East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2009/10 annual report and accounts

23 August 2010

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Chapter 1: about the Trust

The East and North Hertfordshire NHS Trust was created in April 2000, following the merger of two former NHS trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and some tertiary care services from its four hospitals, namely the: Lister in Stevenage; Queen Elizabeth II (QEII) in Welwyn Garden City; Hertford County in Hertford; and Mount Vernon Cancer Centre in Northwood, Middlesex

Both the Lister and QEII are local district general hospitals, with Hertford County being an outpatients and diagnostic hospital. The cancer centre provides tertiary radiotherapy and local chemotherapy services. The Trust owns the freehold for each of the Lister, QEII and Hertford County; the cancer centre operates out of facilities that the Trust leases from the Hillingdon Hospitals NHS Trust.

The area served by the Trust for acute hospital care covers a population of around 600,000 people and includes south, east and north Hertfordshire, as well as parts of south Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to two million people from Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

The Trust's catchment is a mixture of urban and rural areas in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in Stevenage, Hatfield, Welwyn Garden City and Cheshunt. Over the past ten years, rates of death from all causes, early deaths from cancer and early deaths from heart disease and stroke have all improved and are generally similar to, or better than, the England average. The birth rate is close to the England average, with the Trust's core catchment population forecast to rise by 10.5% over the next ten years, along with a corresponding rise of 17.5% in the number of 45 to 74 year olds. Black and minority ethnic groups make up 5.1% of the population in east and north Hertfordshire.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including A&E, maternity care and an urgent care centre – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,000 staff are employed by the Trust, which represents around 4,500 whole time equivalents.

The Trust's annual budget is approximately £315 million. The majority of Trust clinical income comes from three PCTs – the former East and North Hertfordshire PCT (69%) and West Hertfordshire PCT (9%), along with Bedfordshire PCT (7%).

Chapter 2: chairman and chief executive's reports

Chairman's report

The Trust has had another successful year. In terms of its day-to-day operations, it delivered the financial surplus that was required of it, routinely met the performance targets set by the government, materially improved the quality of the clinical care it provides, and by the end of the year the number of patients who said they would recommend the Trust to their friends and relatives had reached 90%.

Perhaps the most important aspect of the year, however, has been the progress the Trust has made in implementing its long-term strategy to consolidate the provision of acute services on the Lister site under the Hertfordshire-wide scheme approved by the community in January 2008. Three of the four phases of the Trust's part of this scheme are well underway – the new £47 million Lister Surgicentre, the £16.4 million maternity expansion project and the multi-storey car park. The fourth phase is, of course, currently subject to the government's review of planned health service reconfigurations.

The Surgicentre is being developed by the independent sector provider Clinicenta and will carry out the vast majority of adult day case and short stay orthopaedic surgery that currently takes place at the Lister and QEII – along with all adult ophthalmology services. It is on track to open in April 2011.

Once completed by the end of 2011, the new maternity unit at the Lister will rival the best facilities to be found anywhere in Eastern England and, quite possibly, the rest of the country. With co-located midwife and consultant-led units, as well as a dedicated day-assessment service, women choosing to give birth in the new unit will have significantly greater choice over how their babies are born.

Construction of the third phase of the Lister's transformation – the new multi-storey car park – will start in September 2010, and take about 12 months to complete. While parking will be inconvenient during its construction, once completed the Trust will have solved most of the parking issues experienced by staff, patients and visitors to the Lister for the foreseeable future.

At the time of writing this report, plans for the fourth, final and largest phase of the Lister's redevelopment, which will see most of the remaining major emergency and acute inpatient care currently performed at the QEII transferring to the Lister by 2014/15, are ready for approval. However, they are of course subject to the government's review of health service reconfigurations. The Trust has welcomed this review, albeit with the caveat that it needs to take place quickly in order to bring clarity to the future of the Trust's hospital services.

In addition, other important long-term infrastructure investments are underway, including a new electrical system for the Lister, the replacement of the 38-year old public lifts in the Lister's main tower block and a new combined heat and power plant at the Lister, which on completion in 2012 will reduce the Trust's overall carbon emissions by 14%.

The Trust remains very sensitive to concerns in the Welwyn Hatfield area about the implications of the consolidation of acute hospital services onto the Lister site. The wider community's agreement to this was dependant on the development by the local primary care trust (PCT) of a new hospital at the QEII. At the time of writing of this report, full agreement as to what services should be provided in this new hospital has yet to be reached between the community's leaders and the PCT.

