East and North Hertfordshire NHS
NHS Trust

Annual Report
2007-08

Your hospital, your care

Contents

Chairman's statement

This is the second year in which we have produced our annual report in this current, more detailed format. Many of those who received the 2006/07 report have told us how useful they found the information it contained, as well as suggesting improvements that we have worked hard to incorporate in this year's document.

Reflecting on 2007/08, three issues stand out in my mind. The first was the work undertaken with our primary care trust colleagues to consult local communities on proposed changes to healthcare services across the county (the Delivering quality health care for Hertfordshire consultation). The second area was the preparatory work required for the Trust to commence its application to become a NHS foundation trust.

Finally, and perhaps most importantly of all, was the continued dedication of our hard working staff in delivering real improvements in the care they give to our patients, while at the same time ensuring that we ended the year with a financial surplus – the first time that this has happened in the Trust's history without the use of special, one-off measures.

Delivering quality health care for Hertfordshire

There can be little doubt that last year the main health-related talking point across east and north Hertfordshire was the proposed changes to the Trust's hospitals, as well as to the wider health service across the county. The Delivering quality health care in Hertfordshire consultation began on 12 June and finished on 1 October 2007.

Its aim was to seek views on proposals that would see more routine hospital services being provided in community and primary care settings closer to where people live, along with the development of a network of urgent care centres across the county. Critically, the consultation also proposed that acute hospital services in east and north Hertfordshire be brought together at either the Lister or QEII hospitals – with the NHS preference being the Lister.

Sixteen weeks after the consultation was launched, work began on assessing the 6,000 plus completed questionnaires, responses given by the NHS to over 600 letters, e-mails and phone call enquiries made by the public, and feedback from the over 160 community events and public meetings attended by our staff. In addition there were several petitions submitted as part of the consultation, which between them accounted for over 55,000 signatures.

For some years now, our doctors and nurses have been telling us that our acute hospital services cannot go on as they are. Unless they are brought together on to a single site, they will stagnate and in some cases even begin to fail. Last year's consultation enabled them to explain their vision to people across east and north Hertfordshire, as well as south Bedfordshire – as witnessed through the presence of our senior doctors and nurses at virtually every meeting we attended during the consultation.

On 19 December, the four NHS organisations involved in the consultation came together and took the decisions necessary to set a clear direction for the future of health services locally. The Lister was chosen as the site where, following significant capital investment, acute hospital services will be brought together from 2010, with Welwyn Hatfield receiving a brand new local general hospital –probably on the QEII site.

In addition, a network of eight urgent care centres – which will care for around two thirds of patients who attend a typical A&E department currently – will be developed over the next few years, including at the Lister, Welwyn Hatfield's new local general hospital and Hertford County.

Our consultation process and the decisions reached by the NHS last year were examined in great detail by Hertfordshire County Council's health scrutiny committee, who found no grounds on which either to ask for more consultation work to be carried out or to refer the decisions to the Secretary of State for Health. Further in March 2008 the local campaign group in Welwyn Hatfield – the Hospital SOS Taskforce – announced that it was not going to seek a judicial review.

Work has since commenced on planning the delivery of these developments, which in most cases will begin to come online from 2010 onwards. I look forward to reporting progress in future annual reports.

NHS foundation trust application

A second major area of work for the Trust in 2007/08 were preparations to apply to become a NHS foundation trust. These are a relatively new NHS organisation for Hertfordshire, although over 90 exist across the country already. Foundation trusts, which are owned by and accountable to their local communities, remain very much part of the NHS family. They uphold the founding principles of the health service – providing high quality health and clinical services free to all entitled to such care, based on need and not ability to pay.

In February 2008, we obtained approval to proceed to consult our staff and the public about the governance arrangements, vision, values and strategic aims for our proposed foundation trust. That consultation – Your hospital, your care, your voice – finished on 30 May, with a detailed report scheduled to go to the Trust Board at its July meeting.

At the same time we commenced this consultation, we began recruiting members to our proposed new foundation trust. While our staff become members

automatically, we also need many thousands of members of the public to apply. Although much more work needs to be done, we are on track to have a sufficiently large and representative membership by the time the Trust is assessed formally by our local strategic health authority and the regulator of foundation trusts – Monitor – towards the end of 2008.

We believe that our application will be successful, which means that our new NHS foundation trust will provide local people with a real say – through their elected governors – in how our hospitals are run and future services developed.

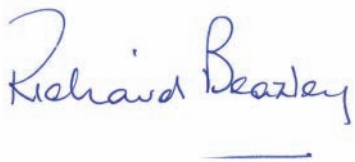
In appreciation of our staff

Finally I would like to turn to the subject of our staff and volunteers and the work they do to ensure our patients receive the care and support that they both need and deserve. Numbering around 6,000 and ranging from hospital porters to senior medical consultants, specialist technicians through to contract cleaners, and WRVS to hospital car service volunteers, our staff and volunteers are highly trained and dedicated in what they do.

While it is important that we hear about, investigate and learn from concerns raised by our patients and their carers, the fact is that the compliments we receive annually outweigh such concerns by a factor of four to one. Indeed the Healthcare Commission's most recent inpatient survey shows that over seven of every 10 patients are happy with the care that they receive at our hospitals – which represents considerable improvement on the position of just a few years ago.

While of course more needs to – and is being – done to improve the position even further, it is only fitting that we reflect for a moment on why and how these improvements are being achieved in the first place. While good leadership – both operational and clinical – plays an important part, principally its down to our highly dedicated and hard working staff who seek on a daily basis to ensure that their patients get the best possible care within the resources available.

Last year was one of much change, disruption and uncertainty for our staff and volunteers, which makes their achievement all the more remarkable. Which is why, through this annual report, I wish to thank them publicly on behalf of the community we serve.



Richard Beazley

Chairman

Chief Executive's statement

During 2007/08, the Trust faced and met three major challenges: delivering a firm financial footing; reducing healthcare-associated infections; and achieving the national 18-weeks waiting time standards.

Delivering a financial surplus

Following its establishment in April 2000, the Trust has had a difficult financial history. In a number of years since its inception, it required substantial financial support from the wider health economy to achieve financial targets.

The roll out of the new national financial system – Payment by Results – in 2005/06 brought about a much greater degree of transparency to NHS finances. At the same time, the Trust commenced a three-year financial recovery programme. The final year of this programme was 2007/08, which saw the Trust deliver its first ever substantial surplus – £2.0 million. This enabled the repayment of £1.5 million of historical debt to be repaid.

The Trust is predicting that it will have a £2.0 million surplus by the end of 2008/09. While representing very good news, such surpluses are not just delivered for their own sake. Rather they enable the Trust to invest in the development of patient services.

Reducing healthcare-associated infections

From a clinical perspective, the biggest challenge that our staff rose to meet last year was the need to reduce levels of healthcare-associated infections – especially those cases caused by MRSA and Clostridium difficile.

Although we have not yet received final confirmed figures from the Health Protection Agency for the last quarter of 2007/08, our own data shows that the level of MRSA bacteraemias (blood infections) dropped by 38% compared to the previous 12 months.

The performance in reducing infections caused by C. difficile was equally impressive, with the number of cases compared to 2006/07 also falling by 38%. While we just missed out meeting our MRSA target – despite the massive drop in infections recorded at our hospitals, we surpassed our C. difficile infection target of 414 cases with relative ease.

In many ways, embedding infection control processes, procedures and policies across the Trust was a major priority last year. Led by the Trust's infection control team, everything from improving hand washing rates – by staff, patients and visitors – to developing isolation wards at the Lister and QEII were at the heart of our efforts to see healthcare-associated infections drop to their lowest recorded levels ever.

We have incorporated the national deep clean initiative in to a continuous programme to ensure that our clinical areas are not just clean, but kept free of clutter and have infection hazards removed as a matter of annual routine.

When it comes to infection control, our progress has been recognised externally following an inspection visit in May from a team led by the local strategic health authority that complemented the Trust and its staff on the excellent work carried out in our hospitals in reducing healthcare-associated infections.

Achieving the 18-weeks referral to treatment standards

By the end of March 2008, every NHS trust in England had to meet a major milestone on the way to delivery of the national 18-week waiting standard by the end of this year. By March, we had to ensure that of those patients admitted to our hospitals, 85% had their first definitive treatment within 18 weeks of being referred to us by their GPs. For patients that could be treated without being admitted, the figure we had to achieve was 90%.

I am very pleased to report that we met both standards, which means that compared to a few years ago waiting times have dropped dramatically. Today a patient being referred to our hospitals is likely to have their outpatients appointment, receive all the necessary investigative tests undertaken, a diagnosis made and treatment commencing within 18 weeks of discussing their health concerns with their GP and being referred to the Trust.

While we need to work hard to improve those rates even further throughout the remainder of 2008, it is only right to reflect on the considerable waiting time improvements that have taken place over the last 12 months or so. But this has only been possible because our staff have engaged in making the necessary changes to how they work to make achieving the 18-week targets possible in the first place.

Annual health check

For 2006/07, the Healthcare Commission reported its annual health check for all NHS organisations. We were rated as being fair on clinical services and weak on use of resources, with the latter rating being unavoidable as we returned a small deficit that year.

While the results for the 2007/08 annual health check will not be known until the Commission publishes its report later this year, our forecast – based on our annual Standards for better health declaration made by the Trust Board in May 2008 – is that we believe we will be rated fair for clinical services and fair for use of resources.

While this expectation reflects the considerable improvements made during the year, the Trust has set itself the challenge to be rated good on quality of clinical services when the results for the 2008/09 year are published towards the end of 2009. It will not be possible for us to be rated good on use of resources until 2009/10 annual health check results are published, as the rules require the achievement of three consecutive years of breakeven or surplus for such a rating to be awarded.

Our staff are at the heart of our future

Like Richard Beazley, I recognise and very much appreciate the work of our staff. Across the organisation I can see the results of their efforts – especially through the thousands of letters and messages I receive from patients, their relatives, carers and friends about the care they received at our hospitals.

Increasingly our senior doctors, nurses and other staff are taking ever greater responsibility for coming up with fully worked through and costed plans to develop their services in line with the Trust's strategic objectives.

In this way – and perhaps for the first time in our relatively short history – long-standing clinical risk issues are being tackled, including: approval to recruit a third vascular surgeon at the Trust; establishment of emergency trauma theatre lists at weekends; creation of infection control isolation facilities at the Lister and QEII; and setting up of a gastroenterologist on-call rota for emergency upper gastro-intestinal bleeds that occur at weekends.

This coming year, further investment – again following sound planning work undertaken by clinical teams – is being made in expanding the Trust's renal dialysis, radiology and critical care services. I very much see this as a taste of the opportunities that will come our way to improve our services if our application to become a NHS foundation trust is approved towards the end of 2008.

Nick Carver

Chief Executive.

Future trends and projections

At the time this annual report for 2007/08 was prepared, the Trust was in the final stages of developing its integrated business plan (IBP) as part of its application to become a NHS foundation trust. Work on the IBP, which covers the Trust's forward business plans through to 2012/13, was taking place at the same time its detailed annual business plan for 2008/09 was also being confirmed.

Changing health sector environment

At the heart of those documents is an increasing understanding of the changing environment in which the Trust operates around:

- Service changes, both following in-year investments and longer term issues relating to implementing Delivering quality health care for Hertfordshire;
- Roll out of the national Choice agenda and the impact that it will have on referrals made by GPs at the request of their patients;
- The enhanced national emphasis that is being placed upon patients' experiences of their care and the increasing impact that these have on trusts' reputations, referral decisions made by GPs and patients' choices.
- The developing role of commissioning as outlined in through the national World Class Commissioning initiative and the continuing impact of the evolving NHS finance system, Payment by Results, including suggestions that the Government's legislative programme for the coming year may include measures that link funding to performance levels.

As an aspirant foundation trust, clear analysis and a more commercial understanding of both our own business and the dynamics and constraints of the local health market underpins our developing integrated business plan. This work is informing future investment decisions and will facilitate the development of effective future partnerships to deliver service developments and enhancements of real benefit to our community

Population demographics on the move

Allied to this work, is ensuring that we are clear about the implications posed by local demographic trends. In line with national projections, the population served by the Trust will change in several ways:

- Increasing diversity, as the numbers of people from minority ethnic backgrounds continue to grow;
- More middle-aged and older people, which is in line with a general trend of an ageing population nationally as life expectancy increases gradually over the years;
- Overall population growth in the communities served by the Trust – as set out in the East of England Plan published by the regional Government Office in May 2008, which sees at least 53,500 more houses being built in the areas served by the Trust by 2021;
- As the population grows and new communities are established, it is also projected that the numbers of babies born will rise.

Increasing clinical specialisation

A decade or so ago, a patient requiring surgery was likely to be cared for by a general surgeon. Today, surgeons – as well as a wide range of other clinicians – specialise in specific areas of medicine. Once confined to major teaching establishments, increasing specialism is now commonplace in most district general hospitals, like the Lister and QEII hospitals.

While that is good for patients in that highly trained specialists who are experts in their particular field treat them locally, it poses a major challenge to the NHS and especially NHS acute trusts. For such specialists to maintain their skills, they need to treat significant numbers of patients. Increasingly that means such specialist services need to centralised if high quality care is to be maintained.

At the Trust, two areas exemplifying these sorts of changes are cardiology and stroke services. Until 2004, when the Trust built a cardiac laboratory at the Lister, patients requiring angiography and angioplasty either waited for a once-weekly visiting mobile service provided by specialist tertiary centres or went outside of the county for their care.

Today such patients receive these vital services in the Trust's own state-of-the-art cardiac laboratory, which has plans in development to build a second laboratory that will enable the service to be expanded, over time, to offer primary angioplasty – now recognised as the emergency treatment of choice for those who suffer heart attacks.

Until 2006, the Trust did not offer a comprehensive acute stroke service. But from August of that year, a Trust-wide stroke service was established at the QEII hospital meaning that all suitable patients received their care in a specialist, dedicated facility.

In a further advancement, the hospital's A&E has begun providing stroke thrombolysis – initially on a restricted hours basis as the service is rolled out with the support of the local ambulance service – with the aim of improving people's chances of not just surviving their stroke, but of making a more full and quicker recovery.

These two examples show how increasing evidence-based specialisation within medicine offers new opportunities for improving the care provided to patients. The challenge, however, is how to provide them in ways that are both sustainable clinically, cost-effective and accessible.

Transport and access

In its wide-ranging discussions with the general public and patients about the future of health care locally, whether through formal consultations or the Trust's on-going engagement with its local communities, time and again the major concerns raised include:

- Transport to and from NHS sites
- Car parking

While some transport issues may be eased in the future as more routine services – diagnostic, outpatient and some types of minor surgery – are moved out in to local community settings, at the same time some patients will be asked to travel further for acute hospital care.

While this latter change in how health services are provided may pose fewer problems for the more affluent and mobile within local populations, for those who do not have access to a car or whose health does not enable them to drive it means increasing reliance on limited hospital transport systems and/or public transport.

Often it is those on the margins of society – the very elderly, those on limited incomes, people with significant disabilities and chronic health issues – who find travelling for their health care problematic.

During the last year, the Trust sought views from on the prioritisation of access to NHS funded transport to hospital. Feedback highlighted the importance of directing these services at those with the greatest physical or medical need but also demonstrated the need for:

- Greater awareness of the range of ways in which patients can be helped to travel to hospital;
- Transport systems in Hertfordshire to be developed to support those relatively small numbers of patients who will be required to travel further for their care than is the case today.

These were both issues that were recognised at the health transport summit organised by the local NHS in 2007 and will remain at the heart of health planning for many years to come.

Of equal importance to transport issues, is ensuring equal access to health services for all communities in the areas served by the Trust. It is only in recent times that the NHS in Hertfordshire has begun to capture information around how traditionally hard to reach groups in the county access health services right across the primary and secondary care spectrum.

Whether it is the longer established traveller communities or the increasing numbers of people from other parts of Europe and the rest of the world who are coming to work and live in Hertfordshire, there is a need to ensure that the NHS understands and is able to respond to their health requirements. While language, customs and practice represent initial barriers, there is

real evidence from work carried out within Hertfordshire already that it is possible to improve access for these important and often highly diverse groups within society. accessible.

As the numbers of people within these communities grow over time, the challenge to the Trust will not just be to include their needs within developing plans, but to embed them as the Trust goes about its day-to-day business. We look forward to progressing this work in partnership with primary care trusts, local authorities, community groups and our future membership.

Delivering quality health care in Hertfordshire

Much of what has been included in this section of the report relates to issues that broadly speaking are within the Trust's external environment. While there is much that it can do to take advantage of the opportunities presented and mitigate threats, one of the biggest areas of activity over the next few years will be delivering the decisions reached following the 2007 Delivering quality health care in Hertfordshire consultation.

Working with the local primary care trust, from 2010 onwards this will see:

- Acute and emergency hospital care for east and north Hertfordshire, as well as south Bedfordshire, being brought together at the Lister following investment of some £100+ million;
- A new £30 million local general hospital – providing diagnostic, outpatient (including some types of minor surgery), ante/post natal and, perhaps, inpatient inter mediate care services – being developed in Welwyn Hatfield, with the current QEII site being the favoured option;
- Development of a network of eight urgent care centres across Hertfordshire, including at the Lister, the new Welwyn Hatfield local general hospital and at Hertford County. These urgent care centres, which will have links in to the Trust's main A&E service at the Lister, will care for at least 60% of those who attend casualty units today;
- Improvements in primary and community based care, especially around managing patients with long-term chronic conditions and avoiding unnecessary admissions to hospital.

This programme of work is probably the most complex and comprehensive set of changes ever experienced by the Trust. It needs to be managed in a way that delivers them effectively, yet maintains the quality of existing services. This is the commitment given by the NHS not just to local people, but also to those who represent their views and interests through the county council's health scrutiny committee.

2007/08 overview

Provided within this section of the annual report are notes on a range of issues that between them provide an overview of the Trust's performance during 2007/08, as well as acting as background reading to more detailed information contained within the operational and financial reviews.

Background

Over the last few years, the Trust has become recognised increasingly as an organisation that performs well across many of the national standards set for the NHS by the Government.

Standards for better health declaration (2007/08)

In October 2008, the Healthcare Commission is expected to publish the latest set of results from its national rating system for the NHS in England – the annual health check. The Commission's assessment for 2007/08 will look at the quality of clinical services that the Trust provided for its patients, as well as the state of its finances.

As part of the Commission's health check process, in April 2008 the Trust Board agreed its annual Standards for better health declaration for 2007/08, which subsequently was published on its website (www.enherts-tr.ns.uk).

The Trust anticipates that it will be rated at least fair on the quality of its clinical services and fair on use of resources, which if confirmed in October represented an improvement on how the Trust was rated for 2006/07.

Annual health check results for 2006/07

On the quality of its services, the Trust complied fully with 53 of the 64 standards measured by the Healthcare and did well on a further eight. Overall, the Commission rated the Trust's clinical services as being fair.

It met fully all but one of the core standards, which cover: safety; clinical and cost effectiveness; governance; care environment and amenities; accessible and responsive care; patient focus and public health. It was rated as having insufficient assurance on just one standard on which it was not compliant for the full year – which is now the case.

In relation to the 12 existing national standards that applied to the NHS in 2006/07, which covered patient access, delayed discharges of care, thrombolysis for heart attack victims, patient choice, rebooking of cancelled operations and access to pain clinics, the Trust met fully with six and did well on a further four. Of the remaining two, one was not applicable to acute trusts and the Trust did not meet the standard expected for rebooking of cancelled operations.

In terms of the 10 new national standards that the Trust was expected to meet in 2006/07 (MRSA levels, improved patient experience, progress towards the 18-week referral to treatment target and a number of broader public health issues), it met four fully and did well on a further three. Of the remaining three standards, one was not applicable to acute trusts and the other two – reducing health inequalities and treating coronary heart disease (CHD) – were not met. The latter has since been tackled by the introduction of Trust-wide stroke service.

With regard to use of resources, which principally is around the state of the Trust's finances, the Commission had no option but to rate the Trust as weak since the system is based on achieving in-year financial balance. This is despite the Trust achieving just a £1.5 million deficit against a recovery plan target set locally by the East of England strategic health authority of a deficit no worse than £7.5 million. This compares even more favourably to the £23 million deficit recorded at the end of 2005/06.

In its commentary, the Commission said that the Trust met the requirements of all the other areas assessed under use of resources – with its value for money judged as being good.

Education and training

The Trust has always placed considerable importance on training and education. During 2007/08 it delivered a comprehensive range of internal training across a range of subjects, including:

- Mandatory training – e.g. health and safety, fire safety and infection control
- Clinical training – e.g. diabetes care, palliative care and wound management
- Developmental courses – e.g. a wide array of leadership and management, assertiveness skills, stress management and IT skills and systems

The Trust continued to rollout its programme of conflict resolution training, as well as a number of e-learning packages – including around equality and diversity – to support some elements of regular update training. This enabled the Trust to create blended learning options for staff to undertake a mix of electronic and classroom-based training.

The Trust also supported the development of new roles and new ways of working to enhance the patient experience with an affordable, effectively trained workforce.

Population served

The Trust provides an extensive range of acute services through its two district general hospitals – the Lister in Stevenage and the Queen Elizabeth II (QEII) in Welwyn Garden City. In addition, the Trust's Hertford County hospital in Hertford offers local people outpatient, diagnostic and minor treatment services. Through these hospitals, the Trust provides several important regional services, including renal medicine and plastic surgery (both of which are based at the Lister). Finally the Trust runs the Mount Vernon Cancer Centre in North-west London, which provides radiotherapy and complex chemotherapy services regionally, as well as even further afield.

