

- Communication;
- Treatment;
- Staff attitude; and,
- Cancellation of appointments.

The Trust's complaints performance and response times are monitored by the Risk Management Committee, which reports to the Trust Board via the Strategic Risk Committee. There has been considerable focus on improving the timeliness of complaint responses and there has been an improvement in this.

Next Stage of Complaints

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 two referrals to the Ombudsman since April 2010. To date, the Ombudsman declined to take on one of the cases, and is considering the other. This is a positive reflection of the robustness of our complaints process.

Learning from Comments and Compliments

Through close working between the PALS team and the clinical divisions, the Trust aims to resolve issues at an early stage whenever possible. Some examples of actions taken as a result of complaints are:

- Volunteers now working in the anti-coagulation clinic to give information and answer queries;
- Dressing gowns and modesty underwear to be routinely offered to endoscopy patients;
- New substantive clinicians recruited for Dental and Orthopaedics;
- Inter-Trust x-ray link set up between Kingston and Sutton.

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 Hospital's complaints process.

Freedom of Information (FOI)

In 2010-11 the Trust received 246 Freedom of Information Requests. However, the complexity of some of these requests have increased and overall 68% have currently been answered within the 20 working days limit (estimated 69% as remaining open FOIs are within 20 working days). This compares with 48% of the 236 requests in 2009/10. Additional resource was allocated to the FOI process this year.

The main areas for requests were around staffing information including organisation structure, finance, policies and procedures, and service performance.

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 1,018 requests and over 80% of these have received all of the information, or the nearest alternative held.

Confidentiality and Data Protection

Protecting the confidentiality of our patients including their personal data, is something the Trust takes extremely seriously. Significant instances involving breaches of confidentiality or loss of data are reported as Serious Incidents (SIs) and thoroughly investigated. During the year we reported 2 cases of unauthorised disclosure; one related to misaddressed correspondence and the other to a wrongly identified patient. Administrative procedures have subsequently been reviewed and revised to reduce the possibility of recurrence.

7. Working with our Partners

Kingston Hospital Membership

As part of our plans to become an FT, the Trust has a public membership of approximately 3,400 and almost all of its staff are members. The Trust regularly communicates with all of its members and keeps them updated about information about the Hospital, through a quarterly magazine 'Insight'.

The Trust Board approved a strengthened membership strategy in January 2011 as part of its preparation for Foundation Status and to support the involvement of public and patients in the newly revised Patient Experience and Public Involvement Strategy.

During this year members have been represented on a number of membership focus groups including:

- Members/Patient Group at the Royal Eye Unit;
- Focus Group in Audiology;
- Diversity – Equality Impact Assessments;
- Readers Panel for Patient Information Leaflets;
- Clinical Ethics Group;
- Quality Account Forums.

Members' events have also been held by the Maternity and Audiology Services. Consultation events have been held with members to support the development of the new membership strategy. Members have also been involved in reviewing the priories in the Trust's quality account for 2010-11 and developing the priorities for 2011-12.

Joint Working with our Consultants and Local GPs

Over the last year, Kingston Hospital has put in place measures that further improve opportunities for joint working between GPs and consultants.

We still have our regular GP and Consultant Clinical Forum which takes place at least three times a year. 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.

The forum continues to cover topical issues, with the more recent ones covering our five year plan as part of our FT application, as well as a Forum in February 2011 which focussed on what we learnt from our programme of engagement with GPs, including an update on what GPs asked the Trust to improve and change.

We have recruited two Business Development Managers who work with the clinicians in our four Clinical Divisions and all GPs in our main primary care catchment areas. They have been meeting with GPs as part of the Trust's wider Stakeholder Engagement Programme which has helped the

Hospital understand the standard of our current services and identify areas for improvement. They also explained the rationale for our application to FT status to GPs. The outputs of this programme of engagement are being reflected in our Integrated Business Plan, and have particularly helped shape one of our main service developments for the next five years which is to improve the experience of our patients and their GPs based on their feedback.

We are also working closely with GPs to redesign clinical pathways to shift appropriate activity from secondary to primary care so that patients can readily access care in the best place at the best time for them. We have already established a number of innovative models to shift work out of the Hospital setting including in diabetes, sexual health, urgent care and stable glaucoma, with the impact of the diabetes model for tier three patients being particularly significant in terms of numbers of patients now being seen in community settings rather than here at the Hospital. Moving appropriate work to community locations continues to be a priority for us and GPs, this is another one of our main service development plans for the next five years which involves supporting GPs to shift care out of Hospital into the community where appropriate, supporting them in prevention, specialist advice and outreach services.

Partnership Working

Kingston Hospital has close working relationship with many partner organisations and is working towards further strengthening these. Our vision sees the Trust working closely with our partners in primary care and other healthcare organisations to improve patient care and enable significant efficiency gains for both GPs and the Hospital.

St George's Healthcare NHS Trust

We have a long history of working with St George's Healthcare NHS Trust. Across both Trusts there are 23 consultants with either joint appointments or sessional commitments in both Hospitals, covering upper GI, vascular, plastics, orthopaedics, urology, oral surgery, paediatric surgery, ophthalmology, ENT, cardiology, respiratory, dermatology and neurology. This ensures good clinical engagement and flow of appropriate patients between the organisations. Both organisations participate in wider South West London clinical networks and recently collaborated on the development of trauma and stroke services for the sector, with Kingston Hospital providing trauma and stroke units to support the centre at St George's Hospital.

In June 2010, the Chief Executives of both organisations met to discuss further opportunities for joint working. Since then, work has been ongoing to explore and scope these opportunities and lay out the basis for a more formal strategic alliance between the two Hospitals. Working together will deliver a number of benefits, support future viability and strengthen the FT Applications from both organisations. Both Hospitals will remain as separate statutory organisations and the alliance will not prevent either Trust from pursuing partnerships with other organisations.

Queen Mary's Hospital (QMH)

For several years the Trust has provided a range of services at QMH on a recharge basis. A Memorandum of Understanding (MoU) has been signed between Kingston Hospital, Community Services Wandsworth and NHS Wandsworth covering the provision of services provided at QMH. The MoU involves a subcontract with Community Services Wandsworth, recently taken over by St George's Healthcare NHS Trust, for the provision of services for Anticoagulation, Audiology, Breast Surgery, Clinical Haematology, Diabetes, ENT, Elderly Care, General Surgery, Gynaecology, Health Records, Information Management and Technology (IM&T), Minor Injuries, Neurology, Ophthalmology, Orthopaedics, Paediatric Medicine, Pain, Pathology, Pharmacy, Phlebotomy, Rheumatology, Stoma Care, Urology and Radiology.

Teddington Hospital

In October 2010, The Trust successfully won a contract from NHS Richmond to provide outpatient clinics at Teddington Memorial Hospital for Rheumatology, Neurology, Gynaecology, Dermatology, Colorectal, Orthopaedics and Gastroenterology.

Royal Marsden and Macmillan Cancer Support

We have an established partnership with The Royal Marsden Hospital NHS Foundation Trust for the delivery of care to our cancer patients. Working in partnership with the Royal Marsden and Macmillan Cancer Support, the Hospital's Sir William Rous Unit provides patients with cancer with the best medical facilities locally as well as being the source of high quality information and advice.

Within the Sir William Rous Unit, The Royal Marsden provides chemotherapy services on the first floor and we provide outpatient and diagnostic services. On the ground floor Macmillan Cancer Support provide information and support.

BMI Healthcare Limited (BMI) Coombe Wing

In October 2009, the Trust entered into a series of agreements with BMI Healthcare Limited (BMI) via their holding company General Healthcare Group Limited. These agreements relate to BMI providing the private patient services on the Hospital site. There are two main phases to the contract. Phase 1, which involves the provision of private patient services, largely through the use of Coombe Wing but also including private patient activity taking place outside of Coombe Wing, e.g. the Day Surgery Unit, Royal Eye Unit and Maternity Unit and Phase 2, which relates to the option of building a new private Hospital facility on the old nurses' home site and adjoining land, which BMI will lease from the Trust for 25 years from the date of occupation. The contract states that by September 2012 BMI must provide detailed plans to the Trust for approval regarding the new build private Hospital. Once built, the new private Hospital reverts to NHS use after 25 years.

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 centre was established by the four South West London acute Trusts, St George's, Croydon Health Services, Kingston Hospital and Epsom and St Helier Hospitals, to deliver a strategic change in the delivery of planned orthopaedic care. It provides orthopaedic services to the patients of these Hospitals.

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.

Prime/ISS

Prime Healthcare Solutions (Kingston) Ltd (Prime) were created solely to manage the Private Finance Initiative (PFI) with the Hospital. It is a consortium of private companies who provided the capital to finance the build of the Kingston Surgical Centre which opened in 2007. Members of the consortium (and their responsibilities) are John Laing Construction and Costain Construction (construction of Kingston Surgical Centre), ISS Mediclean (soft Facilities Management Services – site wide such as cleaning, portering and catering) and Parsons Brinckerhoff (hard FM Services – Kingston Surgical Centre such as building repairs).

Prime provides the hard facility management services (i.e. building repairs) for the Hospital's Surgical Centre only and the soft facility management services (i.e. cleaning, portering and catering) for the whole of the Hospital site.

Dalkia

The Trust are aware of the need to take an environmentally sensitive approach to running the Hospital and are committed to reducing its carbon footprint. To achieve this, the Trust has entered into a partnership agreement with Dalkia, the leading European provider of energy services.

Dalkia designed, built and financed a new energy centre on the Hospital site which went into service in November 2007. This modern, energy efficient engineering plant provides heating and cooling and generates electricity. The contract runs for 15 years (ending 2022) during which time Dalkia will provide energy and energy management services through the operation and maintenance of the systems on a mobile remote basis, supply all fuel and set up the electricity export agreement contract to optimise export revenue and reduce electricity import costs.

Police

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 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.

8. Valuing our Staff

Our Staff

The Trust currently employs 2,403 whole time equivalent 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.

Staff Survey

The 2010 national annual staff survey demonstrated that the Trust is doing well in some areas, but also highlighted some areas for improvement. Overall, scores were either better or the same when compared to other similar Trusts in the country. The Hospital scored higher than other Trusts on four indicators which were:

- Supporting staff to do a good job;
- Providing the opportunity for feedback through appraisals;
- Supporting the health, safety and welfare of staff;
- Improved training to deal with bullying, harassment and awareness of how to report.

The Hospital was similar to other Trusts in five other key areas, including:

- 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 said that they would like to see improved access to training and communication. The Trust has taken on board these comments and will be focussing on these areas in the coming year.

Validation Exercise

The Trust is committed to tackling equality of opportunity and eliminating unlawful discrimination within its workforce. It is very important that we hold accurate and up to date details about all staff working at the Hospital in order to be compliant with current legislation and so that we are able to monitor equality effectively. In September 2010, a validation exercise was launched requiring all substantive employees to review and amend the current data held on the HR/Payroll system via a confidential form. This exercise has been carried out for the last two years within the Trust and it was very encouraging that the response rate this year (57%) was a great improvement on last year (47%). Employees were informed via the internal HR magazine “People Matters”, the staff magazine “Keyhole”, internal team briefings and global emails. All returned forms have now been monitored and a more detailed analysis can be extracted and, if necessary, next year areas with low or little response will be targeted.

Statutory Equality & Diversity Report

The Race Relations (Amendment) Act 2000 places a duty on all public authorities to promote race equality. Currently legislation requires organisations to publish the results of monitoring the workforce by gender, ethnicity and disability. In line with good practice, Kingston Hospital monitors the workforce on all six strands of diversity: gender, ethnicity, age, disability, religious belief and sexual orientation. Monitoring takes place for staff in post, performance development reviews, leavers, employee relations, recruitment activity, promotions and training in at least three strands on an annual basis. Analysis of the data is reported by division and by staff group enabling us to highlight areas which may require improvement, and any areas of concern. From the reports findings, an action plan has been drawn up and monitored by the Equality and Diversity Committee. This years report was much more comprehensive than last year and as a result, recommendations and actions were more detailed than in the past.

Recognition – Staff Excellence Awards

The Trust has performed well this year, due to the tremendous commitment and contributions from all of its staff. This was reflected at the Staff Excellence Awards which once again acknowledged individuals and teams that demonstrated outstanding contribution to improving patient care. Awards were made to the following outstanding teams and individuals:

- Katie Johnston, Admissions Officer – for transforming the co-ordinating arrangements and smooth running of all aspects of the Breast Unit operating schedule;
- Discharge Co-ordinators Team – for working tirelessly to help all of the ward staff to provide a timely and appropriate discharge of patients from the Hospital;
- Multidisciplinary ERP Steering Group – for the Enhanced Recovery programme;
- Paediatric Oncology Team – for improving the pathway for children with cancer over a number of years.

Organisational Change

The new divisional structure introduced in 2009 to enhance the involvement of clinicians as leaders and to improve clinical engagement is now well embedded within the organisation.

Following a consultation in 2009, four new divisions were established: Acute Medicine; Surgery & Critical Care; Ambulatory Care; and, Women & 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.

Learning and Development

The Trust provides training and professional development for staff through its Education Centre, and from Kingston University via the Professional Development Coordinator.

In September 2010, a Training & Development Open Day was held for staff and was a big success, with over 400 members of staff attending and with 30 different stands providing information at the event.

The Education Centre continues to keep staff updated about professional development courses on offer as well as knowledge and practical skills training required to meet mandatory and statutory obligations.

The Clinical Skills Team continue 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 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 proved popular. Internally soft skills training modules have been delivered across areas including communication and managing employee relations.

Research and Education

We have 600 medical students' placements a year with up to 95 students in the organisation at any one time as well as 36 Foundation Year One and 30 full time Foundation Level Two doctors. Our medical students are from St George's Hospital and Imperial College Healthcare. Nurses and Allied Health Professionals (AHPs) access undergraduate and post graduate programmes across a wide range of specialities. We provide pre-registration placements for approximately 100 nursing, midwifery and AHP students at any one time. These students are primarily from Kingston University and St George's University of London, however AHP student placements are also provided for a number of Higher Education Institutes (HEIs) across London.

Additionally staff engage with learning opportunities across the HEIs and other specialist provision contracted to NHS London through Non Medical Education and Training (NMET) funding streams. There are 12 staff undertaking MSc programmes in a range of areas which include Maternal and Child Health, Healthcare Education, Clinical Leadership and Advanced Practice.

The Trust currently chairs the South West London Continuous Personal Professional Development (CPPD) forum and collaborates with partner Trusts in developing learning opportunities for staff generating innovative projects.

We are currently involved in the development of:

- E-learning packages for mandatory mentorship update and infection control;
- Cross-sector development of preceptorship support programmes;
- A foundation degree for assistant practitioners;

- A leadership and management programme delivered through action learning for bands 5 – 7;
- Knowledge transfer partnership major trauma pathway;
- Bespoke programmes to support and develop the knowledge and skills of maternity assistants and maternity support workers.

The Trust contributes to the Academic Health and Social Care Network (AHSN) which provides a collaborative platform to initiate and support research and education in practice. The Hospital is a part of the South London Comprehensive Research Network, which includes St George's, Kings College, Guy's and St Thomas', Epsom and St Helier and the Royal Marsden Hospitals. Our lead clinicians participate in NHS research by running studies and being local investigators for national studies.

Staff Benefits and Work Life Balance

The Trust continues to provide good benefits for staff, including childcare and carer support. 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. 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.

The current staff nursery on-site is being expanded to ensure more staff benefit and will generate income for the Hospital, which can be reinvested into clinical services. The Trust is investing around £200k towards this development and a number of outside organisations have expressed an interest if a partner or financial support is required.

European Working Time Directive (EWTD) Compliance

Kingston Hospital is achieving 100% European Working Time Directive compliant rotas 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 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

The Occupational Health and Wellbeing Team provided various health promotion events for staff throughout 2010 which were well received. In response to the recommendations of the Boorman Report on NHS staff health, published in November 2009, a Trust wellbeing strategy has been developed and the Occupational Health service was rebranded to 'Occupational Health and Wellbeing', which better reflects the range of services delivered. Closer links have also been developed with HR colleagues to ensure there is an integrated approach to promoting and supporting the wellbeing of staff.

The annual staff flu vaccination campaign was successful. As in previous years, the Occupational Health team regularly visited wards and departments to offer the vaccine to staff. The Trust received a good uptake of 43%.

An Annual Health & Wellbeing Day was held on 27 January 2011 to provide information and advice including free cholesterol checks, blood pressure checks, stress management, healthy eating and physical activity advice. Over 200 staff attended the event and the feedback received was very positive.