Much has happened elsewhere in the Trust. Since the Trust took on responsibility for the Mount Vernon cancer centre in April 2005, £29 million has been invested in it (including very significant and generous private donations), and last year the PCT confirmed that the long-term home for the local cancer network would remain at Mount Vernon (with the development of a proposed outreach radiotherapy satellite unit to make access to cancer treatment easier for patients living in Hertfordshire). In addition, the Trust secured the long-term security of the very important research work conducted by staff at Mount Vernon by entering into an academic research partnership with the Institute of Cancer Research and the Royal Marsden NHS Foundation Trust.

In October 2009, the Trust was involved in launching two new urgent care centres at Hertford County and Cheshunt Community hospitals. These important new centres already have become established and popular parts of their respective communities, capable of treating locally and conveniently those illnesses and injuries that require to be seen urgently but do not need the facilities of a full hospital A&E.

Considerable progress has been made by the Trust in preparing to become a NHS foundation trust, and the Trust would undoubtedly have become one but for the need to obtain full agreement on the final phase of the hospital consolidation programme. Becoming a NHS foundation trust is an important step in the Trust's continued development as it supports fully the government's policy for hospitals to become ever closer and more responsive to their patients and the communities they serve – which will be the central theme for the Trust over the next few years.

It is important to recognise that all the progress made by the Trust in the last year was only made possible by the very high quality work performed by the Trust's staff and volunteers. They are very professional, dedicated and hard working people, who care for their patients above all else. The challenges presented by the consolidation programme, developing science and technology, and changes in the community have been significant, but the Trust's staff and volunteers have risen to all of them.

Earlier I mentioned that around 90% of our patients currently would recommend the Trust to their family and friends. None of us see this as being good enough – we are all working to make this figure 100%.

Richard Beazley
Chairman

Chief executive's report

In his report, chairman Richard Beazley, set out a clear account of the changes that the Trust has undergone as it delivers its longer-term plans for the future. Our strategic plan has been the driving force behind the Trust's transformation from a failing organisation to one that is amongst the health service's better performers today.

Over the next few paragraphs, the Trust's performance against a wide range of national operational, clinical and financial standards and targets will be summarised. Before doing so, however, it is appropriate to note the significant challenges facing the Trust – and indeed all NHS organisations – over the next few years as the Government works to reduce the nation's deficit.

The 2010/11 NHS year looks to be one of the most challenging faced by the Trust. At the same time as continuing to meet exacting national standards when it comes to the quality of care provided to patients, the Trust will need to reduce its expenditure considerably, in line with the local primary care trust's commissioning plans, which anticipate fewer patients being referred to acute hospitals for their care as more cost-effective community-based services are introduced over the coming months and years.

While the pace of change in referral patterns being driven by the PCT will bring much change, it is an overall direction of travel that the Trust supports. This is because the implementation of the *Delivering quality health care for Hertfordshire* programme is founded on the principle that more people than ever before will have their routine care provided for them in local settings, with only those who need to go to an acute hospital like the Lister being treated in such facilities.

Indeed when staff, patients, members of the public and local politicians ask if the *Delivering quality health care for Hertfordshire* programme is affordable in today's economic climate, the response has always been the same. Implementing these vital changes is the only way that the Trust can reduce its costs in a way that allows continued investment in leading-edge clinical services for local people. Failure to deliver the strategy, conversely, risks the entire future of acute hospital services in east and north Hertfordshire as the Trust would become both financially unviable and clinically outdated.

Turning to the Trust's performance during 2009/10, this was a year of considerable achievement. By the end of March 2010, the Trust met fully each of the core standards set out through the *Better standards for Health* initiative – the first time that this has been achieved. A wide range of operational, clinical and financial targets were also achieved – with some of the most pleasing being delivery of the A&E four-hour wait and last-minute cancellations standards, both of which represented firsts for the Trust.

The new 18-weeks referral-to-treatment targets for admitted and non-admitted patients were achieved ahead of the national deadline, as were the new cancer waiting times that came in to effect from January 2010. The Trust's clinical divisions are now working to achieving the 18-weeks standard across each and every specialty – something that is all but in place.

At the same time the Trust's patients waited for less time to be seen and treated, experienced fewer delays and last-minute cancellations and received better quality care. Infections acquired in the Trust's hospitals, such as those caused by MRSA and *Clostridium difficile*, plummeted again. Last year, just seven people acquired an MRSA blood infection in one of the Trust's hospital – the equivalent of just one person every other month. Equally the level of infections caused by *C. difficile* is at the lowest level ever.

