The Queen Elizabeth Hospital King's Lynn

NHS Trust

ANNUAL REPORT 2009/10

AT A GLANCE - A FOREWORD

We provide health care to around 220,000 people from Norfolk, Suffolk and Cambridgeshire

During 2009/10 we:

- **Treated over 50,000 patients in our Accident and Emergency department**
- **Saw local people in 251,174 outpatient appointments**

We employ 2418 people in range of jobs including:

- **1018 nurses and midwives**
- **172 consultants and doctors**
- **197 healthcare scientists**

In 2010/11 we aim to live up to our vision of being the preferred hospital for local people and becoming a Foundation Trust by:

- **Always putting the needs and care of our patients first**
- **Aligning services so that they meet the needs of our local population more precisely than anything offered by our competitors**
- **Consolidating our position through investment leading to greater efficiency**
- **Implementing new technology that will improve patient care**
- **Ensuring we achieve and maintain compliance with all performance targets**
- **Developing our position as an asset for the community we serve**

Our successes include:

- **Achieving all our national priority targets**
- **Having the best performing maternity unit in the East of England**
- **Our day surgery is in the top ten in the country**
- **Eliminating mixed sex accommodation**
- **An excellent record for infection control**

CHAIR AND CHIEF EXECUTIVE'S INTRODUCTION

This has been a momentous and exciting year for the hospital as we have seen progress on a whole range of different fronts

We have made some real advances over the last twelve months, thanks to the hard work of all our staff. We are proud to work with people who are so passionate about the Trust and its success.

We are very proud to have achieved all our performance targets. We have been assessed as the best performing maternity unit in the East of England and our day surgery service has been assessed as one of the top ten in England. We also ended the year having achieved the £4.5 million surplus we predicted in 2009.

Our patients now enjoy the privacy and dignity they should expect as mixed sex accommodation has now been eliminated in all of our wards, our central delivery suite has been updated, we opened our new clinical decision unit, and work began on updating our Accident and Emergency (A&E) department, we opened a new ward to help ease seasonal pressures on bed space.

Throughout the year, thousands of local people have received high quality care through the commitment and dedication of our staff. Not only have they shown the friendliness and warmth that is our hallmark, but they have also made every effort to be imaginative and innovative to make services for patients better than ever. You will see some examples as you read on.

We continue to work towards achieving Foundation Trust status. This will make us much more accountable to our local community with local people becoming members and governors. It will allow us to decide how to improve our services as well as allowing us to reinvest any surpluses we achieve in new services and to borrow to support those investments.

We are delighted to be able to report on such a successful year and look forward to many more achievements over the coming months.

Nerissa Vaughan – Chief Executive

Kate Gordon – Chair

2 June 2010

A YEAR OF ACHIEVEMENT

April 2009

Our groundbreaking POSSI (Post Operative Shoulder Surgery Initiative) project received a further boost when one of the founding clinical staff, Sister Julie Whitear, received an innovations award at the NHS Norfolk prize giving

Our four-bed specialist high-dependency stroke unit was opened on West Raynham Ward by NW Norfolk MP, Henry Bellingham

May 2009

Our patients voted us in the top 20 per cent of NHS Trusts for the choice of food on offer and staff communication, in the annual in-patient survey conducted by the Picker Institute

We were named as one of the Top 40 NHS Trusts in the UK for the quality of our data. A bronze trophy was presented by benchmarking group CHKS

QEH consultant anesthetists, Joe Carter and Peter Young, scooped first prize in the Health Enterprise East NHS Innovations competition for their life-saving invention. The non-injectable connector for arterial systems is a safety modification for arterial lines and prevents the risk of accidental arterial injection

Three senior nursing staff were awarded travel scholarships at our awards ceremony to mark Nurses' Week and International Nurses' Day

June 2009

Our first, dedicated Lithuanian and Russian interpreter, Inga Kupkiniene, was appointed to ensure non-English speaking expectant and new mothers from Eastern Europe are able to communicate effectively with healthcare professionals

Studies carried out by consultant neurologist, Jeremy Brown, played a major role in developing a new test to help detect Alzheimer's disease. Results of the tests, carried out in conjunction with Addenbrooke's Hospital, were published in the British Medical Journal

Results for the Productive Ward scheme, for which we are a regional pilot, showed that up to 20 per cent more quality time is being spent on direct patient care

Our staff displayed additional skills, with the hospital's first-ever talent show at The Arts Centre in King's Lynn – a dazzling, professional level display of music, song and dance

A dissertation on urinary tract infections written by electro bio medical engineering technician, Carla Wood, for her Masters degree became an important reference work in medical libraries around the UK and overseas

July 2009

The annual Patient Environment Action Team (PEAT) survey for the Care Quality Commission gave us an excellent rating for our food and good for the hospital environment.

The Central Delivery Suite was officially re-opened following a £500,000 rebuild and fit-out. The new unit gives parents more options for births, including a low-level couch and a birthing pool

A major recruitment drive was launched, to help fill nursing and midwifery vacancies

The first Jackie Rees Award for infection prevention and control, set up in memory of a former infection control lead nurse, was won by Martine Mitchell from Oxborough ward

August 2009

Patients waiting to be seen by consultants in our ear, nose and throat (ENT) department enjoyed the calming influence of watching our first artist in residence, Maureen Drake, at work

Our new Direct Digital X-ray system came on-line, promising better quality images and less risk to patients from radiation

Accident and Emergency (A&E) patients took part in a county-wide review of access to emergency care, to explore more appropriate ways of receiving treatment

September 2009

A new phlebotomy service was launched for Macmillan patients, to allow blood samples to be taken faster and with lower risk of infection, thanks to a grant from cancer charity Big C

We had major input to a toolkit aimed at improving the care of inpatients with diabetes, which was launched nationally under the banner ThinkGlucose

We were highly rated for patient safety following an inspection visit by the NHS Litigation Authority

October 2009

Our first two single sex compliant wards, Gayton and Leverington, opened in line with government directives

Our Haemochemistry laboratory was accredited under new clinical governance requirements, demonstrating that our diagnostic service is top quality

We exceeded national targets for a 50% reduction in MRSA and Clostridium difficile. We have some of the lowest infection rates in the country

The Audit Commission's Auditor's Local Evaluation reported that we were performing well in financial management

IVF treatment facilities were extended, with new links with Bourn Hall Clinic

The Care Quality Commission rated us good for financial management and fair for service quality

A total of 26 nurses from Spain joined our staff following an international recruitment drive

November 2009

A new seven-bed clinical decisions unit opened for business. It is used to speedily assess patients who come in as medical emergencies or are referred by their GPs

December 2009

The Special Care Baby Appeal, launched in conjunction with the Lynn News to raise funds for our NeoNatal Intensive Care Unit, reached its £150,000 target ahead of schedule

Our unsung heroes – our volunteers – were honoured with a special tea party at which long-service awards were presented

The Clinical Decisions Unit was officially opened by Baroness Shephard

January 2010

A pilot scheme to encourage patients with minor ailments to see their GP or pharmacist, rather than come to the A&E department, was launched in partnership with NHS Norfolk

Pioneering work carried out by a team led by our consultant microbiologist, Professor Lynne Liebowitz, to reduce MRSA was featured in more than 300 newspapers around the world

Security was stepped up with regular patrols of the site by a 'spying eye' community safety vehicle with links to Norfolk police and the CCTV operations room in King's Lynn

February 2010

Approval was granted for a wind turbine to be built in the hospital grounds. It will be used to generate enough energy to power 580 homes, and will save around £20,000 a year on our current energy costs

Work began on a £450,000 upgrade of the A&E department

Patients on the Norfolk, Cambridgeshire and Suffolk borders benefited from the launch of an outreach service for minor surgery at St George's Medical Centre, Littleport, providing treatment closer to home and saving them up to a 50-mile round trip

A new trial reminder appointment service was launched. Several days before their next appointment patients are contacted by phone with a reminder – and the option of changing the date if it is no longer convenient.

The 2009 National Outpatient Survey was published – with patients reporting that we had improved on cleanliness, privacy during medical examinations and choice of appointment times. We were also voted significantly better than many other hospitals on courtesy of receptionists, cleanliness and clear explanations being given to patients

Additional clinics introduced by our Stroke team have improved outcomes for patients suffering mini strokes by diagnosing them faster

March 2010

A Care Quality Commission staff survey revealed that our staff are more engaged and settled in their jobs than many other NHS counterparts

The same survey showed the number of potentially harmful incidents or near-misses is falling

We were granted a licence by the Care Quality Commission to provide healthcare services, under a tough new regime aimed at regulating NHS care standards. No special conditions were imposed, indicating that the Commission believes we are providing a service that meets all current healthcare standards

We finished the year with a surplus of £4.5 million as predicted at the beginning of the year

We celebrated the hospital's 30th anniversary on the current site

PERFORMANCE REPORT

During the year we were assessed by the Care Quality Commission on our performance. Its rating was good for financial management and fair for patient safety, cleanliness and waiting times.

We scored full marks for treating patients with dignity and respect, 13 out of a possible 14 for safety and cleanliness and 17 out of 18 for good management.

The CQC reported we were meeting requirements to protect people from the risk of infection. This followed an inspection in December 2009 when CQC identified three areas from a total of 16 where it felt further improvement was needed to protect patients, staff and visitors from infection. After a return visit in February 2010 to ensure that improvements had been made, the Commission reported we "provided assurance that the Trust had addressed all three areas for improvement".

By the end of the financial year we had achieved all the national top priority targets, including:

- **98% performance for the A&E 4-hour wait**
- **90% and 95% for admitted and non-admitted 18-week referral to treatment targets**
- **Cancer waits for 14-day referrals, 31 and 62-day pathways**

During the year we treated:

- **50,452 patients in A&E at the QEH**
- **9,941 patients in the Minor Injuries unit at North Cambridgeshire Hospital**
- **4,018 elective patients – (non-urgent) operations or procedures**
- **27,281 day-case patients**
- **31,012 emergency admission patients**
- **251,174 outpatients – 76,106 new cases and 175,068 follow-ups**

OVERALL PERFORMANCE DURING THE YEAR

In short it was a year of all-round improvements, while we continued to strive to meet the tough demands necessary to qualify for Foundation Trust status. During the year our application to become a Foundation Trust was submitted and the outcome will be known during 2010.

We met all key Care Quality Commission targets for patient care. We are undertaking additional work in areas where we underperformed to improve standards in stroke care, 18 week referral to treatment times and participation in heart disease audits.