Sickness Absence Rate

Having a healthy workforce is important to the Trust and the support provided by the Hospital's Occupational Health Service is therefore vitally important. These are reflected in the Trust's relatively low sickness absence rates which for 2010-11 is averaged at 2.61%, compared to an average for Acute London Medium Trusts of 3.54%.

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 values 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 the 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.

9. Clinical Governance

Care Quality Commission (CQC)

From 1 April 2010, all Trusts must be registered with the CQC in order to provide services. Trusts are required to meet essential standards of quality and safety set down by the CQC. Kingston Hospital is currently registered with the CQC without compliance conditions.

CQC Visit

The Trust had an unannounced spot check visit from the CQC in March 2011.

The inspectors spent the day on two of the elderly care wards, looking specifically at how the Hospital treated elderly patients and if their privacy and dignity was being respected as well as how nutrition was provided for them.

The inspectors were very impressed with the positive atmosphere on both of the wards. In general, they found that privacy and dignity was good and that staff interacted very well with patients and communicated well with each other. They also found that we have good audit systems and processes in place. There is evidence of good two way communication and we respond well to what staff and patients tell us and take notice.

The Trust awaits the full report on the visit.

CHKS "Top 40" Hospital for ten years running

In 2010 Kingston Hospital was awarded second place in the CHKS Data Quality Award, which recognises the importance of accurate recording of clinical data and excellence in clinical coding. Winning this award is an outstanding achievement and demonstrates the Hospital's commitment to provide high quality, safe care to its patients.

The Hospital's Auditor and two external studies have also shown that the Hospital is particularly good at recording information about patients and their treatment, which is reassuring for patients, GPs and the public.

Healthcare Associated Infections

Infection prevention and control remains a top priority for the Trust. Significant progress has continued to be made in maintaining low levels of healthcare associated infections during 2010-11.

Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia rates remained at or below the projected rates with three cases of infections acquired within the Hospital (against a max ceiling of three) and two cases outside of the Hospital (against a projection of nine) between April 2010 and March 2011. In January 2011 the Trust started reporting of Meticillin Sensitive Staphylococcus Aureus (MSSA) bacteraemias in line with Department of Health (DH) requirements. There have been

24 MSSA bacteraemia cases in total during the past year, of which three were acquired during admission to the Hospital.

Between April 2010 and March 2011 the Trust had a total of 48 Clostridium difficile positive specimens in the laboratory. This consisted of 28 in-patient cases, with 17 of those being classified as hospital acquired, and the remainder from patients in the community via their GP. The Trust remained within this year's max ceiling of 25 hospital acquired cases.

The Trust had no confirmed cases of Norovirus this year.

MRSA screening for all admissions has been implemented during the past year in line with Department of Health requirements. Monthly senior nurse hand hygiene and bare below the elbow audits continue, as do the Department of Health Saving Lives audit activity carried out by the infection control link practitioners. Environmental and equipment cleaning (including curtains and commodes) continue to be a Trust priority.

Reports on infection prevention and control are routinely presented at divisional governance meetings. Aspects of Infection Prevention and Control will feature in the Nursing and Midwifery Quality Scorecard which is currently being developed. The Director of Nursing and Patient Experience is also Director of Infection and Prevention Control (DIPC) and reports to the Trust Board every time it meets.

New Dress Code Policy

Healthcare Associated Infections are a priority for the Trust and in June 2010 a new dress code policy was introduced for staff, volunteers and contractor staff working at the Hospital. The revised policy focuses on the standards of dress expected whilst people are at work, whether or not a uniform is worn.

Commissioning for Quality and Innovation (CQUIN)

2010-11 was the second year of the CQUIN payment framework. Additional income was available to the Trust for the achievement of specific quality and innovation improvements in line with national, regional and locally agreed improvements. During the year initiatives have been implemented across 10 CQUINS including:

- Venous Thromboembolism (VTE) risk assessment;
- Improving patient experience;
- Implementing the IHI Global Trigger Tool;
- Implementing the Enhanced recovery programme in colorectal and urology surgery;
- Improving the timeliness and quality of discharge information;
- Implementing the London dementia services framework;
- Reducing emergency readmissions in specific specialties;
- Developing maternity services and improving the user experience;
- Increasing smoking cessation;

- Improving the management of medicines.

All CQUIN schemes have had a series of standards to achieve over the year, split by quarter. Excellent progress has been made against all schemes and real improvements in patient experience, safety and clinical effectiveness. There will be eight CQUIN schemes in 2011-12, some of which will build on the 2010-11 schemes and others will be new, responding to the needs of the local South West London population.

Patient Safety

Kingston Hospital has a strong patient safety culture and we continue to strive to be a safer Hospital, working towards avoiding deaths and minimising preventable harm.

In May 2010, the new Patient Safety Strategy was approved by the Trust Board. The main principles of the strategy are as follows:

- The culture of the organisation will put patient safety first. It will be open, just and treat staff, patients and their families in the same way;
- Information will flow from patient to Board and back through effective systems that are timely, efficient and accurate;
- There will be effective communication throughout the organisation and externally;
- There will be a systematic approach to risk management and clinical governance;
- Innovation will be required.

As a result of the changes made set out in the strategy, in March 2011 the Trust won a prestigious national award for putting patient safety first. The Trust won in the Board Leadership Category of the Nursing Times and Health Service Journal Patient Safety Awards which celebrate excellence in patient safety.

There were almost 400 entries across 15 categories. Those that were shortlisted for the same category as the Hospital included the Ministry of Defence Surgeon General Headquarters, Salford Royal NHS Foundation Trust, Worcestershire Acute Hospitals NHS Trust, NHS Quality Improvement Scotland and Hounslow and Richmond Community Healthcare.

Kingston Hospital was highlighted by the judges as having the best practice for putting patient safety first and was specifically praised for the senior changes in the board that enabled a refocus on patient safety. This included, eliminating avoidable deaths, staff putting patient safety at the heart of all their decisions, reducing mortality rates across the Trust and minimising preventable harm to patients and staff.

In the coming year, the Trust will be focussing on further improving patient safety by reducing Patient Safety Indicators (PSI) alerts, eliminating avoidable deaths, reducing falls causing harm by 15%, work towards reducing Grade 3 and 4 Pressure Ulcers by 70% and Grade 2 by 50% as well as introducing

standard communication handover tools across the Trust and reporting progress through the bi-monthly Quality and Safety Report.

The Trust submits data regarding High Impact Actions (pressure ulcers, falls and indwelling catheters) to NHS London to enable benchmarking within London. We have commenced providing pressure ulcer, readmission, falls and cancelled operation data to Richmond LINk. The Nursing and Midwifery indicators are being included into a Nursing and Midwifery Quality Scorecard which will be implemented in April 2011.

Response to National Alerts on Patient Safety

The Trust regularly receives national alerts on patient safety issues and performance of medical equipment. During 2010-11, 50 alerts were issued, of which 30 were relevant to the services or equipment provided by the Trust. For these 30 alerts, the Trust completed the actions recommended in each alert within the required timescale in 93% of cases.

Same Sex Accommodation

The Trust is compliant with the Governments requirement to eliminate mixed sex accommodation, except when it is in the patients overall best interest, or reflects their personal choice. We have particular challenges in the Hospital's Day Surgery Unit (DSU) and some side rooms in Esher Wing, but we have plans to improve these facilities. By 31 March 2012, we will have reconfigured showers in Esher Wing and created an alternative access route in the DSU.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in the Intensive Care Unit or Recovery areas, or when patients actively choose to share for instance children and adolescents).

Matrons report, measure and analyse any mixed sex breaches monthly. These are then rated and integrated into Trust and Divisional scorecards which are reviewed at the Trust Board in the Clinical Quality and Patient Safety report and the monthly Risk Management Committee.

Identification of the Deteriorating Patient

In 2010, the Trust 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 and a new communication tool introduced. A regular audit of its use is being continuously monitored to ensure it becomes well embedded in everyday practices and the audit results are now reported as a key performance indicator.

Productive Ward Programme

The Productive Ward improvement programme is a part of the NHS "Releasing time to Care", a change initiative lead by the NHS Institute. The programme provides a systematic way of delivering safe, high quality care to patients across the Hospital and ensures working practices are of gold

standards. It aims to empower ward teams to identify areas for improvement by giving information, skills and time to enable them to take control of care delivered to patients. By enhancing day-to-day management focusing on improved clinical processes and working environments the Productive Ward Programme has shown to increase the time nurses and therapists spend on direct patient care.

The Trust has already had considerable success in implementing and rolling out the programme across a number of areas. It has had the greatest impact on Worcester Ward were it is now embedded into their day to day delivery of care, demonstrating measurable improvements in patient safety and experience. Following on from this success, the Productive Ward implementation team will be working together initially with the medical division and subsequently with areas throughout the Hospital in 2011.

Frontline Focus Fridays

As part of the new Trust-wide initiative called 'Frontline Focus Fridays', the Director of Nursing and other senior nurses now dedicate time each week to provide direct clinical leadership at ward level and meet to discuss an area of focus as well as audit clinical professional standards. The sessions have now been successfully running since the end of 2010. Attendance at the sessions have been encouraging with approximately 18 members of staff attending each week with representation by Heads of Nursing, Ward Sisters, Infection Control, Practice Development, Midwifery, Estates and ISS. The focussed sessions are a good way of raising awareness of areas which require attention and agreeing actions. A different area of focus will be included in the Nursing and Midwifery Scorecard each month in 2011-12.

Equality and Diversity

In 2010, Kingston Hospital signed up to Mencap's – "Getting it Right" Charter, to show its commitment to ensuring people with a learning disability get the healthcare they have a right to receive. By signing up to the Charter, the Trust has pledged to take action on nine key points, including; making sure that people with learning disabilities get an annual health check, as well as ongoing training for all staff. Kingston Hospital has identified a Link Nurse for each individual ward instead of appointing a single Learning Disability Nurse.

Swine Flu

From December 2010 through to January 2011, Kingston Hospital, like other acute Trusts across the country treated a number of patients with H1N1. The flu planning previously undertaken put the Trust in a good place to respond. Although there was an increased demand on the Hospitals bed capacity due to normal winter pressures, the Trust responded well and ensured that all patients were treated in an appropriate environment, with a ward area becoming a dedicated flu ward. This enabled other Hospital services to run with little disruption.

The swine and seasonal flu vaccination programme for staff commenced in November 2010. Occupational Health and Wellbeing staff visited the clinical areas, initially prioritising staff working in

high risk areas which was followed up with open ‘drop in’ sessions. 43% of front line staff were vaccinated.

In December 2010, Kingston Hospital had its first death from swine flu. In total, the Trust had two deaths. There were underlying health issues in both cases. The Trust admitted a total of 32 patients with confirmed swine flu, with no further cases from mid January 2011 onwards.

The Trust will be updating its Flu Pandemic plan 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

10. Fundraising

Kingston Can

Kingston Can is the charity that was set up to raise funds to build the Hospital's Sir William Rous Unit (SWR). Although the major fundraising effort for Kingston Can is complete and the unit has been open for some time, nevertheless donations continue to be received on a regular basis from the Hospital's supporters who remain keen to provide ongoing support to the unit. Over £100,000 has been donated during the financial year, from a tremendous variety of sources, and people.

The charity has kept its appeal open to continue to raise money for The Sir William Rous Unit to help fund equipment used for the treatment of cancer.

Born Too Soon

Kingston Hospital's Born Too Soon Charity celebrated its 25th Anniversary in 2010. The charity was established in 1985 to offer information and support to parents with premature or unwell babies being cared for on the Hospital's Neonatal Unit.

Since the charity was set up, it has raised in the region of £3million and has helped the unit purchase medical equipment such as an apnoea monitor, ventilator, top of the range incubators, sipap machines, biliblankets, hot cots and infusion pumps. Born to Soon also offers the little 'extras' that the NHS cannot provide, including photographs, albums, baby clothes as well as Christmas Day and Mother's Day presents and cards.

Born to Soon also offers invaluable advice and support to those families which could be anything from help registering the baby's birth, or sadly if the baby dies, to register his or her death, and helping to arrange a funeral. As well as this, the charity provides the Paediatric Outreach Nursing Team with vital equipment to help families whose baby is being cared for out in the community. The charity also helps provide funding towards a weekly parents support group 'At Welcare' for families, and a twice-yearly memorial service organised in conjunction with the Chaplaincy and the Maternity Unit.

Born Too Soon has been chosen as the nominated charity for 2010-11 by the staff of NIKON UK, together with many other local schools, organisations, and businesses.

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 2010, Momentum raised funds for a new clinical area in the Dolphin Ward, which will ensure the safe and efficient administration of chemotherapy and blood transfusions in a child-friendly environment. The unit will be completed by Spring 2011 and will consist of a two-bedded oncology room, with an outside reception and waiting area. The room will be designed to create an atmosphere of fun and adventure, to help the child being treated and their family to relax as much as possible.

Momentum continues to use donations to support families in a number of ways, particularly to provide treats and outings, which they might otherwise not be able to afford. The charity also continues to run their holiday home in Dorset for family respite breaks. For Christmas 2010, Momentum once again created a wonderful Santa's Grotto in the Paediatric Department, which all the oncology and other seriously ill children were invited to visit.

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 £60,000 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.

Since 2000, the Friends have raised over £500,000 for the Hospital. In the past twelve months, they have purchased new Matrons' uniforms, the bedside patient booklets, new foetal dopplers for the Maternity Unit, twenty rotastands to be used throughout the Hospital to help the movement of patients, and have also agreed to fund the falls equipment and sensors to be used in various wards at a cost of almost £14,000. In addition to this, the Friends have also funded the refurbishment of the two adult sound booths in Audiology and falls alarms for the medical wards.

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.

Financial Standing and Results

The Trust planned to deliver a £1.9m surplus in 2010-11. The Trust ended the year with a £2.0m surplus.

During the year the Trust incurred additional costs relating to increased activity levels. These were offset by additional income due to over-performance, during the year.

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.

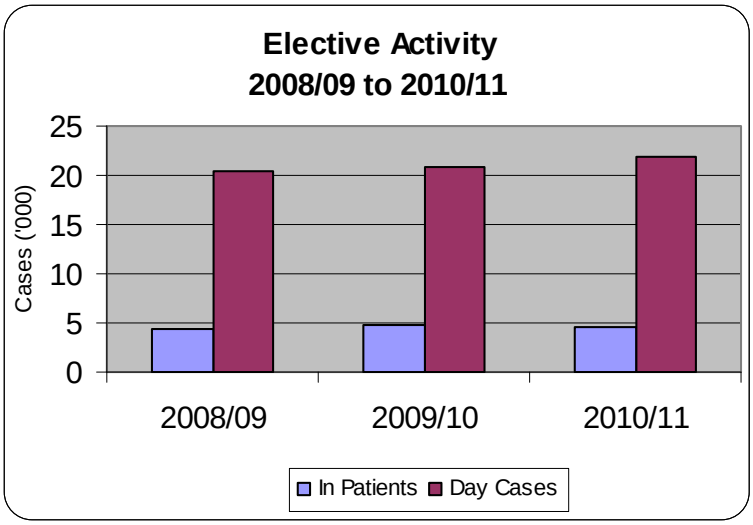
	Plan	Actual	Achieved
Financial Balance (before technical adjustments)	£1.9m surplus	£2.0m surplus	✓
External Financing Limit	£0.1m	£0.0m	✓
Capital Resource Limit	£7.2m	£7.0m	✓
Rate of return on capital employed (Capital Cost Absorption Rate)	3.50%	3.50%	✓

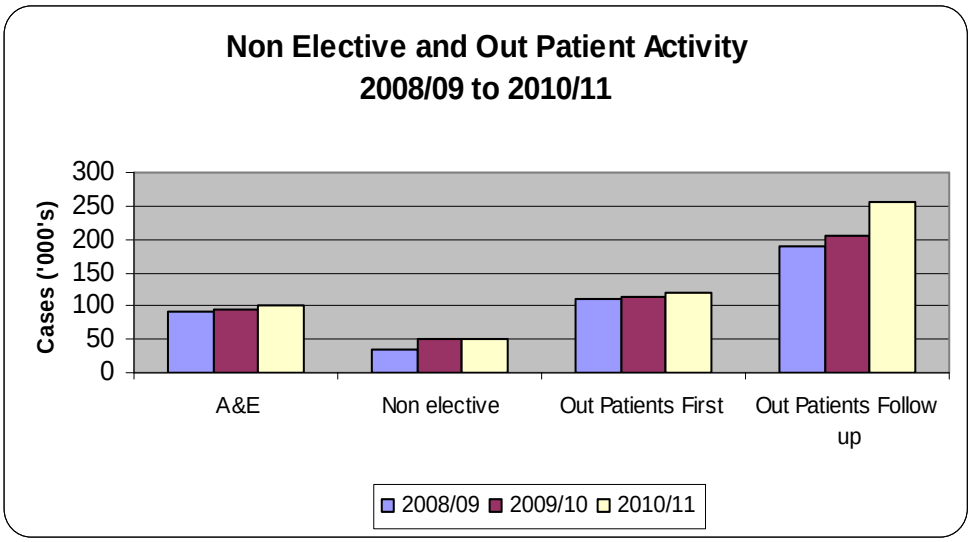
Operational Performance

In 2010-11 the Trust's clinical activity increased by 2.5% over 2009-10 (excluding the impact of Direct access for which the activity currency changed during 2010-11, and the counting change in outpatients in relation to physiotherapy and maternity episodes).