Another indicator of improving quality can be found in the Trust's mortality rates. While crude mortality rates – the percentage of patients who die out of every 100 people admitted to its hospitals – have been dropping year-on-year, the biggest fall has been in the last 18 months or so. Back in 2005/06, the Trust's crude mortality rate stood at 2.25%; today, the latest figure available is 1.8%. While the decrease may appear small in percentage terms, this equates to many people being alive today who might otherwise have died thanks to improvements made in the Trust's clinical services.

This improvement has also been echoed by corresponding falls in the Trust's hospital standardised mortality ratio (HSMR), which is a statistical device that is used nationally to compare the performance between different NHS trusts. The Trust's HSMR figure for 2009/10 is 91.7, which compares favourably to the score of 115.8 received the previous year. The Trust's score improved at double the rate of that for the country as a whole.

A further example of quality standards improving across the Trust comes from patient feedback. A combination of patient experience mechanisms employed by the Trust during 2009/10 show a consistent pattern. The latest results show that over 90% of patients would recommend the Trust's hospitals to their friends and family, with equally high ratings being given to privacy, respect and dignity standards, ward cleanliness and the quality of food that patients eat.

Financially-speaking the Trust's performance during 2009/10 remained good. The predicted £2.5 million surplus was achieved, as were a number of other important financial targets – including delivering just over 100% of the £9.6 million cost improvement programme set out at the start of the year. The Trust remains well positioned, therefore, to meet what is set to become one of the most challenging years for some time.

It would be wrong to suggest that the Trust's overall performance left no room for improvement. Attention is being paid to improving further the quality, breadth and depth of the Trust's recording of patient-related data on its computer systems in order to make sure that it meets national standards. Equally, efforts have been underway to reduce the numbers of patients failing to show for their outpatient appointments, through more effective booking and reminder systems, as well as making it easier for people to make changes to their booked dates.

After this impressive year for the Trust, it is important to remember that the achievements and successes delivered would not have been possible without the dedication of our staff and their continued desire to improve the quality of care they provide to patients.

Nick Carver
Chief Executive

Chapter 3: future trends and projections

Strategic change underway

Both within Hertfordshire and through the Mount Vernon Cancer Centre, the Trust is focusing on providing services to standards that are recognised by the community as being better than those elsewhere; and as being as accessible as is possible, without compromising quality.

For many years, the Trust has provided emergency and planned acute services from its two district general hospitals in Hertfordshire, with limited scope for economies of scale and without the critical mass required to introduce key service improvements. Whilst some consolidation has been achieved over the last three years, for fully efficient, modern and high quality services to be developed, all of the Trust's acute services need to be consolidated on one site, the Lister, with outpatient and diagnostic services provided in other hospitals – including Hertford County and the new local general hospital being developed on the QEII site.

The NHS in Hertfordshire approved the *Delivering quality health care for Hertfordshire* strategy in December 2007, following extensive public consultation. Since then, the Trust has been implementing a detailed phased programme of developments managed under its *Our changing hospitals* programme, which will address a number of clinical and financial challenges, including:

- Enabling the achievement of best clinical practice, whilst at the same time improving outcomes and productivity across the Trust's hospitals;
- Improving the Trust's ability to attract and retain high quality staff in a way that is supportive of a fast-approaching future in which more acute care is provided in the community;
- Creating a critical mass of clinical and specialist staff to support the introduction of new technologies, as well as sustain a wider range of high quality acute services than otherwise would be possible;
- Maintaining viable 24/7 medical staffing rotas for all of the Trust's clinical services;
- Facilitating the modernisation of the Trust's facilities, improving their attractiveness to patients and staff alike and enabling them to be fit for purpose;
- Reducing estate and related costs from the reshaping of the QEII site to offset income loss and support the revenue consequences of capital investment in the Lister.

The *Our changing hospitals* programme being delivered at the Lister currently takes a phased approach to change, testing deliverability and flexibility at each stage. The following progress has been made to date:

- Phase one – the Lister Surgicentre: financial close on this important development was reached between the NHS and its independent sector partner Clinicenta in 2009, following which construction on the new £47 million facility began. The service will become operational from April 2011 and mobilisation work needed for this to happen is underway.

- Phase two – maternity expansion: full business case approval for this £16.5 million NHS-funded scheme was achieved in August 2009, with construction commenced the following month. The new service is scheduled to start from October 2011.