OUR KEY STRENGTHS

- **We have been assessed to have the best performing maternity unit in the East of England**
- **Our day surgery service has been assessed as one of the top ten in England**
- **We have been named by NHS Norfolk as the model for stroke services across the county, although our service is still expanding to meet challenging, revised government guidelines**
- **We currently meet all targets for cancer referrals and are rated to provide amongst the best services in the country. A modern Macmillan unit forms part of our specialist cancer care**

WHAT WE DID WELL AND IMPROVEMENTS WE'VE MADE

During the year we:

- **Opened a new high-dependency stroke unit**
- **Increased the number of clinic sessions available for stroke patients**
- **Won an award for efficient data collection**
- **Played a major role in developing a new test for diagnosing Alzheimer's disease**
- **Opened a redesigned £500,000 birth suite**
- **Set up a new phlebotomy service for cancer patients**
- **Extended the range of our fertility treatment services**
- **Opened a new seven-bed Clinical Decisions Unit**
- **Opened a new ward to help ease seasonal pressure on bed space**
- **Extended our minor surgery outreach services at a medical centre in Littleport**
- **Set up an appointment phone-call reminder service for patients**
- **Introduced tests that save up to 100 potentially fatal blood clots a month**
- **Eliminated mixed-sex accommodation**

OUR VISION FOR THE FUTURE

The preferred hospital for local people

To achieve this, we will continue to focus on living our values:

Quality: providing the highest-possible quality service for our patients

Efficiency: making the best use of the resources available to us – and making sure we continue to live within our means

Partnership: working in partnership with our patients, staff, the various commissioning bodies and other local health and social care organisations

With an eye to our development, particularly when we become a Foundation Trust, we have set out clear objectives for the future. They are:

- **Always put the needs and care of our patients first**
- **Align services so that they meet the needs of our local population more precisely than anything offered by our competitors**
- **Consolidate our position through investment leading to greater efficiency**
- **Implement new technology that will improve patient care**
- **Ensure we achieve and maintain compliance with all performance targets**
- **Develop our position as an asset for the community we serve**

The NHS Constitution sets out 25 rights and 14 pledges for patients and public. This means clarity for patients and local people about what they have the right to expect from their NHS. The Constitution also sets out rights, pledges and responsibilities for staff.

The Queen Elizabeth Hospital Board is committed to taking account of the NHS Constitution in its decision making about the Trust's services.

Our aspirations to become a Foundation Trust in 2010/2011 will embed patient and public involvement even further. As a Foundation Trust, we will have a Governors' Council of elected and appointed governors representing our patients, the local community and our staff in our strategic decision-making processes.

Foundation Trust

We have over 3,000 public members signed up to date and expect this number to grow as our Foundation Trust application progresses.

By the end of the financial year we had successfully passed through the initial gateways necessary to achieve Foundation Trust status. The next stages include an in-depth visit by Monitor, the official examining body representing the Department of Health, to obtain first-hand experience of the way we work, and to evaluate the organisation at all levels.

One of our focus areas during 2009/10 has been on achieving Foundation Trust status. This has involved an immense amount of work behind the scenes to ensure we meet the high standards expected, so we can gain greater autonomy and work towards self-government.

Our application was submitted and has progressed through various stages of approval in anticipation of achieving FT status later in 2010. We aim to build on our success as a top-quality provider of acute healthcare services and to live up to our vision of being the preferred hospital for local people.

WHO'S WHO

The Trust Board at 31 March 2010:

Kate Gordon (1)
Chair
Non Executive Director

Neil Harrison (2)
Chair of Audit Committee
Non Executive Director

Shawn Haney (3)
Non Executive Director

Jules Hillier (4)
Non Executive Director

Sean Green (5)
Non Executive Director

Dr Jill Robinson (6)
Non Executive Director

Nerissa Vaughan (7)
Chief Executive

Noel Scanlon (8)
Chief Nurse and
Deputy Chief Executive

Dr Geoff Hunnam (9)
Medical Director

Chris Preston (10)
Director of Finance

John Fletcher (11)
Commercial Director

Executive Directors attending Board meetings:

Mark Henry (12)
Director of Operations

Barbara Cummings (13)
Director of Performance and Informatics

Jacqui Bate (14)
Director of Human Resources and Organisational Development


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Sean Green, Shawn Haney and Jules Hiller are members of the Audit Committee which is chaired by **Neil Harrison**
Carol Townsend retired from the Board in November 2009

WHO WE ARE AND WHAT WE DO

The Queen Elizabeth Hospital King's Lynn NHS Trust is an acute general hospital with 515 beds, which employs 2,418 staff. We are located on the eastern side of King's Lynn town centre and provide secondary healthcare services to around 220,000 people from Norfolk and parts of Cambridgeshire and Lincolnshire.

Our catchment area is largely rural, with a minimum of one hour's travelling time to neighbouring acute hospitals in Norwich, Cambridge, Peterborough or Boston. West Norfolk is a popular holiday and retirement area, so our population includes a high proportion of older residents, which brings an above average demand for acute services.

We provide secondary healthcare services to around 220,000 people from Norfolk and parts of Cambridgeshire and Lincolnshire

Recent surveys by local councils indicate that more than 100 languages are now spoken in Norfolk, adding to the challenge of delivering healthcare and eliciting information on medical conditions.

We provide a broad range of secondary care, including a number of specialist services, including chemotherapy, Level 2 neonatal intensive care, and fertility services, including IVF treatment. We excel in a number of areas including our maternity services, which are considered to be among the best in the East of England, and day surgery, which is rated as one of the top ten units in the entire country.

We also provide a number of outreach services, with clinics at North Cambridgeshire Hospital in Wisbech, Swaffham Community Hospital, Wells Community Hospital and St George's Medical Centre in Littleport.

Our medical staff fulfill the NHS vision of making health services accessible to patients by running regular clinics at other locations, saving patients from having to make a round-trip of up to 50 miles to King's Lynn. Our outreach services have been further developed by extending the range of minor surgery facilities available in Littleport.

CASE STUDY

"BRILLIANT SERVICE!" SAY PATIENTS

"Absolutely fantastic!" was the verdict of one of the first patients to have a minor operation at St George's Medical Centre, Littleport as part of a new scheme launched in February.

Those patients who live on the borders of Norfolk, Suffolk and Cambridgeshire could face a round trip of up to 50 miles to travel to their nearest hospital but now they can have minor operations close to home.

Peter Hedges of Littleport, who was one of the first patients to take advantage of the service, says: "It was painless and the staff were fantastic. It took me about ten minutes to get there, whereas if I'd gone to the QEH site it would have taken me about 45 minutes. This whole experience has been brilliant."

WHERE WE FIT IN THE LOCAL HEALTH SCENE

Our geographic position means that, for many patients, the Queen Elizabeth Hospital is the only viable option for treatment relatively close to home. Now the increased use of Choose and Book, coupled with patient choice, mean patients can exercise their right and seek treatment elsewhere if we are unable to match their expectations on waiting times and treatment availability.

Other health providers in the immediate area are the neighbouring BMI Sandringham hospital, the Norfolk and Norwich University Hospital (for patients on the eastern side of our catchment area), and community services provided by Primary Care Trusts and local practice based commissioners.

We remain committed to greater efficiency in providing our services and we have achieved a planned operating surplus of £4.5 million this year. Investments in data collection during the year have enabled us to monitor our activity more effectively.

In March 2010 we were successfully registered by the Care Quality Commission as a healthcare provider, a new legal requirement for all health and social care providers to ensure that equitable care is available to all. Our registration was without any special qualifying factors – an indication that we successfully meet the Commission's stringent healthcare requirements and high standards.

HOW WE ARE ORGANISED

The Trust is governed by a Trust Board, comprising executive and non-executive directors, one of whom is the Board Chair. The Chair and other non-executive directors are appointed independently by the Appointments Commission. They have considerable input into the strategic development of hospital services.

The hospital's day-to-day running is in the hands of the executive directors and their divisional managers.

There is a Trust Executive Board, into which the main committees report. This is composed of senior hospital staff and implements decisions and procedures at operational level.

OUR TEAM

The clinical activities of the hospital are managed by the following divisions:

- **Emergency care**
- **Elective care**
- **Clinical support**
- **Women and children**

A number of support departments provide services to the various divisions. These include:

- **Finance**
- **Estates**
- **Hotel services**
- **Patient services**
- **Risk management & Patient safety**
- **Human resources**
- **Security**
- **Complaints and legal services**
- **Communications**
- **IT and Information**

We are also supported in many front of house activities and on wards by a highly-valued team of volunteers, many of whom are former staff or patients. Our staff work closely as a team at all levels and with colleagues in other NHS organisations in our region.

Human resources will be working closely with all departments to explore new and innovative ways of attracting staff to key posts

OUR STAFF

We are an equal opportunities employer and committed to treating all job applicants fairly. 1816 of our staff are female and 602 male. The percentage of disabled staff is 0.74%.

Previous patient surveys highlighted concerns that too few nursing staff appeared to be on duty on wards. Although recruiting enough professionally trained nursing staff has been difficult, staffing levels on wards have always been within safety limits. We launched recruitment campaigns in the UK this year– particularly to encourage trained nurses on family and career breaks to return to work. For the first time we also actively recruited in Spain and Ireland, yielding 30 qualified nursing staff and a qualified pharmacist.

We also launched a campaign to attract doctors to particularly hard to fill positions. We were fortunate to recruit an emergency care specialist for our accident and emergency department – one particular area where there was an urgent need. During the coming financial year our human resources department will be working closely with all departments to explore new and innovative ways of attracting staff to key posts.

Our staff participated in the national staff opinion survey and rated us in the top 20% of Trusts in 18 findings areas, they also took part in focus groups to explore communications issues. We keep staff up to date with a regular weekly newsletter.

During the year staff at all levels were required to undertake equality and diversity training, in accordance with our equal opportunities policy and as part of a wider, extensive programme of mandatory training.

Our links with education providers were also developed with Beacon East, focusing largely on professional development placements. This has allowed local school and college lecturers and career advisers direct access to the hospital for conducted tours of all areas and classroom based presentations delivered by some of our key specialists.

A day long event was held on construction and the built environment, to give a group of 14 to 19 year olds an insight into the array of jobs available in the Estates department – for example, carpenters, electricians and plumbers. Other similar events arranged by human resources included business administration and finance, and infection control.

Students with learning disabilities are also being supported through a partnership, with local employers, Remploy, and the College of West Anglia. Under the banner Project Search our long-term aim is to create eight placements across a range of jobs, to allow students to experience various occupations and gain real work experience.

We are managing staff sickness more effectively through the electronic staff record. This allows staff sickness to be recorded and reviewed as it occurs, so managers can develop back to work action plans to support staff on their return. Under the previous system of recording data there was a two month timelag before statistics became available and problem areas could be identified.

Staff by role:

By the end of the financial year we employed 2418 people in a range of roles, including:

- **1018 nurses and midwives**
- **172 consultants and doctors**
- **146 medical trainees**
- **197 healthcare scientists**
- **170 allied health professionals**
- **225 ancillary staff**
- **381 administration and clerical staff**
- **33 maintenance staff**
- **76 senior managers**

OUR BUSINESS PARTNERS AND STAKEHOLDERS

We continue to develop strong links at local and regional level with other NHS providers ensuring, wherever possible, that we provide a seamless service for our patients.