The area served by the Trust for acute hospital care primarily is east and north Hertfordshire, as well as parts of south Bedfordshire. This represents a population of around 500,000 people. In addition, the Mount Vernon Cancer Centre provides its specialist cancer services to two million people living in Hertfordshire, Bedfordshire, North-west London and parts of the Thames Valley.

Budget and patient activity

Since it was formed in April 2000, the Trust has invested more than £78 million in modernising and expanding its hospital facilities, including new medical equipment and upgrading its IT services. With a budget of some £286 million in 2007/08, the Trust treated more than 74,000 inpatients and day cases, provided some 96,300 first outpatient consultations, attended to nearly 134,000 A&E patients and saw 5,500 babies born through its two maternity units.

Developments in the past year

During 2007/08, the Trust completed a number of major developments, including:

- The Trust met the national 18-week referral to treatment standards by the end of March 2008, whereby 85% of admitted patients had to have their first definitive treatment within 18 weeks of being referred to the Trust by their GP; the standard for patients that were not admitted was 90%. The Trust's performance against both standards was 85.2% and 92.9% respectively.

- Working with colleagues in the Hertfordshire primary care trusts, the Trust delivered a successful consultation – Delivering quality health care for Hertfordshire –on the future of the county's health services, which culminated in decisions being made on 19 December 2007 that from 2010 will see acute hospital services for east and north Hertfordshire beginning to be brought together at the Lister hospital, a new local general hospital developed in the Welwyn Hatfield area and a network of eight urgent care centres established across the county. In its separate public deliberations, the county council's health scrutiny committee concluded that the consultation process was robust and that the decisions reached by the NHS served the best interests of all residents across Hertfordshire, enabling the health service to move forward to plan the implementation of these important changes.
- Compared to the previous 12-month period, in 2007/08 the Trust achieved a 38% reduction in the number of MRSA bacteraemias (blood infections) reported. The number of such cases dropped from 53 to 33, although this was above the target of 22 cases set for the Trust.
- Over the same time period comparison, the Trust recorded a similar 38% reduction in the number of infections reported caused by Clostridium difficile in 2007/08. This represented 354 cases against the 574 that occurred in 2006/07 – which met easily the Trust's target of 414 cases of infection for the year.
- In May 2007, the Trust received £300,000 dedicated funding from the East of England strategic health authority to improve a range of infection control measures, including: 16 new en-suite facilities in single rooms on wards at the Lister; 22 new clinical sinks, with sensor taps, on the QEII's Princes Wing and Knebworth ward; new staff and public toilet facilities within the A&E treatment area at the Lister; 10 dishwashers installed in ward kitchens at the Lister and QEII; various works to improve infection control issues within the QEII's laundry; and improved access to clinical sinks, with remote sensor taps, by entrances to wards at the Lister.
- Also in May 2007, inpatient cardiology services were centralised on ward 9B at the Lister, with coronary care units continuing to being provided at both the Lister and QEII hospitals. Bringing together inpatient cardiology services at the Lister brought the benefit of their being located on the same site as the Trust's cardiac laboratory.
- September and November 2007 saw the Trust open dedicated isolation wards at the Lister and QEII hospitals respectively. Aimed at isolating and treating patients with C. difficile infections, these two wards were created following an initial investment of £400,000. They played an important role in helping to reduce cross-infection to other patients in either hospital through increasing significantly the Trust's ability to isolate these patients during their infection.
- In the last quarter of 2007/08, the Trust commenced a rolling and continuous deep cleaning programme of all inpatient clinical areas at its main hospitals. This involved the creation of decant wards to enable patients in areas set to be cleaned to be moved prior to a deep clean commencing, which comprises: de-cluttering; estates repairs and minor refurbishment; followed by thorough deep cleaning, including the use of a remote controlled fogging robot. This procedure is now embedded in to a rolling programme that is continuous moving forward, not a one-off procedure.

- Also in November 2007, the Trust linked up with the University of Hertfordshire and two other NHS trusts to create a pioneering research centre to study changes in patients' health over time. The Centre for Lifespan and Chronic Illness Research – CLiCIR – deals specifically with those who have chronic illnesses and aims to identify common factors that could influence the onset and progression of their conditions. Experts at the centre hope that by gathering enough data to spot crucial trends and patterns, they will be able to help people live longer and more comfortably with their illnesses.
- On 3 March 2008, the local NHS in Hertfordshire – which included the Trust – began offering every resident of the county aged 60-69 bowel cancer screening once every two years. The programme is part of a three-year nation-wide initiative led by the Department of Health, the rollout of which is scheduled to be completed in 2009. This form of cancer is the third most common in the UK and claims the lives of more than 16,000[1] people every year. Research has shown, however, that regular screening reduces the risk of dying from bowel cancer by 16 per cent[2].
- From the 1 April 2008, the Trust commenced providing a stroke thrombolysis service for patients identified to fall into the appropriate treatment category. Stroke thrombolysis is an important development in the management of patients with acute ischaemic stroke. Evidence suggests that it improves clinical outcomes, with reduced disability; its use has been recommended by NICE. The new service, which will run initially between 9.00am to 5.00pm, Monday to Friday, has been supported by the local cardiac/stroke network and the East of England Ambulance Service NHS Trust. From 1 April 2008, paramedics began taking relevant patients directly to the QEII from the whole catchment area served by the Trust.
- Finally April 2008 saw the Trust formally become one of the first in the country – and the first in Bedfordshire, Hertfordshire and Essex – to introduce cardio-pulmonary exercise (CPX) testing as part of the new pre-operative assessment service established for patients being admitted for surgery at the Lister.

Future developments

For the coming year and beyond, the Trust has planned the following developments:

- A major stream of activity for the Trust is to continue implementing the work required to bring together acute hospital care at the Lister from 2010 onwards. The business case planning process, along with the detailed plans themselves, will be finalised for approval during the early part of 2008/09. Planning of the new women's unit at the Lister is advancing well, informed by views from service users and clinical staff.

1 Cancer Research UK, 2005. Cancer stats

2 Cochrane Database of Systematic Reviews, 2006. Screening for colorectal cancer using the faecal occult blood test: an update.

- From late September 2008, the Trust is working to implement the final outstanding decision that was made following the 2005 Better care for sick children consultation. This involves bringing together all nighttime emergency care for children in to a single, expanded service based at the Lister hospital that includes a safeguarding children suite developed in partnership with Hertfordshire police and the county council. A children's centre at the QEII – which comprises a children's A&E and paediatric assessment unit – will remain open between 7.30am and 9.00pm daily.
- By the end of 2008, the Trust will have a more clear indication on the progress of its application to become a NHS foundation trust. It is expected that around this time of the year, the regulator of foundation trusts – Monitor – will meet to examine the Trust's governance and performance management arrangements in order to assess whether or not it should be recommended to the Secretary of State for Health for foundation trust status.
- July 2008 is the planned start date for the work to create the long-awaited expansion of the renal dialysis service at the Lister. The £750,000 project will see the unit located in a facility that is around 50 per cent larger than the current clinical area. The move will allow the number of dialysis stations to be increased from 20 to 25, meaning an extra 25 to 30 patients can be treated on top of the 110 who use the facility currently. It will also see the inclusion of four side rooms compared to just two at the moment.
- The Trust is also working to approve the final details of the business cases that will enable significant improvements to several important services. These include the: introduction of improvements to the Trust's critical care services and capacity, including the introduction of an outreach service for hospital wards; and investment in new ultrasound and CT scanning services to reduce waiting times for, as well as improve the range of, diagnostic tests available through the Trust.
- 2008/09 will also see the Trust develop dedicated pre-operative assessment and elective admission units at the QEII, which will improve the environment for patients and the pathways followed in how they receive their treatment, especially surgery, at the hospital.
- During 2008, the Trust expects the Hertfordshire primary care trusts to complete its review of how it intends to commission cancer services in the future. This work will help inform how the Trust delivers one of its longer-term aims of increasing the range of cancer services provided within east and north Hertfordshire.

The environment in which the Trust operates during 2008/09 will continue to change. The Hertfordshire primary care trusts, in line with the original Investing in your Health strategy approved in 2003 and confirmed by the 2007 Delivering quality health care for Hertfordshire consultation, will continue to provide greater levels of care for patients closer to where they live, typically through community hospitals, health centres and GP surgeries.

This means that during the coming years, fewer patients overall should be referred to the Trust's hospitals than has been the case historically. At the same time, patients are exercising greater influence on where they receive their care through the national Choice initiative, which continues to be rolled out across Hertfordshire. Equally, the practice-based commissioning also influences patient flows to and away from the Trust's hospitals.

All of these commissioning uncertainties also need to be set in the context of the national Payment by Results financial system, which continues to be expanded. The Trust will also continue to plan for the implementation of the next phase of the European Working Time Directive, which comes into force from August 2009 and will reduce the number of hours that doctors in particular can work to 48 per week.

Despite these and other challenges being faced by the Trust, its financial plan for 2008/09 is to deliver a £2.0 million surplus. This is after all the planned investment in services described already above. As part of its application to become a NHS foundation trust, a five-year integrated business plan is also being developed that will demonstrate the Trust's continued viability over this time period.

Significant activities in research and development

Although not a teaching hospital, the Trust supports a strong and varied portfolio of research projects. Particular areas of strength lie in cancer, renal medicine and urology, where the Trust provides regional services that enjoy national and international reputations.

During 2007/08 the Trust had 281 active studies, of which 241 were funded externally. In 2006, the last year for which complete figures are available currently, researchers at the Trust produced over 200 publications in peer-reviewed journals.

Systems are in place to ensure that the principles and requirements of the national research governance framework are applied consistently. The management and administrative arrangements for research activity are governed by a full set of policies and standard operating procedures that are ratified by the Trust. A record of all research being conducted is maintained and an annual report is submitted to the Department of Health.

The Trust's multidisciplinary research and development committee reviews all projects. This group includes lay representation, with patient involvement in projects encouraged actively wherever possible. Each research proposal requires approval from the National Research Ethics Service [NRES] and the committee before it can commence. All studies involving other organisations have agreements in place ensuring that responsibilities are allocated clearly.

Recruitment into clinical trials designed to improve outcomes for oncology patients has been increasing dramatically within the Mount Vernon Cancer Research Network, which includes the Lister and QEII hospitals.

At the Mount Vernon, a new clinical trial centre is planned and £1.2 million has already been raised towards the building of the new facility, which is expected to start during 2008. This centre will increase further the number of patients who can participate in research studies, as well as improve efficiency and patient experience. It will also allow clinicians to conduct more translational research that aims to move successful laboratory results through clinical studies into new treatment options for patients.

Researchers at the Lister's renal unit have been awarded a Research for patient benefit grant from the Department of Health to investigate end-of-life issues in the dialysis population.

Staff and staff-related issues

Pensions

The Trust participates in the NHS Pension scheme. Details of the accounting policy for pension schemes are set out in note 1.14 to the annual accounts.

Equality and diversity

The Trust is committed to promoting equality of opportunity for all staff. In line with employment legislation and good employment practice, the Trust's commitment is reinforced in its policies and procedures aimed at preventing discrimination – whether on the grounds of: age; disability; gender; marital status; membership or non-membership of trade union; race; religion; domestic circumstances; sexual orientation; ethnic or national origin; social and employment status; HIV status; or gender re-assignment. The Trust values diversity and promotes respect and recognition for the value of difference.

The Trust's recruitment and selection policy and procedure encourages applications from people with a disability, including running a guaranteed interview scheme in line with the national Positive about disabled people initiative.

The Healthcare Commission undertook a review of the Trust's race equality standards at the end of 2007. Following this visit, an action plan was developed to address the issues raised – which included a need to look at the availability of information for patients in other languages and formats. This work is being led by the Trust's equality and diversity committee, which was established in 2007 and is responsible for promoting and valuing equality and diversity across the organisation.

Information on Board members

Details of the remuneration received by the Trust's senior employees during 2007/08 are set out in the relevant sections of this annual report and accounts.

All of the Trust's directors – both executive or non-executive – make annual declarations of directorships and/or other interests they hold that are relevant and material to NHS business matters. This register of directors' interests can be inspected at the Trust's premises; equally a copy can be supplied on request. For further information, please contact:

Victoria Fisher, Trust Secretary

Tel: 01438 781594 (direct line)

E-mail: victoria.fisher@nhs.net

External auditor

Due to the special accountabilities attached to public money and the conduct of public business, the Audit Commission independently of the Trust appoints external auditors. The Audit Commission Act 1998 sets out the role of the Audit Commission in the appointment of external auditors for NHS bodies. The Commission appoints auditors from its own staff and from private firms of auditors. For 2007/08, the Audit Commission appointed Grant Thornton UK LLP as the Trust's external auditor.

Private finance initiative (PFI) schemes

Currently the Trust is involved in one PFI scheme: the new Hertford County Hospital that opened to patients in November 2004. The hospital, which was an £8.5million PFI scheme, was built and is operated by Ryhurst Ltd. It involves an annual unitary payment of approximately £1 million. This fee is payable every year until 2034, when the hospital reverts to ownership by the NHS. Further financial information is provided in note 25 of the accounts.

The capital investment associated with Trust's plans to reconfigure its acute hospital services, recently the subject of the Delivering quality health care for Hertfordshire public consultation, will be funded through Trust borrowing and possibly a PFI scheme. This will be explored further and determined as part of the business case development process.

Fixed assets

As set out in note 1 to the 2007/08 accounts, fixed assets are stated at the lower of replacement cost and recoverable amount. A review is carried out annually for any potential impairments and a formal revaluation of land and building values is carried out at least every five years.

It is the directors' opinion that there are no fixed assets where the market value is significantly different from the value included in the financial statements.

Post balance sheet events

There have been no post balance sheet events to the 2007/08 accounts.

Political and charitable donations

As an NHS trust, funded principally through the taxpayer, it makes neither political nor charitable donations. The Trust continues to benefit, however, from charitable donations received and is grateful for the efforts of organisations and members of the public for their continued support; this includes the fundraising team employed directly by the Trust.

The Trust receives the majority of its donations from the East and North Hertfordshire NHS Trust Charitable Fund, which is now known more commonly as enhance herts; the Trust Board acts as the corporate trustee.

In terms of funds received and/or raised through enhance herts, particular thanks are extended to the:

- The Lister and QEII hospitals' leagues of friends, who between them have donated equipment and funded improvements in excess of £40,000 during 2007/08;
- At Mount Vernon, the Comforts Fund and the Friends of Mount Vernon Cancer Centre have continued to make donations to fund new equipment and facilities in excess of £20,000 during the year;
- The Friends of Michael Sobell House, the hospice run by the Mount Vernon Cancer Centre, have con tributed more than £1.2 million during 2007/08 to the day hospice and social work services;
- The Lister Kidney Foundation, which has continued to provide support to the Lister hospital renal unit.

During 2007/08, the Trust's fundraising team have built on a number of initiatives:

- The CTRT Appeal continued to grow in income during the year, reaching more than £750,000 given by the end of March 2008, with a further £405,000 pledged by the Wolfson Foundation in December 2007. The appeal is aiming to raise at least £1.5 million to fund the development of a chemotherapy research unit and ongoing associated research at the Mount Vernon Cancer Centre. Other generous support received in the year has been from the Christopher Laing Trust, Dowager Countess Eleanor Peel Trust, Steel Charitable Trust, Girdlers' Livery Company and the Childwick Trust. Of particular note should be the fundraising efforts of Dina Rabinovitch, who sadly lost her fight against cancer in October 2007. By the end of March 2008, more than £110,000 had been raised for the appeal by her or in her memory.
- The Building Blocks appeal for children and babies' services received additional support, particularly through being nominated as charity of the year by The Comet newspaper, as well as by Stevenage Town Centre, Westgate Shopping Centre and Letchworth's Garden Square Shopping Centre.

Environmental footprint

In November 2007, the Trust Board approved an energy strategy. It summarised the principal requirements for the Trust to:

- Record and demonstrate compliance with new national and international energy consumption reduction targets and directives;
- Identify the need to develop planned and cost-effective site service infrastructure proposals to meet the changes set out through the Delivering quality health care for Hertfordshire programme;
- Detail and secure approval for a range of capital energy bids submitted recently to the East of England strategic health authority.

Energy is a high priority for the Trust as it is vital to the provision of current and future health services. In 2007/09, the Trust spent approximately £2.18 million on energy and significant cost increases are expected in the future. Steps are being taken to control energy usage and the Trust's energy strategy will bring long-term financial gains and other benefits:

Organisations such as the Trust are being encouraged to calculate their carbon footprint as a first step in a programme to reduce the emissions they cause. A carbon footprint is the total set of greenhouse gas emissions caused directly and indirectly by an individual or organisation. The calculation can be complex as it should include not just energy consumed, but emissions caused from the goods and products it uses and from transport associated with its business (including employees driving to work) and other sources. The two main reasons for calculating a carbon footprint are to:

- Manage the footprint and reduce emissions over time;
- Report the footprint accurately to a third party.

Detailed energy surveys were carried out for the Lister and QEII sites in 2003 and 2005 respectively, which benchmark historic performance (to enable baselines to be set) and help identify efficiency measures. European energy performance of buildings directive (EPBD) figures will be calculated, following staff training, for all relevant Trust buildings; these will be displayed publicly before October 2008.

During 2008/09, the Trust will begin widening out its environmental footprint work to understand, amongst other things, the carbon emissions impact of its goods and services purchasing, as well as in how staff, patients and visitors choose to travel to and from the Trust's sites. While the latter will help to inform and improve the Trust's existing Green travel plan, much work remains to be done.

Operating and financial report

In this section of the Trust's annual report and accounts, greater detail is provided on its performance for 2007/08 relating to a wide range of areas, including:

- Patient access and activity;
- Improving patient care quality, including healthcare-associated infections;
- Ensuring the Trust has the right staff;
- Finance activity

In summary the operational and financial report explains what the Trust does, how it has worked to develop and improve services over the past year and sets out the performance against key national standards and targets – which are all to do with providing good quality health care for the community the Trust serves.

Vision

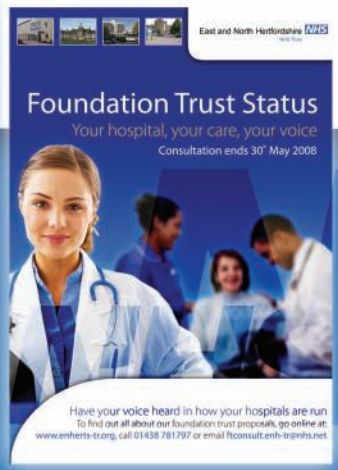
The Trust's proposed vision moving forward – which is subject to the outcome of the Your health, your care, your voice public consultation on the Trust's application to become a NHS foundation trust that closed on 30 May 2008 – is to be: Trusted by our community.

In this context, the Trust is committed to being trusted by the community it serves to provide a comprehensive range of modern, convenient, high quality and caring acute hospital services.

Values

Underpinning its vision, the Trust is proposing five core values (which are subject to the outcome of the Your health, your care, your voice public consultation):

- We put our patients first;
- We work as a team;
- We value everybody;
- We are honest and open;
- We value diversity.



Operational report

Performance highlights

- In the second year of the Healthcare Commission's new performance rating system for the NHS, the annual health check, the Trust was judged as being fair for the quality of its clinical services and weak on its use of resources for 2006/07. The results of the 2007/08 health check, which are expected to be published by the Healthcare Commission in October 2008, are anticipated as being fair for both the quality of the Trust's clinical services and its use of resources.
- In 2007/08, the Trust delivered a financial surplus of £2 million, which covered the £1.5 million of historical deficit that had to be paid back. The forecast for 2008/09 is to return a £2 million surplus.
- By March 2008, 85.2% of patients admitted to the Trust's hospitals received their first definitive treatment within 18 weeks of being referred by their GPs. The target to be achieved was 85%.
- By March 2008, 92.9% of patients not admitted to the Trust's hospitals received their first definitive treatment within 18 weeks of being referred by their GPs. The target to be achieved was 90%.
- The total number of people on the Trust's waiting lists at the end of March 2008 stood at 4,300, which is the lowest ever recorded by the Trust and just over one third of the number of people who were waiting at the list's peak in July 2003.
- The national cancer treatment standards were achieved by the Trust over the year.
- The Trust's total budget for treating patients in 2007/08 was £286 million. This was used to treat some 74,000 people as inpatients or on day case basis. The Trust also cared for around 96,300 patients through a first outpatient appointment and there were nearly 134,000 attendances at the Trust's two A&E departments.
- The 12 months to March 2008 saw the Trust achieve a 38% year-on-year reduction in the number of infections reported caused by MRSA and Clostridium difficile. While the Trust missed its reduction target of 22 cases for MRSA cases (33 blood infections reported in 2007/08), it more than achieved the C. difficile target of no more than 414 infections (354 cases for the year were reported).
- Of the Trust's £278 million operating expenses last year:
  - £143.0 million (51.4%) was spent on the salaries of clinical staff
  - £20.2 million (7.3%) on drugs
  - £26.2 million (9.4%) on clinical services and supplies
  - £3.9 million (1.4%%) on cleaning
  - £2.4 million (0.9%) on fuel, light and power
  - £1.1 million (0.4%) on building and engineering.
- In 2007/08, the total capital investment made by the Trust to provide improved patient services and facilities was £9.0 million (excludes donations).