Increases were seen in elective activity (2.6%), non elective activity (4.8%) and A&E attendances (6.1%) with the latter including the transfer of the GP triage service from NHS Kingston to the Trust in November 2010.

The underlying increase in outpatients was 0.4% for 2010-11 (once the impact of the counting changes is removed).

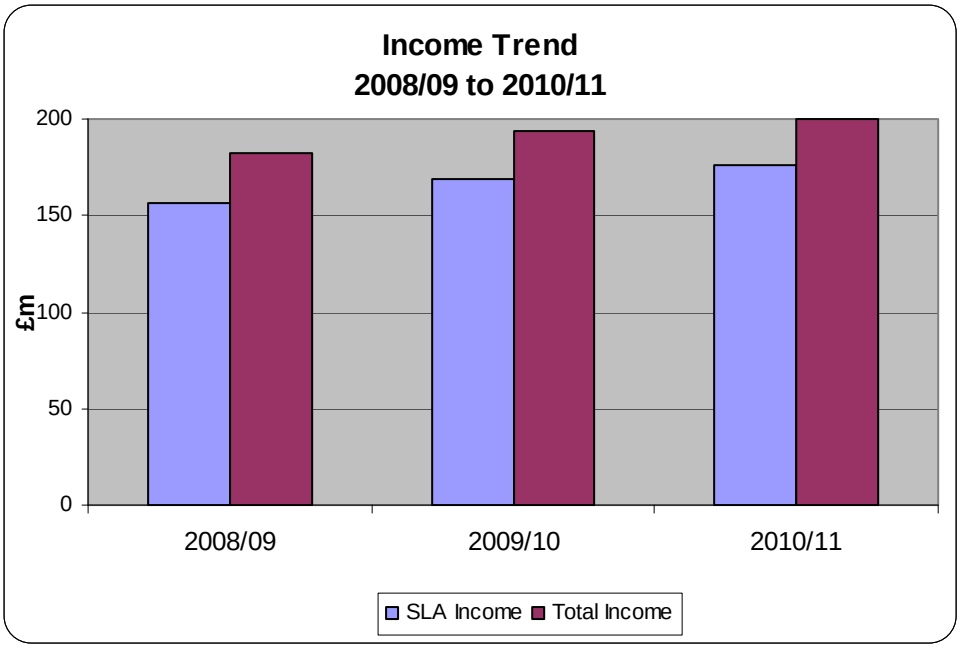

Elective Activity
2008/09 to 2010/11
Cases ('000)
25
20
15
10
5
0
2008/09
2009/10
2010/11
In Patients
Day Cases


Non Elective and Out Patient Activity
2008/09 to 2010/11
Cases ('000's)
300
250
200
150
100
50
0
A&E
Non elective
Out Patients First
Out Patients Follow up
2008/09
2009/10
2010/11

Revenue

In 2010-11 the Trust received £200.1m income. This is an overall increase of 2.2% on the income received in 2009-10.

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



Income can be classified as following:

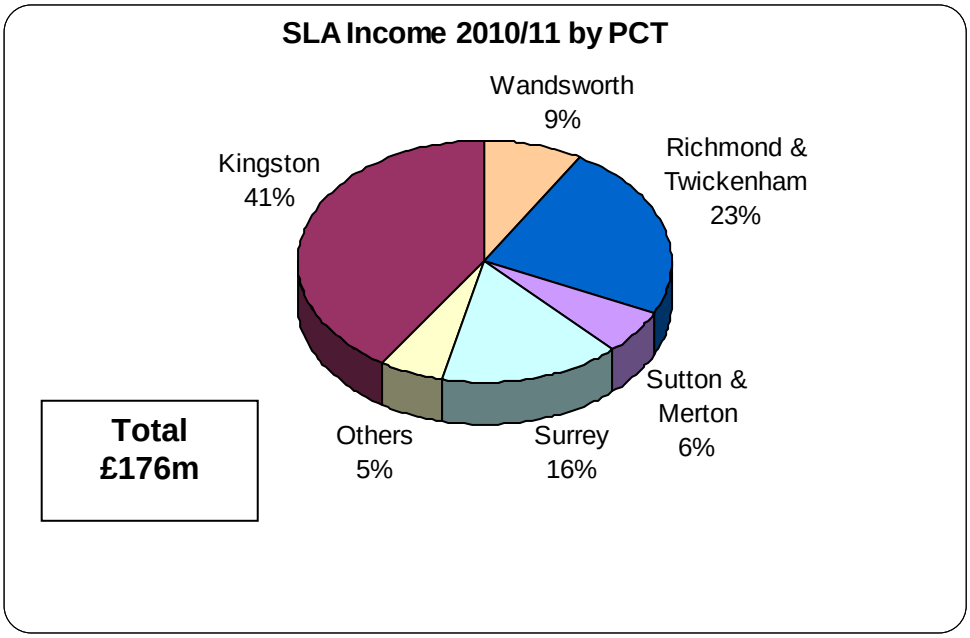
- direct patient treatment 89%
- training and education 4%
- other income 7%

Trust income relating to direct patient care activities increased by £4.5m in 2010-11. Revenue from Primary Care Trusts increased during the year by £6.7m, which was partially offset by a reduction in private patient income of £1.2m. 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. The service has performed well and is generating increased revenue for the Trust and is now shown within other operating revenue.

The PCT income increase is spread across specialties however two key points to note are the agreed change in non PbR prices implemented from 1 October 2010 and the increase in income in relation to high cost drugs.

During 2010-11 the Trust continued to work in partnership with other providers (e.g. Queen Mary's Roehampton) to deliver patient care on their sites. This activity and its associated tariff income are not included within the Trust's financial position.

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

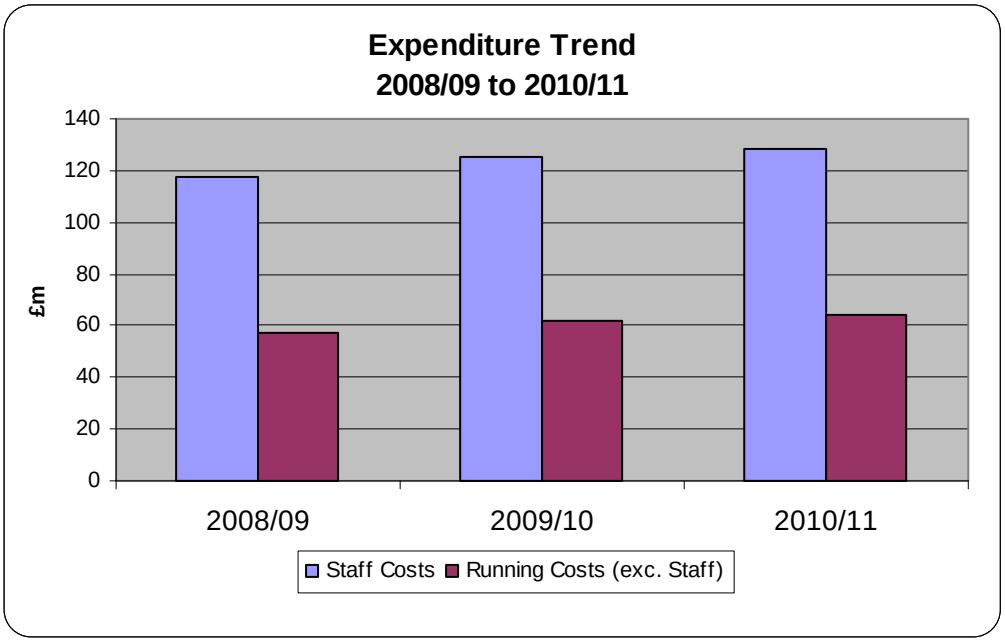


Expenditure

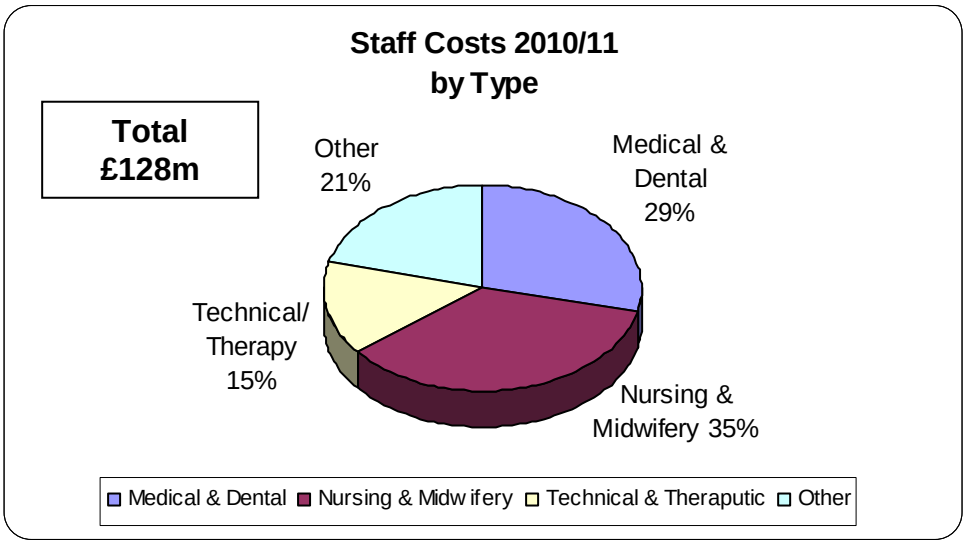
The total cost incurred in 2010-11 was £198.0m. This can be summarised in the following categories:

- staff costs £128.0m
- running costs (excluding staff) £64.7m
- finance costs (PFI) £2.3m
- public dividend payable (to Treasury) £2.5m
- write down on disposals £0.5m

The graph below shows the costs incurred excluding any non recurrent expenditure to support projects in year:



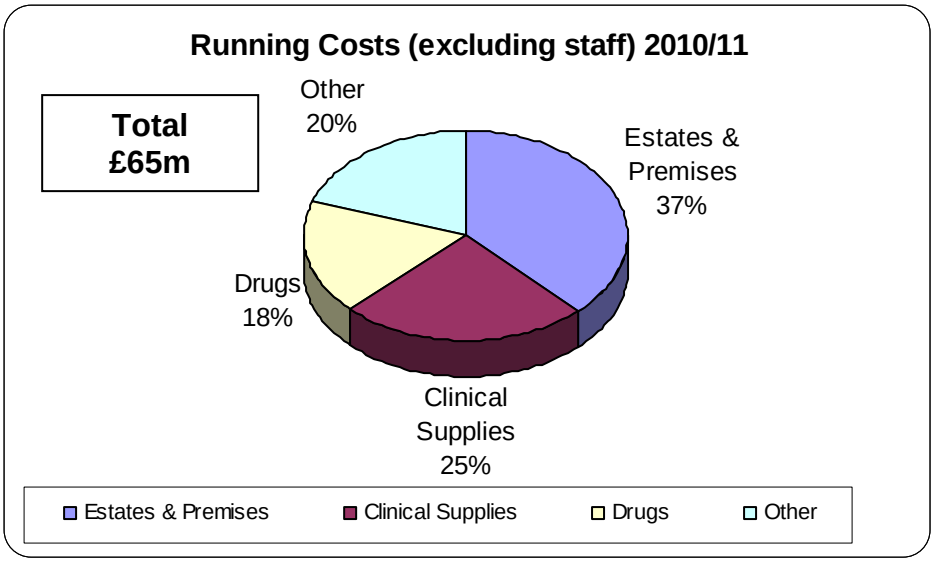
Staff costs increased by £2.5m (2%). This can be attributed to pay awards and increments £5.3m (4.2%); staffing to deliver increased levels of activity £1.2m; planned staffing increases in relation to midwives, the GP triage service and new consultant posts £1.2m, partially negated by staff savings of £5.5m which include a decrease in bank and agency spend of £1.7m compared with 2009-10.



The Trust's running costs (excluding staff) showed a net increase of £0.8m (1.3%). The main changes are due to:

- clinical insurance premiums increased across the NHS in 2010-11 and the impact on the Trust was £1.4m;

- expenditure on consultancy services decreased by £0.7m;
- the Trust decreased expenditure on education and training by £1.0m as one off costs were incurred in the prior year in relation to CRS training;
- expenditure on establishment expenses decreased by £0.3m;
- drug spend rose by £1.4m as a result of price and volume increases (this includes high cost drugs).



The finance costs incurred by the Trust are in line with those for 2009-10 and relate to the lease contracts now reported on the Statement of Financial Position e.g. PFI.

Capital Investment, Return on Assets, Capital Structure, Cash and the External Financing Limit

The Trust had an approved capital expenditure limit of £7.2m for 2010-11 (after taking asset disposals and donations into account). 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 Trust incurred £7.6m of gross capital expenditure in 2010-11 by continuing to maintain and update its estate (£3.4m, 45%), its clinical equipment (£2.4m, 31%) and invest in IT infrastructure and systems (£1.8m, 24%). This included improving the ward environment and investing in additional equipment to support clinical services such as the new CT scanner.

During 2010-11 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 £4.6m (6.2%) of which £2m 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 (£0.1m). The affect of reduction in asset value has led to a reduction in the public dividend payable to the Treasury (£0.5m less than 2009-10).

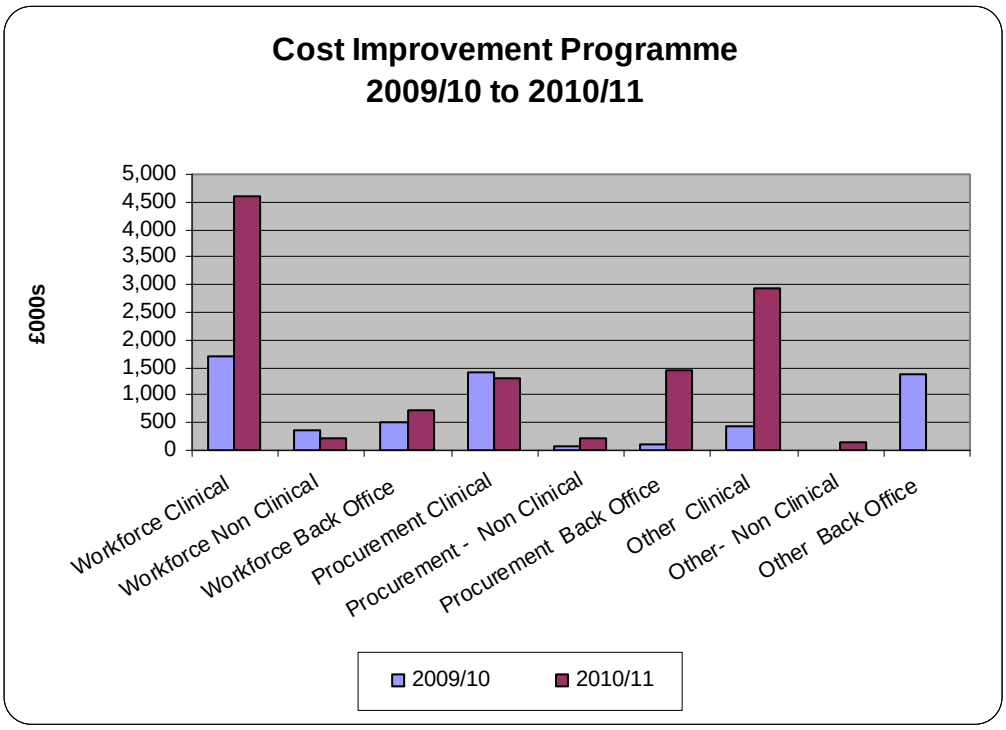
Planned capital expenditure for 2011-12 is £7.5m of which 46% relates to estates, 37% to IM&T and 14% to clinical equipment. The remainder is a contingency for emergency capital items in year.