Our principal business partners continue to be the three Primary Care Trusts serving our catchment area: NHS Norfolk, NHS Cambridgeshire and NHS Lincolnshire, as well as the East of England Ambulance Service, with overall strategic control from NHS East of England. We also work closely with Norfolk and Waveney Mental Health Foundation Trust, which manages the Fermoy Unit on the main hospital site, as well as the West Norfolk Practice Based Commissioning Consortium, of which our medical director is a board member.

We maintain strong links with medical and nursing schools at the University of East Anglia and the University of Cambridge, and continue to train and recruit medical and nursing graduates from both universities.

We have continued to maintain a valuable relationship with the BMI-owned Sandringham Hospital co-located with us. We also work closely with Norfolk Social Services and the Red Cross, particularly in arranging continuing care for discharged patients, as part of our seamless service.

Close co-operation with our local GP practices and community hospitals ensures that our medical staff provide valuable outreach services at centres some distance from the main hospital. These include Wells Hospital, North Cambridgeshire Community Hospital in Wisbech, Swaffham Community Hospital and St George's Medical Centre in Littleport. Local GP practices with operating theatre facilities, such as Gayton Road and Southgates medical centres offer patients alternative choices for minor surgery and procedures.

Particularly strong links are maintained with Norfolk Constabulary and Norfolk Fire and Rescue Service. Norfolk police, its local Safer Neighbourhood team, now includes the hospital and its grounds in its routine beat, and has taken part in a number of security initiatives with our security specialist.

CASE STUDY

CLINICAL DECISIONS OPEN FOR BUSINESS

Just in time for the increase in patients coming into hospital at the beginning of the winter, we opened our new clinical decision unit. The new unit assesses the condition of patients who come in to the hospital as medical emergencies or who are sent by their GPs and determines whether they need to be admitted or treated and sent home.

There are seven beds and a clinic room with a couch, effectively providing eight beds on the unit. Open Monday to Friday for 12 hours each day, the unit means that there is bed space available at the beginning of each day for people coming in as emergencies without having to wait for patients to be discharged. When the unit closes at 10pm, all the beds are empty.

Before the unit was opened there was often a lack of beds, particularly on the Medical Assessment unit (MAU), this caused delays in diagnosis and assessment for new patients.

"We are absolutely delighted with this new facility. MAU is very busy and now we can focus on assessing our patients without other distractions" – Senior Sister Helen Smith

PROMPT PAYMENTS CODE

We have signed-up to the NHS Prompt Payments Code which is a payment initiative developed by government with the Institute of Credit Management to tackle the crucial issue of late payment and aim to pay small businesses within ten days of invoice.

EMERGENCY PREPAREDNESS

In June 2009 the World Health Organisation raised the pandemic flu alert level, which triggered our own response plans to a possible swine flu pandemic. We were required to show how we would handle large numbers of patients and staff affected by swine flu.

During July, under the direction of our Emergency Planning Officer, we took part in a 'tabletop' exercise, QEH Morbus, to test our responses to a swine flu pandemic.

The following month all divisional and senior managers attended a business continuity workshop, to help managers complete business impact analysis (BIA) data collection for our key processes.

We have in place a major incident plan which is fully compliant with the NHS Planning Guidance 2005 and all associated guidance.

SOCIAL AND COMMUNITY LINKS

We have continued to keep our 3,000 prospective Foundation Trust members up to date with events through our membership newsletter. Invaluable support has been provided by our Patient Experience group, which continues to represent the interests of our patients on committees and special interest groups.

Patients and their friends and families give continuing support and during the year links have been established with community groups which have participated in fundraising and general support activities. Fundraising and careers advice have allowed us to promote our services and activities to a variety of local organisations.

FUNDRAISING

The Special Care Baby appeal, launched in partnership with the Lynn News on 23 May 2008 reached its £150,000 target in 18 months in November 2009 – earlier than anticipated, thanks to the generosity of the newspaper's readers and our supporters, despite very difficult economic times.

The money is being used to develop the Neonatal Intensive Care unit (NICU), to improve the care of sick, premature and vulnerable babies. Extra support is also being given to parents and families through the creation of a second parents' overnight room.

RISK MANAGEMENT AND PATIENT SAFETY

A 5% reduction of our Hospital Standardised Mortality Ratio was achieved in 2008-09, and a further 5% reduction has been targeted for 2009-10

We encourage staff to report all incidents as an opportunity for learning and improving services. As a result we have seen an upward trend in reporting. A total of 5010 incidents were reported from April 2009 to end of March 2010. Of these 881 were non clinical and 4129 were clinical incidents.

Nine of the clinical incidents were identified and reported as serious untoward incidents, including four related to outbreaks of Norovirus. None of these related to data loss or confidentiality breaches. All patient safety incidents are reported to the National Patient Safety Agency through their National Reporting and Learning System.

We focus on all aspects of patient safety through the formation of a new Health Care Governance Committee. This committee reviews and implements national guidance on patient safety issues, considers clinical practice arising from individual incidents and communicates best practice to all the clinical teams.

We have also participated in the second wave of the national *Leading Improvements in Patient Safety* programme and undertaken a number of initiatives to reduce our Hospital Standardised Mortality Ratio. A five per cent reduction was achieved in 2008-09 and a target of a further five per cent reduction in 2009-10 is on target to be delivered.

Risk management has been further embedded into the culture of the organisation through the delivery of risk management workshops supporting staff in the risk assessment process. Staff have been encouraged to develop a better understanding of patient safety issues and risk management through the introduction of a patient safety bulletin.

HEALTH AND SAFETY

During 2009/10, 228 incidents were recorded in which staff reported an injury. This is fewer than last year when 372 incidents were reported. Work continues to support safe practice, particularly around the safe use of sharps and needles. Health and Safety training has been reviewed and updated to reflect current issues.

SUSTAINABILITY

In recent years we have taken a pioneering role in reducing the carbon footprint generated by hospital activities and we received an award in January 2008 to recognise this work.

The NHS has launched its carbon reduction strategy, which requires all NHS organisations to reduce their 2007 carbon footprint by ten per cent by 2015. The carbon footprint of Queen Elizabeth Hospital King's Lynn for the period of April 2007 to March 2008 is 25,608 tonnes CO2e. This equates to 0.42 t/m2 or 8.5 tonnes per staff member.

We have progressed work over the past year to develop our sustainability action plan to generate a number of major environmental improvements across the organisation. Modernising and upgrading existing power equipment and services has been planned as part of a rolling programme.

Most visible of the new projects will be our wind turbine, which has received planning permission by green energy supplier, Ecotricity. Construction is due to begin later in 2010.

Carbon reduction and other environmental concerns are now built in to the planning, design and construction phases of all our new buildings and facilities. Advances in lighting technology mean we can achieve energy savings of up to 50 per cent compared with just ten years ago, the savings coming from better efficiency in equipment. New lighting controls switch off unnecessary lighting automatically during daylight hours – an important consideration, as lighting is one of the principal uses of energy in a hospital.

We also signed-up to the Good Corporate Citizenship Assessment Model proposed by the NHS Sustainable Development Unit.

CASE STUDY

GOING GREEN

Planning approval has been given for a wind turbine to be built on the hospital site by green energy provider, Ecotricity. This will generate around £20,000 worth of green electrical power each year and will add to the continuing massive reductions in our carbon footprint.

The 1.9 million units of electricity generated by the turbine are equivalent to the energy needed to power 580 homes for a year and over the next 25 years will reduce the amount of CO_2 that hospital processes release into the atmosphere by 700 tonnes a year.

CASE STUDY

STOP THE CLOT CAMPAIGN

A stay in hospital can lead to an increased risk of developing deep vein thrombosis (DVT). Now, thanks to a new screening project, between 50 and 100 patients a month are saved from this ordeal.

The Stop the Clot campaign has raised awareness of the risk to patients which could affect up to two percent of all people who are hospital inpatients. And once a patient is identified as being at risk of developing DVT, they are given a course of a blood-thinning drug to cut the risk.

Sister Elizabeth Macleod-Collins, anticoagulation specialist practitioner, says "We average more than 5,400 people admitted each month so we could expect more than 100 patients a month to be diagnosed with a DVT.

"Since starting the Stop the Clot campaign, we have seen six patients per month with DVT associated with hospital admission. Thanks to the hard work and commitment of hospital staff we have managed to prevent between up to 100 patients a month from getting a potentially fatal DVT."

SECURITY

Through co-operation and a joint approach to tackling security matters, particularly criminal offences, we continue to deal effectively with criminal behavior and reduce losses from breaches in security. Our security specialist is committed to delivering a secure environment for patients, visitors and staff.

Our security specialist is committed to delivering a secure environment for patients, visitors and staff

Our partnership working with Norfolk police continues to go from strength to strength with daily high visibility patrols and regular meetings to discuss issues

Major improvements have been made this year with community lone working staff provided with lone-worker devices. New improvements and vastly enhanced security protection are in place for staff in Accident and Emergency through an extensive new CCTV system which can be security-monitored at all times. It includes a panic button system activating a link to the borough council's CCTV suite in the centre of King's Lynn, so police assistance can be summoned.

CASE STUDY

FOOD FOR THOUGHT

When they were asked about the food on offer at the QEH our patients put us in the top 20% of hospitals in the country.

With almost half a million meals a year to serve just to patients – staff aren't counted in that number – our kitchens are stretched to the limit. Fresh meals are cooked from scratch using locally produced ingredients wherever possible.

A recent patient, Mrs Bailey, wrote "To all who work preparing food. The food was lovely and always hot, especially the beef, gravy and dumpling. The meat was lovely and the pudding was also very good."

CASE STUDY

FACELIFT FOR A&E

"The new A&E department means a safer, quicker, more comfortable and satisfying experience for our patients." – Barbara Cummings, Director of Performance and Informatics

Work on improving the Accident and Emergency department began in the spring. With the aim of cutting waiting times, improving patient privacy and dignity and opening a dedicated area for children, the work was scheduled to take 17 weeks at a cost of £450,000.

Up to 200 people visit the department each day and, once complete, the work will mean they will be treated in an area much more suited to their needs. Staff who work in the department were heavily involved in driving the project forward.

Barbara Cummings, Director of Performance and Informatics, says: "This investment is essential for us to deliver a top class service for patients. There will be more treatment rooms to allow patients greater privacy. Separate facilities for children are the gold standard and we are delighted to now be able to provide these."

COMPLAINTS

We received 459 complaints during the year and dealt with 85% in the target timescale of 30 working days while some 89% were resolved locally following a first response.