Performance management arrangements

The Trust provides a wide range of acute clinical services for people who live and/or work in east and north Hertfordshire, as well as south Bedfordshire. In addition the Mount Vernon Cancer Centre provides a regional service to the populations of North-west London, Hertfordshire, Bedfordshire and parts of the Thames Valley.

Inpatient services are provided through the Lister and QEII hospitals, as well as the Mount Vernon Cancer Centre; there are no inpatient services at the Hertford County hospital. People attend as outpatients at all four hospital sites.

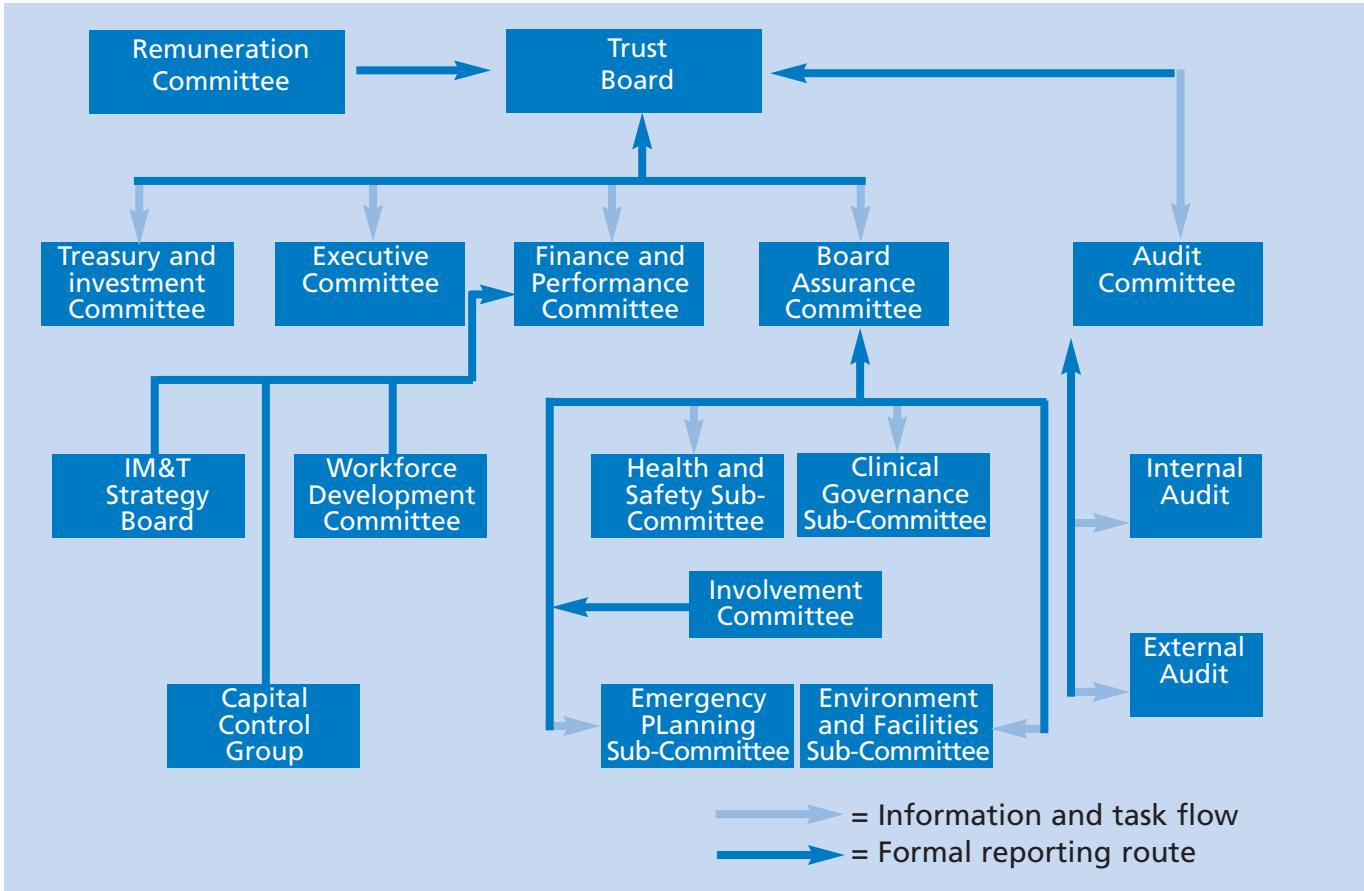
Routine and emergency radiology and pathology diagnostic services are provided through Hertford County, Lister and QEII hospitals. This includes phlebotomy (blood tests) and anticoagulation clinics. Routine radiology and pathology services at the Mount Vernon Cancer Centre are provided by third party organisations – The Hillingdon Hospital NHS Trust (radiology), West Hertfordshire Hospitals NHS Trust (pathology) and the Paul Strickland Scanner Centre (specialised scanning, which is a service co-located next to the cancer centre).

The Trust's clinical services are organised into 10 clinical directorates. Each is led by a clinical director and general manager, supported by a modern matron/lead nurse.

Clinical directorate	Specialties
Anaesthetics, theatres and critical care	Anaesthetics Critical care, including intensive care and high dependency units Sterile services Theatres
Cancer services	Clinical haematology Mount Vernon Cancer Centre Oncology Palliative care
Emergency medicine and elderly	A&E Elderly care Emergency medicine
General surgery, urology and gastroenterology	Breast surgery Colorectal surgery Gastroenterology General surgery Upper gastro-intestinal surgery Urology Vascular surgery
Radiology and pathology	Pathology Radiological imaging
Renal medicine	Renal medicine, including dialysis
Specialist medicine	Cardiology, including coronary care units Dermatology Diabetes and endocrinology Neurology Respiratory medicine Rheumatology
Surgical specialties	Audiology Ear, nose and throat (ENT) Ophthalmology Oral and maxillofacial surgery (OMFS) Plastic surgery
Trauma and orthopaedics	Trauma Orthopaedics
Women and children's services	Child health Gynaecology Maternity/obstetrics Neonatal intensive care, including special care baby units

With the Trust applying to become a NHS foundation trust, it is planning to reorganise the management structure supporting its clinical services. The outcome of this work, which will require a period of internal consultation with the Trust's staff, it is expected to be finalised later in 2008; it will be reported on in the 2008/09 annual report and accounts.

The Trust's executive committee – the membership of which comprises all executive directors, the director of strategic estates, head of public affairs and the Trust Secretary – fits into a governance structure that was updated by the Trust Board during 2007. This structure is depicted in the chart below.



The clinical directors and general managers meet monthly with the Trust's executive directors at the senior management team meeting, where major clinical, operational and financial issues affecting the organisation are discussed and decisions made and/or confirmed. The Trust's modern matrons/lead nurses attend the monthly nursing executive committee with the Trust's director of nursing.

Service and financial performance issues are considered at the weekly meetings of the Trust's executive committee. In addition, each directorate now meets routinely with relevant executive directors through the service line reporting performance management system introduced during 2007/08.

While this places greater responsibility for the performance of each directorate on to those running them, it also encourages them to take equal responsibility and empowers front line staff in developing their services using NHS business planning processes. During the year, it led several directorates to begin to set out sustainable cases for investment in existing and new services, which are viable financially and at the same time tackle some long-standing clinical risks issues and/or opportunities for improvement.

Activity plans

The number of patients using the Trust's services is influenced by three main factors:

- Commissioning plans of primary care trusts (PCTs);
- Choices made by patients through the national Patient Choice and Free Choice initiatives;
- Increasingly, the impact of decisions made by GPs through practice-based commissioning.

Although the Trust is working towards developing medium-term activity plans through the integrated business plan required as part of the application process to become a NHS foundation trust, for the purposes of this annual report and accounts the information available on activity plans is limited to the year ahead (i.e. 2008/09). This information, along with comparisons against 2006/07, is set out in the table below (excludes Mount Vernon).

Activity	2006/07 actual	2007/08 actual	2008/09 plan
A&E attendances	134,609	133,767	133,095
Outpatients – first appointments	91,057	91,711	89,312
Outpatients – follow-up appointments	192,035	176,949	177,191
Elective inpatients (planned admissions)	10,343	10,508	9,926
Elective day cases	21,545	22,929	21,748
Average length of stay for elective patients (days)	3.5	3.4	3.3
Non-elective (unplanned or emergency admissions)	40,893	41,219	40,805
Average length of stay for non-elective patients (days)	5.7	5.5	5.4
Average bed occupancy rates (the proportion of beds occupied at any point in time)	90.8%	93.8%	90.0%

Activity	2007/08 planned	2007/08 actual	Variance (%)
A&E activity (attendances)	129,716	133,767	+3.1%
Outpatient activity (first attendances)	89,385	91,711	+2.6%
Elective activity (number of planned episodes of surgery/treatment)	34,724	33,437	-3.7%
Non-elective activity (number of emergency admissions)	40,766	41,219	+1.1%

Major service moves and changes

In 2007/08, the Trust made a number of changes in how some of its clinical services used directly by patients were organised. These are set out below:

- In May 2007, the Trust brought together inpatient cardiology on ward 9B at the Lister ensuring that this service was located on the same hospital site as the Trust's cardiac laboratory.
- A pre-operative assessment unit was created at the Lister in December 2007, which provided a dedicated facility for the assessment of patients prior to their surgery going ahead.
- In September and November 2007, the Trust opened Clostridium difficile isolation wards at the Lister and QEII respectively.

Patient access and activity performance

The Trust's performance against key national patient access standards during 2007/08 are listed in the tables below:

National standard	2007/08
Progress towards 18 weeks target (85% admitted and 90% non-admitted by March 2008))	Admitted patients – 85.2% Non-admitted patients – 92.9%
26-week inpatient waiting standard	No breaches
13-week outpatient waiting standard	No breaches
Six-week diagnostic waiting standard (new standard measured from March 2008 onwards)	Eight breaches
A&E four-hour wait (national standard is 98% average)	97.27%
Delayed transfers of care (numbers at month end)	3.8% of inpatients
Cancelled operations	2.4% of elective operations, but with 95.2% re-admitted within 28 days
All cancers – one month from diagnosis to treatment (national standard is 98%)	99.4%
All cancers – two months GP urgent referral to treatment (national standard is 95%)	95.0%
All cancers – two-week maximum wait (national standard is 100%)	100%
Rapid access to chest pain clinics within two weeks (national standard is 98%)	100%

During 2007/08, the Trust performed particularly well against several key patient access standards – especially in achieving the 18-weeks referral-to-treatment targets that were required to be met by March 2008. Other areas of success were the continued achievement of the 26-week inpatient and 13-week outpatient waiting standards, as well as meeting the targets set for the two-week and one-month cancer waiting times for urgent GP referrals and diagnosis to treatment respectively.

While the Trust recorded good performance in many areas, there were some that require even greater attention during 2008/09. These include:

- Working with colleagues at the primary care trusts (PCTs) and adult care services to reduce the number of people waiting in the Trust's beds to be discharged whose acute medical care has been completed, but who have on-going or other needs that require support to be put in place before they can leave hospital.
- Again working with the PCTs to improve the uptake and performance of the Choose and Book initiative through GP practices.
- Improving the Trust's performance in reducing further the numbers of operations cancelled at the last minute for non-clinical reasons. While performance improved significantly during 2007/08 in ensuring these patients had their operation rebooked within the stated 28 days, more remains to be done in the coming year.

Infection control

In 2007/08, the Trust was set a target by the Government to reduce the number of bacteraemias (i.e. blood infections) caused by methicillin-resistant Staphylococcus aureus (MRSA) bacteria to 22 cases by the end of March 2008. Although the final figure has yet to be confirmed by the Health Protection Agency (HPA), the Trust's data suggests that 33 MRSA bacteraemias were confirmed in its hospitals during the year – a reduction of 38% on the previous year.

While this excellent performance represents the first real reduction in the number of MRSA bacteraemias in several years and is significantly lower than the 86 cases reported back in 2002/03, the level of improvement was not sufficient to meet the Trust's target for the year.

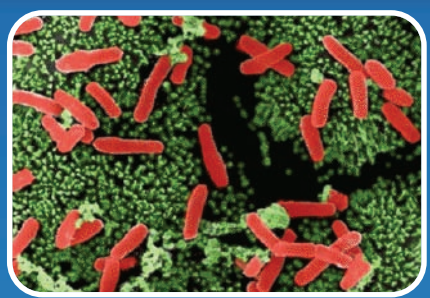
As the table below shows, however, this does not tell the whole story. In each of the last three quarters of the year, the Trust achieved a reduction of at least 50% compared to the same time period in 2006/07. The problem came with the first quarter when the reverse scenario happened, which despite the excellent performance for the remaining three quarters of 2007/08, made it all but impossible to reach what was an exceptionally challenging target.

MRSA blood infections (Full year target: 22 cases)	2006/07	2007/08	% change
April to June	9	12	+33.3%
July to September	8	4	-50.0%
October to December	20	10	-50.0%
January to March	16	7	-56.3%
Total (12 month period)	53	33	-37.7%

For 2007/08, the Trust also had a target to achieve in terms of reducing the number of infections caused by the bacterium, Clostridium difficile – which was set at 414 cases. Through a number of important measures taken during 2007/08, the Trust recorded 354 cases, pending final verification from the Health Protection Agency.

Again looking at the Trust's performance in-year, which is set out in the table below, reveals that sustained improvements were delivered in the second half of the year – a time when historical data would suggest cases of C. difficile tends to increase. This is particularly true of the last quarter of the year (i.e. January to March), when the Trust recorded a near 60% decrease compared to the same period just 12 months earlier.

C. difficile infections (Full year target: 414 cases, over 65s)	2006/07	2007/08	% change
April to June	154	119	-22.7%
July to September	110	84	-23.6%
October to December	133	77	-42.1%
January to March	177	74	-58.2%
Total (12 month period)	574	354	-38.3%



Infection control was one of the areas where the Trust focussed major efforts during 2007/08; it was also one where the Trust received several visits from specialist teams from the Department of Health and the Healthcare Commission. Partly through their assistance and advice, but principally through the efforts of the Trust's staff – led by the infection control nursing team and consultant microbiologists – a range of important initiatives were undertaken during the year, including:

- Investment in new hand washing facilities in many parts of the Trust, as well as relaunching hand washing campaigns (for staff, patients and visitors) as well as setting far stricter compliance standards for every clinical area (which were monitored assiduously on a weekly and monthly basis);
- Introducing care bundles with the aim of following best practice in reducing healthcare-associated infections, especially around cannula insertion and the use of peripheral lines;
- Introduced and embedded a strict antibiotic prescribing policy, which prevented infections from happening through the use of antibiotics known to predispose patients to a greater risk of such infections, especially C. difficile;
- Routine screening for MRSA was extended beyond traditional high-risk patient groups – i.e. those transferring from other hospitals, moving wards within the Trust's hospitals, previously testing positive for MRSA and/or having been residents of care/ nursing homes within the last 12 months. During 2007/08, screening was widened to cover patients undergoing: renal dialysis; surgery where implants and/or grafts were being used, pregnant women booking in with the Trust's maternity services who fell in to a high risk category; and anyone who was a carer.
- Opened two isolation wards, one each at the Lister and QEII hospitals, which between them increased markedly the Trust's ability to isolate patients with C. difficile infections.

Service performance improvement objectives for 2008/09

The Trust's principal service aims and objectives for 2008/09 are:

- By 31 December 2008, 90% of patients who require to be admitted will receive their first definitive treatment within 18 weeks of being referred by their GPs;
- By 31 December 2008, 95% of patients who do not require to be admitted will receive their first definitive treatment within 18 weeks of being referred by their GPs;
- 98% of those attending the Trust's A&E departments will be seen, treated and discharged or admitted within four hours of their arrival;
- 95% of cancer patients referred urgently by their GPs will wait no more than two months before receiving their treatment;
- No more than 21 cases of MRSA bacteraemias (blood infections);
- No more than 183 Clostridium difficile infections. The basis on which this target is being recorded has been changed nationally for 2008/09 from all cases in the over 65s (whether acquired in the community or hospital), to all cases in those aged over two acquired in hospital only.

Detailed action plans are in place and being implemented to secure each of these standards during 2008/09.

Stakeholder relations

The Health and Social Care Act 2001 (sections 7) places a statutory duty on NHS bodies to consult the local authority's overview and scrutiny committee on proposals for substantial change to services. Regulations may, in relation to an overview and scrutiny committee of an authority to which this section applies, make provision:

- As to matters relating to the health service in the authority's area which the committee may review and scrutinise;
- As to matters relating to the health service in the authority's area on which the committee may make reports and recommendations to local NHS bodies;
- As to matters on which local NHS bodies must consult the committee in accordance with the regulations;
- As to information which local NHS bodies must provide to the committee;
- As to information which may not be disclosed by a local NHS body to the committee;
- Requiring any officer of a local NHS body to attend before the committee to answer questions.

Similarly, section 11 of the Act places a duty on NHS organisations to make arrangements to involve and consult patients and the public in:

- Planning services;
- Developing and considering proposals for changes in the way services are provided;
- Decisions that affect how services operate

The overall aim of section 11 is to ensure patients and the public are involved and consulted from the very beginning of any process to develop health services or change how they operate. This imposes a wider duty to involve and consult patients and the public, not just when a major change is proposed, but in the planning of services; and not just when considering a proposal, but in developing that proposal.

In July 2006, the Department of Health issued a framework document entitled: A stronger local voice. Subsequenlty the Local government and public involvement in health Act 2007 set out the Government's plans for the future of patient and public involvement in health and social care, including the establishment of Local Involvement Networks (LINks) during 2008 that will replace patient and public involvement forums – which ceased to operate from April 2008.

LINks, which in Hertfordshire are the responsibility of the county council, will work with existing voluntary and community sector groups, as well as interested individuals, to promote public and community influence in health and social care. The package of plans is designed to promote the importance of user and public involvement at all levels of the health and social care system, as well as to create a system that enables more people to become involved and have their voices heard.

In July 2007, the Trust Board received and approved an involvement strategy for the organisation, which builds on the Patient and public involvement strategy published in 2003. The latter provided firm foundations for the development of patient and public involvement across the Trust, including the establishment of the Patient Advice and Liaison Service (PALS) and Patients' Panel, both of which have made a significant contribution to the Trust's work.

The Trust's new involvement strategy is based on five key principles, namely:

- **Key principle 1:** Staff and service users should be involved early on whenever service changes are being considered, in a way that is proportionate to the level of change under consideration.
- **Key principle 2:** Sufficient information should be given upfront to enable staff and service users to understand and comment on any projects or proposals about which their views are sought.
- **Key principle 3:** Involvement work should be tailored and focussed; the Trust should be clear about the objectives of involving people and articulate from which groups of people views primarily are being sought.
- **Key principle 4:** The Trust should demonstrate that it listens to staff and the public by providing timely feedback to comments received about its services.
- **Key principle 5:** The Trust should co-ordinate internally, evaluate and share learning from its involvement work.

As part of the implementation of the Trust's involvement strategy, an involvement committee was established in the autumn of 2007. Its membership includes a wide range of representatives from Trust staff, patients, LINks, local authorities and organisations from the voluntary sector.

The Trust also continued to have Board-level and, where relevant, senior management representation on the local strategic partnerships that exist in Stevenage, Welwyn Garden City and Hatfield. Strong working relationships have been maintained with all district and borough councils within east and north Hertfordshire, with the Trust often attending community-based meetings organised by several of these councils. The Trust's commitment to partnership working is also underlined through its active membership of local clinical network boards.

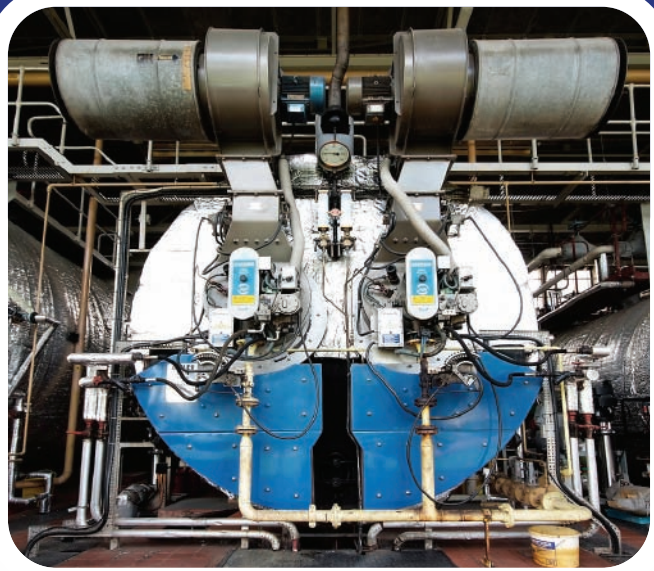
The Trust also enjoys very positive experiences working with Hertfordshire County Council's health scrutiny committee, being a signatory during 2007/08 to the Hertfordshire Concordat. The Trust is also beginning to build similar relationships with the relevant scrutiny committee in Bedfordshire and continues to have strong links in place with the University of Hertfordshire – in particular its schools of: health and emergency professions; pharmacy; postgraduate medicine; and nursing and midwifery.