- Phase three – multi storey car park: financial close was reached with the Trust's preferred bidder, Vinci, in June 2010. Work on building the new car is set to start in September 2010, with it opening for use by August 2011. The additional parking spaces, which include much improved provision for blue badge holders, will help to support the transfer of inpatient and emergency services to the Lister over the coming years.

- Phase four – full consolidation of all remaining emergency and planned acute hospital services: the Trust is refining the outline business case to reflect NHS Hertfordshire's refreshed commissioning strategy for the next few years. The outline business case is ready for approval and will be taken to the respective boards of the Trust, NHS Hertfordshire and NHS East of England as soon as the outcome of the Coalition Government's national review of planned health services reconfiguration is known. If all goes to plan, the new services should be up and running from 2014.

This strategic framework provides an opportunity for the Trust to extend some services, on cost-effectiveness and quality grounds, into community settings. Examples include the provision of urgent care centres, such as the one launched by the Trust at Hertford County hospital in October 2009, and working with NHS Hertfordshire on its plans for the new local general hospital that it is developing on the QEII site.

At the same time, the framework will also support the development of more specialist services locally within Hertfordshire, reducing the need for people to travel outside of the county for their cardiac and cancer treatment in particular. For example the Trust is developing heart attack and stroke services to rival centres of excellence elsewhere in the region, whilst supporting strongly NHS Hertfordshire's interest in developing a satellite radiotherapy service within the county.

The Mount Vernon Cancer Centre has been a key component of the Trust since 2005, following which £28.9 million of combined NHS and charitable investment has been made in developing its services. Whilst many of the centre's facilities have been transformed, there remains a need for further investment. Mindful of this, the Trust's cancer services divisional team is implementing plans to maintain Mount Vernon at the *top table* of cancer centres nationally, with new research facilities, chemotherapy capacity and stereotactic body radio-surgery – the new CyberKnife that will be ready for its first patients in the autumn of 2010.

The strategy's financial implications

In implementing its strategy, the Trust will have to raise the necessary funds to allow the capital developments to take place. This borrowing will, in turn, be financed by savings released as services shift to the Lister site in accordance with the defined phases outlined above. While the funding source for the fourth and final phase of the *Our changing hospitals* programme has yet to be confirmed, the Trust's long term financial model assumes that it is accessed via the Department of Health – i.e. traditional NHS capital funding, involving interest bearing debt.

Bearing in mind the current economic climate, consolidating acute services on to one main hospital site helps to ensure that the Trust has a viable financial future, at the same time as supporting the very real improvements in clinical quality being demanded of the NHS. Between 2010/11 and 2012/13, the Trust will deliver relatively modest net surpluses of around 1%. Post configuration, the achievable level of surplus grows, albeit slowly.

Achieving NHS foundation trust status

The Trust is pursuing actively its NHS foundation trust application and throughout 2009/10, has built its public membership to nearly 7,000 foundation trust members whilst continuing to strengthen its governance arrangements as part of its preparations. Following a positive NHS East of England and Trust *Board-to-Board* meeting in September 2009, the Trust has since held an equally successful formal review meeting with the chairman and chief executive of NHS East of England at the end of March 2010.

The Trust has since submitted its updated integrated business (IBP) plan and long term financial model IBP to NHS East of England, with its outline business case for the fourth and final phase of the Lister's redevelopment submitted at the start of April 2010. The approval process undertaken by the boards of first NHS Hertfordshire and the Trust, followed by NHS East of England, is expect to be completed by mid-2010.

During last year's Board-to-Board meeting with NHS East of England, the principal issues and requirements discussed and agreed were for the Trust to:

- Evidence improvements in quality and patient experience;
- Achieve an overall rating of minor concern or better;
- Demonstrate a reduction in HSMR to average or better;
- Submit an updated long term financial model, which works through the impact of the revised phase four outline business case and two years of detailed cost improvement programmes that take in to account NHS Hertfordshire's new commissioning strategy;
- Produce an unequivocal letter of support from NHS Hertfordshire;
- Maintain current levels of performance against all national operational, clinical and financial standards and targets.

Since September 2009, the Trust has succeeded in achieving all of these requirements according to the timetable agreed at the *Board-to-Board* meeting.

The Trust expects that its application to become a NHS foundation trust will now continue subject to the completion and outcome of the Government's review of acute hospital reconfigurations, which was announced on 21 June 2010.