Where justifiable complaints are received, we make sure we learn from them and review policy and practise.

We have adopted the Principles of Remedy good practice guidance in our complaint handling procedure

ESTATES

Under a separately funded government initiative all NHS Trusts were required to eliminate mixed sex sleeping accommodation in our general wards. This became a major rolling programme for our Estates department, providing separate bathroom and toilet facilities in all areas. The work was completed a month ahead of schedule.

Major improvements were also carried out to increase our capacity for handling sick patients. At the end of 2009 a new clinical decision unit was opened, close to our existing medical assessment unit to allow emergency patients to be assessed rapidly.

Completing the major building upgrade, work started on an extensive refurbishment and rebuild of our A&E department, creating more examination and treatment rooms, and a specialist paediatric area.

FINANCIAL REPORT

This annual report has been prepared to reflect the activities and financial position of the Queen Elizabeth Hospital King's Lynn NHS Trust for the year ending 31 March 2010.

During the year, we met the three key financial targets – break even, our External Financing Limit and our Capital Resource Limit. Plans submitted to the East of England Strategic Health Authority were used to monitor our financial performance during the year.

The income that the Trust generates relates primarily to the patient services provided at the Queen Elizabeth Hospital in King's Lynn and comes predominantly through three service arrangements with our primary PCTs, NHS Norfolk, NHS Cambridgeshire and NHS Lincolnshire. The form of these service arrangements is based largely on the national Payment by Results tariff.

We are reporting a retained surplus of £4.5m for the year ending 31 March 2010 (which compares to £6.1m for 2008/9) and have made one significant change to accounting policy during the year, moving to a Modern Equivalent Asset basis for valuing the fixed assets which led to a net reduction in fixed asset values of 4.5%.

The number of emergency patients continued to increase in 2009/10 (activity levels were 2.3% higher than in 2008/9) and provided significant operational challenges for the Trust, particularly during January and March.

The profile of the activity led to higher than expected front-line agency costs and a key challenge for the Trust in 2010/11 is to reduce that reliance on agency staff.

The higher number of emergency patients combined with a number of outbreaks of Norovirus disrupted the Trust's ability to deliver the planned level of elective care at several points during the year (although total patient flows were in line with expectations). As a result, the Trust incurred additional costs at various times of the year to ensure delivery of waiting list targets. During 2010/11, the Trust will be working hard with its commissioners to support initiatives aimed at reducing emergency activity and is also in the process of developing plans to ensure that the operational impact of any Norovirus outbreaks is reduced.

The number of outpatients seen by the Trust was just under 1% higher than in 2008/9. During 2010/11, the Trust will be focusing on reducing the number of patients that fail to turn up for appointments. This should help us to increase the efficiency of the hospital while at the same time improving the quality of the service being provided to patients.

The Trust continues to work with its commissioners to improve the services that it provides and a number of service enhancements were delivered during the year, the largest of which has significantly improved the recovery prospects of individuals in the region who suffer a stroke.

Our contracted clinical income for 2010/11 has increased, when compared to 2009/10 full year actual income, by 1.1%. This increase includes an additional 1% that will fund specific quality improvements. Unavoidable increases in the cost base (e.g. national pay increase, national increases in clinical insurance premiums) exceed the increase in clinical income and so we have put in place an efficiency improvement programme to ensure that we deliver our targeted surplus of £2.6m in 2010/11.

The introduction of the partial cap on the revenue received for emergency activity (only 30% of the national tariff will be paid for activity above the 2008/9 level) will pose a threat to the achievement of the planned surplus if expected emergency activity levels are exceeded.

The key focus areas for the Trust during 2010/11 are to continue to achieve national quality standards and improve the quality of services provided, to support the demand management initiatives needed to stem the increases in acute activity and to embed and deliver the efficiency improvement plan.

SENIOR MANAGERS REMUNERATION REPORT

This report sets out The Queen Elizabeth Hospital King's Lynn NHS Trust policy on the remuneration of its senior managers, who are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust, and who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. In this context, and for the purposes of this report, senior managers are taken to be those persons who have served during the year as Executive and Non-Executive Directors on the Trust's Board.

REMUNERATION COMMITTEE: CONSTITUTION AND OPERATION

The Remuneration Committee, a sub-committee of the Board of Directors, sets the remuneration policy for Executive Directors. This Committee deals with all matters relating to the remuneration of Executive Directors and is responsible for the determination and maintenance of overall remuneration policy and review and agreement of Executive Director salaries and benefits. The membership of the Committee consists of all Non Executive Directors with the exception of the Chair of the Audit and Governance Committee, which was Neil Harrison throughout the year.

In addition, meetings are attended by the Chief Executive and the Director of Human Resources, who advise on matters relating to the other Executive Directors and the overall performance of the Trust. Neither is present, however, when matters concerning their own remuneration are considered.

The Committee places high value on the independence of its decision-making processes. In consultation with the Director of HR, the Committee draws on information from external bodies on particular remuneration matters. During the year the Committee used benchmarking information from the NHS on comparative market data to assist in the determination of pay and benefits.

The Committee's approach to policy going forward will continue to reflect these principles, underpinned by regular review and monitoring of remuneration policy and practice in similar organisations' outside the Trust.

CASE STUDY

NEW BIRTH SUITE DELIVERS

A £500,000 refurbishment of the central delivery suite was completed in July with facilities including a birthing pool, low level couch and stool and accessories designed to provide alternative pain relief.

The suite now provides ensuite showers and toilets to allow greater access and convenience for mothers and is a top security area with an airlock entry and exit system to provide reassurance to new parents.

The work was split into ten phases so staff could continue to provide a service as work was carried out. One of the first users of the new facilities was Rachel O'Donnell, whose daughter was born there in July. Rachel said:

"It was a beautiful experience because it was exactly as I wanted it to be. None of the decisions I had written into my birth plan were taken away from me and it all happened exactly as I wanted it to.

"I used the birthing pool, it was lovely because the staff kept topping it up with hot water and it really helped. All the staff were brilliant, they put me first at all times. It was everything I had hoped for."

CASE STUDY

"DON'T FORGET" MESSAGE FOR PATIENTS

Missed appointments cost the NHS huge amounts of money every year. The estimated cost to the QEH alone is up to £750,000 a year. Now a new scheme to remind patients about their next appointment has begun.

The scheme means that all our clinics are fully attended as patients have the chance to rearrange their appointment if they wish when they are reminded about it. Women and Children's services manager, Fran Rose-Smith, explains:

"We are confident that most people understand that the more efficient we become, the better the standard of health care we can provide. This scheme benefits patients who remember or rearrange their appointment and those who can have their appointment brought forward because someone else has cancelled."

NON-EXECUTIVE DIRECTORS: REMUNERATION POLICY

Non-Executive Directors receive a fee determined by the NHS Appointments Committee. This fee is reviewed annually. In addition, Non-Executive Directors are reimbursed for expenses incurred on Trust business.

EXECUTIVE DIRECTORS: REMUNERATION POLICY

The remuneration policy for Executive Directors tries to balance the Trust's status as a public sector body (and in the expectation that all areas of spend, including executive remuneration, must deliver value to the tax payer) with the fact that the Trust operates in a competitive environment and needs to offer remuneration that enables it to attract, retain and motivate high calibre individuals with the skills and competences required to lead the organisation.

In doing so, the remuneration policy seeks to:

- **Remunerate individuals fairly for individual responsibility and contribution**
- **Take into account wider salary policy and employment conditions within the Trust and the relationship that should exist between the remuneration of Executive Directors and other employees**
- **Have regard to the market median levels of remuneration**

CASE STUDY

NEW MEMORY TEST

Studies carried out by consultant neurologists at the QEH have played a major role in developing an improved test to help diagnose Alzheimer's disease.

Results of the study carried out by consultant neurologist, Dr Jeremy Brown, were published in the British Medical Journal to international acclaim.

The Test Your Memory evaluation detected Alzheimer's disease in 93% of people in a trial involving 139 sufferers and 540 healthy people. This compares with a 52% success rate using an old style MMSE test, which was criticised as being too easy leading to some patients being missed in the early stages of the illness.

ELEMENTS OF REMUNERATION

Salary

Salaries are reviewed annually, taking into account external market levels and internal comparisons as well as the individual's responsibilities and overall performance against annually agreed objectives. The basic salary is paid as a fixed sum monthly and there is no separate payment or bonus related directly to performance.

Pensions

All Executive Directors are eligible to participate in the NHS Pension Scheme that provides salary-related pension benefits on a defined benefit basis.

Employment contracts

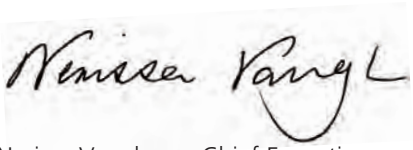
The policy of the Remuneration Committee is for the contracts of employment of Executive Directors to contain a maximum notice period of six months. Each contract expires on the pensionable age of the individual, which is the normal NHS retirement age, but is subject to earlier termination for cause or if notice is given under the contract. There is no entitlement to any additional remuneration in the event of early termination other than in the case of termination on grounds of redundancy.

Remuneration received

The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only.

Details of remuneration and audited information.

Details of Directors' remuneration for the years ended 31 March 2010 and 2009 are set out in the tables on pages 62 and 63.



Nerissa Vaughan – Chief Executive

2nd June 2010

STATEMENT ON INTERNAL CONTROL

The Queen Elizabeth Hospital King's Lynn NHS Trust

1. Scope of responsibility

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

The Board has developed its governance arrangements around the requirements of national guidance in respect of risk management and assurance.

The Trust has mechanisms in place to facilitate effective working with key partners; regular reporting to and meetings with the Trust's Commissioners. These meetings are a forum to discuss performance, future plans and initiatives, ensuring the cohesion and co-ordination of services. The Trust also regularly reports to and meets with the Strategic Health Authority.

2. The purpose of the system of internal control

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

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

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

3. Capacity to handle risk

The Trust has a Risk Management Strategy which is regularly reviewed and updated, it provides a framework for managing risk and clearly lays out the delegation of responsibility to Executive Directors, managers, clinicians, and staff as appropriate. Executive Directors have been delegated responsibility for specific areas of risk management. The Deputy Chief Executive / Chief Nurse is responsible for co-ordinating the management of organisational and clinical risk. The Director of Finance is responsible for the management of financial risk and for ensuring there are sound systems of financial control in place. The Chief Executive Officer is responsible for ensuring that risk management is integral to the corporate planning processes.

The Committee structure of the Trust ensures risks are regularly reviewed and appropriately managed. Staff are provided with risk management training and each ward or department has a designated risk champion. There are a range of Trust Policies available on the Trust's Intranet that describe the roles and responsibilities in relation to the identification and management of risk. The risk scoring matrix and risk assessment procedure have been reviewed to ensure that there is a consistent approach to both assessing and managing risk.