In terms of consultations undertaken or commenced during 2007/08, these include:

- In partnership with the Hertfordshire primary care trusts and the West Hertfordshire Hospitals NHS Trust, conducted the 2007 Delivering quality health care for Hertfordshire consultation, which achieved significant engagement with NHS staff, community and other stakeholders in proposals for the future of the county's health service;
- Completed focussed consultations on non-emergency patient transport services and public car parking arrangements;
- Commenced consultation – called Your hospital, your care, your voice – on the Trust's proposed governance arrangements in its application to become a NHS foundation trust.

Throughout these consultations, the Trust has continued to learn from experience – as well as from best practice and guidance from elsewhere in the NHS and the wider public sector. This has enabled it to improve the quality and effectiveness of its consultation work, especially around reaching out to traditionally harder-to-engage groups and using wider means of engagement, including new media.

During 2007/08, the Trust's stakeholder engagement programme was reviewed and assessed through internal audit. This provided substantial assurance around the Trust's work in this important area of ensuring staff and community involvement in service development and decision-making processes. With the Trust applying to become a NHS foundation trust, which will require it to establish a membership of many thousands of local people, will only serve to enhance the organisation's ability in involving the community it serves in the way acute hospital services are managed in future.



Environmental impact

The UK healthcare sector now spends more than £400 million annually on energy, but a significant proportion of this energy is wasted – and that means money being wasted too. It has been estimated by the Department of Health that the NHS contributes currently approximately 3% of England's total CO_2 emissions.

The Trust is taking steps to control its energy usage, which will take in to consideration the NHS carbon reduction strategy that was published at the end of May 2008. While the Trust's efforts will bring long-term financial gains, there are other benefits too including:

- Energy-efficient buildings providing better indoor conditions for patients and staff;
- Taking control of energy usage will enable the organisation to achieve mandatory government targets;
- Energy-efficiency campaigns cut across departmental boundaries and specialities, fostering an inclusive atmosphere that improves general morale;
- Organisations that publish their energy-efficiency achievements receive positive feedback from stakeholders and the local community.

More than a quarter of healthcare organisations are already feeling the value of these benefits. There is another reason, however, why action should be considered.

The global environment – and by implication, the health of nations – is being damaged by the burning of fossil fuels (coal, oil and gas) to supply an ever increasing demand for energy. The UK, together with many of the world's governments, has pledged to curb its reliance on fossil fuels so that it can cut carbon emissions to a sustainable level.

The carbon challenge

The 1997 Kyoto Protocol to the United Nations framework convention on climate change established a framework for nations to work towards the achievement of sustainable emissions levels. This commits the UK government to reducing emissions of CO_2 to 12.5% below 1990 levels by 2012. In addition, the UK has set a domestic goal to reduce emissions by 20% by 2010, with a further goal of a 60% reduction by 2050.

In April 2001, the Secretary of State for Health wrote to all NHS chief executives and senior managers of healthcare organisations setting out the government's mandatory energy targets for England. These are set out in the table below.

UK Region	Energy consumption	New capital developments, major redevelopment or refurbishments	Existing facilities
England	Reduce primary energy usage by 15% (0.15 million tonnes of carbon) from a base year of 1999/2000 to March 2010	35–55 (GJ/100m^3)	55–65 (GJ/100m^3)

Emerging issues

The European Energy Performance of Buildings Directive (EPBD) took effect in 2006 and will be implemented through the application of Building Regulations by local authorities.

One of the main changes coming from the 2006 directive is the need for an energy certificate and an energy label – if appropriate – for all:

- New buildings;
- Existing buildings, when they are sold or rented out;
- Existing buildings when they undergo substantial refurbishment.

In addition, all public buildings that are over 1,000 m^2 in floor area will need to display its energy label – the operational rating – for the public to see. This should be in place by October 2008.

The Government also set a nationwide target to source at least 10% of electricity from renewable sources by March 2008. Renewable energy can be generated from a range of power sources, including: wind; wave; tidal; solar thermal and photo-voltics; hydro-generation; geothermal; and biomass (energy from forestry or crops). All of these technologies are applicable to the healthcare sector, with various financial incentives existing to encourage organisations to introduce them.

Europe Union emission trading scheme

A letter was issued to the chief executives of NHS trusts on 11 December 2003 to give notice of this scheme and to advise the statutory requirement for NHS installations of 20 megawatts or more thermal capacity per site to register with the Department for Environment, Food and Rural Affairs (DEFRA). Eighty-three NHS trusts are now registered – this does not include the Trust as currently its estate does not fall within the scheme's limits, although this will change in future.

The scheme works on a cap and trade basis. The Government sets emission limits and issues allowances to reflect limits to all registered installations, with one allowance equating to one tonne of carbon dioxide. Installations can buy and sell these allowances on the open market.

Participants of the scheme, therefore, have three choices:

- Limit emissions to their cap;
- Reduce emissions to below their cap and either sell their surplus allowance or hold them for the next year (provided that it is the same phase of the scheme);
- Produce emissions above their cap and buy additional allowances or borrow from the following year's allocation (provided that it is the same phase of the scheme) or incur a penalty (in which case the shortfall allowances must still be made good).

The Trust's current position

There has been an 88.75% increase in the cost paid for electricity at the Lister hospital over the two years to 2007/08. This is despite only a modest 5.5% increase in consumption (GJ). Over the same period, the QEII has seen a 112% increase in the cost paid for electricity with a 9.5% increase in consumption.

There has been a 27% increase in the cost paid for gas at Lister over this two-year time span; this is despite a reduction in consumption of 6%. The QEII has seen the cost paid for gas decrease over the past three years by 2.5%, with a corresponding 32.5% reduction in consumption.

Comparing the actual degree-day (climate correction) data for the three years under comparison, it has been found that second year was 10% colder than the first year and the last year (2007/08) was 34% warmer than the second year.

During this time, the Trust has experienced a year-on-year reduction in CO_2 emissions, which equates to a 5% reduction overall. This reduction can be attributed to the:

- Milder winter of 2007/08;
- Centralising of sterile services at the Lister;
- Energy conservation measures employed by the Trust;
- Capital investment in a new water treatment plant for the gas boilers at the Lister.

Next steps

The Trust's preferred energy source is gas, as cost and consumption figures are beneficial currently. Future development plans for the Lister site, as set out through the Delivering quality health care for Hertfordshire programme, are in line with the Trust's preferred energy strategy of pursuing a combined heat and power (CHP) installation that enables it to generate electricity on site.

The strategy of using gas to produce electricity on site will reduce the Trust's CO_2 emissions and assist, therefore, in achieving the Government's targets. It is also environmentally friendlier to produce electricity in this way, since approximately three times more $C0_2$ is produced in supplying electricity from the national grid via a non-renewable source such as a coal fired electricity generator.

It is anticipated that the Trust will need to register with DEFRA for the EU emission trading scheme in the next few years as its generating capacity rises (above 20 MW), in line with its strategy to generate its own electricity from associated cost savings and the freeing up of additional electrical capacity on site far out weighs the drawbacks of having to register with the scheme.

The Trust's estates team will continue to manage the organisation's energy usage and develop strategies for future energy conservation, compliance and supply. An action plan has been developed, which identifies all current energy saving initiatives.

The Trust's utility contracts are procured through the NHS Purchasing and Supply Agency. It negotiates on behalf of 91% of NHS organisations in England and ensures that, through economies of scale and a flexible purchasing strategy, the very best price for utility procurement has been achieved. It also makes sure that 10% of the electrical supply purchased has come from a renewable resource, as per the Government target that the NHS had to meet by March 2008.

Other environmental footprint issues

The Trust is aware of its role as one of the major employers and landowners in east and north Hertfordshire. It recent years, it has introduced a number of measures relating to sustainability and the environment including:

- Green travel plan, which was developed by the Trust in order to promote and demonstrate its commitment to sustainable solutions to current transport issues. The plan's main aim is to reduce adverse environmental impacts of transport to and from the Trust's hospital sites.
- Improved purchasing arrangements, through the centralised buying power of the NHS, has enabled the Trust to begin considering the wider environmental impact of the services and goods that its uses. Although much work remains to be done, a good example of such initiatives is a Hertfordshire-wide print buying tender process that began during 2007/08, which stipulates improved environmental performances in the chosen bidders.

Hertford County hospital and the Mount Vernon Cancer Centre

Ryhurst Ltd carries out the running of Hertford County hospital, which was built through a PFI project to modern insulation and energy efficiency standards just a few years ago. Although the Trust pays for the energy used in the new hospital, it is able to monitor Ryhurst's performance in this regard.

The situation at the Mount Vernon Cancer Centre is more complex. It is located on the Mount Vernon hospital site in North-west London, which is run by the Hillingdon Hospital NHS Trust. Through the service level agreement that the Trust has with Hillingdon for estates and facilities services, it has some leverage in seeing the environmental impact at the cancer center being reduced over time.

Given the age and standard of some of the buildings on the site, as well as aspects of the cancer centre being grade-listed, presents particular problems when it comes to conserving energy and reducing carbon emissions. Work continues, however, to influence Hillingdon Hospital NHS Trust's plans around reducing its carbon footprint on the site.

Improving patient care

Highlights of the year

Elsewhere in this report, major developments in 2007/08 affecting patient care – such as the creation of two isolation wards at the Lister and QEII, centralised inpatient cardiology service at the Lister and the Trust-wide stroke thrombolysis service established at the QEII – are outlined in some detail.

In this section, the Trust highlights a few of the many smaller, yet equally important, projects, initiatives and developments that took place during the year. All either led to, or recognised, improvements in the care that patients and their carers/families received from Trust staff.

- In the Trust's annual staff awards held in April 2007, over 120 staff and invited guests came together to hear BBC-personality Pam Rhodes recognise the efforts of:
  - Kath Evans, matron/lead nurse for children's services (best team leader award)
  - Cardiac laboratory (best team award)
  - Ella van Raders, pain management specialist (innovation award)
  - Claire Randall, staff nurse, Lister children's A&E (chief executive's award)
  - Prof. Ken Farrington, consultant nephrologist (chief executive's award)
  - Chris Boseley, safety and security manager (chief executive's award)
- The Trust began participating in a multi-centre clinical trial to evaluate the potential for silver-containing pyjamas and bed linen to combat skin pathogens such as MRSA and other bacteria;
- Patients at the Mount Vernon Cancer Centre began using the improved services provided through the £21 million New Radiotherapy Wing, which was opened officially by the national cancer director for the NHS, Prof. Mike Richards;
- The immediate future of the highly successful Health Shuttle service was secured, following the Trust reaching a funding agreement with Hertfordshire county council and the East of England Ambulance Service NHS Trust;
- Robots installed in the Lister and QEII's pharmacies helped to speed up the provision of prescribed medicines to the Trust's patients, with turnaround times being reduced by a third to just two hours in 80% of requests coming in to the department;

- Work began on the development of the Trust's new patient administration computer system (PAS), which is due to be launched across the Trust from June 2008. It will bring many improvements on the cur rent system, which will make it easier to track patients' journeys through the Trust's hospitals and the services they provide;
- June 2008 saw the Trust hold its annual long services awards, which saw 24 staff recognised for having given at least 25 years' service for the NHS in east and north Hertfordshire;
- From November 2007, the Trust introduced a cook-chilled food system for inpatients at the QEII. This has been extremely successful and popular with patients and staff – not one single complaint has been received formally about the new service. It has also aided the Trust's ability to provide protected meal times on wards;
- Funding was secured from UK Transplant (now NHS Blood and Transplant) for a full-time living donor co-ordinator working within the Trust's renal department from 2008. This important initiative will increase opportunities for patients with chronic renal disease to have a life-enhancing kidney transplant.

Improving existing services

Throughout 2007/08, the Trust continued to ensure its services were improved through concentrating on four key areas:

- Ensuring that patients had improved quality of information during their time in hospital;
- Making it clear how patients and their carers can raise issues of concern;
- Improving infection control policies and procedures to combat healthcare-associated infections
- Encouraging staff to report errors, even those that were caught before they happened (i.e. so called near misses)

Improving information for patients

The Trust comprehensive patient handbook, which was launched in 2006/07, covers all aspects of a patient's stay while in hospital. Moving forward, the Trust faces a major project in improving the range and quality of patient information leaflets available – especially when it comes to those with sight and/or reading difficulties and for whom English is not their first language.

Following the results of the 2007 inpatient survey, which highlighted the Trust's need to improve patient information materials, a project will commence from 2008/09 to begin addressing this important issue.

The Trust's interpretation and translation service is now also managed by its patient advice and liaison service (PALS) team, which has enabled a much clearer understanding of its population's needs in accessing health care services.

Listening to patients' concerns

The 2007 inpatient survey indicated that the Trust was in the top 20% of NHS organisations in the country when it came to patients feeling that they were assisted in raising concerns and making complaints if they needed to. This may account for an almost 20 % increase in PALS contacts compared to 2006/07.

In order to enable the Trust's patients and their carers/families to continue to voice concerns and raise issues, rather than make a formal written complaint, the PALS team has been strengthened over the last year – both through the appointment of permanent staff, as well as increasing the number of volunteers that assist on all of the Trust's sites.

In July 2007, PALS was brought under the same management structure as the complaints team. This enabled both services to work in closer collaboration for the benefit of early resolution of concerns raised by patients and their carers. Where possible all such concerns are directed through PALS in the first instance, in order to facilitate their earliest possible resolution. Where the issues raised are of a more serious nature, they are escalated speedily to the appropriate manager within the Trust.

During the year the Trust has promoted the availability of PALS widely through the display of posters and leaflets, with the service now being accessible via e-mail provided through the Trust's new website that was launched in 2007.

The Essence of care initiative, which sets benchmarks for the way patients are treated in hospital, is now well embedded within the Trust. A key focus of this work is improving the privacy and dignity afforded to the Trust's patients, where improvements have been seen – as witnessed by the most recent NHS inpatient survey. This initiative helps the Trust to learn from patient concerns and prevent others from having similar experiences, which in turn lead to unnecessary complaints.

Finally the Trust's modern matrons have continued to help drive through changes that result in improved quality of care through tackling issues of importance to both patients and staff. In many ways, matrons and their ward sisters engage with patients and their carers/families at an early stage, with the aim of resolving their concerns before they become intractable. Often people just want to be heard and, if appropriate, have someone say sorry where that is the right thing to do.

Formal complaints and compliments

The Trust places great importance on the views of its service users. Responding to, as well as learning from, complaints is one way in which it seeks to improve the services it provides to the local community.

In 2007 the parliamentary and health service ombudsman (PHSO) published a report entitled: Principles for remedy. The principles outlined in this document form the basis by which the Trust strives to put things right when they have gone wrong.

During 2007/08, the Trust received 837 formal complaints – a 14% increase on the number received in the previous year. This increase seems, in part, to be due to the Trust's higher public profile resulting from the run up to, and the running of, the Delivering quality health care for Hertfordshire consultation last year.

A second contributing factor to the rise in complaints is likely to have been the work carried by Trust staff to ensure patients were aware of how they made a formal complaint should they need to – which is reflected in the positive scores received by the Trust for this aspect of the 2007 inpatient survey published by the Healthcare Commission in May 2008.

For 2007/08, 94% of formal complaints received were investigated and resolved at what is called the local resolution stage. The majority of complainants were sent a detailed response within 25 working days of the complaint being received and recorded by the Trust; where this process took longer, it was with the involvement of the complainant.

Everybody who makes a formal complaint to the Trust is offered an opportunity of a meeting with the relevant staff if they remain dissatisfied after receiving their response. During 2007/08, of the 837 formal complaints investigated, 41 such meetings were held. This represents fewer than 5% of complainants wishing to engage Trust staff directly over their concerns.

In addition, 18 patients asked the Healthcare Commission to review their complaint. Although the Healthcare Commission made recommendations to improve complainant satisfaction, it did not carry out any formal independent reviews. To date, the Trust is not aware that any individuals have taken their complaint to the health ombudsman.

At the same time that the Trust receives formal complaints from some patients and/or their carers, during 2007/08 it also received 139 letters complimenting the care provided by the Trust's staff. This represented an increase on the previous year and is in addition to the very many informal conversations, cards, notes and small gifts given to ward staff directly on a daily basis

Improving infection control policies and procedures

Healthcare-associated infections remain the issue of greatest concern to patients and their carers. Apart from the fear they raise in people's minds, whether justified or not, they are a major reason why some patients spend longer in hospital then they should. Indeed if someone is already very ill, then an infection may even lead, or more commonly be a contributory factor, to their untimely death.

It is for all these reasons that the Trust's infection control team and consultant microbiologists, with the input and support of modern matrons and facilities and estates maintenance teams, seek to raise standards of cleanliness across the Trust – especially around hand hygiene and washing – still the single biggest factor in eliminating the bacteria and viruses that cause infections in hospitals.

During 2007/08, one of the Trust's main operational and clinical focuses was to improve infection control through making high impact changes that are derived from best practice from across the NHS. This and other work were necessary to ensure that the Trust was compliant with the Health Act 2006 hygiene code, for which the Healthcare Commission is responsible for ensuring that all NHS trusts meet their statutory obligations under the Act.

The code requires the Trust to ensure that patients are cared for in a clean and safe environment. It outlines legal duties to: establish appropriate systems; assess and manage risks; implement clinical care protocols; ensure health care workers' access to occupational health services; and provide induction and training.

The Trust received an inspection visit from the Healthcare Commission in 2007, which coincided with the assistance and advice that it was receiving already from a specialist joint Department of Health/strategic health authority team. In a follow up report, the Commission confirmed that the Trust was compliant with Hygiene Code – although it did also make recommendations where some practices and procedures could be improved.

Elsewhere in this annual report, many of the initiatives and actions that commenced during 2007/08 – which of course carry on in to 2008/09 – are documented in some detail. Suffice it to say that reflecting back on the year, it can be characterised as one where infection control was the single biggest area of activity across all parts of the Trust.

The improvements made by the Trust saw levels of MRSA bacteraemias and Clostridium difficile infections reduce by some two-fifths of the levels recorded in 2006/07. In the case of MRSA, this was the first time in several years that the number of bacteraemias had reduced significantly.

It is also interesting to note that the latest confirmed data published by the Health Protection Agency (HPA), which is for the period October to November 2007 suggests that the Trust's performance has continued to improve compared to that of similar NHS trusts in the country.

Equally the HPA's figures for the third quarter of 2007/08 show a slowing down in the rate of reduction in MRSA and C. difficile infections reported across England. During the same time period, the Trust's levels of these important infections reduced by 56% and 58% respectively.

Finally the Trust, working in partnership with members of its patient and public involvement forum and patient panel, carried out PEAT inspections at each of its hospital sites. While the results for 2007/08 have yet to be received, the Trust anticipates receiving an acceptable rating on cleanliness and the environment, as well as for food.

Reporting errors

The Trust continues to take part in the National Patient Safety Agency's (NPSA) national reporting and learning and system (NRLS). Reports produced by the NPSA continue to characterise the Trust as having a very high level of incident reporting. The vast majority – around 98% - involved no or little harm to patients.

This profile is typical of an organisation that has a positive and open approach to error reporting, encouraging staff to document incidents and ensure that lessons are learnt and actions taken. Such organisations also tend to have low levels of incidents where patient harm is more serious.

Developing new services

The 12 months to March 2008 was the first time in several years that Trust reported a financial surplus. During the previous two years especially, the Trust embarked on an extensive programme to bridge an historical underlying gap of around £10-15 million between annual expenditure and income. A combination of income improvement, cost-reduction and efficiency initiatives undertaken across the Trust during this period enabled it to achieve true financial stability for the first time since the Trust was established in 2000.

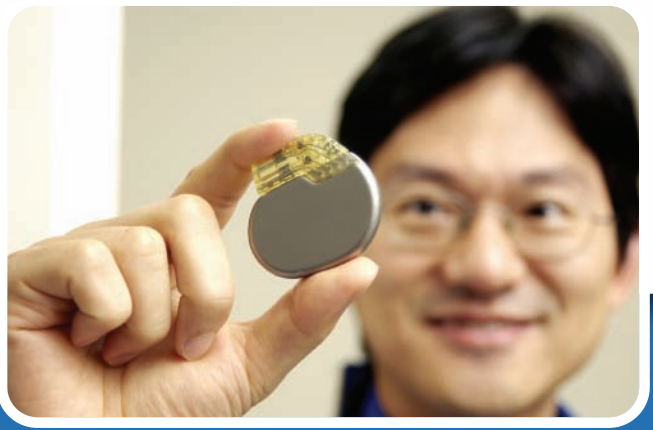
The Trust's financial plan for 2008/09 has confirmed a projected £2.1 million surplus, which is after significant planned investment that will begin to be made, pending the final approval of new business cases being developed by several clinical directorates – including radiology, cardiology and critical care services.

Radiology

The recent growth in radiology services provided by the Trust to GPs' patients under open access arrangements has been a key aspect driving the additional funding received from the Hertfordshire primary care trusts (PCTs). In addition, the PCTs have accepted the need to transfer recharges for radiology services on to a cost and volume basis for 2008/09.

The challenge posed by this step up in activity, mapped against the pressures in the department to deliver national 18-week diagnostic target times, prompted a comprehensive service bid requiring both an expansion in ultrasound (obstetric and non-obstetric) services and a request for a second CT scanner at the Lister.