Current service development plans

In addition to the longer-term strategic change being implemented by the Trust, which is due to be completed by 2014, other, more immediate, service development plans are also being pursued. All those listed below are in line not just with the Trust's strategic framework, but the new commissioning intentions being followed by NHS Hertfordshire.

Cardiology

From April 2009, the Trust has provided a weekday, 9.00am to 5.00pm primary percutaneous coronary intervention service for patients who have had a heart attack. The Bedfordshire and Hertfordshire Heart and Stroke Network is supporting the Trust's plans to develop a second cardiac catheter laboratory, which will allow the expansion of cardiology capacity. Plans to achieve this outcome are underway.

Renal dialysis

The Trust's existing tertiary renal service is recognised widely as a flagship service. In response to recommendations made by the East of England Specialist Commissioning Group in 2009, the Trust has begun piloting home dialysis and has developed a home dialysis training unit. Subject to the outcome of regional consultation on the way forward for renal services, the Trust is keen to explore potential opportunities to provide satellite renal dialysis services within Bedfordshire and Hertfordshire to complement those it provides already at the Lister, Luton & Dunstable and St Albans City hospitals.

Hertfordshire's satellite radiotherapy service

NHS Hertfordshire's proposal to assess the feasibility of developing a satellite cancer centre unit in Hertfordshire is consistent with the Trust's aim of providing more cancer services locally. Over the coming months, the Trust will continue to work with clinicians, stakeholders and commissioners to assess the feasibility of this development and identify the benefits for the communities of Hertfordshire and south Bedfordshire of a local satellite cancer centre unit.

Securing research at the Mount Vernon Cancer Centre

The Trust has entered in to an academic partnership for the cancer centre that will enable further expansion of clinical research activity and secure the pre-eminence of Mount Vernon as a centre for cancer research. A formal launch of the partnership arrangement was held on 28 June 2010 with the cancer centre's partners, the Institute of Cancer Research and Royal Marsden NHS Foundation Trust. The partnership helps to secure Mount Vernon's future research capability and meets one of the key recommendations made through NHS Hertfordshire's review of cancer services conducted in 2009.

The first CyberKnife for robotic radio-surgery in the NHS

From the autumn of 2010, the Trust will start providing a new CyberKnife robotic radio-surgery service from the Mount Vernon Cancer centre. The opportunity for this £2.7 million project arose from the generous offer of a major donation to be used towards radiotherapy equipment, which currently is not available in the NHS. The new CyberKnife service will give patients access to robotic radio-surgery treatment services that presently are only available in two private facilities within the UK. The technique is suitable for both small and complex tumours, as well as solitary metastases. It will also allow the Trust to develop innovative techniques for patients that can be evaluated and expanded for use within the NHS more generally.

Replacement of Mount Vernon's ward block

The Trust is working in partnership with Hillingdon Hospitals NHS Trust, the landlord of the Mount Vernon hospital site, to agree a site development programme that will enable a plan to be developed to replace the cancer centre's existing wards.

Improving the Trust's information management and technology

The Trust's IM&T strategy will continue to build on its commitment to the *National Programme for IT* and the use of the iPM patient administration system (PAS); initially, the latter is being extended to include the Mount Vernon Cancer Centre. The IM&T plans for 2010/11 include rolling out the implementation of electronic discharge letters, e-prescribing (at the cancer centre) and resource planning for the Trust's operating theatres. The emphasis is on providing enhanced clinical applications support.

The Trust has developed a new information strategy, which will see the development of a new informatics regime that will manage and utilise data more effectively across its life-cycle – from creation, collection, storage and retention, through to distribution.

Key deliverables to achieve the vision are to:

- Establish a *data warehouse* development programme with a clear business change request process in place;
- Improve data quality scores, as measured by the NHS Information Centre and Quality Care Commission, through improved governance and staff engagement;
- Establish the Trust's new informatics organisation structure to provide business intelligence and information infrastructure capabilities.

Delivering NHS Hertfordshire's commissioning intentions

As outlined already, the Trust is progressing actively its outline business case for the final phase of acute service consolidation at the Lister. This work is being carried out in partnership with NHS Hertfordshire, reflecting the latter's revised future commissioning intentions. The final business case put forward for approval will, of course, be informed by the outcome of the Coalition Government's national review of planned health service reconfigurations, which is underway currently.