The Trust learns from good practice through internal audits, Clinical audits, performance management, peer reviews, continuing professional development, incidents and complaints. There are specialist advisors in place to continually develop policies and procedures, and to provide advice to managers and staff.

4. The risk and control framework Board Assurance Framework and Risk Register

The Trust Board agrees and monitors the Board Assurance Framework and the high scoring risks on the risk register. The Board Assurance Framework sets out the principle risks to the delivery of the Trust's strategic objectives. Each risk has a lead Executive Director assigned to it and details the controls in place to mitigate against it. Any gaps in controls are highlighted through this process allowing management action to be taken. The Board assesses residual risk against its key strategic aims once assurance is received that effective internal controls are in place.

Each division or department has a risk register which they review and update monthly, all high scoring risks are included on the Trust's central risk register. Risks are scored using a matrix system that takes account of the likelihood and impact of the risk if it were realised.

Committee Structure

The Healthcare Governance Committee reports to the Board. This Committee monitors all high scoring and high value risks. There are currently two sub-committees that report to the Healthcare Governance Committee, each of these committees monitors risks relevant to their associated areas of the organisation, thus ensuring all organisational risks

are reported into a committee that has a reporting chain through to the Board, through the escalation of risk by exception.

The Finance and Investment Committee reports directly to the Board. This committee monitors and reviews the adequacy of the Trust's financial risk assessments, assumptions, sensitivities, mitigation plans and contingencies.

The Audit Committee reports directly to the Board; it receives reports from Internal Audit including the counter fraud service. Internal Audit agrees their annual plan with the Audit Committee; the work includes identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Auditing Standards. Reports emanating from the reviews are submitted to the Audit Committee, where recommendations are made and action plans are agreed with managers. The recommendations and agreed actions are input onto the Outstanding Actions Database which is maintained by Internal Audit, updated by managers and reported back to the Audit Committee for monitoring.

The Audit Committee receives reports from external audit, including the annual management letter, the results of the Auditor's Local Evaluation and other reports agreed as part of their annual plan.

The Audit Committee also receives the minutes of the Healthcare Governance Committee meetings and updates on action plans emanating from previous reviews or changes.

Information risk is managed through the Information Governance Committee, which reports into the Capacity and Infrastructure Committee. The Trust assessed compliance with the requirements of the Connecting for Health Information Governance (IG) Toolkit, and signed the annual IG statement of compliance in March 2010. It assessed itself at level two which is a pre-requisite of unconditional registration with the Care Quality Commission. There have been no serious untoward incidents that require disclosure in relation to personal data.

Public and Staff

The public are involved in the risk management process within the Trust through their involvement in the Readers Panel and the Patient Experience Group (PEG). Also, a member of the public attends both the Capacity and Infrastructure Committee and the Healthcare Governance Committee.

Staff are expected to provide safe clinical practice, report incidents, accidents and potential hazards, be familiar with the Trust's Risk Management Strategy and departmental risk issues, comply with all Trust policies and procedures and take reasonable care of their own safety and the safety of others. Each specialty undergoes an annual review where a panel assesses evidence that the Trust's governance agenda is being adhered to.

There has been a considerable amount of work and training throughout the year, to ensure continuous improvements are made to the robustness of the Trust's business continuity plans, ensuring they are aligned across departments and with the organisation's risks.

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. Internal Audit conducted an audit of the Trust's payroll services, the conclusion of which gave substantial assurance.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality and Diversity has been combined into the Trust's Single Equality Scheme, which was ratified by the Board; 81% of staff were trained during the year via an on-line Equality and Diversity training programme, a human rights policy is in place.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingencies requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has a Sustainable Development Management Action Plan and a Non-Executive champion for sustainability.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal controls. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Although the focus of internal audit work is on internal controls, risk management and governance there have been a number of assignments that have reviewed economy, effectiveness and efficiency of the processes within other departments including Human Resources and Purchasing. Internal Audit also reviewed the Board Assurance Framework, which was given substantial assurance. Records Management, SLA's and Contracts, Sale of Ultra-sound Images, Dr Foster Data Submission, this was an additional review requested by the Board and the Use of the Authorised Signatory Database were all given

insufficient assurance; however robust management action plans have been agreed to address the risks and control weaknesses identified.

The overall level of assurance given by the Head of Internal Audit remains at substantial, although it is noteworthy that for the following reviews, namely Debtors, the Cash and Treasury Management element of the Bank, Cash and Treasury Management audit, and the Ledger Maintenance element of Control Accounts and Ledger Maintenance, the level of assurance given improved from moderate last year to substantial for the current year. An action plan to improve the Internal Controls has been agreed with management.

As detailed above, the Board, its committees and sub-committees have a key role in maintaining and reviewing the effectiveness of the system of internal control.

I also gain assurance from executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control. The Board has received regular reports on risk, performance and clinical governance.

The Assurance Framework itself provides me with evidence that, the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by recommendations made by the external auditors in their management letter and other reports; the review mechanisms in place for the risk register, reviews undertaken by the Care Quality Commission and NHS Litigation Authority along with the declaration of compliance with Standards for Better Health core standards made to the Care Quality Commission.

The Trust submitted a declaration to the Care Quality Commission in respect of compliance with core standards. The Trust declared itself fully compliant with the Care Quality Commission essential standards and has been granted unconditional registration.

The Care Quality Commission completed an initial review of the Trust's compliance with the Hygiene Code - Infection Control. Recommendations were made and subsequently followed up by a further inspection by the Care Quality Commission when the Trust was found to be fully compliant.

The Trust predicts it will achieve the vast majority of its national targets, those predicted not to be achieved are cancelled operations, stroke patients admitted to an acute stroke unit and the submission and quality of data provided for the national MINAP audit.

The Trust underwent an assessment of its risk management standards by the NHS Litigation Authority in September 2009 and was successful in achieving compliance at level two. The Clinical Negligence Scheme for Trusts undertook an assessment of Maternity Risk Management standards in December 2009, the result of which was that maternity services maintained compliance at level one.

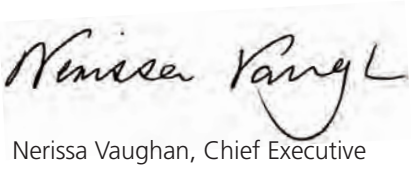
Recommendations made in reports received from the external auditors have been agreed and action plans developed.

I have been advised on the implications, of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Healthcare Governance Committee, Clinical Governance Committee, Capacity and Infrastructure Committee and Finance and Investment Committee.

Plans are in place to address weaknesses and ensure continuous improvement of the system.

As a result of my review I am satisfied that the Statement of Internal Control provides an accurate assessment of the control system in the Trust. With the exception of the internal control issues that I have outlined in this statement, my review confirms that The Queen Elizabeth Hospital Kings Lynn 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.

Signed on behalf of the Board on 2nd June 2010.



Nerissa Vaughan, Chief Executive

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE NHS TRUST

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

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

2nd June 2010

Nerissa Vaughan, Chief Executive

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

- **Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;**
- **Make judgments and estimates which are reasonable and prudent; and 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 NHS 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 NHS 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

2nd June 2010

Nerissa Vaughan, Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS TRUST

Opinion on the financial statements

I have audited the financial statements of The Queen Elizabeth Hospital King's Lynn NHS Trust for the year ended 31 March 2010 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service set out within them.

I have also audited the information in the Remuneration Report subject to audit on page 67.

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

Respective responsibilities of directors and auditor

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

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

I report whether the financial statements and the part of the Remuneration Report subject to audit on page 67 has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Finance Report included in the Annual Report, is consistent with the financial statements.

I review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'Guidance on Completing the Statement on Internal Control 2009/10' issued in February 2010. I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Foreword, the Chair and Chief Executive's Introduction, and the sections of the annual report headed "A year of achievement", "Performance Report", "Our vision for the future", "Who's who", "Who we are and what we do", and the unaudited part of the Senior Managers' Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the Audit Commission Act 1998, the Code of Audit Practice issued by the Audit Commission and International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report subject to audit on page 67. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- **the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and**
- **the financial statements and the part of the Remuneration Report subject to audit on page 67 have been properly prepared.**

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report subject to audit on page 67.

Opinion

In my opinion:

- **the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2010 and of its income and expenditure for the year then ended;**
- **the financial statements and the part of the Remuneration Report subject to audit on page 67 have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and**
- **information which comprises the commentary on the financial performance included within the Finance Report, included within the Annual Report, is consistent with the financial statements.**

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

Directors' Responsibilities

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

Auditor's Responsibilities

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

Conclusion

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

Certificate

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

Mark Hodgson

Officer of the Audit Commission

Regus House, 1010 Cambourne Business Park, Cambourne, Cambridge, CB236DP.

Please note that the Remuneration Report referred to in the independent auditor's report, is now located at pages 62 and 63, and not at page 67.

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	Note	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	4	**141,911**	128,348
Other operating revenue	5	**13,822**	12,512
Operating expenses	7	**(148,983)**	(131,978)
Operating surplus (deficit)		**6,750**	8,882
Finance costs:			
Investment revenue	13	**32**	210
Other gains and (losses)	14	**(240)**	(391)
Finance costs	15	**(241)**	(368)
Surplus/(deficit) for the financial year		**6,301**	8,333
Public dividend capital dividends payable		**(1,791)**	(2,204)
Retained surplus/(deficit) for the year		**4,510**	6,129
Other comprehensive income			
Impairments and reversals		(4,832)	(877)
Receipt of donated/government granted assets		100	49
Reclassification adjustments:			
- Transfers from donated and government grant reserves		(385)	(396)
Total comprehensive income for the year		**(607)**	**4,905**

The notes on pages 37 to 63 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	Note	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	16	**65,041**	66,446	68,993
Intangible assets	17	**65**	88	62
Trade and other receivables	20	**940**	843	793
Total non-current assets		**66,046**	67,377	69,848
Current assets				
Inventories	19	**2,234**	1,984	2,013
Trade and other receivables	20	**4,619**	4,751	4,919
Cash and cash equivalents	23	**8,078**	7,612	2,350
Total current assets		**14,931**	14,347	9,282
Total assets		**80,977**	81,724	79,130
Current liabilities				
Trade and other payables	21	**(13,352)**	(10,918)	(10,856)
DH Working capital loan		**0**	(2,100)	(2,100)
DH Capital loan		**(435)**	(435)	(435)
Borrowings	22	**(77)**	(77)	(77)
Provisions	25	**(173)**	(156)	(150)
Net current assets/(liabilities)		**894**	661	(4,336)
Total assets less current liabilities		**66,940**	68,038	65,512
Non-current liabilities				
Borrowings	22	**(330)**	(397)	(444)
DH Capital loan		**(1,955)**	(2,392)	(4,927)
Trade and other payables	21	**(578)**	(576)	(408)
Provisions	25	**(429)**	(418)	(383)
Total assets employed		**63,648**	64,255	59,350
Financed by taxpayers' equity				
Public dividend capital		**44,812**	44,812	44,812
Retained earnings		**(755)**	(5,784)	(13,993)
Revaluation reserve		**14,403**	19,661	22,618
Donated asset reserve		**5,121**	5,492	5,831
Government grant reserve		**67**	74	82
Total Taxpayers' Equity		**63,648**	64,255	59,350