The expansion of the Trust's ultrasound service has been agreed already and primed with £200,000 non-recurrent funding in 2008/09. A second CT scanner at the Lister requires substantial enabling works from the Trust's capital budget. If 18-week waiting time targets are to be achieved during 2008/09, work must be completed by November 2008 ready for installation of the new scanner. The department's up-to-date technology will also increase the range of diagnostic tests available to patients.



Cardiology

Previously the Trust's finance committee has reviewed presentations setting out an exciting expansion possibility for the Trust's cardiology services, particularly if it could be linked to designation as a heart attack centre. Cardiology activity coming to the Trust has been growing rapidly and the proposed expansion has been supported by the PCTs.

Critical care

The Trust's critical care team has highlighted both the clinical evidence base for its proposed developments, given the almost 100% utilisation of existing facilities at the Lister and QEII. The resulting business case sets out a phased implementation of the team's proposals, including:

- Medical staffing – required to meet national standards for ITUs and to meet current demand, already funded in the 2008/09 start-point budget;
- Outreach service – a multi-disciplinary approach to the identification and management of patients already in the hospital at risk of and/or developing critical illness, so avoiding deterioration and ITU admission by support to ward teams.

Clinical governance and audit

The Trust's clinical governance and clinical audit teams play an important role in helping to improve the quality of care received by patients - although their contribution often remains unseen by the general public.

In January 2007, following two separate inspections from the NHS Litigation Authority, the Trust was informed that the quality of its management of clinical risks for patients had improved significantly. As a result, it was awarded with the second highest rating available (called level two) for both its general hospital and maternity services. It also means that the annual premium its pays the Authority will be reduced by around £1.2 million over the next three years.

In carrying out its inspections, the Authority looks in detail at how the Trust and its staff manage clinical risk by considering detailed evidence relating to fifty separate standards across areas such as:

- Staff training and development;
- Security and safety of patient environments;
- Child protection;
- Clinical governance arrangements.

This welcome achievement is the culmination of at least two years' hard work on the part of a wide range of clinical teams, for which the Trust is very grateful.

The Trust's clinical governance team centre works closely with clinical directorates to manage incidents, claims, clinical audit, clinical effectiveness and complaints processes. Throughout 2007/08, trends relating to incidents and claims have remained stable and following their analysis, safer systems have been put in place. A study into the impact of reconfiguration on patient safety has demonstrated encouraging results.

The Trust's risk register continues to evolve and now captures comprehensive data, which is used for both local and strategic decision-making. An established committee structure continues to monitor progress in all the areas listed above, with reports escalated routinely to the Trust Board, as necessary.

During 2007/08, all clinical specialties across the Trust continued to respond well to the forward planning process, which continues to reflect all of the Trust's key priority topics. The Trust also participated in a number of important national audits, in particular the national sentinel stroke and continence audits, as well as the national paediatric diabetic audit – all of which were supported by the clinical audit team.

Progress was also made in maintaining the Trust's clinical audit database, which is used to produce reports, by specialty, on all audit activity. From information received by the clinical audit team, a large number of audits took place within the year, many of which resulted in changes in practice.

Involving the public and patients in the Trust's decision-making

Over the past year, while the Trust continued to develop close working relationships with its patient and public involvement forum, it also prepared for the latter's abolishment to make way for the establishment of local involvement networks (LINks). How these new bodies evolve and the way in which the Trust engages with their work will become clearer during 2008/09.

The advice and input of the forum and the Trust's patient's panel both continued to prove invaluable during 2007/08 as the Trust sought to make changes to the services it provides to local communities or in ensuring that existing ones continue to be delivered to a high standard. Examples of these close working relationships include the:

- Annual patient environment action team (PEAT) assessment survey of its hospitals, with forum and patient panel members joining Trust staff, including executive directors, infection control nurses, modern matrons and facilities staff.
- Engagement around a range of service planning and improvement issues, including reconfiguration of acute hospitals services through the Delivering quality health care for Hertfordshire consultation.

Responding to national patient surveys

Every year, the Healthcare Commission carries out a national inpatient survey, with information provided for every NHS trust in the country. The 2007 survey, which was published in May 2008, showed that those cared for at the Lister and QEII found much to their liking. They also identified some areas where more work is needed in future.

According to the survey's findings, patients treated at the Trust's hospitals felt that clinical staff supported their right to privacy while being examined or treated. They also felt that had they a need to raise issues of concern, they knew how they could go about doing this. Patients reported improvements in hand washing, which reflects well the major reductions in healthcare-associated infections seen at the Trust recently.

Compared to 2006, improvements were seen in 14 areas – including around cleanliness, food choice and quality, hand washing by clinical staff and having sufficient numbers of staff on duty. There were a further 14 areas – several of which relate to the quality of information provided to patients – where more work needs to be done.

This fifth survey of adult patients involved 166 acute and specialist NHS trusts across England and was carried out on the Healthcare Commission's behalf by Picker Institute Europe. In total, responses were received from just under 76,000 patients – a response rate of 56% (the Trust's response rate was 53%, up significantly on the previous year).

Patients were eligible for the survey if they were aged 16 years or older, had at least one overnight stay and were not admitted to maternity or psychiatric units (these patients are the subject of separate surveys).

Similar national surveys of adult inpatients have been carried out every year since 2002. They form part of a wider programme of NHS patient surveys, which covers a range of topics including:

- Community mental health;
- Health services for children and young people;
- Accident and emergency care for adults;
- Ambulance services;
- Primary care services.

To find out more about the detailed survey results for the Trust, detailed spreadsheets are available from the Healthcare Commission's website:

www.healthcarecommission.org.uk/PatientSurveyInpatient2007

The role of volunteers

Volunteering with the Trust is an excellent example of the local community and NHS staff working together. Indeed volunteers have always supported the work of the Trust.

In total the Trust has approximately 700 people from its local communities who come in to its hospitals to work alongside staff. They undertake a variety of roles from assisting with the meal service on wards to helping in specific outpatient areas and providing transport for patients.

The Trust also has just over 300 volunteers associated with the regional specialist cancer services provided at Mount Vernon. Between them, they support staff working on the wards in the cancer centre, as well Michael Sobell House. At Hertford County, 21 volunteers assist with outpatient clinics and at the QEII and Lister, 140 and 190 volunteers respectively support staff on wards, in clinics and in administration.

A recent review of the Trust's voluntary services showed that 99% of volunteers felt supported by the staff with whom they worked and 97% enjoyed their role thoroughly. According to the same survey, staff were equally enthusiastic about having volunteers in their departments and continue to find new roles for them to undertake.

Ensuring the Trust has the best staff

Highlights of the year

- The Trust's annual staff awards ceremony continues to go from strength-to-strength and is now established firmly in the Trust's annual calendar of events. The fourth annual event was held in March 2008, when around 150 staff and their guests assembled at Knebworth Barns. This year's awards were presented for best team leader and best team, as well as four chief executive awards presented to individuals who made exceptional contributions to the Trust during the year.
- During 2007/08, the Trust introduced a new attendance management policy, focusing on the Bradford score for short-term sickness absence, as well as reinforcing individual responsibility regarding absence. Workshops to support the roll out of the new policy were organised across the Trust by the human resources team.
- In 2007, the Trust surveyed its entire staff regarding issues of health and well-being. The last such survey had been conducted three years previously, which gave the Trust an excellent platform from which to launch services to assist staff balance their health, working lives and family commitments. The results of the 2007 health and well-being survey will be used to formulate an action plan for the next two years.
- As in previous years, the Trust celebrated the vital role played by nursing and midwifery staff through the annual International nurses week held in May 2007. In addition the Trust also held the 2007 long service awards, which this year recognised the contributions of 25 members of staff, who each have contributed at least 25 years of service to the NHS in east and north Hertfordshire.
- Once again a large cohort of staff from across the Trust were successful in achieving a wide range of qualifications, from NVQs through to specialist doctorates. All are to be congratulated for their efforts.
- In 2007, the Trust introduced three new programmes – The effective supervisor, The effective manager and The effective leader – to support managers at different levels within the organisation in performing their management and leadership roles more effectively.

Recruiting and retaining staff

The Trust's staff are its most important and valuable resource – it cannot strive to deliver high quality, ever-improving services if the Trust does not recruit and retain a top quality workforce. That is why the Trust works hard to ensure that its staff are well trained, motivated and supported.

The Trust continues to enjoy a generally positive reputation as being a good employer, both locally and nationally. Within Hertfordshire, it continues to work in partnership with the education sector in promoting careers within the NHS. In 2007/08, the Trust's recruitment process was awarded CNST level two for adherence and compliance with all relevant codes of practice.

Thanks to its growing national profile and developments such as the Trust's new cardiac laboratory, high calibre staff continue to be attracted to come and work at its hospitals.

Nursing and midwifery strategy

The Trust's current nursing and midwifery strategy was produced in 2003 and is now due for review. It focuses on improving the patient experience and quality of care, with modern matron/lead nurses having a particular role to play in this aspect of the Trust's work.

The strategy includes on-going work to ensure that the Trust has the correct levels of skilled nursing and midwifery staff, leadership is strengthened and that the Trust's education and training strategy meets future nursing and midwifery needs.

The Trust works closely with the East of England strategic health authority's workforce development directorate and higher education institutions to ensure that future training and developments provision will meet the changing demands and challenges facing the organisation.

In reviewing the strategy, attention will be paid to the impact that the Delivering quality health care for Hertfordshire programme will have for the Trust's nursing and midwifery staff, as well as national initiatives around the role of nurse prescribing and the need for more nurse consultants.

Modernising pay and conditions

This section of the Trust's 2007/08 annual report looks at updates relating to:

- Non-consultant career grade doctors;
- Agenda for Change

Non-consultant career grade (NCCGs) doctors

Following lengthy national negotiations and ballot, the speciality doctor terms and conditions were agreed. Roll-out and national implementation began on 1 April 2008.

Agenda for Change

2007/08 saw the finalisation of the national terms and conditions for the payment of unsocial hours for staff covered by Agenda for Change. Called Maintaining 24-hour services in the NHS, it gives a comprehensive way of rewarding staff for working unsocial hours and unpredicted work patterns.

Improving working lives

The Trust continues to support and maintain the Improving working lives practice plus pledges made back in 2005. The Trust is aware that staff work best for patients when they are able to have a healthy balance between their work and other aspects of their lives.

A new childcare and carers group – which is made up of managers, trade union representatives, parent and carers' representatives – has been working on a number of initiatives to support further the staff in the achieving a good work/life balance.

Working in partnership with all local health care providers, the Trust continues to ensure that the important issues of equality and diversity are at the heart of all its activities.

A highly skilled workforce

The Trust is committed to having a highly skilled and flexible workforce, through continued investment in the personal development of its staff.

In 2007/08, the Trust supported undergraduate medical training by developing more clinical placements and expanding its research base. Last year saw the second year of the national Modernising medical careers – the new national curriculum for the foundation years in postgraduate training and education. Like for many NHS trusts, implementing the latter was particularly challenging but was delivered on time with all the available posts being filled.

The Agenda for Change knowledge and skills framework now underpins all of the Trust's education and training provision. Set out below is a summary of the training achievements from 2007/08:

- 50 staff began national vocational qualifications (NVQs) through local institutes of higher education;
- There were 924 attendances on IT skills or IT systems-related training courses;
- There were 579 attendances on in-house management development courses;
- There were 285 attendances on in-house personal skills development courses

Clinical staff also engaged in a wide range of training activities related directly to their areas of special interest.

Informing and consulting staff

The Trust aims to ensure that its staff are aware fully of what is going on within the organisation, particularly any new developments and decisions that may affect them. To this end, the Trust communicates with staff in specific ways as set out below.

Strategic issues

Issues of strategic importance are discussed with staff through a combination of the following principal routes:

- Trust Brief – monthly cascade briefing process, which reports discussions that take place on strategic issues taken in public session at Trust Board meetings;
- Trust conference – ad hoc meetings for the Trust's senior clinical and non-clinical staff, through which the executive team present and discuss major issues affecting the Trust. Those attending are expected to carry the discussion back to their teams;
- Roadshows/briefings – where the views of all staff is required the Trust seeks to take issues out to staff – either in full open house sessions, which anyone can attend, or to individual departmental and/or team meetings;
- Workshops – dedicated time where invited staff can debate specific issues relating to aspects of major strategic projects being worked on by the Trust.

Tactical/operational issues

To support strategic messages delivered through the above communications channels, the Trust also operates further vehicles that allow more detailed information to be shared with staff, as well as deliver purely operational notices. Principally such communication is achieved through:

- Intranet – overseen by an editorial board, the Intranet has grown to become one of the single biggest sources of general information within the Trust. This service is in the process of being reviewed with the aim of an improved Intranet service becoming available during 2008/09;
- Trust Bulletin – weekly electronic newssheet, issued by all staff e-mail, carrying a wide range of operational articles.

Celebrating success

Published by staff, for staff, the Trust's bi-monthly staff newsletter, Grapevine, has been an unqualified success since its launch in 2003. Grapevine provides staff with a unique platform to recognise the contribution of their colleagues. In addition, the annual staff awards, which is now in its third year, is one of the main means through which the Trust now celebrates the success of its staff.

Trust Partnership

Running alongside all of these staff communication and involvement activities, the Trust also has a history of positive working between staff and management side representatives through Trust Partnership.

With the chair of this group alternating between the staff side chair and the Trust's director of human resources, Trust Partnership meets every month. This forum is used to discuss and agree a wide range of issues, including new and updated Trust policies and change management issues.

Around once a quarter, the Trust's chief executive and other directors meet with staff side representatives to brief them in more detail on strategic issues, as well as on the organisation's clinical, operational and financial performance. During the NHS foundation trust consultation process, the relevant Trust directors have been meeting with staff side representatives on a monthly basis.

Listening to staff

The 2007 NHS staff survey, conducted by the Healthcare Commission, found that compared to the 2006 survey results the Trust's staff were:

- Working less extra hours;
- Achieving a better work-life balance;
- Being supported more by their line managers;
- Witnessing fewer patient-related incidents;
- Even less likely to leave their job.

While gratifying, the survey also revealed areas where more work is required:

- Ensuring that appraisals are carried out every year for all staff;
- Reducing bullying and harassment rates – these have reduced compared to levels recorded in 2006, but remains areas for important attention;
- Reducing levels of work-related stress – although again the 2007 results were an improvement on the position in the previous year.

The Trust is working in partnership with staff side representatives to address issues of concern raised in the 2007 survey. A more detailed action plan is available from the Trust's human resources team.

Equal opportunities

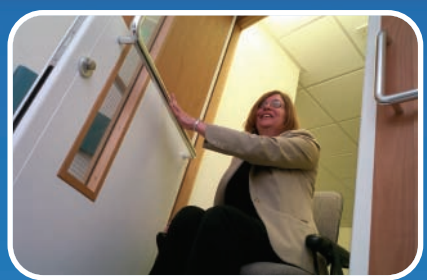
It is the Trust's policy is to be able to demonstrate that it is improving the quality of working life for all staff. It is committed to developing an organisation where all staff, whatever their differences, feel valued and have a fair and equitable quality of working life.

The Trust accepts that not only do such differences between individuals exist, but that it values the benefits that diversity brings to the organisation, its patients and the people served in the local community. Diversity and Respect for people training can now be accessed by all staff via a range of learning methods, including workshops, e-learning and workbooks.

Disability policy

The Trust's recruitment procedures adhere to the statutory requirements of the Disability Discrimination Act. Furthermore, the Trust is committed to gaining and retaining the nationally-recognised Disability ✓✓Award, which marks commitment to the employment, development and retention of people with a disability.

To use the ✓✓Award symbol, organisations such as the Trust must take action on five set areas. The current policy statement on disability is due for review in line with pending legislation. Copies are available from the Trust's human resources team.



Occupational health policy

The Trust's occupational health team is responsible for the clinical assessment and interpretation of the health status of workers and the relevance of workplace risks to health. The team plays a vital role in supporting managers and staff on all matters relating to the effect of work on health and health on work, ensuring that all staff are able to achieve their full capabilities at work.

The team also supports the Trust in the formulation and delivery of its workforce strategy, which includes the: setting up of operational policies for the management of staff health; development of strategic policies to improve the working lives of staff; and also interventions to understand and improve the health and well being of staff. Copies of the Trust's occupational health annual report are available on request.

Health and safety

It is the Trust's policy to do all that is reasonably practicable to provide a safe and healthy workplace for its employees, as well as a safe and healthy environment for patients, visitors and others using its hospital sites. The appropriate policies, procedures and risk assessments are in place, which are reviewed regularly, to ensure that the Trust meets its statutory responsibilities.

The Trust recognises that successful health and safety management requires partnership working, especially the awareness and co-operation of its staff to take care of themselves and others. The Trust supports this work through relevant training, information, instruction and supervision of staff and the monitoring of any third party contractors.

The Trust has an accredited local security management specialist and it is a partner in local crime and disorder partnerships. The Trust is also committed to conflict resolution training, with all staff being required to attend this training, which is delivered to a nationally agreed syllabus. During 2007/08, more than 1,100 staff received such training.

Whisteblowing policy and procedure

The Trust has a whistleblowing policy and procedure in place, entitled Raising issues of concern. Its primary aim is to encourage staff to come forward if they are concerned that the interests of others or of the organisation itself are being put at risk. The Trust investigates every potential malpractice that is reported and takes appropriate step to deal with such issues, as they arise. Whenever possible, the Trust will give feedback to the individual who raised the matter.

Emergency preparedness – major incident plan

The Trust has a comprehensive major incident plan, which covers its two hospitals with accident and emergency departments – the Lister in Stevenage and the QEII in Welwyn Garden City; it complies with Department of Health guidelines. During 2007/08, the plan did not need to be activated by the Trust.

Further information on the plan is available on request via the Trust Secretary:

Victoria Fisher, Secretary to the Trust Board

Tel: 01438 781594 (direct line)

E-mail: victoria.fisher@nhs.net

Review of 2007/08 performance

2007/08 saw a major improvement in the Trust's financial performance, with the delivery of a £2.0 million surplus at the year-end marking the completion of a tough three-year plan to achieve financial turnaround.

The £2.0 million surplus was in line with the East of England strategic health authority's revised target and was within 0.5% of turnover, thus ensuring that the Trust satisfied its statutory breakeven duty.

Throughout the year, the Trust's staff and managers again handled successfully a range of financial pressures – including those associated with the delivery of the 18-week waiting standard. Savings of over £13.0 million were achieved, which included a 2.5% reduction in staffing costs (including bank staff) across all directorates.

The level of surplus achieved in 2007/08 provided the cash for the Trust to repay the first year of a £7.8m loan agreed in 2006/07. The Trust will need to deliver further surpluses of at least £1.56 million in each of the next four years to complete repayment of this loan.

During 2007/08, the Trust introduced service line reporting (SLR) across all its clinical directorates. Simply put, SLRs allow each clinical team to understand its contribution to the Trust's financial position by matching budget spend to the tariff income received under the national Payment by Results system for the number of patients seen and treated.

In summary, the Trust's performance for 2007/08 was as follows:

	Contribution (before allocation of overheads) £m	Net surplus/ deficit £m
All medical specialities	22.9	4.3
All surgical specialities	17.2	(0.3)
All women's and children's services	6.4	(5.7)
Critical care	3.2	1.6
All cancer services	5.5	2.1
Totals	**55.2**	**2.0**

This approach still requires further development and refinement, but clearly will be an important part of managing the Trust's financial plans in the future.

In 2007/08, the Trust was only able to spend capital up to the level of its depreciation provision. This was achieved successfully, thereby ensuring delivery of the remaining two statutory duties (i.e in addition to achieving breakeven); namely not to exceed its external financial limit (EFL) and to achieve a 3.5% return on net relevant assets.

The total capital spend in year was £9.1 million and involved major investment of £1.9 million in improving the Trust's IT and information systems and £2.4 million on new and replacement medical equipment. Infection control remained a priority, with the creation of isolation wards at both the Lister and QEII hospitals and a spend of £400,000 to replace all chairs and other furniture in clinical areas with items that could be cleaned easily and more thoroughly.

Overall, the 2007/08 outturn of a £2.0 million surplus now allows the Trust to progress its NHS foundation trust application with some confidence and work on its long term financial model (LTFM) has started already. This modelling work will need to capture the Delivering quality health care for Hertfordshire plans for the next seven years, along with the Trust's more immediate service development plans.

The NHS is expected to continue to meet increasingly tough and challenging performance standards in the new financial year. Sound financial management remains key, therefore, to ensuring that the Trust's resources continue to be used as efficiently as possible.

Financial notes

Going concern

After due consideration, the Trust's directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Better payment practice code

The Trust has responsibility to pay its suppliers in line with the payment terms agreed at the time of purchase. Failure to do this harms the reputation of the Trust and the wider NHS, as well as damaging supply sources and straining relationships with suppliers.

The Trust has adopted the national NHS Better payment practice code. The target set is that at least 90% of all trade creditors should be paid within 30 days of a valid invoice being received or the goods being delivered, whichever is the later, unless other terms have been agreed previously. The Trust's performance against this target for non-NHS creditors is set out in the table below.

	2006/07		2007/08	
	Number	Value (£000)	Number	Value (£000)
Total bills paid	65,283	76,352	67,483	102,944
Total paid within 30 days	42,333	41,197	56,386	79,706
Percentage within target	64.85%	53.96%	83.56%	77.43%

Governance and the Trust Board

This section of the annual report is used to set out how the Trust is managed, how decisions are made and the governance arrangements that are put in place as appropriate checks and balances.