NHS trusts must plan to achieve a rate of return on capital employed of 3.5% which is known as the Capital Cost Absorption Rate, 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. 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 ended the year with an increase in cash reserves (marginally undershooting its EFL by £12k and therefore achieving the target) and has consistently met this target.

Productivity and Efficiency

The Trust successfully managed to deliver £11.6m of efficiency savings in year (c.f. £6.0m in 2009-10) and looks to build on this position in 2011-12.



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 (i.e. 100) of 92 in 2009-10.

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 2011-12.

Financial Standards

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 2010-11 the Trust paid 92% by value and 87% by number for non-NHS trade invoices and 90% by value and 92% by number for NHS 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.

External Auditors

The Trust's external auditors for the financial year 2010-11 were the Audit Commission. Their fees amounted to £165k (2009-10: £153k), 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 2010-11 were 6.1% of income received in the year.

Pension Liabilities

Treatment of pension liabilities can be found in note 11 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:

Gren Collings, the Trust's Associate Director currently holds the position of Property Advisor to South West London & St Georges Mental Health Trust. During 2010-11, The Trust has procured products and services from this NHS body totalling £54k, and provided products and services to the same to them of £800k. The interest is properly disclosed in the Trust's register of interests

Changes in accounting policies

The annual accounts in section 18 are presented under the International Financial Reporting Standards (IFRS) format, introduced in 2009-10 to bring the NHS in line with private sector reporting. There have been no changes to accounting policies in 2010-11.

Financial 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 operation of clinical and non-clinical risk management processes (excluding finance) is overseen by the Risk Management Committee (RMC), chaired by the Chief Executive. The role of the Strategic Risk Committee (SRC), through close liaison with the RMC, is to monitor and review the Trust's risk management processes, to assist with the identification of strategic risks and provide the Board with assurance that strategic risks are appropriately controlled. The SRC is also responsible for assuring the Board that the Trust complies with its statutory duties relating to quality, patient and public involvement, care to the workforce and partnership.

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.

Financial Outlook

The Trust has developed a financial plan for 2011-12 recognising public spending is required to reduce. This is a significant change from the previous 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 £2.1m (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 in service development.

The level of savings required to attain this surplus whilst continuing to invest in quality of care is £12.5m. This is a challenging target and developing schemes to deliver the savings has been a key part of the planning process for 2011-12. Efficiency targets have been developed using service line reporting information for each department. This has enabled clinical engagement and appropriate levels of savings to be identified in all services. For 2011-12 back office functions have been set a higher percentage savings target than the clinical divisions, to ensure that the maximum funding is direct towards front line services.

2011-12 will see continued use 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 2011-12 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.

12. Trust Board

Strong and visible leadership, providing direction and momentum and regularly reinforcing our values, is led by an experienced Chairman and Chief Executive. They are supported by a diverse and talented team of Executive and Non Executive Directors (NEDs) drawn from both the private and public sectors.

Our Board members bring a range of complementary skills and experience in areas such as finance, commerce and health policy. All Non Executive Director appointments have been made through the Appointments Commission taking account of the skill sets already represented on the Board and recognising where gaps could be filled. The level of interest in the vacancies (now filled) for the two NEDs that left the Trust in December 2010 indicate a positive desire on the part of local people to contribute as Board members. In the future it is expected that Foundation Trust status and the development of a Council of Governors will provide a means of developing future Non Executive Directors from within the local community.

The Board currently comprises five Non Executive Directors, plus the Chairman and five Executive Directors. The constitution also makes provision for other Directors to attend meetings of the Board of Directors to provide operational advice and support to the Board in the discharge of their responsibilities. These Directors are not voting members of the Board and do not bear the legal responsibility of a Director. The Director of Workforce and Organisational Development and the Commercial Director attend Board meetings but are not voting members of the Board. Further details are provided below.

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 normally held every other month at the Hospital site on Galsworthy Road, Kingston Upon Thames. Dates of future meetings and minutes of previous meetings can be found at www.kingstonHospital.nhs.uk

Trust Board Profiles

Christopher Smallwood – Chairman

Christopher was appointed Chairman from 1 January 2009. Prior to this he was Chair of NHS Hounslow between January 2007 and 2009. From 2001 until 2005, he was Group Economic Adviser to Barclays Plc, following several years as a partner at the City consultancy Makinson Cowell, and for much of the last decade he was at the same time a Member of the UK Competition Commission. In

the early 1990s, he was Strategic Development Director and Chief Economist at TSB Group, and during the 1980s Chief Economist and Head of Financial Strategy and Planning for BP, before a three-year spell as Economics Editor of The Sunday Times. He has also been an Economic Adviser to HM Treasury and a Special Adviser at the Cabinet Office.

Christopher also chairs the Finance and Investment Committee and the Remuneration Committee

Charles Carter – Non Executive Director (until May 2010)

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 was a member of the Audit, Finance & Investment and Remuneration Committees and chaired the Charitable Funds Committee.

John Charlick – Non Executive Director (until December 2010)

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 chaired the Audit Committee and was a member of the Remuneration Committee.

Gren Collings – Associate Non Executive Director (until March 2011)

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 NHS Trust.

Gren chaired the Charitable Fund Committee and a member of the Remuneration Committee.

Candace Imison – Non Executive Director

Candace was appointed as Non Executive Director from 1st December 2009. Candace holds substantive post as Deputy Director of Policy of the King's Fund and is also on the governance board for the Centre for Workforce Intelligence. Candace has been Deputy Director of Policy at the King's

Fund since January 2009 and subsequently published work on a wide range of health policy topics. Previously she was Director of Strategy at Epsom & St. Helier University Hospitals NHS Trust (2006-2008). Between 2001 and 2006 she held range of senior strategy and modernisation roles at the Department of Health. From 1999 – 2001 she was Director of Acute Strategy at Ealing, Hammersmith & Hounslow Health Authority and between 1993-1999 she worked for the Kingston & Richmond Health Authority where latterly she was Associate Director – Acute Services Development.

Candace is chair of the Strategic Risk Committee and is a member of the Remuneration Committee.

Michael Jennings – Non Executive Director (from June 2010)

Michael was appointed as a Non Executive Director on 1 June 2010. Michael worked for Surrey County Council from 1984 until his retirement in 2009, in a number of Director-level posts responsible cumulatively for corporate planning, emergency management, policy, performance, partnerships (including health, police, business and the voluntary sector), external affairs, marketing and communications, and governance and scrutiny, culminating in acting as Deputy Chief Executive. Previously he worked for the Greater London Council between 1971 and 1984 in various strategic, planning, finance and management roles. His other current non executive roles are as a Member of the Government's Advisory Panel on Public Sector Information, and as a Director of the Local Government Information House Limited (a company he founded which trades on behalf of all councils). He has been a member of a number of Cabinet Office, Audit Commission and Chartered Institute of Finance & Accountancy advisory groups on issues such as access to services, partnerships, competition, performance management, and management accounting. He has lectured at the National School of Government, and runs his own consultancy company.

Michael is a member of the Finance and Investment Committee, the Audit Committee, the Charitable Funds Committee and the Remuneration Committee.

Joan Mulcahy – Non Executive Director (from January 2011)

Joan was appointed as a Non Executive Director in January 2011. She is a Management Consultant whose clients include both charities and commercial companies. She is a professionally qualified accountant and an experienced Board level Director with significant experience in the Banking industry. Previously she worked for Allied Irish Bank Group where she held a variety of roles, culminating as Chief Operating Officer and Board Director of AIB Group (UK) PLC. She currently undertakes a number of non executive roles in various strategic bodies and is a Board Director of Elmbridge Housing Trust and an Audit and Treasury Committee Member of Paragon Community Housing Group Ltd. She holds an MBA and is a graduate of University College Dublin.

Joan is chair of the Audit Committee and a member of the Strategic Risk Committee and the Remuneration Committee.

Cherill Scott – Non Executive Director

Cherill was appointed as a Non Executive Director in August 2005. She is an Oxford history graduate and a trained 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 is currently Senior Research Fellow in the School of Health and Social Care, University of Greenwich. She has produced reports for national charities and government agencies, including the Health Education Council, The Clinical Standards Advisory Group, NHS Estates, the World Health Organisation, The Department of Health Policy Research Programme and the NHS National Service Delivery & Organisation Research Programme.

Cherill is a member of the Strategic Risk Committee, the Remuneration Committee and the Faculty Committee and is Chair of the Trust's Organ Donation Committee.

Peter Thomas – Non Executive Director (until December 2010)

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 was a member of the Remuneration and Audit Committees and chaired the Compliance and Risk Scrutiny Committee until November 2010.

Jacqueline Unsworth – Non Executive Director (from March 2011)

Jacqueline was appointed as a Non Executive Director in January 2011 and took office on 21 March 2011. She was previously Vice Chair and Non Executive Director of Hounslow PCT and has been a Trustee of the charity Family Action for the past 8 years. She is a retail strategy specialist with over 20 years experience in market analysis, customer insight and business planning and has worked as a Board level consultant with a range of retail brands since leaving her position as Strategy and Marketing Director for Liberty plc in 2005. Prior to this she was a Director at specialist retail consultancy Piper Trust Ltd and has also worked in strategic planning roles for Storehouse plc and Abbey National. She started her career in 1984 as a management consultant in the Strategic Services division of Coopers & Lybrand Associates. She holds an MBA from the University of Evansville, Indiana, USA and a BSc (Hons) in Economics with First Class Honours from the University of Bristol.

Jacqueline is a member of the Audit Committee, the Finance and Investment Committee and the Remuneration Committee.

Kate Grimes – Chief Executive

Kate joined Kingston Hospital NHS Trust as Chief Executive on 1st December 2008. Prior to starting her career in the NHS, Kate spent a year in the Sudan teaching English after graduation 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 in both DGH and teaching Hospitals. After gaining a distinction in her Masters in Health Service 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 2005 and successfully managed the Hospital through a challenging period, working with partners to secure its strategic future.

Rachel Benton – Commercial Director

Rachel joined the Trust in March 2010. She has worked in the NHS since 1990 in a variety of roles covering general management, strategy, planning, business development and marketing. She joined Kingston Hospital from Imperial College Healthcare NHS Trust where she headed up the planning and business development function. Prior to this she undertook a similar role at Hammersmith Hospitals NHS Trust, during which time she led the development a number of successful business cases for large capital developments. Rachel is a graduate with an MSc in Health Services Management.

David Grantham – Director of Workforce & Organisational Development

David joined the Trust in March 2010, following a secondment to NHS Employers where he led national programmes of work on the medical workforce, productivity and flexible staffing for two years. He continues to represent NHS Employers on the GMC's UK revalidation programme board and is co-chair of its Medical Workforce Forum. Prior to that he was Director of Human Resources and a Board member at Whipps Cross University Hospital in North East London. He previously worked for the British Medical Association as an Industrial Relations Specialist and is a Law and Politics graduate.

Lance McCarthy – Chief Operating Officer

Lance joined the Trust in January 2010. He 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 NHS Trust and prior to that the Associate Director for Performance at Hammersmith Hospitals NHS Trust. Lance is an economics graduate and has an MBA.

Simon Milligan – Director of Finance & Information

Simon joined the Trust in March 2010. He previously worked at 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 prior to that at Hammersmith Hospitals NHS Trust, St Mary's Hospital and South Durham Health Care NHS Trust. Simon's first role in the NHS was in 1991 at the Northern Regional Health Authority. He started his accountancy career at KPMG.

Jenny Parr – Director of Nursing & Patient Experience (from September 2010)

Jenny joined the Trust in September 2010. She has worked in the NHS since 1993. Prior to joining the Trust Jenny worked as Deputy Director of Nursing at Imperial College Healthcare NHS Trust and previously in a similar role at Hammersmith Hospitals NHS Trust. Jenny is trained as a nurse and a midwife. She has worked at international and regional levels, setting up international recruitment mechanisms, has managed clinical services, led nursing initiatives, delivered organisation wide projects and has an MSc in healthcare management.

Jane Wilson – Medical Director

Jane has been Medical Director since August 2009. She continues in her clinical role as Consultant Obstetrician and Gynaecologist to which she was appointed in August 1993. She has held previous leadership and management roles in the Trust including Clinical Director. As Director of Medical Education from 2002-2009 she oversaw the introduction of significant changes in Post Graduate Medical Education and merged the Training Departments in the Hospital.

As at March 2011 the interests declared by Board Directors are as follows:

Name	**Board Position**	**Current Declared Interest(s)**
Christopher Smallwood	Chairman	Nothing to Declare
Gren Collings	Associate Director	Chair of Board, Kingston University Strategic Property Advisor, South West London & St Georges Mental Health Trust
Candace Imison	Non Executive Director	Deputy Director of Policy at the King's Fund Governance Board Member, Centre for Workforce Intelligence
Michael Jennings	Non Executive Director	Managing Director, Way Ahead Associates Ltd NED Local Government Information House Ltd Consultant Adviser, DHL – runs NHS supply chain Member, Twining Enterprise Ltd Member, Advisory panel on public sector information KHT Registered with Staff Bank for one off projects - Wife: Alison Jennings
Joan Mulcahy	Non Executive Director	Director, Elmbridge Housing Trust Audit & Treasury NED member, Paragon Community Housing Group Ltd
Cherill Scott	Non Executive Director	Nothing to Declare
Jacqueline Unsworth	Non Executive Director	Trustee, Family Action

Name	Board Position	Current Declared Interest(s)
Kate Grimes	Chief Executive	Nothing to Declare
Rachel Benton	Commercial Director	Nothing to Declare
David Grantham	Director of Workforce & Organisational Development	Nothing to Declare
Lance McCarthy	Chief Operating Officer	Nothing to Declare
Simon Milligan	Director of Finance & Information	Nothing to Declare
Jenny Parr	Director of Nursing & Patient Experience	Honorary Senior Fellow at the Faculty of Health and Social Sciences at Kingston University and St George's University of London
Jane Wilson	Medical Director	Nothing to Declare

13. Remuneration Report

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

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.

Membership of the Committee comprises:

- The Trust Chairman; and,
- All Non-Executive Directors.

The Chief Executive and the Director of Workforce & Organisational Development attend meetings by invitation only.

The objectives of the Committee are:

- To advise the Board about the appropriate remuneration and terms of service for the Chief Executive, and other Executive Directors and senior managers;
- Make such recommendations to the Board on the remuneration and terms of service of the Chief Executive and other Executive Directors and senior managers to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;
- Monitor and evaluate the performance of Executive Directors (and other senior employees);
- Advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance including that issued by NHS London;
- To be responsible for appointing any independent consultants in respect of executive director remuneration;
- To address other tasks referred to the Committee 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.