The financial statements on pages 33 to 63 were approved by the Board on 2 June 2010 and signed on it's behalf by:

Nerissa Vaughan, Chief Executive
Date 2 June 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2008							
As previously stated	44,812	(13,993)	22,618	5,831	82	0	59,350
Restated balance	44,812	(13,993)	22,618	5,831	82	0	59,350
Changes in taxpayers' equity for 2008/09							
Total Comprehensive Income for the year:							
Retained surplus/(deficit) for the year	0	6,129	0	0	0	0	6,129
Transfers between reserves	0	2,080	(2,080)	0	0	0	0
Impairments and reversals	0	0	(877)	0	0	0	(877)
Receipt of donated/ government granted assets	0	0	0	49	0	0	49
Transfers from donated asset/government grant reserve	0	0	0	(388)	(8)	0	(396)
Balance at 31 March 2009	44,812	(5,784)	19,661	5,492	74	0	64,255
Changes in taxpayers' equity for 2009/10							
Balance at 1 April 2009	44,812	(5,784)	19,661	5,492	74	0	64,255
Total Comprehensive Income for the year:							
Retained surplus/(deficit) for the year	0	4,510	0	0	0	0	4,510
Transfers between reserves	0	519	(519)	0	0	0	0
Impairments and reversals	0	0	(4,739)	(93)	0	0	(4,832)
Receipt of donated/ government granted assets	0	0	0	100	0	0	100
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(378)	(7)	0	(385)
Balance at 31 March 2010	44,812	(755)	14,403	5,121	67	0	63,648

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**6,750**	8,882
Depreciation and amortisation		**4,717**	5,071
Impairments and reversals		**0**	0
Net foreign exchange gains/(losses)		**0**	0
Transfer from donated asset reserve		**(378)**	(388)
Transfer from government grant reserve		**(7)**	(8)
Interest paid		**(246)**	(368)
Dividends paid		**(1,791)**	(2,204)
(Increase)/decrease in inventories		**(250)**	29
(Increase)/decrease in trade and other receivables		**35**	118
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables		**2,156**	26
Increase/(decrease) in other current liabilities		**(20)**	0
Increase/(decrease) in provisions	25	**19**	33
Net cash inflow/(outflow) from operating activities		**10,985**	11,191
Cash flows from investing activities			
Interest received		**32**	207
(Payments) for property, plant and equipment	16	**(8,013)**	(5,622)
Proceeds from disposal of plant, property and equipment		**0**	2,065
(Payments) for intangible assets	17	**0**	(44)
Proceeds from disposal of intangible assets		**0**	0
(Payments) for investments with DH		**0**	0
(Payments) for other investments		**0**	0
Proceeds from disposal of investments with DH		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Revenue rental income		**0**	0
Net cash inflow/(outflow) from investing activities		**(7,981)**	(3,394)
Net cash inflow/(outflow) before financing		**3,004**	7,797
Cash flows from financing activities			
Loans repaid to the DH		**(2,538)**	(2,535)
Net cash inflow/(outflow) from financing		**(2,538)**	(2,535)
Net increase/(decrease) in cash and cash equivalents		**466**	5,262
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**7,612**	2,350
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	23	**8,078**	7,612

NOTES TO THE ACCOUNTS

1. Accounting Policies

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

1.1 Accounting convention

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

1.2 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.

1.2.1 Critical judgements in applying accounting policies

There were no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies.

1.2.2 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.

The Trust's land and buildings were revalued as at 1 April 2009 by the District Valuer, the valuer also assessed the lives of the buildings. The Trust used the BCIS All In Tender Price Index to revalue its buildings upto the balance sheet date, this resulted in a 4.1% (£1,759,000) impairment in the value of buildings.

1.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Where a patient care episode is partially completed at the financial year end, an average tariff is used to calculate the attributable income.

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

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

1.4 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

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.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the Trust's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the pensions reserve and reported as an item of other comprehensive income.

1.5 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.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS Trusts must apply these new valuation requirements by 1 April 2010 at the latest.In accordance with this requirement the Trust had its land and buildings valued, as at 1 April 2009, based on a Modern Equivalent Asset, the effect of which is included within the accounts.

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

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

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

Subsequent expenditure

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

1.7 Intangible assets

Recognition

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

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

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

Measurement

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.

1.8 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.

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

1.9 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.

1.10 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.

	Min life (years)	Max life (years)
Software Licences	5	5
Licences and trademarks	5	5
Patents	5	5
Development Expenditure	5	5
Buildings exc dwellings	15	80
Dwellings	15	80
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	5	15

1.11 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.

1.12 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching

liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

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

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

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

The Trust as lessor

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

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

1.13 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.

1.14 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.

1.15 Provisions

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

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

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

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

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

1.17 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.

1.18 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.

1.19 Financial assets

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

Financial assets are initially recognised at fair value.

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

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.

1.20 Financial liabilities

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

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

Other financial liabilities

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

1.21 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.

1.22 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 the Trust had no monetary items denominated in foreign currency.

1.23 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 32 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

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

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

1.25 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).

1.26 Subsidiaries

The Trust has no subsidiaries and which it has are consolidated.

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

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

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

IAS 27 (Revised) Consolidated and separate financial statements

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

Amendment to IAS 39 Eligible hedged items

IFRS 3 (Revised) Business combinations

IFRIC 17 Distributions of Non-cash Assets to Owners

IFRIC 18 Transfer of assets from customers

1.28 Accounting standards issued that have been adopted early

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

2. Operating Segments

Healthcare related activities are the only activity of the Trust, given this the results for the segment are represented in the Statement of Comprehensive Income and Statement Of Financial Position.

3. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The Trust had no income generation activities whose full cost exceeded £1m or was otherwise material.

4. Revenue from patient care activities	**2009/10 £000**	2008/09 £000
Strategic health authorities	**0**	0
Primary Care Trusts	**141,061**	127,400
Foundation Trusts	**105**	104
Department of Health	**54**	129
Non-NHS:		
Private patients	**5**	4
Overseas patients (non-reciprocal)	**44**	(3)
Injury costs recovery	**566**	618
Other	**76**	96
	141,911	**128,348**

Injury cost recovery income is subject to a provision for impairment of receivables of 8.7% to reflect expected rates of collection.

5. Other Operating Revenue	2009/10 £000	2008/09 £000
Education, training and research	**5,557**	4,963
Charitable and other contributions to expenditure	**306**	469
Transfers from Donated Asset Reserve	**378**	388
Transfers from Government Grant Reserve	**7**	8
Non-patient care services to other bodies	**1,459**	1,788
Income generation	**4,167**	4,266
Rental revenue	**5**	5
Other revenue	**1,943**	625
	13,822	**12,512**

6. Revenue	2009/10 £000	2008/09 £000
From rendering of services	**155,733**	140,860

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

7. Operating Expenses	2009/10 £000	2008/09 £000
Services from other NHS Trusts	**947**	737
Services from PCTs	**4,360**	3,819
Services from Foundation Trusts	**177**	166
Purchase of healthcare from non NHS bodies	**876**	495
Directors' costs	**1,380**	1,041
Other Employee Benefits	**99,534**	87,648
Supplies and services - clinical	**22,888**	21,309
Supplies and services - general	**2,302**	2,147
Consultancy services	**1,392**	601
Establishment	**1,639**	1,418
Transport	**500**	418
Premises	**4,289**	4,528
Provision for impairment of receivables	**40**	119
Inventories write offs	**27**	0
Depreciation	**4,694**	5,050
Amortisation	**23**	21
Audit fees	**120**	119
Clinical negligence	**2,597**	1,476
Research and development	**0**	7
Education and Training	**388**	315
Other	**810**	544
	148,983	131,978

8. Operating leases

The Trust has no significant operating leases

Payments recognised as an expense	**2009/10 £000**	2008/09 £000
Minimum lease payments	**49**	52
	49	52

Total future minimum lease payments	**2009/10 £000**	2008/09 £000
Payable:		
Not later than one year	9	23
Between one and five years	18	4
After 5 years	0	0
Total	**27**	27

9. Employee costs and numbers

9.1 Employee costs	**2009/10**			2008/09		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**85,468**	**77,066**	**8,402**	73,841	68,921	4,920
Social Security Costs	**6,626**	**6,315**	**311**	5,939	5,660	279
Employer contributions to NHS Pension scheme	**9,189**	**8,758**	**431**	8,909	8,491	418
Employee benefits expense	**101,283**	**92,139**	**9,144**	88,689	83,072	5,617
Of the total above:						
Charged to capital	370			0		
Employee benefits charged to revenue	100,913			88,689		
	101,283			88,689		

9.2 Average number of people employed	2009/10 Total Number	2009/10 Permanently Employed Number	2009/10 Other Number	2008/09 Total Number	2008/09 Permanently Employed Number	2008/09 Other Number
Medical and dental	**318**	**318**	**0**	296	296	0
Administration and estates	**414**	**405**	**9**	365	356	9
Healthcare assistants and other support staff	**356**	**310**	**46**	325	288	37
Nursing, midwifery and health visiting staff	**746**	**712**	**34**	693	654	39
Nursing, midwifery and health visiting learners	**1**	**1**	**0**	0	0	0
Scientific, therapeutic and technical staff	**320**	**313**	**7**	294	286	8
Other	**322**	**288**	**34**	316	283	33
Total	**2,477**	**2,347**	**130**	2,289	2,163	126
Of the total above:						
Number of staff (WTE) engaged on capital projects	9			6		

9.3 Staff sickness absence	2009/10 £000
Total days lost	**20,225**
Total staff years available	**2,272**
Average working days lost	9.30

9.4 Management Costs	2009/10 £000	2008/09 £000
Management costs	7,346	6,041
Income	155,733	140,855

10. Pension costs

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

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

date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the cost 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 actuarial review by the Governement actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS pension scheme taking effect from 1 April 2008, this 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 of 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 verified from time to time to reflect changes to the scheme's liabilities.

b) Accounting valuation

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

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

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and the best of the last three years pensionable pay for each year of srevice, 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 pensionable earnings over the relevant pensionable service.

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

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (increase) Act 1971, and are based on changes in retail prices in twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

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

Ill-health Retirement

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

Death Benefits

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

Additional Voluntary Contributions (AVCs)

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

Transfer between Funds

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

Preserved Benefits

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

Compensation for Early Retirement

Where a member of the scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employers cost.