In its commissioning plans, NHS Hertfordshire has set significantly reduced levels of acute hospital patient activity from 2012 onwards; these commissioning intentions have informed the capacity planning work which has defined the future configuration of hospital services at the Lister. The Trust Board is keen, however, to ensure that the outline business case provides sufficient flexibility to allow the Trust to respond to a range of future demand scenarios.

At the same time, the Trust's clinicians are engaging with NHS Hertfordshire to develop the new models of care that will be necessary to reduce the number of patients being referred for acute-based care. The Trust recognises that its involvement and leadership of a number of these key initiatives is essential for the successful delivery of the national/regional quality, innovation, productivity and prevention (QIPP) initiative underway currently.

Delivering the East of England health strategy – *Towards the Best, Together*

The Trust is committed to working in partnership to support the delivery of the pledges set out in the regional *Towards the Best Together* health strategy, with a number of senior Trust clinicians are members of regional working groups.

The Trust has also ensured that all its planned service developments are consistent with the pledges set out in *Towards the best, Together* – this vision for improving the health of people living and working across the region is supported by the Trust's *Our changing hospitals* programme, which focuses on providing localised services, where possible and centralising complex care, where appropriate, in order to improve clinical outcomes for patients. The planned actions that will support the principles and pledges outlined in the *Towards the best, Together* strategy are:

- Providing specialist urology cancer surgery for all of Hertfordshire;
- Investing in specialist cancer services at the Mount Vernon Cancer Centre;
- Developing a home renal dialysis training centre and piloting home dialysis;
- Working in partnership with Assura Medical LLP in delivering urgent care centre services at Hertford County and Cheshunt Community hospitals;
- Developing partnerships with primary care, patient groups and local authorities to support health and well-being more generally.

Meeting the expectations of regulators

During 2009/10, the Trust:

- Saw its annual health check rating, published in October 2009 covering the 2008/09 year, improve (use of resources improved from *fair* to *good*, with quality of services just missing out on a *good* rating;
- Received a successful Hygiene Code inspection in November 2009, which found only one area where improvement was necessary – introducing a more robust plan for the cleaning and replacement of mattresses, which has since been completed;
- Achieved registration, without conditions, for infection control from 1 April, 2009. (*The Trust protects patients, staff and others from known risks of acquiring an HCAI.*)
- Achieved registration, without conditions, with the Care Quality Commission on 1 April 2010.

During the coming year, the Trust will be seeking to improve upon this performance with regulators such as the Care Quality Commission and, depending on the outcome of its NHS foundation trust application, Monitor.

Chapter 4: implementing the NHS Constitution

The NHS Constitution was first published on 21 January 2009. It was one of a number of recommendations in Lord Darzi's report *High Quality Care for All*, which was published on the 60th anniversary of the NHS and set out a ten-year plan to provide the highest quality of care and service for patients in England. The NHS Constitution brings together in one place, for the first time in the history of the NHS, what staff, patients and public can expect from the health service.

As well as capturing the purpose, principles and values of the NHS, the Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and public and it reflects what matters to them.

From 19 January 2010, following the successful passage of the Health Act through Parliament, all providers and commissioners of NHS care are under a new legal obligation to have regard to the NHS Constitution in all their decisions and actions. This means that the Constitution, its pledges, principles, values and responsibilities need to be embedded and ingrained fully into everything the NHS does. This is a duty that the Trust takes seriously and seeks to demonstrate through the decisions it takes.

New legal rights

On 8 March 2010, following extensive consultation, the Department of Health confirmed that from 1 April 2010, patients would get additional rights around waiting times under the NHS Constitution. This will mean that patients will have the legal right to start treatment by a consultant within 18 weeks of a GP referral and to be seen by a specialist within two weeks of an urgent GP referral for suspected cancer. If this doesn't happen, the NHS will be obliged legally to take all reasonable steps to offer them a range of alternative providers.

From 1 April 2012, everyone between 40 and 74, who is eligible, will have the legal right to an NHS Health Check every five years. The consultation also received support for future rights on evening and weekend access to GPs, access to NHS dentistry, and the right to key diagnostic tests for patients suspected of having cancer within one week of seeing a GP, with an interim milestone of two weeks.

The Government has a legal duty to renew the Constitution every 10 years. No Government will be able to change the Constitution without the full involvement of staff, patients and the public.

Further information on the NHS Constitution and its accompanying documents is available on the Department of Health website at: www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm

Chapter 5: quality improvements and outcomes

Overview

The Trust is committed to delivering high quality care to patients, whilst also minimising their exposure to risks. Initiatives such as the implementation of the safer surgery checklist, providing essential training to staff, learning from errors and having clear policies and procedures, ensure that the Trust continues to make improvements in patient safety and clinical outcomes.