Salaries and Allowances

	2010-11			2009-10		
	Salary £'000	Other Remuneration £'000	Benefits in Kind £'000	Salary £'000	Other Remuneration £'000	Benefits in Kind £'000
Christopher Smallwood *Chairman*	20-25	0	0	20-25	0	0
Claudette Asgill *Interim Director of Workforce & Organisational Development (from 4 January 2010 to 19 March 2010)*	n/a	n/a	n/a	45-50*	0	0
Rachel Benton *Commercial Director (from 1 March 2010)*	105-110	0	0	5-10	0	0
Charles Cater *Non Executive Director (to 31 May 2010)*	0-5	0	0	5-10	0	0
John Charlick *Non Executive Director (to 31 December 2010)*	0-5	0	0	5-10	0	0
Gren Collings *Associate Director (to 31 March 2011)*	5-10	0	0	5-10	0	0
Helen Dirilen *Director of Nursing & Quality (to 31 March 2010)*	n/a	n/a	n/a	95-100	0	0
Simon Ellen *Non Executive Director & Deputy Chairman (to 30 November 2009)*	n/a	n/a	n/a	0-5	0	0
Jan Grant *Interim Director of Nursing & Patient Experience (from 1 April 2010 to 25 September 2010)*	40-45	0	0	n/a	n/a	n/a
David Grantham *Director of Workforce & Organisational Development (from 22 March 2010)*	100-105	0	0	0-5	0	0
Kate Grimes *Chief Executive*	145-150	0	0	145-150	0	0
Candace Imison *Non Executive Director (from 1 December 2009)*	5-10	0	0	0-5	0	0
Michael Jennings *Non Executive Director (from 1 June 2010)*	5-10	0	0	n/a	n/a	n/a

	2010-11			2009-10		
	Salary £'000	Other Remuneration £'000	Benefits in Kind £'000	Salary £'000	Other Remuneration £'000	Benefits in Kind £'000
Sylvia Kennedy *Director of Strategy (to 3 January 2010)*	n/a	n/a	n/a	75-80	0	0
Ruth Lewis *Director of Workforce & Organisational Development (to 26 January 2010)*	n/a	n/a	n/a	80-85	0	0
Lance McCarthy *Chief Operating Officer (from 7 January 2010)*	105-110	0	0	25-30	0	0
Simon Milligan *Director of Finance & Information (from 1 February 2010)*	110-115	0	0	15-20	0	0
Joan Mulcahy *Non Executive Director (from 13 January 2011)*	0-5	0	0	n/a	n/a	n/a
Mark Ogden-Meade *Interim Chief Operating Office (to 24 January 2010)*	n/a	n/a	n/a	220-225*	0	0
Jenny Parr *Director of Nursing & Patient Experience (from 27 September 2010)*	45-50	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 7 February 2010)*	n/a	n/a	n/a	90-95	0	0
Peter Thomas *Non Executive Director (to 31 December 2010)*	0-5	0	0	5-10	0	0
Colin Todd *Medical Director (to 1 July 2009)*	n/a	n/a	n/a	15-20	35-40	0
Jacqueline Unsworth *Non Executive Director (from 21 March 2011)*	0-5	0	0	n/a	n/a	n/a
Jane Wilson *Medical Director (from 3 August 2009)*	25-30	140-145	0	15-20	90-95	0

* 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

	Real increase in pension at age 60 £'000	Real increase in pension lump sum at age 60 £'000	Total accrued pension at age 60 at 31 March 2011 £'000	Lump sum at age 60 related to accrued pension at 31 March 2011 £'000	Cash Equivalent Transfer Value at 31 March 2011 £'000	Cash Equivalent Transfer Value at 31 March 2010 £'000	Real increase (decrease) in Cash Equivalent Transfer Value £'000	Employer's contribution to stakeholder pension £'000
Rachel Benton *Commercial Director*	15-17.5	45-47.5	20-25	65-70	285	106	179	0
Jan Grant *Interim Director of Nursing & Patient Experience (from 1 March 2010 to 25 September 2010)*	0-2.5	2.5-5	25-30	75-80	505	505	0	0
David Grantham *Director of Workforce & Organisational Development*	2.5-5	10-12.5	10-15	35-40	145	119	26	0
Kate Grimes *Chief Executive*	0-2.5	5-7.5	40-45	120-125	587	653	(66)	0
Lance McCarthy *Chief Operating Officer*	0-2.5	2.5-5	20-25	60-65	219	258	(39)	0
Simon Milligan *Director of Finance & Information*	2.5-5	12.5-15	25-30	75-80	364	335	29	0
Jenny Parr *Director of Nursing & Patient Experience (from 27 September 2010)*	2.5-5	7.5-10	10-15	45-45	181	170	11	0
Jane Wilson *Medical Director*	5-7.5	20-22.5	55-60	170-175	1,036	1,006	30	0

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

Cash Equivalent Transfer Values

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.

Exit Packages

Exit package cost band (including any special payment element)	Compulsory Redundancies	Other Departures Agreed	**Total**	**Total**	Special Payment Element of Total	
	Number	Number	**Number**	**£000**	Number	£
< £20,000	0	7	**7**	**26**	0	0
£20,001 to £40,000	0	1	**1**	**24**	0	0
£40,001 to £100,000	0	0	**0**	**0**	0	0
£100,001 to £150,000	0	0	**0**	**0**	0	0
£150,001 to £200,000	0	0	**0**	**0**	0	0
> £200,001	0	0	**0**	**0**	0	0
TOTAL	**0**	**8**	**8**	**50**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Where the Trust has agreed early retirements the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included here.

The table above includes the number and total value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous year.

The relevant tables and narrative within the Remuneration report have been subject to audit.

Kate Grimes
Chief Executive

25 May 2011

14. Statement of Internal Control 2010-11

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 Kingston Hospital NHS Trust'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 Sir William Rous unit at the Trust and is a partner in the South West London Elective Orthopaedic Centre. In addition, a Strategic Alliance has been formed with St George's. The Trust also has close links with local GPs, individual PCTs, the Sector, Local Authorities and other Acute Trusts. Members of the Executive Team, including myself, attend Health Overview and Scrutiny Committee meetings 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 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 Kingston Hospital NHS Trust for the year ended 31 March 2011 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 Board during 2010-11 including the appointment of a new Director of Nursing & Patient Experience and three new Non Executive Directors. The Trust Board has continued to function well during this period.

As Chief Executive I have overall responsibility for risk. Day to day responsibility for risk management processes is delegated to the Head of Corporate Affairs with Executive Directors taking responsibility for specific risk areas as follows:

Medical Director	Audit and Clinical Effectiveness
	Clinical Outcomes
	Patient Safety
Director of Nursing & Patient Experience	Patient Experience
Chief Operating Officer	Health and Safety
Director of Workforce & Organisational Development	Workforce
Director of Finance & Information	Information Governance

The remit of the Director of Finance & Information includes the formal role of Senior Information Risk Officer (SIRO) as well as being the lead for financial risk management.

I also take the lead in the area of Equality and Diversity.

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 managers and staff. As indicated above, 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 January 2011.

The Risk Management Committee, which I chair, meets monthly. Its membership includes the Executive Directors with specific responsibilities for risk and has been extended to include representation from each of the Divisions. The Risk Management Committee receives reports and monitors action plans from the subgroups covering the main areas of risk identified above. The Risk Management Committee reports to the Strategic Risk Committee, which meets bi-monthly and is a sub-committee of the Board. The Strategic Risk Committee takes an overview of the Corporate Risk Register and monitors the risks identified in the Board Assurance Framework. It also has a particular focus on quality and safety. The Audit Committee continues to have primary responsibility for financial risk and associated controls, corporate governance and assurance.

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 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 Incidents at Grade 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 e.g. 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 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. In January 2011 the Risk Management

Strategy and Risk Management Policy were combined into one document at the recommendation of the NHSLA. More detail has been included about the risk management structures and roles and responsibilities in relation to risk management within the Divisions and how they link with the corporate risk management structure.

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 and the development of its productivity plans.

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 Corporate Risk Register. This is supplemented by the identification of strategic risks at Trust level e.g. through the identification of key risks in the Trust's Integrated Business Plan.

During 2010/11 each of the Divisions and Corporate Departments has continued to undertake regular reviews of their risks. The Risk Management Strategy sets the framework for the escalation of risk. Risks rated as 8 or more on initial assessment must be supported by a time framed action plan and recorded on the Trust's Corporate Risk Register. These risks and their action plans are reviewed by the Risk Management Committee on a bi-monthly basis and reported to the Strategic Risk Committee quarterly and the Board six monthly. The process outlined in the Risk Management Strategy 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 CQC's Essential Standards of Quality and Safety and the Corporate Risk Register.

The Assurance Framework for 2010-11 covered the following areas:

- Compliance with the Care Quality Commission requirements to maintain license to practice;
- Sustainable delivery of national access standards and targets and CQUIN targets;
- Development and implementation of a strategy and plan to improve clinical outcomes across every clinical specialty;

- Development and implementation of a strategy and plan to improve patient experience across the Trust;
- Securing and improving our NHSLA levels;
- Improving the patient experience of our outpatient service;
- Developing a plan to improve the 24/7 functioning of the hospital;
- Ensuring all staff have clear objectives, regular appraisals and a personal development plan;
- Design and delivery of a statutory and mandatory training programme that enables the Trust to demonstrate that all staff are training to protect themselves and our patients;
- Development and delivery of a programme that embeds robust management processes and competencies throughout the Trust;
- Reduction of staff turnover across the Trust;
- Development of a workforce strategy;
- Active contribution to the Healthcare for SW London proposals;
- To clarify and strengthen the Trust's alliance with St George's;
- Ensuring the active monitoring, management and pro-active development of our existing partnerships;
- Development and implementation of a membership strategy and plan;
- Working with PCTs and GPs to redesign clinical pathways to shift outpatient care out of the hospital and into polysystems;
- Implementation of an urgent care centre within the A&E;
- Establishment of an effective sexual health network across Kingston;
- Driving further improvements in the way that care is delivered across the local health economy through JHIP;
- Identification and exploitation of opportunities to enhance care for patients through integration with community services;
- Maximisation of the benefits of CRS and associate IT;
- Delivery of the 2010/11 financial plan;
- Development of a productivity plan that supports the delivery of a long term financial plan for the Trust;
- Development of patient level costing;
- Development of a refreshed long term financial plan for the Trust;
- Development of an integrated business plan for the Trust;
- Embed revised governance arrangements;
- Development of a refreshed IT strategy.

Public stakeholders have been involved where appropriate in managing risks which impact on them. Example of such involvement are:

- The Trust's involvement with the Kingston Learning Disability Parliament and the adoption by the Board of the MENCAP charter. Each ward has identified a link nurse to work with patients with learning disabilities;

- Monthly meetings have been initiated between the Director of Nursing & Patient Experience and the Kingston and Richmond LINks. This is in addition to regular inspection visits to the Trust from LINks members;
- Public involvement in a group set up by the Director of Estates to review the Trust's compliance with the Disability Discrimination Act;
- Trust members, LINks and NHS Kingston are being involved in the development of priorities for the 2011/12 Quality Accounts;
- The low vision group have been working with the Trust to finalise a visual awareness guidance booklet for staff.

The Trust has been increasing its public membership in anticipation of achieving Foundation Trust Status. Members are key to the Trust's public and patient engagement and this is being developed further through the Trust's revised patient experience and public involvement strategy and the recruitment of a Patient Assembly whose members will also sit on Trust committees and groups.

A number of minor gaps in controls and/or assurance were identified in reviewing and agreeing the Assurance Framework. These have been monitored as appropriate within the committee structure.

Key areas of risk relating to the Assurance Framework in 2010-11 have been:

- Achievement of national targets. Waiting list administration issues have impacted significantly on the 18-week admitted and 6-week diagnostic targets. Performance against both has been below plan since December. Neither will be achieved for the full year. Cancer target performance was impacted on in quarter 3 and early quarter 4 due to the lack of appropriate capacity for breast patients. A temporary solution has been implemented and performance in February is good. A long term solution is being developed for Executive Management Committee sign off in early April2011;
- The Trust remains at Level 1 for NHSLA across the hospital following a successful assessment in February 2011. The Corporate Objectives for 2011-12 include achieving Level 2 in both maternity and across the Trust by the end of the next financial year;
- Work to improve the patient experience of the Trust outpatient service will continue although this is not a specific Corporate Objective for 2011-12;
- The Trust needs to continue to clarify and strengthen its alliance with St George's and this will continue as a Corporate Objective in 2011-12;
- Although progress has been made towards implemented patient level costing, this piece of work is still underway and will continue as an objective in 2011-12;
- There is still further work to do to embed the revised governance arrangements at Divisional Level and this will be an objective for 2011-12.

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 Trust is fully compliant with the CQC's Essential Standards of Quality and Safety. Compliance is monitored on a quarterly basis and any areas of potential weakness are addressed through the development of an action plan which is monitored through the Trust's risk management structures.

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 a climate change risk assessment and developed an Adaptation Plan, to support its emergency preparedness and civil contingency requirements, as based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

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 by the work of the internal auditors and the executive management within the organisation who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports.

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 internal audit's work. The Head of Internal Audit Opinion for 2010-11 was substantial assurance.

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 February 2011);
- NHSLA Acute Services Accreditation Level 1 February 2011;
- 100% compliance with CNST Accreditation Level 1 January 2011;
- Successful achievement of Care Quality Commission registration without compliance conditions with effect from 1 April 2010;
- Level 3 ALE in 2009-10.

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, Strategic Risk Committee 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.

1. The Board

   The Board has reviewed the Assurance Framework and also received regular information from the Audit Committee and the Strategic Risk Committee. In addition, the Board receives a Clinical Quality and Patient Safety Report at each meeting, and has reviewed various significant policies including the Risk Management Strategy.

2. 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.

3. The Strategic Risk Committee

   The role of the Strategic Risk Committee (SRC), through close liaison with the Risk Management Committee, is to monitor and review the Trust's risk management processes with a particular focus on quality and safety, to assist with the identification of strategic risks and provide the Board with assurance that these strategic risks are appropriately controlled.

4. Executive Directors

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

5. 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 February 2011. 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 will be taken to address the single priority two recommendation made in the internal audit report.

6. Accreditation

   The Trust has successfully achieved the A2 in Standards for Stroke Care as defined by Healthcare for London. The Trust achieved 100% compliance at CNST Level 1 and maintained its Level 1 rating for NHSLA general. The Trust had a successful unannounced visit from the Care Quality Commission on 23rd March 2011 focusing on dignity and nutrition in older people (Outcomes 1 and 5).

7. Care Quality Commission Registration

   The Trust has been registered with the Care Quality Commission without compliance conditions since1 April 2010.

As indicated above, the Trust has had a number of 18 week RTT target breaches in the final quarter of 2010/11. A comprehensive action plan has been developed to resolve the waiting list issues including actions required, leads and timescales. An interim senior manager has been appointed to take this forward and a Waiting List Improvement Board has been established, chaired by myself as Chief Executive, to oversee its implementation.

Cancer target performance was impacted on in quarter 3 and early quarter 4 due to the lack of appropriate capacity for breast patients. A temporary solution has been implemented and performance in February 2011 is good. A long term solution is being developed for Executive Management Committee sign off in early April 2011.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that Kingston Hospital NHS 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.

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

25 May 2011

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.

By order of the Board

Kate Grimes
Chief Executive

25 May 2011

Simon Milligan
Director of Finance & Information

25 May 2011

17. Independent Auditor's Report to the Directors of Kingston Hospital NHS Trust

I have audited the financial statements of Kingston Hospital NHS Trust for the year ended 31 March 2011 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 under the accounting policies set out in the Statement of Accounting Policies. I have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of Kingston Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective Responsibilities of Directors and Auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements

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

Opinion on Financial Statements

In my opinion the financial statements:

- give a true and fair view of the state of Kingston Hospital NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and,
- have been properly 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 in England.

Opinion on Other Matters

In my opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and,
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I Report by Exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

Conclusion on the Trust's Arrangements for Securing Economy, Efficiency and Effectiveness in the use of Resources

Trust's Responsibilities

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

Auditor's Responsibilities

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements 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 relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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.

Basis of Conclusion

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

- securing financial resilience; and,
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, I am satisfied that, in all significant respects, Kingston Hospital NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Delay in Certification of Completion of the Audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide external assurance over the Trust's annual quality report. I am satisfied that this work does not have a material effect on the financial statements.

Lindsey Mallors
Officer of the Audit Commission

Audit Commission,
1st Floor, Millbank Tower,
Millbank, London, SW1P 4HQ

9 June 2011

18. Annual Accounts

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	**2010-11 £000**	2009-10 £000
Revenue			
Revenue from patient care activities	4	**177,774**	173,271
Other operating revenue	5	**22,292**	22,424
Operating expenses	7	**(192,742)**	(189,355)
Operating surplus		**7,324**	6,340
Finance costs			
Investment revenue	12	**21**	21
Other losses	13	**(520)**	(99)
Finance costs	14	**(2,280)**	(2,114)
Surplus for the financial year		**4,545**	4,148
Public dividend capital dividends payable		**(2,524)**	(2,982)
Retained surplus for the year		**2,021**	1,166
Other comprehensive income			
Impairments and reversals		**(4,115)**	(30,537)
Gains on revaluations		**2,475**	2,994
Receipt of donated/government granted assets		**53**	187
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:			
- Transfers from donated and government grant reserves		**(462)**	(513)
- On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**(28)**	(26,703)

The notes on pages 84 to 118 form part of these accounts.

Reported NHS financial performance position (adjusted retained surplus)	**2010-11 £000**	2009-10 £000
Retained surplus for the year	**2,021**	1,166
IFRIC 12 adjustment	**590**	875
Impairments	**113**	748
Reported NHS financial performance position (Adjusted retained surplus)	**2,724**	2,789

A Trust's Reported NHS financial performance position is derived from its retained surplus/(deficit), but adjusted for the following:

a) The revenue cost of bringing Private Finance Initiative (PFI) assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10): NHS Trusts' 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 PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the Trust's operating position.

b) Impairments to Fixed Assets: 2009-10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the Trust's operating position.