11. Retirements due to ill-health

During 2009/10 there were 5 (2008/09, 5) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £259,363 (2008/09: £238,014). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

12. Better Payment Practice Code	2009/10		2008/09	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**39,606**	**42,392**	37,383	34,920
Total Non NHS trade invoices paid within target	**36,385**	**39,043**	34,428	31,307
Percentage of Non-NHS trade invoices paid within target	**92%**	**92%**	92%	90%
Total NHS trade invoices paid in the year	**1,290**	**10,760**	1,263	9,743
Total NHS trade invoices paid within target	**1,251**	**10,685**	1,209	9,083
Percentage of NHS trade invoices paid within target	**97%**	**99%**	96%	93%

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.

13. Investment revenue	2009/10 £000	2008/09 £000
Interest revenue:		
Bank accounts	**32**	210
Total	**32**	210

14. Other gains and losses	2009/10 £000	2008/09 £000
Gain/(loss) on disposal of property, plant and equipment	**(240)**	(391)
Total	**(240)**	(391)

15. Finance Costs	2009/10 £000	2008/09 £000
Interest on loans and overdrafts	**232**	346
Interest on obligations under finance leases	**0**	14
Interest on obligations under PFI contracts:		
Total interest expense	**232**	360
Other finance costs	**9**	8
Total	**241**	368

16. Property, plant and equipment

2009/10:	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	5,961	47,081	2,487	19,540	733	8,467	458	84,727
Additions purchased	0	875	5,381	1,598	16	389	0	8,259
Additions donated	0	0	0	100	0	0	0	100
Reclassifications	0	1,648	(1,874)	82	0	126	18	0
Disposals other than by sale	0	(82)	0	(679)	(33)	(115)	0	(909)
Impairments	(1,546)	(3,028)	(255)	(3)	0	0	0	(4,832)
At 31 March 2010	**4,415**	**46,494**	**5,739**	**20,638**	**716**	**8,867**	**476**	**87,345**
Depreciation at 1 April 2009	0	0	0	11,052	676	6,350	203	18,281
Disposals other than by sale	0	0	0	(528)	(33)	(110)	0	(671)
Charged during the year	0	2,290	0	1,686	19	651	48	4,694
Transfer to Foundation Trust	0	0	0	0	0	0	0	0
Depreciation at 31 March 2010	**0**	**2,290**	**0**	**12,210**	**662**	**6,891**	**251**	**22,304**
Net book value								
Purchased	4,415	39,874	5,739	7,573	54	1,975	223	59,853
Donated	0	4,304	0	814	0	1	2	5,121
Government granted	0	26	0	41	0	0	0	67
Total at 31 March 2010	**4,415**	**44,204**	**5,739**	**8,428**	**54**	**1,976**	**225**	**65,041**
Asset financing								
Owned	**4,415**	**44,204**	**5,739**	**8,137**	**54**	**1,976**	**225**	**64,750**
Finance Leased	**0**	**0**	**0**	**291**	**0**	**0**	**0**	**291**
Total 31 March 2010	**4,415**	**44,204**	**5,739**	**8,428**	**54**	**1,976**	**225**	**65,041**

16.1. Property, plant and equipment Prior year: 2008/09:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	6,838	48,351	1,342	1,469	18,839	754	8,127	403	86,123
Additions purchased	0	1,193	0	2,090	1,983	9	284	55	5,614
Additions donated	0	7	0	0	42	0	0	0	49
Reclassifications	0	919	0	(1,072)	89	0	64	0	0
Disposals other than by sale	0	(1,147)	(1,342)	0	(1,413)	(30)	(8)	0	(3,940)
Impairments	(877)	0	0	0	0	0	0	0	(877)
At 31 March 2009	**5,961**	**49,323**	**0**	**2,487**	**19,540**	**733**	**8,467**	**458**	**86,969**
Depreciation at 1 April 2008	0	0	0	0	10,665	678	5,629	158	17,130
Disposals other than by sale	0	(434)	0	0	(1,186)	(29)	(8)	0	(1,657)
Charged during the year	0	2,676	0	0	1,573	27	729	45	5,050
Depreciation at 31 March 2009	**0**	**2,242**	**0**	**0**	**11,052**	**676**	**6,350**	**203**	**20,523**
Net book value									
Purchased	5,961	42,523	0	2,487	7,481	57	2,116	255	60,880
Donated	0	4,529	0	0	962	0	1	0	5,492
Government granted	0	29	0	0	45	0	0	0	74
Total at 31 March 2009	**5,961**	**47,081**	**0**	**2,487**	**8,488**	**57**	**2,117**	**255**	**66,446**
Asset financing									
Owned	**5,961**	**47,081**	**0**	**2,487**	**8,099**	**57**	**2,117**	**255**	**66,057**
Finance Leased	**0**	**0**	**0**	**0**	**389**	**0**	**0**	**0**	**389**
Total 31 March 2009	**5,961**	**47,081**	**0**	**2,487**	**8,488**	**57**	**2,117**	**255**	**66,446**

All donated asset additions in the year were donated by The Queen Elizabeth Hospital Kings Lynn NHS Trust Charitable Fund.

A revaluation as at 1 April 2009 of the Trust's Land and Buildings was undertaken by the District Valuer using the Modern Equivalent Asset methodology as prescribed by International Financial Reporting Standards.

The valuation of each property is on the basis of Market Value on the assumption that the property is sold as part of the continuing enterprise in operation, effectively the Existing Use Value.

There has been no compensation received from third parties for assets, impaired, lost or given up.

No assets have been written down to their recoverable amount.

The values of property in existing use are not materially different to open market value.

	Min life (years)	Max life (years)
Software Licences	5	5
Licences and trademarks	5	5
Patents	5	5
Development Expenditure	5	5
Buildings exc dwellings	15	80
Dwellings	15	80
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	5	15

17.1 Intangible assets

2009/10:	**Computer software purchased £000**	**Total £000**
Gross cost at 1 April 2009	168	168
Gross cost at 31 March 2010	**168**	**168**
Amortisation at 1 April 2009	80	23
Charged during the year	23	103
Amortisation at 31 March 2010	**103**	**126**
Net book value		
Purchased	65	**65**
Total at 31 March 2010	**65**	**65**

Prior year:
17.2 Intangible assets

2008/09:	**Computer software purchased £000**	**Total £000**
Gross cost at 1 April 2008	121	121
Additions purchased	47	47
Gross cost at 31 March 2009	**168**	**168**
Amortisation at 1 April 2008	59	59
Charged during the year	21	21
Amortisation at 31 March 2009	**80**	**80**
Net book value		
Purchased	88	**88**
Total at 31 March 2009	**88**	**88**

18. Capital commitments

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

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	**657**	1,449
Total	**32**	210

19. Inventories

19.1 Inventories

	31 March 2010 £000	31 March 2009 £000
Drugs	**914**	802
Work in progress	**0**	0
Consumables	**1,241**	1,104
Energy	**79**	78
Other	**0**	0
Total	**2,234**	1,984
Of which held at net realisable value	0	0

19.2 Inventories recognised in expenses

	31 March 2010 £000	31 March 2009 £000
Inventory recognised expenses	**10,763**	9,701
Write-down of inventories (including losses)	**27**	29
Total	**10,790**	9,730

20. Trade and other receivables

20.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
NHS receivables-revenue	**3,359**	3,077	**281**	290
Non-NHS receivables-revenue	**260**	539	**659**	553
Provision for the impairment of receivables	**(226)**	(186)	**0**	0
Accrued income	**534**	556	**0**	0
VAT	**121**	103	**0**	0
Other receivables	**571**	662	**0**	0
Total	**4,619**	4,751	**940**	843

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

20.2 Receivables past their due date but not impaired	31 March 2010 £000	31 March 2009 £000
By up to three months	**809**	79
By three to six months	**125**	30
By more than six months	**371**	33
Total	**1,305**	142

20.3 Provision for impairment of receivables	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**(186)**	(67)
(Increase)/decrease in receivable impaired	**(40)**	(119)
Balance at 31 March	**(226)**	(186)

Non-NHS receivables are impaired as follows, a 50% provision is created for debts more than 60 days old and a 100% provision is created for debts more than 90 days old.

21. Trade and other payables	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Interest payable	**11**	25	0	0
NHS payables-revenue	**2,996**	2,518	**0**	0
Non NHS trade payables - revenue	**3,806**	2,909	**0**	0
Non NHS trade payables - capital	**500**	254	**0**	0
Accruals and deferred income	**205**	1,994	**578**	576
Social security costs	**1,005**	990	**0**	0
Tax	**1,199**	1,077	**0**	0
Other	**3,630**	1,151	**0**	0
Total	**13,352**	10,918	**578**	576

Other payables include:
£1,195,610 (prior year £930,403) outstanding pensions contributions at 31 March 2010 .

22. Borrowings	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Loans from:				
Department of Health	**435**	2,535	**1,955**	2,392
Finance lease liabilities	**77**	77	**330**	397
Total	**512**	2,612	**2,285**	2,789

The Department of Health loan is repaid twice a year, in March and September, the final payment will be made in September 2015. The finance lease is repaid once a year, the final payment will be made in January 2013.

23. Cash and cash equivalents	31 March 2010	31 March 2009
	£000	£000
Balance at 1 April	**7,612**	2,350
Net change in year	**466**	5,262
Balance at 31 March	**8,078**	7,612
Made up of		
Cash with Office of HM Paymaster General	**8,007**	7,502
Commercial banks and cash in hand	**71**	110
Cash and cash equivalents as in statement of financial position	**8,078**	7,612
Cash and cash equivalents as in statement of cash flows	**8,078**	7,612

24. Finance lease obligations

The finance lease contains clauses ensuring that the lessor is not responsible for any claim, losses or demands arising from the rental of the property. The lessee, must also ensure the property is fully insured and maintained during the lease period. The lease period can be extended for up to 7 years if required.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease payments	
	31 March 2010	31 March 2009	31 March 2010	31 March 2009
	£000	£000	£000	£000
Within one year	**78**	77	**77**	77
Between one and five years	**349**	427	**330**	397
After five years	**0**	0	**0**	0
Less future finance charges	**(20)**	(30)	**0**	0
Present value of minimum lease payments	**407**	474	**407**	474
Included in:				
Current borrowings	**77**	77	**77**	77
Non-current borrowings	**330**	397	**330**	397
	407	474	**407**	474

25. Provisions	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	**31 March 2010 £000**	31 March 2009 £000
Pensions relating to former directors	**0**	0	**0**	0
Pensions relating to other staff	**4**	33	**152**	418
Legal claims	**169**	123	**277**	0
Restructurings	**0**	0	**0**	0
Continuing care	**0**	0	**0**	0
Equal pay	**0**	0	**0**	0
Agenda for change	**0**	0	**0**	0
Other (specify)	**0**	0	**0**	0
Total	**173**	156	**429**	418

	Pensions relating to other staff £000	**Legal claims £000**	**Total £000**
At 1 April 2008	0	0	**0**
Arising during the year	0	0	**0**
Used during the year	0	0	**0**
Reversed unused	0	0	**0**
Unwinding of discount	0	0	**0**
Transfers in year	0	0	**0**
At 1 April 2009	160	414	**574**
Arising during the year	8	71	**79**
Used during the year	(15)	(35)	**(50)**
Reversed unused	0	(10)	**(10)**
Unwinding of discount	3	6	**9**
Transfers in year	0	0	**0**
At 31 March 2010	156	446	**602**
Expected timing of cash flows:			
In the remainder of the spending review period to 31 March 2011	4	169	**173**
Between 1 April 2011 and 31 March 2016	16	20	**36**
Between 1 April 2016 and 31 March 2021	16	20	**36**
Thereafter	120	237	**357**

Other provisions include employer's liability and early retirements. The amounts and timing of the pension provision is known, the provision has been calculated using life expectancy tables and has been discounted at 2.2%. £13,980,559 is included in the provisions of the NHS Litigation Authority at 31/3/2010 in respect of clinical negligence liabilities of the Trust (31/03/09 £15,019,433).