Patient safety is foremost in everything the Trust and its does. Patients and their carers should not have to worry about acquiring an infection while in hospital, which is why the Trust makes sure that infection prevention is considered in every aspect of hospital management, patient care and each step of the patient journey in order to make sure that any risk involved as low as possible.

The Trust's approach is to embed infection prevention and control in all aspects of services provided to patients. This applies not just to nurses, midwives and doctors, but to the wider clinical and non-clinical teams whose work impacts on patient care. As a result, the Trust's staff have achieved and sustained significant improvements in managing at-risk patients, which is evidenced by achieving over and above the target reduction set by our local primary care trust when it comes to reducing hospital-acquired infections.

Much of the improvement in the Trust's infection prevention and control performance, along with a similarly strong performance when it comes to issues such as mortality rate, falls reductions and patient experience, are set out in this chapter. This work underlines the Trust's ambition to become a NHS foundation trust by 2011, which will provide the financial freedom to invest in developing better services for patients. It will also allow the Trust to become far more accountable to it members, both public and staff.

It is well documented that these are difficult times economically, with big challenges lying ahead for the NHS in the years to come. This is why the Trust is planning carefully the future shape of its services, ensuring that it is able to continue to develop and deliver high quality health care that is valued and trusted. Truly world-class services are efficient as well as effective, with high quality care resulting from both.

It is the Trust's job, therefore, to ensure that its services are provided in the most efficient and effective way achievable, with a focus on the best possible treatments and outcomes for patients. To that end, each of the Trust's four hospitals will play a key role in delivering this objective.

Priorities from 2009/10

In this section, a summary of progress identified in the pilot quality account produced for 2008/09 is provided.

Priority 1: Infection prevention and control

Priority 2: Improving outcomes for patients with fractured hips

Priority 3: Increasing the percentage of patients who would recommend the Trust

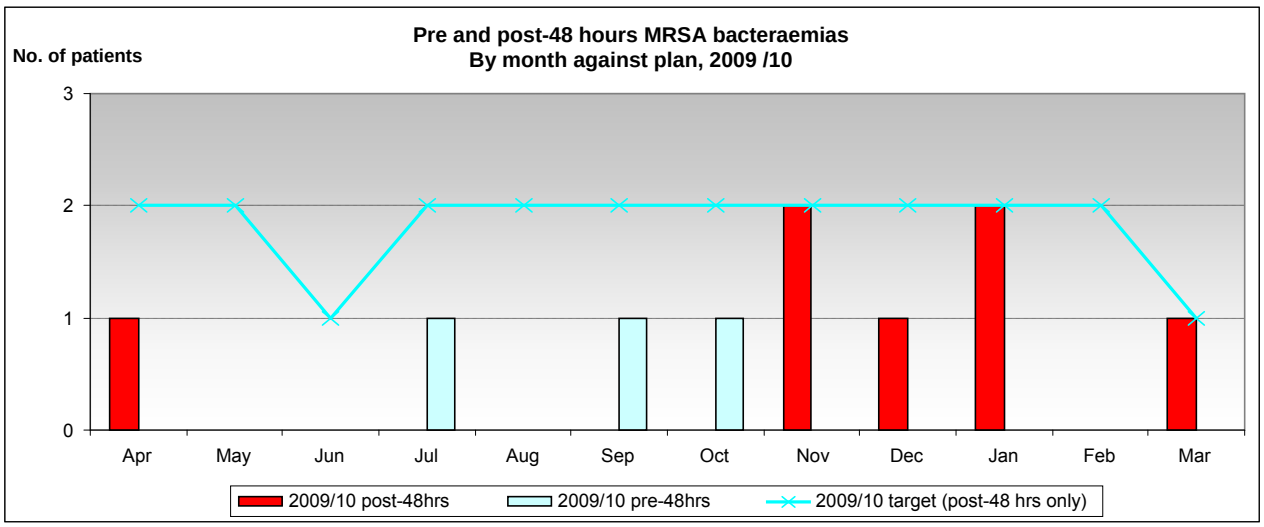
Priority 4: Improving outcomes in acute medical care (stroke, pneumonia, COPD)