The Trust Board

The Trust's board consists of a non-executive chairman, five non-executive directors and five executive directors – the chief executive and the medical, nursing, finance and operations directors. In addition, three further executive directors – for corporate development, human resources and strategic development – take a full part in Board meetings, but do not have voting rights.

The Trust Board is the body legally responsible for the leadership of the Trust, setting the strategic direction for the management of services provided to local people. Its members are accountable individually and collectively for the Board's actions. To this end, both executive and non-executive members function as a team, working closely together – although with different responsibilities.

The chairman and non-executive directors are appointed following a process overseen by a national body, the Appointments Commission. The normal term of office served by the chairman and non-executive directors is a period of four years.

The role of the NHS trust board

In terms of the role of NHS trust boards, these are set out below.

Collective responsibility for adding value to the organisation

The Trust Board is responsible collectively for promoting the success of the Trust by directing and supervising its affairs at a strategic level.

Leadership and control

A key role of the Trust Board is to provide active leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed.

Looking ahead

The Trust Board sets the Trust's strategic aims and ensures that the necessary financial and human resources are in place for the organisation to meet its objectives. The board also reviews management performance in achieving these objectives.

Setting and maintaining values

In setting the Trust's values and standards, the Trust Board ensures that its obligations to patients, the local community and the NHS are understood and met.

The role of the NHS trust chairman

The chairman is key in creating the conditions for overall board and individual director effectiveness. Specifically, it is the responsibility of the chairman to:

- Run the board and set its agenda, taking into account the issues and concerns of all board members. S/he is expected to be forward looking, concentrating principally on strategic matters;
- Ensure that members of the board receive accurate, timely and clear information to enable them to take sound decisions, monitor effectively and provide advice to promote the success of the Trust;
- Arrange regular evaluation of the performance of the Trust Board, its committees and individual non-executive directors; it is the chief executive who evaluates, with input from the chairman if required, the performance of the board's executive directors;
- Ensure that effective communications exist between the Trust Board, the Trust's staff, patients, members of the public and their representatives.

The role of non-executive directors

Non-executive directors are appointed to:

- Help the board work in the public interest and keep its patients and the public properly informed;
- Help to plan for the future to improve healthcare services;
- Make sure that the management team meets its per formance targets;
- Make sure that the finances of the organisation are managed properly, with accurate information;

The time commitment required of non-executive directors is two and a half days per month.

To add most value, non-executive duties should not extend into operational matters – which are the responsibility of the chief executive and his/her executive director colleagues. Through focusing on strategy, scrutiny of performance and clinical governance, risk and financial management, the non-executive directors enrich the governance of the Trust.

The chairman and non-executive directors appoint the Trust's chief executive, which is a process that involves the local strategic health authority. Together with the chief executive, the chairman and non-executive directors appoint all other executive directors and determine their remuneration.

Richard Beazley Nick Carver

The Trust Board 2007/08

In this section of the annual report, details on the members of the Trust Board – both voting and non-voting – are provided, including their Board committee membership.

Key to principal committee membership
BAC – board assurance committee
AC – audit committee
FPC – finance and performance committee
RC – remuneration committee
TIC – treasury and investment committee
EC – executive committee

Richard Beazley, chairman

Appointed chairman of the Trust on 1 April 2002, Richard was reappointed for a second four-year term as chairman in 2006. He is a former chief executive, international lawyer and economist.

Richard became a solicitor in 1974 and spent 25 years working in the oil industry, including 21 years with the Mobil Oil Corporation. During those 25 years, he spent 12 of them living and working abroad in Norway, Indonesia, Canada and the USA. After various assignments with Mobil working as an international lawyer and economist, Richard became chief executive of Mobil's subsidiary companies. He left the oil industry in 2000.

Richard's current term of office runs from 1 April 2006 to 31 March 2010. He lives in Standon, near Ware.

Committee membership: FPC, RC, TIC

Nick Carver, chief executive

The chief executive is the accounting officer for the Trust and carries full responsibility for its performance, forward planning and leadership of the executive team and clinical directors.

Nick was appointed as the Trust's chief executive in November 2002, having been a successful chief executive of the George Eliot Hospital NHS Trust in Warwickshire for the previous three and a half years

Nick started his NHS career as a qualified registered nurse in 1982, before developing his interest in health service management. That interest resulted in a number of senior roles prior to becoming an NHS chief executive, including being the director of operations and nursing at the Royal United Hospitals NHS Trust in Bath. Nick has also worked at the Morriston Hospital, Swansea, Singleton Hospital, Swansea and the Gloucester Royal Hospital.

In addition to holding his registered general nurse (RGN) qualification, Nick has a BA (Hons) in political theory and government, as well as an MSc in health care management.

Committee membership: EC, FPC, TIC

Alison Murray, non-executive director and deputy chair

Currently an adviser on research projects, Alison has experience in working in various NHS trusts – especially in developing acute services for older people, stroke services and also adult mental health. She is a research psychologist, who originally trained as a nurse.

Alison has experience in human resource development and staff training, having worked for the former Government Department of Employment and Education and as a university officer in personnel at the University of Cambridge. Alison chairs the Trust's board assurance committee and is the deputy chair of the board.

Alison was reappointed from 1 December 2007 for a period of up to two years. She lives in Ashwell, near Baldock.

Committee membership: BAC, RC

Stephen Brooker, non-executive director

A chartered accountant, Stephen has a variety of business and other interests. He serves on the boards of several companies, as well as working as an independent consultant.

Stephen was previously a partner in Ernst & Young, finance director of the British Red Cross Society and, until May 1997, bursar and fellow of Emmanuel College, Cambridge. He is chairman of the Trust's audit committee. Stephen was re-appointed as a non-executive director in 2006; his current term of office runs from 1 January 2007 to 31 December 2011.

Committee membership: AC, RC, TIC

Ian Morfett, non-executive director

Seconded from BT, where he had worked for 30 years, to the Cabinet Office as deputy director of the Better Regulation Executive, Ian was tasked with finding and eradicating unnecessary red tape to enable industry to be more successful.

Prior to that, he was the managing director of strategy and business development for BT Wholesale – the network and carrier services arm of BT. The business serves the wholesale needs of the intermediate market, other licensed telecom operators and service providers, including BT Retail. Ian chairs the Trust's finance and performance committee.

Ian took up his role of non-executive director with the Trust on 1 August 2005, and is due to serve until 31 July 2009. He lives in Letchworth.

Committee membership: BAC, FPC, RC

Roger Bailey, non-executive director (to 31 December 2007)

Roger joined the Trust as a non-executive director in January 2003, before being reappointed to the role in 2006.

An environmental health officer by professional background, Roger worked in local government for 30 years, most recently as chief executive of East Herts District Council. Roger chaired the Trust's complaints committee, as well as being a member of the audit committee and the board assurance committee.

Roger was re-appointed as a non-executive director in 2006 and resigned from the post on 31 December 2007, following his move to Suffolk.

Committee membership: AC, BAC, FPC, RC

Alison Murray

Stephen Brooker

Ian Morfett


Michael Gibbons


Alison Bexfield


James Quinn


Noel Scanlon

Michael Gibbons, non-executive director (from 1 June 2007)

Michael was a director of Powergen and has held a wide variety of commercial and public appointments during his career. Since 2002 he has worked towards better regulation for the UK government as a member of the Better Regulation Commission and its predecessor body. He runs a small energy consultancy and, among other appointments, is deputy chair of the British Energy Association and chair of the Hertfordshire Family Mediation Service Ltd.

Michael lives in Tewin and was appointed non-executive director from 1 June 2007; he is due to serve until 31 May 2011. He chairs the Treasury and Investment Committee.

Committee membership: AC, FPC, RC, TIC

Alison Bexfield, non-executive director (from 1 February 2008)

Alison is the chief financial adviser to the BBC Trust, providing its trustees with advice on the Corporation's strategic and financial plans. She also sits as an independent audit committee member for the Medical Research Council.

Alison was appointed from 1 February 2008 and is due to serve until 31 January 2012. She lives in Letchworth.

Committee membership: AC, BAC, FPC, RC

James Quinn, medical director

James was appointed Medical Director from 1 April 2007. Prior to this he held a six-month post as deputy medical director, with a remit for clinical efficiency, and had been clinical director for surgical specialties for three years.

James was appointed as an ENT surgeon to the Trust in 1998. He has a specialist interest in ear surgery and balance disorders. His medical training was in London and Cambridge.

Committee membership: BAC, EC, FPC

Noel Scanlon, director of nursing

Noel joined the Trust in May 2002 from the Oxford Radcliffe Hospitals NHS Trust, where he was its assistant chief nurse. Noel has more than 18 years of nursing experience, having trained as a nurse at Southampton University Hospitals in 1983 before specialising in cancer nursing at the Royal Marsden in 1986.

He then held senior posts in Bristol and Bath, before spending nine years in Oxford. In December 2001, he was seconded to the Department of Health to be the critical care lead at the former South East regional office of the NHS Executive.

Committee membership: BAC, EC, FPC

Wendy Hull, finance director

Wendy joined the Trust in December 2006, having had extensive and varied experience in the NHS previously. This is her fifth post as a director of finance and she came to the Trust from her most recent role at South Tees Hospitals NHS Trust. Prior to that Wendy had been the finance director at the Greater Glasgow Health Board.

Wendy has specific expertise in financial turnaround and has been building a strong finance team at the Trust as well as strengthening financial governance across the organisation.

Committee membership: EC, FPC, TIC

Julie Lowe, deputy chief executive (operations) to 14 May 2007

Julie joined the Trust in May 2002 from the North East Yorkshire Healthcare NHS Trust, where she was executive director/general manager of acute services. She became one of two deputy chief executives from 1 November 2006.

Julie left to become chief executive of the Ealing Hospital NHS Trust in May 2007.

Committee membership: BAC, EC, FPC

Juliet Walters, deputy chief executive (operations) from 18 June 2007; deputy chief executive (projects) from 6 November 2007

Juliet joined the Trust from Newcastle upon Tyne Hospitals NHS Foundation Trust, where she was deputy director of business and development and, subsequently, acting director of business and development. She had joined the NHS in 2003 in the first cohort of the Gateway to Leadership programme, which is designed to bring in senior managers from outside the NHS with demonstrable track records. Prior to joining the NHS, Juliet was an academic registrar.

In November 2007, Juliet moved from being deputy chief executive (operations) to deputy chief executive (projects).

Neil Dardis, acting director of operations (15 May to 17 June 2007 and from 6 November 2007)

Neil, who was appointed director of operations in June 2008, has enjoyed a successful association with the Trust over several years. Previous to joining the organisation, he held posts at the Hammersmith Hospitals and Royal Free Hospitals NHS trusts. Neil has risen through several successful management positions at the Trust before becoming its deputy director of operations in July 2007. He is responsible for all operational aspects of the Trust and leads a group of general managers and senior clinicians who run the Trust's clinical directorates. Neil is responsible for the effective delivery of services and ensuring that they meet both national and local performance and quality standards.

Committee membership: BAC, EC, FPC


Wendy Hull


Juliet Walters


Neil Dardis

Stephen Posey

John Webster

Sarah Crowther, deputy chief executive (strategy) to 14 January 2008

Sarah joined the Trust's executive management team in October 2004. Prior to taking up her appointment, she had been the deputy director of performance at Leicestershire, Northamptonshire and Rutland strategic health authority.

Sarah was responsible for leading the Trust's work on strategic planning, and in particular on the recent consultation Delivering Quality Healthcare for Hertfordshire. She became one of two deputy chief executives from 1 November 2006 and left to become chief executive of Harrow primary care trust.

Committee membership: EC, FPC, TIC

Stephen Posey, director of strategic development (from 21 January 2008)

Stephen joined the Trust in January 2008 from the East of England strategic health authority (SHA), where he had been its provider development and foundation trust lead. Prior to his time at the SHA, he had undertaken a number of senior management roles within acute hospitals and primary care trusts in Eastern England, having started his career in the NHS in 1995.

Stephen's remit with the Trust covers responsibility for commercial and strategic estates issues, which includes the delivery of the Trust's elements of the Delivering quality health care for Hertfordshire consultation. His directorate also leads the Trust's involvement and engagement work, including consultations, partnerships and business development.

Committee membership: EC, FPC, TIC

John Webster, director of performance and information (to July 2007); director of corporate development (from July 2007)

In July 2007, John took up the newly created post of director of corporate development. Prior to this, he was the Trust's director of performance and information and had been the performance lead within the former Midlands and Eastern directorate of health and social care.

John is leading on the Trust's application for NHS foundation trust status and on strengthening governance across the organisation.

Committee membership: BAC, EC

Danny Mortimer, director of human resources and organisational development (to 29 June 2007)

Danny's career in human resources began in 1993, when he became a regional trainee in Stoke-on-Trent, before going on to work in human resource roles in NHS trusts in the South West and on the South Coast. He came to the Trust in April 2003, having joined from the Royal West Sussex (NHS) Trust/Western Sussex primary care trust, where he had been director of human resources.

Danny left in June 2007 to take up the post of director of human resources at Nottingham University Hospitals NHS Trust.

Committee membership: BAC, EC

Janet Lynch, director of human resources and organisational development (from 1 October 2007)

Janet took up her post on 1 October 2007, joining from Barnet, Enfield and Haringey Mental Health NHS Trust, where she had been director of human resources for the last five and a half years. Previously Janet had held a similar post at Riverside Community Healthcare NHS Trust in west London and prior to that, a range of human resources posts in health organisations in the North-West. She originally joined the then Mersey Regional Heath Authority on a personnel management training scheme in 1986.

Committee membership: BAC, EC

Remuneration and interests

The remuneration of individual directors can be found in the accounts section of this annual report.

All the Trust's directors – both executive and non-executive – make annual declarations of directorships and/or other interests they hold that are relevant and material to NHS business matters. This register of directors' interests can be inspected at the Trust's premises; equally a copy can be supplied on request. For further information, please contact:

Victoria Fisher, Trust Secretary

Tel: 01438 781594 (direct line)

E-mail: victoria.fisher@nhs.net

Janet Lynch

Trust Board, 2007/08

	Title	Appointment date	Term of office (yrs)	End of term of office
Mr Richard Beazley	Chairman	1 April 2006	Four	31 March 2010
Mr Nick Carver	Chief executive	18 November 2002	-	-
Ms Alison Murray	Non-executive director	1 December 2007	Up to two	30 November 2009
Mr Stephen Brooker	Non-executive director	1 January 2007	Four	31 December 2011
Mr Ian Morfett	Non-executive director	1 August 2005	Four	31 July 2009
Mr Roger Bailey	Non-executive director	1 January 2007	Four	31 December 2007
Mr Michael Gibbons	Non-executive director	1 June 2007	Four	31 May 2011
Mrs Alison Bexfield	Non-executive director	1 February 2008	Four	31 January 2012
Mr James Quinn	Medical director	1 April 2007	Four	31 March 2011
Mr Noel Scanlon	Nursing director	6 May 2002	-	-
Ms Wendy Hull	Finance director	3 December 2006	-	-
Ms Julie Lowe	Deputy chief executive (operations)	13 May 2002	-	14 May 2007
Ms Juliet Walters	Deputy chief executive (operations)	18 June 2007	-	6 November 2007
Ms Juliet Walters*	Deputy chief executive (projects)	6 November 2007	-	
Mr Neil Dardis	Acting director of operations	15 May to 17 June 2007 & from 6 Nov 2007	-	-
Dr Sarah Crowther*	Deputy chief executive (strategy)	4 October 2004	-	14 January 2008
Mr Stephen Posey*	Director of strategic development	21 January 2008	-	-
Mr John Webster*	Director of performance and information Director of corporate development	20 July 2003 July 2007	- -	July 2007 -
Mr Danny Mortimer*	Director of human resources and organisational development	22 April 2003	-	29 June 2007
Ms Janet Lynch*	Director of human resources and organisational development	1 October 2007	-	-

*Take part in Trust Board meetings, but without voting rights

The executive committee

The Trust's executive committee, which meets weekly, comprises the Trust's chief executive and eight executive directors. Also in attendance are the director for strategic estates, head of public affairs, and the Trust Secretary.

The executive directors meet with the Trust's clinical directors and general managers at the monthly senior management team meeting to ensure wider clinical input into decision-making processes. The clinical directors are all senior consultants who take on management responsibilities in addition to their clinical duties.

For 2007/08, the management of the Trust's 10 clinical directorates was

Cancer services

- Peter Ostler, clinical director
- Cathy Williams, general manager

Emergency care

- Simon Greenfield, clinical director
- Sharn Elton, general manager

General surgery, urology and gastroenterology

- Sadisavam Selvakumar, clinical director
- John Fitzmaurice, general manager

Radiology and pathology

- Colm Prendergast (radiology) and Howard Davis (pathology) – joint clinical directors
- Philippa Graves, general manager

Renal medicine

- Roger Greenwood, clinical director
- Bridget Sanders, general manager

Specialist medicine

- Barbara Jenkins, clinical director
- Alison Rose, general manager

Surgical specialties

- Nick James, clinical director
- Jo Carter, general manager

Anaesthetics, theatres and critical care

- Tim Walker, clinical director
- David Govan, general manager

Trauma and orthopaedics

- Andrew Waterfield, clinical director
- Jo Carter, general manager

Women's and children's services

- Rob Sattin (obstetrics/maternity and gynaecology) and Andy Raffles (child health) – joint clinical directors
- Bernadette Herbert, general manager

Patient information governance

On 20 May 2008, the NHS chief executive wrote to the chief executives and finance directors of every NHS organisation, setting out new requirements around delivering improved information governance processes.

The further actions required to be taken by all NHS organisations were:

- Include all details of serious untoward incidents involving data loss or confidentiality breach in annual report for 2007/08 onwards (see table below);
- Make specific reference to information governance in terms of identifying and managing information risks in their annual statement of internal controls from 2007/08 onwards;
- Identify a senior information risk owner at Board level, which in the case of the Trust is its director of finance, Wendy Hull.

Summary of serious untoward incidents involving personal data as reported to the Information Commissioner's office in 2007/08

Date of incident (month)	Nature of incident	Nature of data involved	Number of people affected potentially	Notification steps
March 2008	Patient's pathology result faxed to member of public's fax machine instead of to GP surgery in error	Pathology result with patient name, address and result recorded	One	SHA and Hertfordshire PCTs informed on 20 March 2008
Further action on information risk .	Root cause analysis investigation and report in progress			

Remuneration report

The Trust's remuneration policy states that Agenda for Change terms and conditions apply to all directly employed staff, except very senior managers (principally directors) and those covered by the doctors' and dentists' pay review body. The Knowledge and Skills Framework has been adopted to assess the performance and development of those staff subject to Agenda for Change, with a system of annual appraisal and personal development planning.

The Trust's remuneration committee agrees the remuneration package and conditions of service for executive directors. This is a committee of the Trust board, consisting of all five of the Trust's non-executive directors and the chairman.

Remuneration for executive directors does not include any performance-related bonuses; none of the executives receives personal pension contributions other than their entitlement under the NHS pension scheme.

Every year, the remuneration committee considers the contribution of each director against the functions of the post as defined in the current job description and as foreseen for the future. This is carried out in parallel with a review at least every two years of remuneration for individual posts within regional and national markets. The remuneration committee commissioned an external review of the pay system for very senior managers, which it considered at its May 2007 meeting.

All executive directors hold permanent contracts. The notice period for executive directors is generally three months though in the case of the director of finance and deputy chief executives it is six months. There are no arrangements for termination payments or compensation for early termination of contract.

The remuneration and terms of office of non-executive directors are those set out by the Appointments Commission. The level of remuneration is paid for a minimum of two and a half days per month for non-executive directors and four days per week for the chairman. The Trust is not liable for any compensation payments to former senior managers or amounts payable to third parties for the services of a senior manager.

Nick Carver

Chief Executive

Salary and pension entitlements of senior managers

Details of director remuneration and their pension entitlements are shown in the tables below.

Remuneration Name and Title	2007-08 Salary (bands of £5000) £000	2007-08 Other Remuneration (bands of £5000) £000	2007-08 Benefits in kind Rounded to the nearest £1000 £000	2006-07 Salary Bands of £5000 £000	2006-07 Other Remuneration (bands of £5000) £000	2006-07 Benfits is kind Rounded to the nearest £1000 £000
Executive Directors						
Nick Carver, Chief Executive	155-160	0	1	145-150	0	1
Wendy Hull, Director Finance	130-135	0	8	40-45	0	0
Julie Lowe (to 14th May 2007) Director of Operations	10-15	0	0	85-90	0	1
Noel Scanlon, Director of Nursing	90-95	0	2	85-90	0	0
Danny Mortimer (to 29th June 2007) Director of Human Resources	20-25	0	0	85-90	0	1
John Webster Director of Performance & Information	90-95	0	1	85-90	0	1
Sarah Crowther (to 14th January 2008) Director of Strategic Development	75-80	0	1	91-95	0	1
Juliet Waters (From 18th June) Deputy Chief Executive (Projects)	75-80	0	18		(not in post)	
James Quinn, Medical Director	40-45	0	0		(not in post)	
Neil Dardis (From 6th Nov 2007) Acting Director of Operations	35-40	0	0		(not in post)	
Stephen Posey (From 21st January 2008) Director of Strategic Development	15-20	0	0		(not in post)	
Janet Lynch (From 1st October 2007) Director of human Resources and Organisational Development	40-45	0	0		(not in post)	
Non-Executive Directors						
Rrichard Beazley, Chairman	20-25	0	0	20-25	0	0
Roger Bailey (to 31st December)	0-5	0	0	5-10	0	0
Stephen Brooker	5-10	0	0	5-10	0	0
Alison Murray	5-10	0	0	5-10	0	0
Michael Gibbons (From 1st June 2007)	0-5	0	0		(not in post)	
Ian Morfett	5-10	0	0	5-10	0	0
Alison Bexfield (From 1st February 2008)	0	0	0		(not in post)	

Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of travel expenses, lease cars and removal expenses for new starters. The medical director remuneration quoted above relates to senior manager duties only. Alison Bexfield's remuneration entitlement is remitted to and retained by her employer, The British Broadcasting Corporration, in lieu of time spent on Trust business.