26. Contingencies

26.1 Contingent liabilities

The Trust had no contingent liabilities as at 31 March 2010.

27. Financial Instruments

27.1 Financial assets	At fair value through profit and loss	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Receivables	**0**	4,282	**0**	**4,282**
Cash at bank and in hand	**0**	7,547	**0**	**7,547**
Other financial assets	**0**	0	**0**	**0**
Total at 31 March 2009	**0**	11,829	**0**	**11,829**
Receivables	0	**3,694**	0	**3,694**
Cash at bank and in hand	0	**8,078**	0	**8,078**
Other financial assets	0	**0**	0	**0**
Total at 31 March 2010	**0**	**11,772**	**0**	**11,772**

27.2 Financial liabilities	At fair value through profit and loss	Other	Total
	£000	£000	£000
Payables	0	7,903	7,903
PFI and finance lease obligations	0	474	474
Other borrowings	0	4,927	4,927
Total at 31 March 2009	0	13,304	13,304
Payables	0	**7,769**	7,769
PFI and finance lease obligations	0	**397**	397
Other borrowings	0	**2,390**	2,390
Total at 31 March 2010	**0**	**10,556**	**10,556**

28. Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

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

29. Events after the reporting period

The Trust is in the process of applying to become a Foundation Trust, this process is due to be completed during 2010/11.

30. 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.

30.1 Breakeven Performance	2005/06	2006/07	2007/08	2008/09	2009/10
	£000	£000	£000	£000	£000
Turnover	99,230	113,469	126,063	140,855	155,733
Retained surplus/(deficit) for the year	(10,986)	1,407	4,565	6,158	4,510
Adjustment for:					
Timing/non-cash impacting distortions:					
Other agreed adjustments	8,591	0	0	0	0
Break-even in-year position	(2,395)	1,407	4,565	6,158	4,510
Break-even cumulative position	(11,331)	(9,924)	(5,359)	799	5,309

*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.

The Trust's recovery plan, approved by the SHA achieved break-even in 2008/09.

	2005/06	2006/07	2007/08	2008/09	2009/10
	%	%	%	%	%
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	-2%	1%	4%	4%	3%
Break-even cumulative position as a percentage of turnover	-11%	-9%	-4%	1%	3%

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.

30.2 Capital cost absorption rate

For 2008/09 the Trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £1,791,000, bears to the actual average relevant net assets of £51,100,000, that is 3.5% (prior year 4.3%).

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%.

30.3 External financing

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

		2009/10	2008/09
	£000	£000	£000
External financing limit		**(102)**	(3,050)
Cash flow financing	(3,007)		(7,797)
External financing requirement		**(3,007)**	(7,797)
Undershoot/(overshoot)		**2,905**	4,747

30.4 Capital Resource Limit

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

	2009/10	2008/09
	£000	£000
Gross capital expenditure	**8,359**	8,080
Less: book value of assets disposed of	**(238)**	(30)
Plus: loss on disposal of donated assets	**0**	28
Less: donations towards the acquisition of non-current assets	**(100)**	(121)
Charge against the capital resource limit	**8,021**	7,957
Capital resource limit	**8,296**	8,217
(Over)/Underspend against the capital resource limit	**275**	260

31. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £	Receipts from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
J. Bate	3,878	0	3,878	0

During the year there was one related party transaction with the husband of J.Bate, the above was in relation to management training provided by his company to the Trust.

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

- NHS Norfolk
- NHS Cambridgeshire
- NHS Lincolnshire
- East of England Strategic Health Authority
- Department of Health
- NHS Litigation Authority
- NHS Purchasing and Supply Agency
- Norfolk & Waveney Mental Health Partnership NHS Trust
- NHS Business Services Authority
- NHS Pension Scheme
- HMRC
- East Of England Ambulance Service

The Trust has conducted transactions with other Health Authorities and NHS bodies, which individually are not regarded as material, during the normal course of the Trust's activities.

The Trust has also received revenue and capital payments amounting to £306,165 (2008/09 £469,360) from the Queen Elizabeth Hospital King's Lynn NHS Trust Charitable Fund, the Trustees for which are also members of the Trust Board. A copy of the Queen Elizabeth Hospital King's Lynn NHS Trust Charitable Fund accounts can be obtained on request (Tel: 01553 613981).

The Trust has also received revenue from and incurred expenditure with the Sandringham Private Hospital. The Trust's Medical Director also provides some consultancy services to Sandringham Private Hospital, the total income in the year amounted to £1,218,347, the expenditure in the year totalled £298,065 (2008/09 – income of £1,187,297; expenditure of £374,101).

32. Third Party Assets

The Trust held £2,900 cash and cash equivalents at 31 March 2010 (£385 - at 31 March 2009) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

33. Intra-Government and Other Balances	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other Central Government Bodies	3,413	281	4,997	0
Balances with NHS Trusts and Foundation Trusts	67	0	203	0
Intra Government balances	3,480	281	5,200	0
Balances with bodies external to Government	1,139	659	8,152	578
At 31 March 2010	**4,619**	**940**	**13,352**	**578**
Balances with other Central Government Bodies	2,667	290	3,923	0
Balances with NHS Trusts and Foundation Trusts	391	0	459	0
Intra Government balances	3,058	290	4,382	0
Balances with bodies external to Government	1,693	553	6,536	576
At 31 March 2009	**4,751**	**843**	**10,918**	**576**

34. Losses and Special Payments

There were 42 cases of losses and special payments (2008/09: 35 cases) totalling £55,562 (2008/09: £93,208) accrued during 2009/10.

35. Transition to IFRS	Retained earnings	Revaluation reserve	Donated asset reserve	Gov"t grant reserve
	£000	£000	£000	£000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**5,427**	**19,661**	**5,492**	**74**
Adjustments for IFRS changes:				
Private finance initiative	0	0	0	0
Leases	99	0	0	0
Others (specify): deferred income, land asset and holiday pay accrual	258	0	0	0
Adjustments for:				
Impairments recognised on transition	0	0	0	0
UK GAAP errors	0	0	0	0
Taxpayers' equity at 1 April 2009 under IFRS:	**5,784**	**19,661**	**5,492**	**74**

	£000
Surplus/(deficit) for 2008/09 under UK GAAP	**6158**
Adjustments for:	
Leases	-33
Others (specify)deferred land income	4
Surplus/(deficit) for 2008/09 under IFRS	**6129**

The impact of IFRS on the Income and Expenditure of the Trust is immaterial, a lease for beds was capitalised and has a Net Book Value of £291,000. Land where the Trust is lessor has also been capitalised, which is currently valued at £15,000. Income associated with one of the Land and buildings leases has also been deferred, the balance at the year-end amounts to £404,000.

AUDITED DIRECTORS RENUMERATION

		2009/10		2008/09	
		Salary	Benefits in kind	Salary	Benefits in kind
		Bands of £5,000	To the nearest £10	Bands of £5,000	To the nearest £10
J.Cook (to 29/05/09)	Finance Director	90-95	1,060	100-105	6,510
C Whipp (06/07/09-20/10/09)	Finance Director	105-110	-	-	-
B O'Sullivan (21/10/09-22/11/09)	Finance Director	15-20	-	-	-
C Preston (From 23/11/09)	Finance Director	40-45	1,270	-	-
B.Cummings	Director of Performance and Informatics	100-105	-	40-45	4,000
J.Fletcher	Commercial Director	95-100	-	70-75	-
K.Gordon	Chairman	20-25	-	20-25	-
S.Haney	Non-executive	05-10	-	05-10	-
N.Harrison	Non-executive	05-10	-	05-10	-
G.Hunnam	Medical Director	170-175	-	185-190	-
C.Townsend (To 30/10/09)	Non-executive	0-5	-	05-10	-
N.Vaughan	Chief Executive	145-150	-	130-135	-
S Green (From 01/06/09)	Non-executive	5-10	-	-	-
M Henry (From 01/05/09)	Director of Operations	80-85	-	-	-
N Scanlon	Chief Nurse/Dep CEO	105-110	-	15-20	2,500
J Hillier	Non-Executive	05-10	-	0-5	-
J Bate	HR Director	95-100	11,410	50-55	-
J Robinson (From 01/10/09)	Non-Executive	0-5	-	-	-

Pension Benefits							
Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 as at 31 March 2010	Lump sum at age 60 related to accrued pension at 31 March 2010	Cash equivalent transfer value at 31 March 2010	Cash equivalent transfer value as at 31 March 2009	Real increase in cash equivalent transfer value	Employer's contribu-tion to stakeholder pension
To the nearest £2,500	To the nearest £2,500	To the nearest £5,000	To the nearest £5,000	To the nearest £1,000	To the nearest £1,000	To the nearest £1,000	To the nearest £1,000
0-2.5	0-2.5	45-50	30-35	224	208	11	4
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-
-	-	0-5	0	25	-	-	6
2.5-5	10-12.5	85-90	65-70	357	280	70	13
0-2.5	(10-12.5)	0-5	0	30	12	17	12
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-
0-2.5	2.5-5	255-260	190-195	1,513	1,384	95	22
-	-	-	-	-	-	-	-
(0-2.5)	(2.5-5)	115-120	85-90	433	420	2	19
-	-	-	-	-	-	-	-
-	-	120-125	90-95	601			11
(0-2.5)	(2.5-5)	150-155	110-115	694	661	16	14
-	-	-	-	-	-	-	-
2.5-5	12.5-15	45-50	35-40	206	122	81	13
-	-	-	-	-	-	-	-

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