STATEMENT OF FINANCIAL POSITION AS AT
31 MARCH 2011

	NOTE	**31 March 2011** **£000**	31 March 2010 £000
Non-current assets			
Property, plant and equipment	15	**116,230**	117,425
Intangible assets	16	**4,813**	4,779
Trade and other receivables	19	**277**	427
Other financial assets	20	**0**	0
Total non-current assets		**121,320**	122,631
Current assets			
Inventories	18	**1,241**	1,346
Trade and other receivables	19	**11,323**	11,116
Other financial assets	20	**0**	0
Other current assets	21	**0**	0
Cash and cash equivalents	22	**5,196**	4,974
		17,760	17,436
Non-current assets held for sale	23	**0**	0
Total current assets		**17,760**	17,436
Total assets		**139,080**	140,067
Current liabilities			
Trade and other payables	24	**(20,250)**	(21,471)
Borrowings	25	**(989)**	(653)
Other liabilities	26	**0**	0
Other financial liabilities	30	**0**	0
Provisions	31	**(440)**	(354)
Net current liabilities		**(3,919)**	(5,042)
Total assets less current liabilities		**117,401**	117,589
Non-current liabilities			
Trade and other payables	24	**0**	(108)
Borrowings	25	**(33,730)**	(33,795)
Other liabilities	26	**0**	0
Other financial liabilities	30	**0**	0
Provisions	31	**(1,392)**	(1,464)
Total assets employed		**82,279**	82,222
Financed by taxpayers' equity			
Public dividend capital		**57,131**	57,131
Retained earnings		**2,708**	(144)
Revaluation reserve		**17,133**	19,584
Donated asset reserve		**4,955**	5,268
Government grant reserve		**352**	383
Other reserves		**0**	0
Total taxpayers' equity		**82,279**	82,222

The financial statements on pages 80 to 118 were approved by the Board on 25 May 2011 and signed on its behalf by:

Kate Grimes
Chief Executive

25 May 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
FOR THE YEAR ENDED 31 MARCH 2011

2010-11	Public dividend capital (PDC) £000	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000	Other reserves £000	Total £000
Balance at 1 April 2010	**57,131**	**(144)**	**19,584**	**5,268**	**383**	**0**	**82,222**
Total comprehensive income for the year:							
- Retained surplus for the year		**2,021**					**2,021**
- Transfers between reserves		**746**	**(746)**	**0**	**0**	**0**	**0**
- Impairments and reversals			**(4,040)**	**(75)**	**0**		**(4,115)**
- Net gain on revaluation of property, plant and equipment			**2,335**	**140**	**0**		**2,475**
- Net gain on revaluation of intangible assets			**0**	**0**	**0**		**0**
- Net gain on revaluation of financial assets			**0**				**0**
- Receipt of donated/government granted assets				**53**	**0**		**53**
- Net gain/loss on other reserves (e.g. defined benefit pension scheme)						**0**	**0**
- Movements in other reserves						**0**	**0**
- Reclassification adjustments:							
- transfers from donated asset/government grant reserve				**(431)**	**(31)**		**(462)**
- on disposal of available for sale financial assets			**0**				**0**
Reserves eliminated on dissolution		**0**	**0**	**0**	**0**	**0**	**0**
Originating capital for trust establishment in year	**0**						**0**
New PDC received	**0**						**0**
PDC repaid in year	**0**						**0**
PDC written off	**0**						**0**
Other movements in year	**0**	**85**					**85**
Balance at 31 March 2011	**57,131**	**2,708**	**17,133**	**4,955**	**352**	**0**	**82,279**

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 for the year		1,166					1,166
- Transfers between reserves		957	(957)	0	0	0	0
- Impairments and reversals			(29,899)	(638)	0		(30,537)
- Net gain on revaluation of property, plant and equipment			2,557	437	0		2,994
- Net gain on revaluation of intangible assets			0	0	0		0
- Net gain on revaluation of financial assets			0				0
- Receipt of donated/government granted assets				187	0		187
- Net gain/loss on other reserves (e.g. defined benefit pension scheme)						0	0
- Movements in other reserves						0	0
- Reclassification adjustments:							
- transfers from donated asset/government grant reserve				(482)	(31)		(513)
- on disposal of available for sale financial assets			0				0
Reserves eliminated on dissolution		0	0	0	0	0	0
Originating capital for trust establishment in year	0						0
New PDC received	0						0
PDC repaid in year	0						0
PDC written off	0						0
Other movements in year	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 2011

	NOTE	2010-11 £000	2009-10 £000
Cash flows from operating activities			
Operating surplus		**7,324**	6,340
Depreciation and amortisation		**6,488**	6,134
Impairments and reversals		**113**	748
Net foreign exchange gains/(losses)		**0**	0
Transfer from donated asset reserve		**(431)**	(482)
Transfer from government grant reserve		**(31)**	(31)
Interest paid		**(2,276)**	(2,074)
Dividends paid		**(2,407)**	(3,050)
(Increase)/decrease in inventories		**105**	(337)
(Increase)/decrease in trade and other receivables		**(4)**	359
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables		**(1,854)**	1,652
Increase/(decrease) in other current liabilities		**0**	0
Increase/(decrease) in provisions		**(22)**	(735)
Net cash inflow from operating activities		**7,005**	8,524
Cash flows from investing activities			
Interest received		**21**	21
(Payments) for property, plant and equipment		**(5,495)**	(4,544)
Proceeds from disposal of property, plant and equipment		**4**	0
(Payments) for intangible assets		**(710)**	(3,190)
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 (outflow) from investing activities		**(6,180)**	(7,713)
Net cash inflow before financing		**825**	811
Cash flows from financing activities			
Public dividend capital received		**0**	0
Public dividend capital repaid		**0**	0
Loans received from DH		**0**	0
Other loans received		**0**	0
Loans repaid to DH		**0**	0
Other loans repaid		**0**	0
Other capital receipts		**0**	0
Capital element of finance leases and PFI		**(603)**	(653)
Net cash (outflow) from financing		**(603)**	(653)
Net increase in cash and cash equivalents		**222**	158
Cash and cash equivalents at the beginning of the financial year		**4,974**	4,816
Effect of exchange rate changes on the balance of cash held in foreign currencies		**0**	0
Cash and cash equivalents at the end of the financial year	22	**5,196**	4,974

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 2010-11 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 Accounting Standards issued but not yet adopted

Neither the Treasury FReM nor the Department of Health's Manual for Accounts require the following Standards and Interpretations to be applied in 2010-11:

- IFRS 7 - Financial Instruments: Disclosures (amendment) - Transfers of financial assets (effective 2012-13);
- IFRS 9 - Financial Instruments: Financial Assets: Financial Liabilities Uncertain;
- IAS 12 - Income Taxes amendment (effective 2012-13);
- IAS 24 (Revised) Related Party Disclosures (2011-12);
- IFRIC 14 amendment (2011-12); and,
- IFRIC 19 - Extinguishing financial liabilities with Equity instruments (2011-12).

The application of the Standards as revised would not have a material impact on the Trust accounts in 2010-11, were they applied in that year.

1.3 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.

1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4.1 Critical judgements in applying accounting policies

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

a) The Trust has undertaken a review of all its leases and agreements and determined that two should be accounted for as a finance lease under International Financial Reporting Standards (A service agreement with Huntleigh Healthcare Limited for Bed Facilities Management and an agreement with Asteral (MES) Limited for the Operation of a Healthcare (CT Scanning) Facility), as the Trust receives significantly all the risks and rewards under the terms of each agreement; and,

b) The Trust has two Private Finance Initiative schemes both of which have been accounted for under IFRIC 12 and are on balance sheet under International Financial Reporting Standards.

1.4.2 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:

1. Accounting Policies (continued)

a) NHS Litigation Authority member provisions. These provisions are subject to future outcome of litigation in progress. The probabilities provided by the NHS Litigation Authority have been used to calculate the provision; and,

b) 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 of National Statistics.

1.5 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is

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 Pensions' 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.

1.6 Employee Benefits

1.6.1 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.

1.6.2 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.

1.7 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.

1.8 Property, plant and equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:
- it is held for use in delivering services or for administrative purposes; and,

- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust; and,
- it is expected to be used for more than one financial year; and,
- 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.

1. Accounting Policies (continued)

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.

1.8.2 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 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; and,
- 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.

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 International Accounting Standard 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 that does not result from a loss of economic value or service potential 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. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that 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.

1.8.3 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.

1.9 Intangible assets

1.9.1 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 £5,000.

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

Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use; and,
- the intention to complete the intangible asset and use it; and,
- the ability to sell or use the intangible asset; and,

1. Accounting Policies (continued)

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

1.9.2 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.

1.10 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. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential 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. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that 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.

1.11 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.

1.12 Government grants

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

1. Accounting Policies (continued)

1.13 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.

1.14 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.

1.14.1 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 and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

1.14.2 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.

1.15 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.

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

1. Accounting Policies (continued)

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.15.1 Services received

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

1.15.2 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 International Accounting Standard 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 International Accounting Standard 16.

1.15.3 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 International Accounting Standard 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 International Accounting Standards 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.

1.15.4 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.

1.15.5 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.

1.15.6 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.

1.16 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.

1. Accounting Policies (continued)

1.17 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.

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.

1.18 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 2.9% (2010: 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 arsing from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.19 Clinical negligence costs

The NHS Litigation Authority operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority 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 NHS Litigation Authority on behalf of the trust is disclosed at note 31.

1.20 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.

1.21 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

1.22 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.

1. Accounting Policies (continued)

1.23 Financial assets

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.

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, which is determined by reference to quoted market prices where possible.

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.

1.23.1 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.

Fair value is determined by reference to quoted market prices where possible.

1.23.2 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.

1.23.3 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.

Fair value is determined by reference to quoted market prices where possible.

1.23.4 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.

Fair value is determined by reference to quoted market prices where possible.

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.

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.

1.24 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, which is determined by reference to quoted market prices where possible.

1.24.1 Financial liabilities 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 liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Fair value is determined by reference to quoted market prices where possible.

1.24.2 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.

1.25 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.

1.26 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.

1.27 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 37 to the accounts.

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the 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. Accounting Policies (continued)

1.29 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).

1.30 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 and 2010-11 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.

1.31 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

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

1.32 Joint ventures

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for by proportional consolidation.

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

1.33 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.34 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

The Trust only has one segment, healthcare.

Income from external customers in the year was £200,066k (2009-10: £195,695k).

The following customers contributed more than 10% of total income:	**2010-11 £000**	2009-10 £000
Kingston PCT	**72,696**	72,627
Richmond & Twickenham PCT	**40,792**	40,019
Surrey PCT	**27,504**	27,404
Sutton & Merton PCT	**11,156**	10,559
Wandsworth PCT	**17,092**	19,456
Other English PCTs	**10,545**	6,719

3. Income Generation Activities

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

4. Revenue from Patient Care Activities	**2010-11 £000**	2009-10 £000
Strategic health authorities	**0**	4
NHS trusts	**140**	329
Primary care trusts	**176,150**	169,413
Foundation trusts	**98**	111
Local authorities	**142**	100
Department of Health	**0**	0
NHS other	**0**	0
Non-NHS:		
- Private patients	**604**	1,764
- Overseas patients (non-reciprocal)	**109**	137
- Injury costs recovery	**513**	617
- Other	**18**	796
Total	**177,774**	173,271

Injury cost recovery income is subject to a provision for impairment of receivables of 9.6% (2009-10: 7.8%) to reflect expected rates of collection.

5. Other Operating Revenue	**2010-11 £000**	2009-10 £000
Patient transport services	**0**	0
Education, training and research	**8,150**	8,153
Charitable and other contributions to expenditure	**0**	0
Transfers from donated asset reserve	**431**	482
Transfers from government grant reserve	**31**	31
Non-patient care services to other bodies	**8,833**	7,781
Income generation	**1,298**	1,399
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**1,044**	529
Other revenue	**2,505**	4,049
Total	**22,292**	22,424

Other revenue includes £368k (2009-10: £529k) of private finance initiative transitional relief income, £40k (2009-10: £85k) merit award income, £313k (2009-10: £85k) for VAT reclaims, £23k (2009-10: £33k) from the Trust's charitable fund for administration overheads and £70k (2009-10: £68k) from pharmacy prescriptions.

6. Revenue

	2010-11 £000	2009-10 £000
From rendering of services	**199,996**	195,627
From sale of goods	**70**	68

7. Operating Expenses

	2010-11 £000	Restated 2009-10 £000
Services from other NHS trusts	**119**	118
Services from PCTs	**747**	1,017
Services from other NHS bodies	**0**	0
Services from foundation trusts	**0**	0
Purchase of healthcare from non NHS bodies	**319**	537
Trust chair and non executive directors	**58**	60
Employee benefits	**127,996**	125,462
Supplies and services - clinical	**27,006**	26,326
Supplies and services - general	**1,563**	2,848
Consultancy services	**800**	1,505
Establishment	**1,387**	1,740
Transport	**1,189**	1,140
Premises	**17,581**	15,530
Provision for impairment of receivables	**(37)**	13
Inventories write down	**0**	7
Depreciation	**5,821**	5,602
Amortisation	**667**	532
Impairments and reversals of property, plant and equipment	**113**	748
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	0
Audit fees	**165**	153
Other auditor's remuneration	**94**	90
Clinical negligence	**5,646**	4,220
Research and development	**40**	0
Education and training	**582**	1,614
Other	**886**	93
Total	**192,742**	189,355

Other auditor's remuneration includes £35k (2009-10: £33k) for the Local Counter Fraud Service and £59k (2009-10: £57k) for Internal Audit services provided to the Trust.

£7,844k of 2009-10 costs associated with the private finance initiative agreements have been reclassified from supplies and services - general to premises, to better relect the nature of the expenditure.

8. Operating Leases

8.1 As lessee

Operating lease expenses in the year include rental of buildings £428k (2009-10: £397k), equipment leases £19k (2009-10: £129k), photocopier leases £44k (2009-10: £21k) and leasing of cars and vans £23k (2009-10: £13k).

8.1.1 Payments recognised as an expense

	2010-11 £000	2009-10 £000
Minimum lease payments	**514**	560
Contingent rents	**0**	0
Sub-lease payments	**0**	0
Total	**514**	560

8. Operating Leases (continued)

8.1.2 Total future minimum lease payments	2010-11 Land £000	Buildings £000	Other £000	Total £000	2009-10 Total £000
Payable:					
Not later than one year	**0**	**395**	**109**	**504**	554
Between one and five years	**0**	**214**	**177**	**391**	1,129
After five years	**0**	**0**	**0**	**0**	0
Total	**0**	**609**	**286**	**895**	1,683

8.2 As lessor

Rental revenue includes £611k (2009-10: £268k) for the lease of floor space to BMI, £311k (2009-10: £121k) for the lease of floor space in the Sir William Rous Unit, £106k (2009-10: £124k) for the lease of roof space for telecoms masts and £16k (2009-10: £16k) for the lease of floor space for the hospital shop.

8.2.1 Rental revenue	2010-11 £000	2009-10 £000
Contingent rent	**631**	0
Other	**413**	529
Total rental revenue	**1,044**	529

8.2.2 Total future minimum rental revenue	2010-11 £000	2009-10 £000
Receivable:		
Not later than one year	**422**	404
Between one and five years	**1,437**	1,403
After five years	**5,454**	855
Total	**7,313**	2,662

9. Employee Costs and Numbers

9.1 Employee costs	2010-11 Total £000	Permanently employed £000	Other £000	Total £000	2009-10 Permanently employed £000	Other £000
Salaries and wages	**107,776**	**93,058**	**14,718**	106,340	89,915	16,425
Social security costs	**7,935**	**7,271**	**664**	7,755	7,056	699
Employer contributions to NHS Pension scheme	**12,171**	**11,705**	**466**	11,890	11,406	484
Other pension costs	**0**	**0**	**0**	0	0	0
Other post-employment benefits	**0**	**0**	**0**	0	0	0
Other employment	**0**	**0**	**0**	0	0	0
Termination benefits	**287**	**287**	**0**	0	0	0
Employee benefits expense	**128,169**	**112,321**	**15,848**	125,985	108,377	17,608
Of the total above:						
Charged to capital	**173**			523		
Employee benefits charged to revenue	**127,996**			125,462		
Total	**128,169**			125,985		

9. Employee Costs and Numbers (continued)

9.2 Average number of people employed

	2010-11 Total	2010-11 Permanently employed	2010-11 Other	2009-10 Total	2009-10 Permanently employed	2009-10 Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**400**	**368**	**32**	398	358	40
Ambulance staff	**0**	**0**	**0**	0	0	0
Administration and estates	**533**	**456**	**77**	541	472	69
Healthcare assistants and other support staff	**351**	**231**	**120**	362	222	140
Nursing, midwifery and health visiting staff	**809**	**731**	**78**	833	718	115
Nursing, midwifery and health visiting learners	**21**	**21**	**0**	17	17	0
Scientific, therapeutic and technical staff	**437**	**424**	**13**	447	426	21
Social care staff	**0**	**0**	**0**	0	0	0
Other	**116**	**111**	**5**	119	115	4
Total	**2,667**	**2,342**	**325**	2,717	2,328	389
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**2**			11		

9.3 Staff sickness absence

	Calendar Year 2010	Calendar Year 2009
	Number	Number
Total days lost	**15,885**	17,149
Total staff years	**2,415**	2,330
Average working days lost	**6.58**	7.36

9.4 Exit packages for staff leaving

	2010-11 Total	2010-11 Compulsory redundancies	2010-11 Other agreed departures	2009-10 Total	2009-10 Compulsory redundancies	2009-10 Other agreed departures
	Number	**Number**	**Number**	Number	Number	Number
< £20,000	**7**	**0**	**7**	14	0	14
£20,001 to £40,000	**1**	**0**	**1**	1	0	1
£40,001 to £100,000	**0**	**0**	**0**	0	0	0
£100,001 to £150,000	**0**	**0**	**0**	0	0	0
£150,001 to £200,000	**0**	**0**	**0**	0	0	0
> £200,001	**0**	**0**	**0**	0	0	0
Total	**8**	**0**	**8**	15	0	15
Total resource cost £000	**50**	**0**	**50**	84	0	84

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pension Scheme. Where the Trust has agreed early retirements the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included here.