Pension benefits

Name and Title	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2008 (bands of £5000) £000	Lump sum at aged 60 related to accrued pension at 31 March 2007 (bands of £5000) £000	Cash equivalent transfer value at 31 March 2008 £000	Cash equivalent transfer value at 31 March 2007 £000	Real increase in cash equivalent transfer value £000	Employers contribution to stakeholder pension To nearest £100
Executive Directors								
Nick Carver, Chief Executive	2.5-5	10-12.5	40-45	120-125	565	486	67	0
Wendy Hull, Director Finance	20-22.5	62.5-65	50-55	160-165	958	824	114	0
Julie Lowe, Director of Operations	2.5-5	0-2.5	20-25	60-65	217	167	6	0
Noel Scanlon, Director of Nursing	2.5-5	7.5 - 10	30-35	95-100	454	388	55	0
Neil Dardis (From Nov 2007) Acting Director of Operations	0-2.5	0-2.5	10-15	35-40	111	89	8	0
Juliet Walters (From 18th June 2007) Deputy Chief Executive (Projects)	0-2.5	12.5-15	30-35	95-100	450	352	70	0
Stephen Posey (From 21st January 2007) Director of Strategic Development	0-2.5	0-2.5	5-10	20-25	66	48	3	0
Janet lynch (From 1st October 2007) Director of Human Resources and organisational development	0-2.5	2.5-5	20-25	70-75	296	258	16	0
Danny Mortimer Director of Human Resources	0-2.5	2.5-5	15-20	50-55	180	143	8	0
John Webster Director of Performance & Information	0-2.5	2.5-5	10-15	30-35	146	121	22	0
Sarah Crowther Director of Strategic Development	0-2.5	2.5-5	5-10	25-30	100	77	17	0

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members. This also applies to the Medical Director, in the same way remuneration for this role is not pensionable, and therefore this post is not listed above.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Accounts

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

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

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

17 June 2008

.....Date.....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 trust and of the income and expenditure of the trust for that period. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

17 June 2008 .....Date.....Chief Executive

17 June 2008 .....Date.....Finance Director

Statement on Internal Control

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.

In undertaking this role I, and my team, have developed strong links with the Strategic Health Authority, local Primary Care Trusts and partner organisations.

Responsibility for ensuring that there is a comprehensive risk management system in place is delegated to the Executive Director of Nursing & Midwifery, for the co-ordination of the management for all clinical risks, supported by the Medical Director for clinical governance, the Executive Director of Finance for financial and non clinical risks including IM&T, Director of Operations for Emergency Planning, and Director of Human Resources for Health & Safety.

Individual accountabilities are set out in the Trust's Risk Management Strategy.

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 East & North Hertfordshire NHS Trust for the year ended 31 March 2008 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

The Trust has approved an Assurance Framework and Risk Management Strategy that ensures:

- that leadership is given to the risk management process
- that staff are trained and equipped to manage risk in a way appropriate to their authority and duties.

Each of the Trust's clinical directorates has identified leads for risk issues and routinely reports these matters to the executive team.

Support and training to staff is provided through a dedicated Clinical Governance Support Unit and via non-clinical risk managers.

4. The risk and control framework

The Trust's Risk Management Strategy reflects the principles set out in the Trust's Corporate Objectives. The objectives for managing risks are:

- To ensure that the organisational structure and management arrangements clearly articulate and support the key elements for risk management
- To provide a process for the effective and efficient management of risk throughout the Trust
- To ensure that the essential complex interrelating systems and services that underpin the management of risk are robust
- To review risk management performance against national standards and key indicators
- To ensure that there is a holistic approach towards risk management, throughout the Trust, which protects all staff, patients and visitors from harm
- To ensure the protection and development of a highly skilled and well educated work force in a high risk industry.
- To ensure that all new developments, new services, service progression, including new medical procedures are assessed for their potential risks at the planning stage before they are commissioned.

The Trust aims to ensure a co-ordinated and holistic process through continuance review which includes the following steps to:

- Assess the risk by a logical and systematic method of identifying, quantifying, analysing and evaluating potential risks, followed by a decision to accept, reduce or eliminate those risks.

- Log the risks onto a register
- Communicate the risks to stakeholders and inform the business planning and governance of the Trust
- Take action to control (or treat) the risks via prioritised action plans
- Review the risk management performance via indicators and via compliance with validated standards.

The Trust has an established Board Assurance Committee, chaired by the Trust's Vice Chairman, which has overall responsibility for the co-ordination and prioritisation of risk management issues within the Trust. The principal objectives of the Board Assurance Committee are to:

- Develop a policy framework for Risk Management
- Ensure that the strategy is being effectively implemented
- Monitor and review the Trust's corporate risk register and key performance indicators
- Advise on how to control areas of high or difficult risk
- Oversee the Trust compliance with statutory and other guidance such as that relevant to CNST, RPST, Standards for Health, Control of Infection, Medical Devices, Health & Safety, Emergency Planning and Finance systems.
- Provide regular risk management reports to the Trust Board
- Liaise with the Audit Committee and the Finance Committee

The Board Assurance Committee is supported by:

- Clinical Governance Committee:
- Finance and Performance Committee:
- Health & Safety Committee:
- Environment & Facilities Committee:
- Emergency Planning Committee:

The assurance process is reviewed by the Trust's Audit Committee.

Where appropriate, through consultation and direct involvement with the Trust, public stakeholders are involved in managing risks which impact on them.

The assurance framework is underpinned by an embedded infrastructure that provides effective:

- Forward Planning
- Incident Reporting and Investigation
- Communication Systems
- Records Management
- Information for patients
- Staff Induction programmes
- Staff Training & Education
- Clinical Equipment Management
- Service Delivery and Operational Policies
- Environmental and Asset Management
- Capital Planning
- Contingency Planning

The Trust has developed risk assessment tools for all identified risks. These enable staff to quantify risks in their respective areas and decide what action, if any, needs to be taken with a view to reducing or eliminating those risks. A common risk score matrix is used by the Trust with risks logged onto 'local' and 'corporate' risk registers.

The above includes the risks associated with the management and control of information. In this respect the Trust also has an Information Governance Statement of Compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage.

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

The Board and all senior staff, clinical and other, are through various meetings and review processes involved in a self assessment process to ensure the Trust complies with the NHS Core Standards for Better Health.

This process has highlighted insufficient assurance in the following Care Standards:

C4a Infection Control

An unannounced hygiene code inspection in August 2007 concluded that further work was required "to ensure the necessary systems are in place to help protect patients, the public and staff from HCAI."

An implemented action plan confirms that the Trust is now compliant with this standard.

C4c Decontamination

The Trust declared 'Insufficient Assurance' in 2006/7 with an action plan through to September 2007. This has now been completed and the trust achieved the required accreditation in October 2007.The Trust has therefore been fully compliant since October 2007, but did not havereasonable assurance prior to this date.

C7e Equality

A Healthcare Commission Race Equality Review in December 2007 identified gaps in information available to the public. An action plan submitted as part of the declaration confirms the Trust's actions to meet this standard.

5. Review of effectiveness

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

made by the external auditors, the Healthcare Commission, clinical audit and specific pieces of work such as the Review of Service Configuration across the Trust's Hospitals.

The Assurance Framework established by the Trust provides a comprehensive process for handling of risk and internal control issues across the Trust:

- the Board regularly review the Trust's objectives and receive reports on key matters of concern
- the Audit Committee comments where appropriate on the overall risk management process and promotes best practice
- the Board Assurance Committee is informed in its work by a number of carefully constructed sub-committees that between them ensure coverage of all the activities of the Trust
- Board level directors and senior managers of the Trust are fully involved with maintaining and reviewing the effectiveness of the system of internal control
- the Board has a well established Finance and Performance Committee chaired by a non executive Director highly experienced in financial matters.
- Internal Audit, through its annual audit plan, provides assurance and comment on all matters related to internal control
- The Board and all senior staff, clinical and other, are, through various meetings and review processes, including monthly Performance Reviews with each Clinical Directorate, involved in the self assessment process required as part of the annual standards for Better Health compliance statement.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, Audit Committee, and the Board Assurance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The head of internal audit through:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year has provided me with an overall opinion that:

"Significant assurance can be given that there is a generally sound system of control, designed to meet the organisation's objectives, and that the controls are generally being applied consistently. However, some weakness in the design and inconsistent application of controls put the achievement of particular Trust objectives at risk".

The particular objectives put at risk include governance arrangements, recruitment and retention of staff and the achievement of waiting targets. The conclusion is drawn from 6 of 25 reviews undertaken where controls offer limited assurance. My management team has accepted and are acting upon the recommendations within these reviews (Isolation Facilities, Safeguarding Children, Medical Records Re-structuring, Knowledge and Skills Framework, 18 Weeks and Governance – Risk Management Process in T&O and Emergency Medicine).

In 2006/07 the Trust reported control issues particularly with standard C4 of the NHS Core Standards for Better Health. "Health care organisations keep patients, staff and visitors safe" The particular weaknesses included:

- partial assurance' for its decontamination requirements.
- the level of MRSA and other hospital acquired infections above target.

- acknowledgement of issues raised by the Environment Agency at Mount Vernon Cancer Centre.

The outcome of actions relating: Infection Control; and Decontamination has been set out above.

Capital monies were made available to undertake the Corrective action raised by the Environment Agency at MVCC.

The table below sets out non-compliance with the NHS Care Standards during 2007/8, together with brief detail of action taken:

Standard	Reason for non compliance	Actions taken
C18 Access to Services - compliance 'not met'.	December 2007 Race Equality Review identified that "the Trust should be able to identify areas where service population are unable to access its services equivitably; the evidence the Trust has collated within the declaration period does not provide this assurance".	An action plan to be implemented by the end of September 2008 has been developed. This includes publishing information on the Trust's internet site, facilities for key information in a number of languages and interpreter services.

17 June 2008 .....Date.....Chief Executive

Independent auditor's report to the Directors of the Board of East and North Hertfordshire Hospitals NHS Trust

Opinion on the financial statements

We have audited the financial statements of East and North Hertfordshire NHS Trust for the year ended 31 March 2008 under the Audit Commission Act 1998. The financial statements comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service set out within them. We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of East and North Hertfordshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than East and North Hertfordshire NHS Trust and the Trust's directors as a body, for our audit work, for this report, or for the opinions we have formed

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.

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

We report to you our opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. We report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England. We also report to you whether, in our opinion, the information which comprises the commentary on the financial performance included in the Annual Report, is consistent with the financial statements.

We review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'The Statement on Internal Control 2003/04' issued on 15 September 2003 and the further guidance relating to that Statement issued on 7 April 2006, 2 April 2007 and 7 April 2008 and 20 May 2008. We report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' Statement on Internal Control covers all risks and controls. Neither are we required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

We 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 unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Financial Review. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of audit opinion

We conducted the 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 to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

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

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In our opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2008 and of its income and expenditure for the year then ended;
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and
- information which comprises the commentary on the financial performance 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

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

Conclusion

We have undertaken our 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, we are satisfied that, in all significant respects, East and North Hertfordshire NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2008.

Certificate

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

Date: 18 June 2008

Grant Thornton UK LLP
Byron House
Cambridge Business Park
Cowley Road
Cambridge
CB4 0WZ

Income and expenditure account for the year ended 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
Income from activities	3	**254,921**	238,722
Other operating income	4	**31,411**	31,535
Operating expenses	5	**(277,950)**	(265,318)
OPERATING SURPLUS/(DEFICIT)		**8,382**	4,939
Profit/(loss) on disposal of fixed assets	8	**0**	0
SURPLUS/(DEFICIT) BEFORE INTEREST		**8,382**	4,939
Interest receivable		**689**	262
Interest payable	9	**(397)**	0
Other finance costs - unwinding of discount	16	**(29)**	(17)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR		**8,645**	5,184
Public Dividend Capital dividends payable		**(6,642)**	(6,711)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		**2,003**	(1,527)

The notes on pages 78 to 102 form part of these accounts.
All income and expenditure is derived from continuing operations.

Balance sheet as at 31 March 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
FIXED ASSETS			
Intangible assets	10	**0**	0
Tangible assets	11	**227,167**	218,936
Investments	14	**0**	0
		227,167	218,936
CURRENT ASSETS			
Stocks and work in progress	12	**3,641**	3,896
Debtors	13	**18,603**	17,695
Investments	14	**0**	0
Cash at bank and in hand	18.3	**3,040**	789
		25,284	22,380
CREDITORS: Amounts falling due within one year	15	**(24,110)**	(20,652)
NET CURRENT ASSETS/(LIABILITIES)		**1,174**	1,728
TOTAL ASSETS LESS CURRENT LIABILITIES		**228,341**	220,664
CREDITORS: Amounts falling due after more than one year	15	**(4,680)**	(6,240)
PROVISIONS FOR LIABILITIES AND CHARGES	16	**(1,607)**	(1,510)
TOTAL ASSETS EMPLOYED		**222,054**	212,914
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	22	**145,034**	143,930
Revaluation reserve	17	**96,837**	91,127
Donated asset reserve	17	**4,255**	4,213
Government grant reserve	17	**15**	22
Income and expenditure reserve	17	**(24,087)**	(26,378)
TOTAL TAXPAYERS' EQUITY		**222,054**	212,914

The financial statements on pages 79 to 102 were approved by the Board on 17 June 2008 and signed on its behalf by:

Signed: .....(Chief Executive)

Date: 17th June 2008

Statement of total recognised gains and losses for the year ended 31 March 2008

	2007/08 £000	2006/07 £000
Surplus/(deficit) for the financial year before dividend payments	**8,645**	5,184
Fixed asset impairment losses	**0**	(1,814)
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	**6,211**	18,886
Increases in the donated asset and government grant reserves due to receipt of donated and government grant financed asset	**220**	1,897
Total gains and losses recognised in the financial year	**15,076**	24,153

Cash flow statement for the year ended 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	18.1	**17,530**	2,317
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**689**	262
Interest paid		**(397)**	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		**292**	262
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed asset		**(8,473)**	(12,826)
Net cash inflow/(outflow) from capital expenditure		**(8,473)**	(12,826)
DIVIDENDS PAID		**(6,642)**	(6,711)
Net cash inflow/(outflow) before management of liquid resources and financing		**2,707**	(16,958)
FINANCING			
Public dividend capital received		**1,104**	24,408
Public dividend capital repaid (not previously accrued)		**0**	(15,153)
Loans received from DH		**0**	7,800
Loand repaid to DH		**(1,560)**	0
Net cash inflow/(outflow) from financing		**(456)**	17,055
Increase/(decrease) in cash		**2,251**	97

Notes to the accounts

1 ACCOUNTING POLICIES

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trust Manual for Accounts which shall be agreed with HM Treasury. The accounting policies contained in that manual follow UK generally accepted accounting practice and HM Treasury's Government Financial Reporting Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of fixed assets at their value to the business by reference to their current costs. NHS Trusts are not required to provide a reconciliation between current cost and historical cost surpluses and deficits.

1.2 Acquisitions and discontinued operations

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

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided, where these services are partly completed during the year an appropriate proportion of total income due for that service is accrued. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.4 Intangible fixed assets

See tangible fixed assets

1.5 Tangible fixed assets

Capitalisation

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

- individually have a cost of at least £5,000; or
- collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Purchased computer software licences are capitalised together with the associated computer equipment where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives.

In accordance with an amendment to the Capital Accounting Manual issued in July 2003, expenditure on digital hearing aids in the year ended 31 March 2004 and subsequent years to 31st March 2007 were treated as capital expenditure, giving rise to an increase in fixed assets regardless of the cost of the individual hearing aids. The Capital Accounting Manual has been withdrawn, as a result, hearing aid expenditure in 2007/08 is reported as revenue in accordance with financial reporting standard 15. This change in accounting policy is not material, comparative figures for 2006/07 are unchanged in accordance with financial reporting standard 3. Previous years expenditure has been written off to I&E reserve.

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

All land and buildings are restated to current value using professional valuations in accordance with Financial Reporting Standard 15 every five years and in the intervening years by

the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the last asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 and were applied on the 31 March 2005. The District Valuer undertook valuations as at 1st April 2006 and 1st April 2007 to include significant recent capital developments.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. The value of land for existing use purposes is assessed at Existing Use Value. For non-operational properties including surplus land, the valuations are carried out at Open Market Value.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

Assets in the course of construction are valued at current cost using the indexes as for land and buildings, as above. These assets include any existing land or buildings under the control of a contractor.

Residual interests in off-balance sheet Private Finance Initiative properties are included in tangible fixed assets where the PFI contract specifies the amount, or nil value at which the assets will be transferred to the Trust at the end of the contract. The residual interest is built up, on an actuarial basis, during the life of the contract by capitalising part of the unitary charge so that at the end of the contract the balance sheet value of the residual value plus the specified amount equal the expected fair value of the residual asset at the end of the contract. The estimated fair value of the asset on reversion is determined by the District Valuer based on Department of Health guidance. The District Valuer estimate of the anticipated fair value of the assets on the same basis as the District Valuer values the NHS Trust's estate.

Operational equipment other than IT equipment, which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets surplus to requirements.

Assets in the course of construction and residual interests in off-balance sheet PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

Impairment losses resulting from short-term changes in price that are considered to be recoverable in the longer term are taken in full to the revaluation reserve. These include impairments resulting from the revaluation of fixed assets from their cost to their value in existing use when they become operational. This may lead to a negative revaluation reserve in certain instances.

Where, under Financial Reporting Standard 11, a fixed asset impairment is charged to the Income and Expenditure Account, offsetting income may be paid by the Trust's main commissioner using funding provided by the NHS Bank.

1.6 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the

asset is released from the Donated Asset Reserve to the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.7 Government Grants

Government grants are grants from government bodies other than funds from NHS bodies or funds awarded by Parliamentary Vote. The government grants reserve is maintained at a level equal to the net book value of the assets which it has financed. Gains and losses on revaluations are also 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 Income and Expenditure account. Similarly, any impairment on grant funded assets charged to the Income and Expenditure Account is matched by a transfer from the Reserve.

1.8 Private Finance Initiative (PFI) transactions

The NHS follows HM Treasury's Technical Note 1 (Revised) "How to Account for PFI transactions" which provides practical guidance for the application of the Application Note F to Financial Reporting Standard 5 and the guidance 'Land and Buildings in PFI schemes Version 2'.

Where the balance of the risks and rewards of ownership of the PFI property are borne by the PFI operator, the PFI obligations are recorded as an operating expense. Where the trust has contributed assets, a prepayment for their fair value is recognised and amortised over the life of the PFI contract by charge to the Income and Expenditure Account. Where, at the end of the PFI contract, a property reverts to the Trust, the difference between the expected fair value of the residual on reversion and any agreed payment on reversion is built up over the life of the contract by capitalising part of the unitary charge each year, as a tangible fixed asset.

Where the balance of risks and rewards of ownership of the PFI property are borne by the Trust, it is recognised as a fixed asset along with the liability to pay for it which is accounted for as a finance lease. Contract payments are apportioned between an imputed finance lease charge and a service charge.

1.9 Stocks and work-in-progress

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

1.10 Research and development

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

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

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

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

1.11 Provisions

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

1.12 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 16.

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2007/08 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

1.13 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.

1.14 Pension costs

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) FRS17 Accounting valuation

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

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

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

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

Scheme provisions as at 31 March 2008

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

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

1.15 Liquid resources

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

1.16 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.

1.17 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.18 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 28 to the accounts.

1.19 Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease. The interest element of the finance lease payment is charged to the Income and Expenditure Account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the Income and Expenditure Account on a straight-line basis over the term of the lease.

1.20 Public Dividend Capital (PDC) and PDC Dividend

Public Dividend Capital represents the outstanding public debt of an NHS Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS Trust.

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash

with the Office of the Paymaster General. The average carrying amount of assets is calulated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.21 Losses and Special Payments

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

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 EU Emmissions Trading Scheme

NHS Trust's with substantial Boiler capacity participate in this scheme. Those within East and North Hertfordshire NHS Trust hospitals are below the capacity to which the scheme applies.

2 Segmental Analysis

All the activities of the Trust fall within the Healthcare segment.

3. Income from Activities

	2007/08 £000	2006/07 £000
NHS Trusts	11	14
Primary Care Trusts	223,678	209,363
Local Authorities	182	644
Department of Health	25,754	23,355
Non NHS:		
- Private patients	3,928	4,140
- Overseas patients (non-reciprocal)	145	125
- Road Traffic Act*	-	789
- Injury cost recovery*	947	0
- Other	276	292
	254,921	238,722

* Road Traffic Act has been replaced by injury cost recovery, income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.

4. Other Operating Income

	2007/08 £000	Restated 2006/07 £000
Education, training and research	14,049	13,309
Transfers from donated asset reserve	391	355
Transfers from government grant reserve	7	8
Non-patient care services to other bodies	15,247	14,813
Income Generation	1,717	2,033
Other income*	0	1,018
	31,411	31,536

* Other income in 2006/07 relates to the sale of drugs to a private hospital. This service ceased in 2006/07

5. Operating Expenses

5.1 Operating expenses comprise:

	2007/08	2006/07
	£000	£000
Services from other NHS Trusts	5,824	4,836
Services from PCTs	3,893	
Services from other NHS bodies	0	3,998
Purchase of healthcare from non NHS bodies	2,742	1,910
Directors' costs	1,124	1,002
Staff costs	177,155	172,835
Supplies and services - clinical	48,542	41,573
Supplies and services - general	7,105	6,876
Consultancy services	618	
Establishment	5,392	7,123
Transport	2,296	807
Premises	10,082	8,179
Bad debts	449	229
Depreciation	6,824	6,170
Fixed asset impairments and reversals	442	0
Audit fees	222	217
Clinical negligence	3,278	3,831
Redundancy costs	2	297
Other	1,960	5,435
	277,950	265,318

5.2 Operating leases

5.2/1 Operating expenses include:

	2007/08	2006/07
	£000	£000
Hire of plant and machinery	877	553
Other operating lease rentals	3,189	2,472
	4,066	3,025

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

	Land and buildings		Other leases	
	2007/08	2006/07	**2007/08**	2006/07
	£000	£000	**£000**	£000
Operating leases which expire:				
Within 1 year	**0**	0	**79**	65
Between 1 and 5 years	**0**	0	**2,543**	2,539
After 5 years	**0**	0	**631**	592
	0	0	**3,253**	3,196

6. Staff costs and numbers

6.1 Staff costs

	2007/08			2006/07
	Total	**Permanently Employed**	**Other**	
	£000	**£000**	**£000**	£000
Salaries and wages	**150,854**	139,075	11,779	146,917
Social Security Costs	**12,227**	11,954	273	11,955
Employer contributions to NHS Pension Scheme	**15,145**	15,009	136	14,912
	178,226	**166,038**	**12,188**	173,784

6.2 Average number of persons employed

	2007/08			2006/07
	Total	**Permanently Employed**	**Other**	
	Number	**Number**	**Number**	Number
Medical and dental	**641**	617	24	584
Administration and estates	**894**	851	43	912
Healthcare assistants and other support staff	**700**	698	2	769
Nursing, midwifery and health visiting staff	**1,616**	1,445	171	1,464
Nursing, midwifery and health visiting learners	**7**	7	0	8
Scientific, therapeutic and technical staff	**653**	631	22	673
Social care staff	**0**	0	0	0
Other	**5**	5	0	8
Total	**4,516**	**4,254**	**262**	**4,418**

6.3 Employee benefits

There are no staff benefits that are a cost to East and North Hertfordshire NHS Trust.

6.4 Management costs

	2007/08 £000	2006/07 £000
Management costs	11,084	11,550
Income	286,333	270,257

Management costs are defined as those on the management costs website at www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/FinanceAndPlanning/NHSManagementCosts/fs/en..

6.5 Retirements due to ill-health

During 2007/08 there were 8 (2006/07,7) early retirements from the NHS Trust on the grounds of ill-health. The estimated additional pension liabilities of ill-health retirements will be £416k (191k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2007/08 Number	2007/08 £000
Total Non-NHS trade invoices paid in the year	64,662	70,901
Total Non NHS trade invoices paid within target	54,685	58,814
Percentage of Non-NHS trade invoices paid within target	85%	83%
Total NHS trade invoices paid in the year	2,821	32,043
Total NHS trade invoices paid within target	1,701	20,892
Percentage of NHS trade invoices paid within target	60%	65%

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.

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

There were no material interest payments relating to late payment of commercial debts.

8. Profit/(Loss) on Disposal of Fixed Assets

There were no profit or losses on the disposal of fixed assets in 2007/08 or 2006/07

9. Interest Payable

	2007/08 £000	2006/07 £000
Loans (with Department of Health)	397	0
	397	0

10. Intangible Fixed Assets

There are no intangible fixed assets - see note 1.4 fixed asset accounting policy.

11. Tangible fixed assets

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account*	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 2007	97,667	98,915	0	2,299	35,323	108	12,206	2,096	248,609
Additions purchased	0	2,739	0	1,059	2,278	0	2,607	383	9,066
Additions donated	0	123	0	0	87	0	0	10	220
Additions government granted	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,144	0	(2,367)	888	0	290	45	0
Indexation	5,284	8,240	0	79	933	3	0	57	14,596
Other in year revaluation	0	(7,081)	0	0	(1,536)	0	0	0	(8,617)
Disposals	0	0	0	0	0	0	0	0	0
Cost or Valuation at 31 March 2008	**102,951**	**104,080**	**0**	**1,070**	**37,973**	**111**	**15,103**	**2,586**	**263,874**
Depreciation at 1 April 2007					20,486	96	7,965	1,126	29,673
Charged during the year	0	2,660	0	0	2,622	3	1,319	220	6,824
Impairments	0	442	0	0	0	0	0	0	442
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Indexation	0	0	0	0	549	3	0	30	582
Other in year revaluation	0	0	0	0	(814)	0	0	0	(814)
Disposals	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2008	**0**	**3,102**	**0**	**0**	**22,843**	**102**	**9,284**	**1,376**	**36,707**
Net book value									
- Purchased at 1 April 2007	97,667	97,139	0	2,299	12,483	12	4,203	897	214,700
- Donated at 1 April 2007	0	1,776	0	0	2,354	0	16	68	4,214
- Government granted at 1 April 2007	0	0	0	0	0	0	22	0	22
- Total at 1 April 2007	**97,667**	**98,915**	**0**	**2,299**	**14,837**	**12**	**4,241**	**965**	**218,936**
- Purchased at 31 March 2008	102,951	98,969	0	1,070	12,962	9	5,793	1,143	222,897
- Donated at 31 March 2008	0	2,009	0	0	2,168	0	11	67	4,255
- Government granted at 31 March 2008	0	0	0	0	0	0	15	0	15
- Total at 31 March 2008	**102,951**	**100,978**	**0**	**1,070**	**15,130**	**9**	**5,819**	**1,210**	**227,167**

Of the totals at 31 March 2008 none of the land, buildings or dwellings are valued at open market value.
The Trust does not hold any finance leases.

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

	31 March 2008 £000	31 March 2007 £000
Freehold	203,929	196,582

12. Stocks and Work in Progress

	31 March 2008 £000	31 March 2007 £000
Raw materials and consumables	3,641	3,896

13. Debtors

	31 March 2008 £000	31 March 2007 £000
Amounts falling due within one year:		
NHS debtors	8,585	10,040
Other debtors	4,806	5,318
Provision for irrecoverable debts	(864)	(540)
Other prepayments and accrued income	4,814	1,572
Sub Total	17,341	16,390
Amounts falling due after more than one year:		
Other debtors	1,262	1,305
TOTAL	18,603	17,695

Other Debtors does not include any prepaid pension contributions at 31 March 2008 or at 31 March 2007

14. Investments

The Trust does not hold any fixed asset or current asset investments

15. Creditors

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

	31 March 2008 £000	31 March 2007 £000
Amounts falling due within one year:		
Current instalments due on loans	1,560	1,560
NHS creditors	3,680	4,374
Non - NHS trade creditors - revenue	7,774	3,529
Non - NHS trade creditors - capital	2,140	1,547
Tax	0	610
Social security costs	0	612
Other creditors	3,171	3,487
Accruals and deferred income	5,785	4,933
Sub Total	24,110	20,652
Amounts falling due after more than one year:		
Long - term loans	4,680	6,240
TOTAL	28,790	26,892

Other creditors include;
-£0 outstanding pensions contributions at 31 March 2008 (31 March 2007 £1,814k).

15.2 Loans (and other long-term financial liabilities)

	31 March 2008 £000	31 March 2007 £000
Amounts falling due:		
In one year or less	1,560	1,560
Between one and two years	1,560	1,560
Between two and five years	3,120	4,680
Over 5 years	0	0
TOTAL	6,240	7,800

	31 March 2008 £000	31 March 2007 £000
Wholly repayable within five years	6,240	7,800

The Loan detailed above is from the Department of Health

15.3 Finance Lease obligations

There are no finance lease obligations

16. Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restruct-uring	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2007	0	1,358	152	0	0	**1,510**
Arising during the year	0	34	137	0	142	**313**
Utilised during the year	0	(111)	(84)	0	0	**(195)**
Reversed unused	0	0	(50)	0	0	**(50)**
Unwinding of discount	0	29	0	0	0	**29**
At 31 March 2008	**0**	**1,310**	**155**	**0**	**142**	**1,607**
Expected timing of cashflows:						
Within one year	0	76	32	0	142	**250**
Between one and five years	0	294	123	0	0	**417**
After five years	0	940	0	0	0	**940**

Pensions relating to other staff: The constructive obligation with NHS Pensions Agency for staff retired early. The obligation is assessed using information provided by the Pensions Agency on pension enhancement and an assessment of expected lives using Government Actuary Department tables.

Legal Claims: The constructive obligation for payments under the Litigation to Third Parties Scheme (LTPS). The balance as at 31st March 2008 is as advised by the Litigation Authority taking into consideration the probability as to the outcome of each claim.

£19,900k is included in the provisions of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the NHS Trust (31 March 2007 £17,362k).

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Government Grant Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	**Total £000**
At 1 April 2007 as previously stated	91,126	4,214	22	0	(26,378)	**68,984**
Prior Period Adjustments	1	(1)	0	0	0	**0**
At 1 April 2007 as restated	91,127	4,213	22	0	(26,378)	**68,984**
Transfer from the income and expenditure account					2,003	**2,003**
Surplus/(deficit) on other revaluations/indexation of fixed/current assets	5,998	213	0			**6,211**
Transfer of realised profits/ (losses) to the income and expenditure reserve	0	0	0		0	**0**
Receipt of donated/ government granted assets		220	0			**220**
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/ government granted assets		(391)	(7)			**(398)**
Other transfers between reserves	(288)	0	0	0	288	**0**
At 31 March 2008	**96,837**	**4,255**	**15**	**0**	**(24,087)**	**77,020**

18. Notes to the cash flow Statement

18. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2007/08 £000	2006/07 £000
Total operating surplus/(deficit)	8,382	4,939
Depreciation and amortisation charge	6,824	6,170
Fixed asset impairments and reversals	442	0
Transfer from donated asset reserve	(391)	(355)
Transfer from the government grant reserve	(7)	(8)
(Increase)/decrease in stocks	255	(547)
(Increase)/decrease in debtors	(908)	6,197
Increase/(decrease) in creditors	2,865	(14,396)
Increase/(decrease) in provisions	68	317
Net cash inflow from operating activities	17,530	2,317

18.2 Reconciliation of net cash flow to movement in net debt

	2007/08 £000	2006/07 £000
Increase/(decrease) in cash in the period	2,251	97
Cash (inflow) from new debt	0	(7,800)
Cash outflow from debt repaid and finance lease capital payments	1,560	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0	0
Change in net debt resulting from cash flows	3,811	(7,703)
Non - cash changes in debt	0	0
Net debt at 1 April 2007	(7,011)	692
Net debt at 31 March 2008	(3,200)	(7,011)

18.3 Analysis of changes in net debt

	At 1 April 2007 £000	Cash Transferred (to)/from other £000	Other cash changes in year £000	At 31March 2008 £000
OPG cash at bank	556	0	2,355	2,911
Commercial cash at bank and in hand	233	0	(104)	129
Loan from DH due within one year	(1,560)	0	0	(1,560)
Loan from DH due after one year	(6,240)	0	1,560	(4,680)
	(7,011)	0	3,811	(3,200)

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2008 were £786k (31 March 2007 £429k)

20. Post Balance Sheet Events

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

21. Contingencies

	2007/08 £000	2006/07 £000
Net value of contingent liabilities	(378)	(59)

22. Movement in Public Dividend Capital

	2007/08 £000	2006/07 £000
Public Dividend Capital as at 1 April 2007	143,930	134,675
New Public Dividend Capital received Trusts) (including transfers from dissolved NHS	1,104	24,408
Public Dividend Capital repaid in year	0	(15,153)
Public Dividend Capital as at 31 March 2007	145,034	143,930

23. Financial Performance Targets

23.1 Breakeven Performance

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

	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000	2007/08 £000
Turnover	191,938	207,374	246,307	270,257	286,332
Retained surplus/(deficit) for the year	19	(8,557)	(22,379)	(1,527)	2,003
Recalibration Adjustment	0	0	8,557	22,379	0
Break-even in-year position	19	(8,557)	(13,822)	20,852	2,003
Break-even cumulative position	(721)	(9,278)	(23,100)	(2,248)	(245)
Materiality test (I.e. is it equal to or less than 0.5%):					
-Break-even in-year position as a percentage of turnover	0.01%	-4.13%	-5.61%	7.72%	0.70%
-Break-even cumulative position as a percentage of turnover	(0.38%)	(4.47%)	(9.38%)	(0.83%)	(0.09%)

Narrative Note:
The recalibration adjustment shown above relates to the East of England SHA's formal agreement in 2006/07 financial year to adjust the Trust's breakeven duty. The cumulative position as at 31st March 2008 is within 0.5% of turnover; the Trust has therefore satisfied this statutory duty.

23.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £6,642k, bears to the average relevant net assets of £211,517k that is 3.1%.

3.1% is per plan, is within 0.5% of the required rate and is therefore within the Department of Health tollerance.

23.3 External financing

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

	2007/08		2006/07
	£000	£000	£000
External financing limit		(2,597)	16,958
Cash flow financing	(2,707)		16,958
External financing requirement		(2,707)	16,958
Undershoot/(overshoot)		110	0

23.4 Capital Resource Limit

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

	2007/08 £000	2006/07 £000
Gross capital expenditure	9,286	15,259
Less: donations towards the acquisition of fixed assets	(220)	(1,897)
Charge against the capital resource limit	9,066	13,362
Capital resource limit	10,556	13,368
(Over)/Underspend against the capital resource limit	1,490	6

23.4 Capital Resource Limit

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	2007/08 £000	2006/07 £000
Gross capital expenditure	9,286	15,259
Less: donations towards the acquisition of fixed assets	(220)	(1,897)
Charge against the capital resource limit	9,066	13,362
Capital resource limit	10,556	13,368
(Over)/Underspend against the capital resource limit	1,490	6

24. Related Party Transactions

East and North Hertfordshire NHS Trust is a body corporate established by order of the Secretary of State for Health.
During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with East and North Hertfordshire NHS Trust.
The Department of Health is regarded as a related party. During the year East and North Hertfordshire NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Strategic Health Authorities
East of England Strategic Health Authority

Primary Care Trusts
Barnet PCT
Bedfordshire PCT
Berkshire East PCT
Brent Teaching PCT
Buckinghamshire PCT
East and North Hertfordshire PCT
Harrow PCT
Hillingdon PCT
Luton PCT
West Hertfordshire PCT

NHS Trusts
The Hillingdon Hospital NHS Trust
West Hertfordshire Hospitals NHS Trust

Other NHS bodies
NHS Business Services Authority
NHS Litigation Authority
NHS Blood and Transplant

Foundation Trusts
Hertfordshire Partnership NHS Foundation Trust
Luton and Dunstable NHS Foundation Trust

Charitable funds
Enhance Herts Charitable Fund

25. Private Finance Transactions

25.1 PFI schemes deemed to be off-balance sheet

	2007/08 £000	2006/07 £000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	**1,094**	1,046
Amortisation of PFI deferred asset	**(136)**	(131)
Net charge to operating expenses	**958**	915

East and North Hertfordshire NHS Trust is committed to make the following payments during the next years.

PFI scheme which expires; 26th to 30th years (inclusive)	**1,094**	1,046
Estimated capital value of the PFI scheme	**6,363**	6,336

Contract start date: October 2004
Contract end date: October 2034
Description of the scheme: Hertford County Hospital

26. Pooled Budget

Some NHS organisations pool their budgets with Local Authorities and these are managed by a single organisation. East and North Hertfordshire NHS Trust does not have any pooled budgets.

27 Financial Instruments

Financial Reprting Standard 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.
As allowed by Financial Reporting Standard 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions should be shown gross. Any amount expected in reimbursement against a provision (and included in debtors) should be separately disclosed.

Liquidity risk

The NHS Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust also largely finances its capital expenditure from funds made available from Government under an agreed borrowing limit. East and North Hertfordshire NHS Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk

All of the Trust's financial assets and all of its financial liabilities carry nil or fixed rates of interest. East and North Hertfordshire NHS Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

27.1 Financial Assets

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2008							
Sterling	3,040	3,040	0	0	0.00%	0	0
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**3,040**	**3,040**	**0**	**0**			
At 31 March 2007							
Sterling	789	789	0	0	0.00%	0	0
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**789**	**789**	**0**	**0**			

27.2 Financial Liabilities

Currency	Total	Floating rate	Fixed rate	Non-interest bearing	Fixed rate: Weighted average interest rate	Fixed rate: Weighted average period for which fixed	Non-interest bearing: Weighted average term
	£000	£000	£000	£000	%	Years	Years
At 31 March 2008							
Sterling	6,240	0	6,240	0	5.45%	5	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**6,240**	**0**	**6,240**	**0**			
At 31 March 2007							
Sterling	7,800	0	7,800	0	5.45%	5	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**7,800**	**0**	**7,800**	**0**			

Foreign Currency Risk

The Trust has no foreign currency income or expenditure.

27.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2008.

	Book Value £000	Fair Value £000
Financial assets		
Cash	3,040	3,040
Financial liabilities		
Loans (Department of Health)	(6,240)	(6,240)
Total	(6,240)	(6,240)

28 Third Party Assets

The Trust held £5k cash at bank and in hand as at 31 March 2008 (£7k - at 31 March 2007) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29 Intra-Government and Other Balances

	Debtors: amounts falling due within 1 year	Debtors: amounts falling due within 1 year	Creditors: amounts falling due within 1 year	Creditors: amounts falling due within 1 year
	£000	£000	£000	£000
Balances with other Central Government Bodies	7,648	0	1,560	0
Balances with Local Authorities	82	0	0	0
Balances with NHS Trusts and Foundation Trusts	937	0	1,937	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	8,674	1,262	20,613	4,680
At 31 March 2008	17,341	1,262	24,110	4,680
Balances with other Central Government Bodies	9,120	880	7,228	6,240
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,493	0	1,530	0
Balances with Public Corporations and Trading Funds	0	0	212	0
Balances with bodies external to government	5,777	425	11,682	0
At 31 March 2007	16,390	1,305	20,652	6,240

30 Losses and Special Payments

There were 911 cases of losses and special payments (31 March 2007: 8,247 cases) totalling £97,686, (31 March 2007: £14,796) approved during 31 March 2008.
The majority of these cases relate to small charges levied for drugs supplied to individuals by the hospital, that have not been paid and the debt is over one year old.

Your views matter

Consultation on the Trust's annual report and accounts

In line with best practice nationally, NHS trusts are expected to consult key audiences on its annual report.

Based on a similar exercise carried out for the current 2007/08 report, which hopefully you have just finished reading, it was suggested that we include the consultation within the document rather than send it out several months later. Not only is this more efficient, it's hoped that it will increase the value of the feedback in terms of producing the 2008/09 annual report.

While the contents and structure of NHS annual reports are prescribed heavily, it is important that we hear your views about the report's production and distribution. To that end, you will find a short questionnaire on the next page that I would be very grateful if you would be willing to complete and return back to me using the address details provided. Hard copies, marked for my attention, can also be faxed to: 01438 781281.

Thank you for your co-operation in advance.

Peter Gibson

Head of public affairs

East and North Hertfordshire NHS Trust
2008/09 annual report and accounts questionnaire

Q1 Did you find the report's contents informative? Please tick appropriate box

Yes ☐
No ☐

If yes, why?……..
……
If no, why?……..
……

Q2 What are your top three topics that you would like the annual report for 2008/09 to address?

1)……..
2)……..
3)……..

Q3 In what format would you wish to receive the annual report and accounts for 2007/08? Please tick appropriate box(es)

Hard copy, posted ☐
E-mailed as a PDF attachment ☐
Available to download from Trust website ☐
Other ☐

If other, please specify……
……
……

Q4 **Have you any special needs that would require the annual report to be provided in alternative to the current format? Please tick appropriate box(es)**

Different languages ☐

Please specify.....

.....

Different font sizes ☐

Please specify.....

.....

Different formats (e.g. Braille) ☐

Please specify.....

.....

Other ☐

Please specify.....

.....

Q5 **Have you any specific comment that you would like to provide about the Trust's annual report?**

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Completed questionnaires should be returned to:

Peter Gibson
Head of public affairs
East and North Hertfordshire NHS Trust
Lister Hospital (L69)
Coreys Mill Lane
Stevenage
Herts SG1 4AB

They can also be faxed to: 01438 781281

The East and North Hertfordshire NHS Trust is recognised widely as an organisation that strives to provide high-quality health care for the people living and working in the local communities that it serves. Over recent years, its performance against clinical, operational and financial targets and standards set nationally has shown steady improvement.

East and North Hertfordshire NHS Trust
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