The table above includes the number and total value of exit packages taken by staff leaving in the year. The expense associated with these departures may have been recognised in part or in full in a previous year.

9. Employee Costs and Numbers (continued)

9.5 Management Costs	**2010-11**	2009-10
Management costs	**12,253**	12,331
Income	**199,779**	187,599
	6.13%	6.57%

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.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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:

10.1 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.

10.2 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 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 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.

10.3 Scheme provisions

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:

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.

10. Pension Costs (continued)

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".

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.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

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.

11. Better Payment Practice Code

11.1 Measure of compliance	**2010-11**		2009-10	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**55,365**	**72,939**	59,854	77,907
Total Non NHS trade invoices paid within target	**48,264**	**67,127**	55,200	74,599
Percentage of Non-NHS trade invoices paid within target	**87%**	**92%**	92%	96%
Total NHS trade invoices paid in the year	**6,802**	**10,556**	7,177	12,174
Total NHS trade invoices paid within target	**6,290**	**9,527**	6,797	10,886
Percentage of NHS trade invoices paid within target	**92%**	**90%**	95%	89%

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.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2010-11**	2009-10
	£000	£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

12. Investment Revenue	**2010-11**	2009-10
	£000	£000
Rental revenue:		
PFI finance lease revenue:		
- Planned	**0**	0
- Contingent	**0**	0
Other finance lease revenue	**0**	0
Interest revenue:		
- Bank accounts	**21**	21
- Other loans and receivables	**0**	0
- Impaired financial assets	**0**	0
- Other financial assets	**0**	0
Total	**21**	21

13. Other Losses	2010-11 £000	2009-10 £000
Gain/(loss) on disposal of property, plant and equipment	**(520)**	(99)
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
Total	**(520)**	(99)

14. Finance Costs	2010-11 £000	2009-10 £000
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**33**	28
Interest on obligations under PFI contracts:		
- main finance cost	**1,927**	1,886
- contingent finance cost	**284**	160
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest expense	**2,244**	2,074
Other finance costs	**36**	40
Total	**2,280**	2,114

15. Property, Plant and Equipment	Land	Buildings excluding dwellings	Dwellings	Assets under construct	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
2010-11	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Restated Cost or valuation at 1 April 2010	**28,000**	**111,832**	**0**	**68**	**22,483**	**0**	**6,805**	**2,454**	**171,642**
Additions purchased	**0**	**353**	**0**	**3,027**	**2,472**	**0**	**989**	**0**	**6,841**
Additions donated	**0**	**0**	**0**	**15**	**38**	**0**	**0**	**0**	**53**
Additions government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**2,579**	**0**	**(2,579)**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**(844)**	**0**	**0**	**0**	**(844)**
Disposals other than by sale	**0**	**0**	**0**	**0**	**(1,666)**	**0**	**(392)**	**(32)**	**(2,090)**
Revaluation/indexation gains	**0**	**4,899**	**0**	**0**	**0**	**0**	**0**	**0**	**4,899**
Impairments	**(2,000)**	**(2,115)**	**0**	**0**	**0**	**0**	**0**	**0**	**(4,115)**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
At 31 March 2011	**26,000**	**117,548**	**0**	**531**	**22,483**	**0**	**7,402**	**2,422**	**176,386**
Restated Depreciation at 1 April 2010	**0**	**36,492**	**0**	**0**	**12,598**	**0**	**3,668**	**1,459**	**54,217**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**(392)**	**0**	**0**	**0**	**(392)**
Disposals other than by sale	**0**	**0**	**0**	**0**	**(1,606)**	**0**	**(389)**	**(32)**	**(2,027)**
Revaluation/indexation gains	**0**	**2,424**	**0**	**0**	**0**	**0**	**0**	**0**	**2,424**
Impairments	**0**	**514**	**0**	**0**	**0**	**0**	**0**	**0**	**514**
Reversal of impairments	**0**	**(401)**	**0**	**0**	**0**	**0**	**0**	**0**	**(401)**
Charged during the year	**0**	**3,299**	**0**	**0**	**1,477**	**0**	**872**	**173**	**5,821**
Depreciation at 31 March 2011	**0**	**42,328**	**0**	**0**	**12,077**	**0**	**4,151**	**1,600**	**60,156**
Net book value									
Purchased	**26,000**	**71,471**	**0**	**516**	**9,034**	**0**	**3,091**	**822**	**110,934**
Donated	**0**	**3,749**	**0**	**15**	**1,020**	**0**	**160**	**0**	**4,944**
Government granted	**0**	**0**	**0**	**0**	**352**	**0**	**0**	**0**	**352**
Total at 31 March 2011	**26,000**	**75,220**	**0**	**531**	**10,406**	**0**	**3,251**	**822**	**116,230**
Asset financing									
Owned	**26,000**	**53,650**	**0**	**531**	**7,305**	**0**	**3,251**	**517**	**91,254**
Finance leased	**0**	**0**	**0**	**0**	**842**	**0**	**0**	**305**	**1,147**
Private finance initiative	**0**	**21,570**	**0**	**0**	**2,259**	**0**	**0**	**0**	**23,829**
Total 31 March 2011	**26,000**	**75,220**	**0**	**531**	**10,406**	**0**	**3,251**	**822**	**116,230**

15.1 Revaluation reserve balance for property, plant and equipment	Land	Buildings excluding dwellings	Dwellings	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total	2009-10
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	£000
At 1 April 2010	**4,543**	**14,382**	**0**	**396**	**0**	**0**	**55**	**19,376**	47,675
Revaluation/indexation gains	**0**	**2,335**	**0**	**0**	**0**	**0**	**0**	**2,335**	2,557
Impairments	**(2,000)**	**(2,040)**	**0**	**0**	**0**	**0**	**0**	**(4,040)**	(29,899)
Release to retained earnings reserve	**0**	**(463)**	**0**	**(70)**	**0**	**0**	**(5)**	**(538)**	(957)
At 31 March 2011	**2,543**	**14,214**	**0**	**326**	**0**	**0**	**50**	**17,133**	19,376

15. Property, Plant and Equipment (continued) 2009-10	Land £000	Restated Buildings excluding dwellings £000	Dwellings £000	Assets under construct £000	Plant and machinery £000	Transport equipment £000	Information technology £000	Furniture and fittings £000	Restated Total £000
Cost or valuation at 1 April 2009	37,473	127,538	0	464	21,644	0	6,458	2,499	196,076
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
At 31 March 2010	28,000	111,832	0	68	22,483	0	6,805	2,454	171,642
Depreciation at 1 April 2009	0	32,597	0	0	11,865	0	2,792	1,293	48,547
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	1,399	0	0	0	1,399
Charged during the year	0	3,147	0	0	0	0	876	180	4,203
Depreciation at 31 March 2010	0	36,492	0	0	12,598	0	3,668	1,459	54,217
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
Total 31 March 2010	28,000	75,340	0	68	9,885	0	3,137	995	117,425

15. Property, Plant and Equipment (continued)

15.2 Donated assets

Three items of medical equipment, valued at £53k were donated by the Kingston Hospital NHS Trust General Charitable Fund during the year.

In addition the Kingston Hospital NHS Trust General Charitable Fund contributed £15k towards the redevelopment of the Maple Unit as a Children's Nursery.

15.3 Property revaluation

Land and building assets were revalued by an independent valuer, Gerald Eve, as at 31 March 2011.

All buildings qualify as specialist properties as per the International Valuation standards Guidance. The standard requires such properties to be valued on a Depreciated Replacement Cost basis. The International Valuation Standards Guidance Note 8.3.1 defines Depreciated Replacement Cost as *'The current cost of replacing an asset with its Modern Equivalent Asset less deduction for physical deterioration and all relevant forms of obsolescence and optimisation'* .

This resulted in land being revalued downwards by £2,000k, some buildings being revalued upwards by £2,475k, in total, and other buildings being revalued downwards by £2,629k, in total. The upward valuation was all taken to the revaluation reserve. £4,115k of the downward valuation was absorbed within the revaluation reserve, with a £514k impairment being taken to the Statement of Comprehensive Income. In addition, some assets that had previously had impairments charged to the Statement of Comprehensive Income had increases in valuation, resulting in a write back to the Statement of Comprehensive Income of £401k.

International Financial Reporting Standards require the Trust to split property, plant and equipment into their constituent significant parts, value each part seperatley and depreciate each part over an appropriate period. Property is therefore split between structure, fit-out and plant & machinery. On revaluation this can result in one part suffering a revaluation loss, whilst another benefits from a revaluation gain.

The major constituents of the amount previously charged to the Statement of Comprehensive Income and now reversed are as follows:	**£000**
Kingston Surgical Centre	**343**
Mortuary	**39**
Substation	**12**

The major constituents of the downward revaluation are as follows:

Charged to the Statement of Comprehensive Income:	**£000**
Esher Wing	**201**
Kingston Surgical Centre	**199**
Computer Room	**68**
Princess Dental	**37**

Charged to the revaluation reserve:	**£000**
Esher Wing	**1,404**
Maternity & Day Surgery Unit	**373**
The Wolverton Centre	**114**
Accident & Emergency	**84**
Princess Dental	**33**
Davies Wood House	**11**

Kingston Surgical Centre is a Private Finance Initiative funded asset. All other assets are owned outright.

15.4 Economic lives

	Minimum Life Years	**Maximum Life Years**
Buildings excluding dwellings	5	80
Plant and machinery	5	28
Information technology	5	14
Furniture and fittings	5	24

16. Intangible Assets 2010-11	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 2010	**6,193**	**0**	**0**	**0**	**0**	**6,193**
Additions purchased	**710**	**0**	**0**	**0**	**0**	**710**
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	**(222)**	**0**	**0**	**0**	**0**	**(222)**
Revaluation/indexation gains	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Gross cost at 31 March 2011	**6,681**	**0**	**0**	**0**	**0**	**6,681**
Amortisation at 1 April 2010	**1,414**	**0**	**0**	**0**	**0**	**1,414**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**(213)**	**0**	**0**	**0**	**0**	**(213)**
Revaluation/indexation gains	**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	**667**	**0**	**0**	**0**	**0**	**667**
Amortisation at 31 March 2011	**1,868**	**0**	**0**	**0**	**0**	**1,868**
Net book value						
Purchased	**4,802**	**0**	**0**	**0**	**0**	**4,802**
Donated	**11**	**0**	**0**	**0**	**0**	**11**
Government granted	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2011	**4,813**	**0**	**0**	**0**	**0**	**4,813**

16.1 Revaluation reserve balance for intangible assets	Computer software - purchased £000	Computer software - internally generated £000	Licences and trademarks £000	Patents £000	Development expenditure (internally generated) £000	Total £000	2009-10 £000
At 1 April 2010	**208**	**0**	**0**	**0**	**0**	**208**	208
Revaluation/indexation gains	**0**	**0**	**0**	**0**	**0**	**0**	0
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	0
Release to retained earnings reserve	**(208)**	**0**	**0**	**0**	**0**	**(208)**	0
At 31 March 2011	**0**	**0**	**0**	**0**	**0**	**0**	208

16. Intangible Assets (continued) 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 gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal 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
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation/indexation gains	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

16.2 Economic lives	Minimum Life Years	Maximum Life Years
Computer software - purchased	5	15

17. Commitments

17.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:	**31 March 2011 £000**	31 March 2010 £000
Property, plant and equipment	**165**	195
Intangible assets	**0**	215
Total	**165**	410

17.2 Other financial commitments

The trust has no non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements) at 31 March 2011 (31 March 2010: £NIL).

18. Inventories

	31 March 2011 £000	31 March 2010 £000
Drugs	**942**	1,011
Work in progress	**0**	0
Consumables	**299**	335
Energy	**0**	0
Other	**0**	0
Total	**1,241**	1,346
Of which held at net realisable value:	**0**	0

18.1 Inventories recognised in expenses

	31 March 2011 £000	31 March 2010 £000
Inventories recognised as an expense in the period	**12,753**	13,487
Write-down of inventories (including losses)	**0**	7
Reversal of write-downs that reduced the expense	**0**	0
Total	**12,753**	13,494

19. Trade and Other Receivables

	Current 31 March 2011 £000	**Non-current 31 March 2011 £000**	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS receivables - revenue	**7,420**	**81**	7,314	178
NHS receivables - capital	**0**	**0**	0	0
Non-NHS receivables - revenue	**2,190**	**196**	1,376	249
Non-NHS receivables - capital	**53**	**0**	0	0
Provision for the impairment of receivables	**(217)**	**0**	(284)	0
Prepayments and accrued income	**1,053**	**0**	1,393	0
Finance lease receivables	**0**	**0**	0	0
Operating lease receivables	**71**	**0**	42	0
VAT	**668**	**0**	1,119	0
Other receivables	**85**	**0**	156	0
Total	**11,323**	**277**	11,116	427

The 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.

19. Trade and Other Receivables (continued)

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 all other outstanding debts in full.

19.1 Receivables past their due date but not impaired	**31 March 2011 £000**	31 March 2010 £000
By up to three months	**119**	669
By three to six months	**535**	958
By more than six months	**436**	715
Total	**1,090**	2,342

The Trust does not hold any collateral against receivables outstanding.

19.2 Provision for impairment of receivables	**31 March 2011 £000**	31 March 2010 £000
Balance at 1 April	**(284)**	(313)
Amount written off during the year	**30**	42
Amount recovered during the year	**105**	0
(Increase)/decrease in receivables impaired	**(68)**	(13)
Balance at 31 March	**(217)**	(284)

19.3 Receivables are provided against at the following rates:	**31 March 2011 %**	31 March 2010 %
NHS debt	**0.0**	0.0
Private healthcare covered by an insurance company policy	**0.0**	0.0
Debt with a payment plan in place that is being adhered to	**0.0**	0.0
Injury cost recovery	**9.6**	7.8
Overseas visitors	**100.0**	100.0
All other non-NHS debt between 90 and 120 days old	**10.0**	10.0
All other non-NHS debt over 120 days old	**100.0**	100.0

20. Other Financial Assets

The Trust had no other financial assets at 31 March 2011 (31 March 2010: £NIL).

21. Other Current Assets

The Trust had no other current assets at 31 March 2011 (31 March 2010: £NIL).

22. Cash and Cash Equivalents	**31 March 2011 £000**	31 March 2010 £000
Balance at 1 April	**4,974**	4,816
Net change in year	**222**	158
Balance at 31 March	**5,196**	4,974
Made up of		
Cash with Government banking services	**5,181**	4,925
Commercial banks and cash in hand	**15**	49
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**5,196**	4,974
Bank overdraft - Government banking services	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**5,196**	4,974

23. Non-current Assets held for Sale	Buildings excluding dwelling £000	Other property, plant and equipment £000	Intangible assets £000	Total £000
Balance at 1 April 2010	**0**	**0**	**0**	**0**
Plus assets classified as held for sale in the year	**0**	**452**	**0**	**452**
Less assets sold in the year	**0**	**(452)**	**0**	**(452)**
Less impairments of assets held for sale	**0**	**0**	**0**	**0**
Plus reversal of impairment of assets held for sale	**0**	**0**	**0**	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	**0**	**0**	**0**	**0**
Balance at 31 March 2011	**0**	**0**	**0**	**0**
Balance at 1 April 2009	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0
Less assets sold in the year	0	0	0	0
Less impairments of assets held for sale	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0
Balance at 31 March 2010	0	0	0	0

The Trust has disposed of two non-current assets via sale in the year:
- CT Scanner. The Trust has entered an agreement with Asteral (MES) Limited to provide a CT Scanning facility, including provision of new equipment. As part of the agreement the existing equipment was disposed of for £1 to Asteral (MES) Limited, resulting in the Trust recognising a loss on disposal of £251k.
- Anaesthetic Machines. The Trust replaced 22 machines in the year, realising £4k in disposal proceeds and recognised a loss on disposal of £197k.

24. Trade and Other Payables	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Interest payable	**0**	**0**	0	0
NHS payables - revenue	**1,273**	**0**	2,352	0
NHS payables - capital	**0**	**0**	0	0
Non-NHS trade payables - revenue	**4,093**	**0**	6,092	0
Non-NHS trade payables - capital	**1,162**	**0**	637	0
Accruals and deferred income	**9,205**	**0**	7,943	0
Social security costs	**1,202**	**0**	1,178	0
VAT	**0**	**0**	0	0
Tax	**1,493**	**0**	1,481	0
Other	**1,822**	**0**	1,788	108
Total	**20,250**	**0**	21,471	108

Other payables include £108k (2009-10: £215k) for payments due in future years under arrangements to buy out the liability for 1 early retirement over 5 instalments and £1,587k outstanding pensions contributions at 31 March 2011 (31 March 2010: £1,553k).

25. Borrowings	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Bank overdraft - Government banking services	**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	**793**	**32,734**	579	33,437
LIFT	**0**	**0**	0	0
Finance lease liabilities	**196**	**996**	74	358
Other	**0**	**0**	0	0
Total	**989**	**33,730**	653	33,795

PFI liabilities relate to the following:
- Agreement for the Development of Phase 5 at Kingston Hospital and Provision of Services. A 29 year agreement expiring in 2036 (current: £673k, non-current: £30,707k).
- Agreement for the re-provision of Energy and Energy Management Services at Kingston Hospital. A 15 year agreement expiring in 2023 (current: £120k, non-current: £2,027k).

Finance lease liabilities relate to the following:
- A lease for hospital beds. A 10 year lease expiring in 2015 (current: £83k, non-current: £271k).
- An agreement for the Operation of a Healthcare (CT Scanning) Facility. A 7 year agreement expiring in 2017 (current: £113k, non-current: £725k).

26. Other Liabilities

The Trust had no other liabilities at 31 March 2011 (31 March 2010: £NIL).

27. Finance Lease Obligations

The Trust has two arrangements that are accounted for as finance leases under International Financial Reporting Standards:
- A service agreement with Huntleigh Healthcare Limited for Bed Facilities Management. The agreement is for 10 years and 3 months, commencing in January 2005 and expiring in March 2015. The minimum payments under the lease total £1,020k payable over 10 years; and,
- An agreement with Asteral (MES) Limited for the Operation of a Healthcare (CT Scanning) Facility. The agreement is for 7 years, commencing in December 2010 and expiring in December 2017. The minimum payments under the agreement total £996k, payable over 7 years.

Future minimum lease payments are calculated by adding the present value of minimum lease payments to the remaining finance lease interest.

27.1 Amounts payable under finance leases - Other:	Minimum lease payments 31 March 2011 £000	Present value of minimum lease payments 31 March 2011 £000	Minimum lease payments 31 March 2010 £000	Present value of minimum lease payments 31 March 2010 £000
Within one year	**244**	**196**	97	74
Between one and five years	**867**	**766**	388	342
After five years	**239**	**230**	16	16
Less future finance charges	**(158)**		(69)	
Present value of minimum lease payments	**1,192**	**1,192**	432	432
Included in:				
- Current borrowings		**196**		74
- Non-current borrowings		**996**		358
Total		**1,192**		432

27. Finance Lease Obligations (continued)

The Trust had no future sublease payments expected to be received at 31 March 2011 (31 March 2010: £NIL).

The Trust had no contingent rents recognised as an expense in the year (2009-10: £NIL).

28. Finance Lease Receivables

The Trust had no finance lease receivables at 31 March 2011 (31 March 2010: £NIL).

29. Private Finance Initiative Contracts

29.1 Private Finance Initiative schemes off-Statement of Financial Position

The Trust does not have any Private Finance Initiative schemes that are excluded from the Statement of Financial Position at 31 March 2011 (31 March 2010: £NIL).

29.2 Private Finance Initiative schemes on-Statement of Financial Position

The Trust has entered into 2 Private Finance Initiative (PFI) agreements:
- A 29 year agreement for the Development of Phase 5 at Kingston Hospital and Provision of Services with Prime Care Solutions (Kingston) Ltd ("Prime"), expiring in 2036; and,
- A 15 year agreement for the re-provision of Energy and Energy Management Services at Kingston Hospital with Dalkia Utilities Services PLC ("Dalkia"), expiring in 2023.

Under IFRIC 12 the assets of both schemes are treated as assets of the Trust. The substance of both agreements is that the Trust has a finance lease and payments comprise of two elements, imputed finance lease charges and service charges.

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

29.2.1 Development of Phase 5 at Kingston Hospital and Provision of Services

Under the PFI agreement Prime's obligation was to build the Kingston Surgical Centre building and car parking facilities at the Trust. Under IFRIC 12 the Kingston Surgical Centre building is treated as an asset of the Trust. The Trust has the right to use the building for the purposes specified in the project agreement and to receive the building at the end of the contract period.

The provision of services at the Trust by 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.

Significant terms of the agreement include:

- 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).

- 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.

- The Trust shall be entitled to terminate the agreement at any time on 6 months written notice to Prime.

There is a 2.5% RPI increase built into the providers financing model with a base date of 1 April 2002. Actual RPI is calculated on an annual basis.

29.2.2 Energy and Energy Management Services

Dalkia provide and maintain a combined heat and power plant to deliver heat and power to the Trust. Under IFRIC 12 the plant is treated as an asset of the Trust. The Trust has the right to use the combined heat and power plant for the purposes specified in the project agreement.

29. Private Finance Initiative Contracts (continued)

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.

Significant terms of the agreement include:

- The party claiming relief under Force Majeure 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.

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

There is a 2.5% RPI built into the scheme with a base date of 1 September 2005. Actual RPI is calculated on an annual basis.

29.2.3 Total obligations for on-statement of financial position PFI contracts due:	**31 March 2011 £000**	31 March 2010 £000
Not later than one year	**3,071**	2,683
Later than one year, not later than five years	**13,430**	12,025
Later than five years	**78,426**	79,917
Sub total	**94,927**	94,625
Less: interest element	**(61,400)**	(60,609)
Total	**33,527**	34,016

29.3 Charges to expenditure

The total charged in the year to expenditure in respect of off-statement of financial position PFI contracts was £NIL (2009-10: £NIL).

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £7,979k (2009-10: £7,844k). Services include: a car parking service; a catering service; all other soft facilities management services across the Trust; and, provision of heat and power to the Trust.

The trust is committed to the following charges for services:	**31 March 2011 £000**	31 March 2010 £000
Not later than one year	**8,359**	8,133
Later than one year, not later than five years	**35,032**	33,264
Later than five years	**223,003**	224,767
Total	**266,394**	266,164

30. Other Financial Liabilities

The Trust had no other financial liabilities at 31 March 2011 (31 March 2010: £NIL).

31. Provisions

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Pensions relating to former directors	**62**	**82**	67	138
Pensions relating to other staff	**126**	**1,310**	135	1,326
Legal claims	**52**	**0**	85	0
Restructurings	**0**	**0**	0	0
Redundancy	**177**	**0**	48	0
Equal Pay	**23**	**0**	19	0
Other	**0**	**0**	0	0
Total	**440**	**1,392**	354	1,464

2010-11	**Pensions relating to former directors £000**	**Pensions relating to other staff £000**	**Legal claims £000**	**Restructuring £000**	**Redundancy £000**	**Equal Pay £000**	**Other £000**	**Total £000**
At 1 April 2010	**205**	**1,461**	**85**	**0**	**0**	**19**	**48**	**1,818**
Arising during the year	**0**	**164**	**36**	**0**	**177**	**4**	**6**	**387**
Used during the year	**(64)**	**(137)**	**(62)**	**0**	**0**	**0**	**0**	**(263)**
Reversed unused	**0**	**0**	**(7)**	**0**	**0**	**0**	**(54)**	**(61)**
Unwinding of discount	**5**	**31**	**0**	**0**	**0**	**0**	**0**	**36**
Change in discount rate	**(2)**	**(83)**	**0**	**0**	**0**	**0**	**0**	**(85)**
At 31 March 2011	**144**	**1,436**	**52**	**0**	**177**	**23**	**0**	**1,832**
Expected timing of cash flows:								
Within one year	**62**	**126**	**52**	**0**	**177**	**23**	**0**	**440**
Between one and five years	**82**	**540**	**0**	**0**	**0**	**0**	**0**	**622**
After five years	**0**	**770**	**0**	**0**	**0**	**0**	**0**	**770**
2009-10								
At 1 April 2009	266	1,561	56	0	562	0	68	2,513
Arising during the year	0	0	69	0	0	19	0	88
Used during the year	(67)	(134)	(23)	0	(25)	0	0	(249)
Reversed unused	0	0	(17)	0	(489)	0	(68)	(574)
Unwinding of discount	6	34	0	0	0	0	0	40
At 31 March 2010	205	1,461	85	0	48	19	0	1,818
Expected timing of cash flows:								
Within one year	62	102	85	0	48	19	0	316
Between 1 April 2011 and 31 March 2016	143	547	0	0	0	0	0	690
After 1 April 2016	0	812	0	0	0	0	0	812

Pension 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.

£31,652k is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the Trust (31 March 2010: £22,673k).

32. Contingencies

32.1 Contingent liabilities

	31 March 2011 £000	31 March 2010 £000
Equal pay cases	**0**	6
Other	**13**	41
Amounts recoverable against contingent liabilities	**0**	0
Total	**13**	47

Other contingent liabilities consist of:
- £13k under the Liability to Third Parties Schemes (LTPS) (31 March 2010: £36k); and,
- £NIL being the balance of the estimated maximum liability for the staff post at risk that is not provided for within provisions (31 March 2010: £5k).

32.2 Contingent assets

The Trust had no contingent assets at 31 March 2011 (31 March 2010: £NIL).

33. Financial Instruments

33.1 Financial assets

	At fair value through profit and loss £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	**0**			**0**
Receivables		**10,547**		**10,547**
Cash at bank and in hand		**5,196**		**5,196**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2011	**0**	**15,743**	**0**	**15,743**
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

33.2 Financial liabilities

	At fair value through profit and loss £000	Other £000	Total £000
Embedded derivatives	**0**		**0**
Payables		**20,250**	**20,250**
PFI and finance lease obligations		**34,719**	**34,719**
Other borrowings		**0**	**0**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2011	**0**	**54,969**	**54,969**
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

33. Financial Instruments (continued)

33.3 Financial risk management

International Financial Reporting Standard 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care trusts and the way those primary care trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The 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 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.

33.3.1 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.

33.3.2 Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the London 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.

33.3.3 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 2011 are in receivables from customers, as disclosed in the trade and other receivables note.

33.3.4 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.

34. Events after the Reporting Period

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

35. 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.

35.1 Breakeven performance	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000
Turnover	161,677	163,728	171,740	183,311	195,695	200,066
Retained surplus/(deficit) for the year	14	1,673	2,713	807	1,166	2,021
Adjustment for:						
- Timing/non-cash impacting distortions:						
- Use of pre 1 April 1997 surpluses [FDL(97)24 Agreements]	0	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	113
- Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					875	590
- Other agreed adjustments	0	0	0	0	0	0
Break-even in-year position	14	1,673	2,713	807	2,412	2,724
Break-even cumulative position	495	2,168	4,881	5,688	8,100	10,824

* 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.

Materiality test (i.e. is it equal to or less than 0.5%):	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %
Break-even in-year position as a percentage of turnover	0%	1%	2%	0%	1%	1%
Break-even cumulative position as a percentage of turnover	0%	1%	3%	3%	4%	5%

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.

35.2 Capital cost absorption rate

Until 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 bears to the actual average relevant net assets.

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%.

35. Financial Performance Targets (continued)

35.3 External financing

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

	£000	2010-11 £000	2009-10 £000
External financing limit		**61**	(158)
Cash flow financing	**(825)**		(811)
Finance leases taken out in the year	**874**		653
Other capital receipts	**0**		0
External financing requirement		**49**	(158)
Undershoot		**12**	0

35.4 Capital resource limit

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

	2010-11 £000	2009-10 £000
Gross capital expenditure	**7,604**	7,234
Less: book value of assets disposed of	**(524)**	(99)
Plus: loss on disposal of donated assets	**5**	8
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(53)**	(187)
Charge against the capital resource limit	**7,032**	6,956
Capital resource limit	**7,200**	6,973
Under spend against the capital resource limit	**168**	17

36. Related Party Transactions

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust, except as noted below:

- Gren Collings, Associate Director, is Strategic Property Advisor to South West London & St. George's Mental Health Trust. During the year the Trust both procured products and services from and provided products and services to the Trust.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
South West London & St. George's Mental Health Trust	**54**	**800**	**9**	**171**

All interests are properly registered in the Trust's Register of Interests.

36. Related Party Transactions (continued)

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

2010-11	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Department for Health	**0**	**0**	**49**	**0**
London Strategic Health Authority	**0**	**8,085**	**0**	**86**
Kingston PCT	**78**	**72,696**	**0**	**1,255**
NHS Business Services Authority	**945**	**0**	**45**	**0**
NHS Litigation Authority	**5,774**	**0**	**0**	**0**
Richmond & Twickenham PCT	**59**	**40,792**	**22**	**1,375**
South West London & St. George's Mental Health Trust	**54**	**800**	**9**	**171**
St. George's Healthcare NHS Trust	**345**	**2,255**	**504**	**1,273**
Surrey PCT	**37**	**27,504**	**0**	**1,182**
Sutton & Merton PCT	**0**	**11,288**	**0**	**652**
The Royal Marsden Hospital NHS Foundation Trust	**69**	**376**	**59**	**256**
Wandsworth PCT	**280**	**17,092**	**597**	**0**

2009-10	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Department for Health	0	2,158	0	0
London Strategic Health Authority	21	7,933	0	102
Kingston PCT	417	72,627	249	1,312
NHS Business Services Authority	887	0	110	0
NHS Litigation Authority	3,915	0	0	0
Richmond & Twickenham PCT	76	40,019	39	1,074
South West London & St. George's Mental Health Trust	93	701	156	118
St. George's Healthcare NHS Trust	613	274	393	564
Surrey PCT	24	27,291	13	1,623
Sutton & Merton PCT	0	10,559	0	1,062
The Royal Marsden Hospital NHS Foundation Trust	90	223	331	291
Wandsworth PCT	817	19,456	833	563

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 & Customs in respect of PAYE, NI contributions and VAT refunds.

The trust received capital contributions from Kingston Hospital NHS Trust General Charitable Fund (Registered Charity Number: 1056510), the corporate trustee for which is the Trust Board. The audited accounts of the Fund are available on the Charity Commission website.

37. Third Party Assets

The Trust held £270 cash and cash equivalents at 31 March 2011 (31 March 2010: £NIL) which relates to monies held by the Trust on behalf of patients.

38. Intra-Government and Other Balances	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other central government bodies	**6,202**	**81**	**4,599**	**0**
Balances with local authorities	**122**	**0**	**0**	**0**
Balances with NHS trusts and foundation trusts	**1,886**	**0**	**967**	**0**
Balances with public corporations and trading funds	**0**	**0**	**0**	**0**
Intra government balances	**8,210**	**81**	**5,566**	**0**
Balances with bodies external to government	**3,113**	**196**	**14,684**	**0**
At 31 March 2011	**11,323**	**277**	**20,250**	**0**
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

39. Losses and Special Payments

There were 122 cases of losses and special payments (2009-10: 290 cases) totalling £134,401 (2009-10: £103,294) accrued during 2010-11.

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): 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.

Integrated Business Plan (IBP): The integrated business plan is the document that sets out the organisation's business strategy for the next five years. It sets out the organisation's plan in strategic, financial, governance and operational terms and evolves over the application process.

Long Term Financial Model (LTFM): The LTFM is the financial summary of the IBP and shows the historic performance of the Trust over the previous three years and a financial projection for the current year and a forecast for the following five years.

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; and,
- 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 (e.g. 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 the statement of comprehensive income 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 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 e.g. 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.