Priority 1 – infection prevention and control

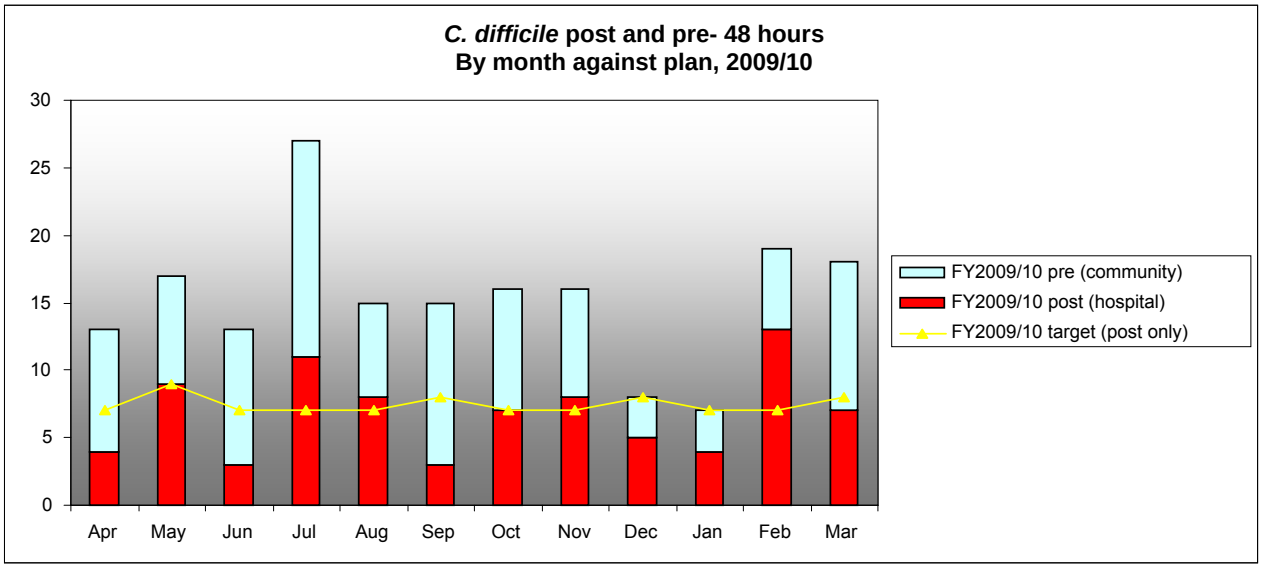
Infection prevention and control has continued as a high priority for the Trust following the success of a range of initiatives undertaken during 2008/9. This success has continued throughout 2009/10, with results far exceeding the targets set for the Trust.

Aim	Target 2009/10	Actual 2009/10	Actual 2008/09	Actual 2007/08
Exceed SHA target for reducing MRSA bacteraemias (blood infections)	22	10	18	33
Exceed the SHA target for reducing *Clostridium difficile* infections	159	82	108	354

Throughout 2009/10, the reduction in MRSA bacteraemias (blood infections) consistently has been better than the plan set for the Trust by NHS East of England – see graph below.



The Trust's performance in reducing numbers of hospital-acquired *Clostridium* difficile infections, as shown in the graph below, was also better than the year's plan.



This continued excellent performance around infection prevention and control was achieved through the implementation of a range of co-ordinated initiatives:

- Monthly reporting and monitoring of all high impact interventions;
- Strict management of antimicrobial usage;
- Strict monitoring of ward and department cleaning schedules;
- Review and replacement of mattresses;
- Immediate departmental investigation of any outbreaks;
- Mandatory training for all staff;
- Enhanced screening for MRSA, with treatment of positive cases;
- Increased provision of specimen testing arrangements to seven days a week.

Priority 2: Improving outcomes for patients with fractured hips

Data from 2008 suggested that when it came to the care of patients with fractured hips, outcomes from the Trust's surgical procedures were not in line with national averages. A programme to deliver real improvement around this important clinical issue was put in place in late 2008, which continued to be implemented during 2009/10.

A new clinical pathway for patients with a fractured hip was put in place, the aim of which was to operate on people within 48 hours. This initiative resulted in 87.4% of patients going to theatre much more quickly for their operations – see table below for further information.

Data (26 March 2009 to 14 April 2010)	Number	%
Total number of patients operated on	444	n/a
Number of patients operated on within 48 hours	388	87.4%
Number of patients needing an operation who underwent surgery after 48 hours	56	12.6%

The true impact of this important clinical improvement, however, was a consequent reduction in the number of patients who died:

- Mortality prior to new clinical pathway being introduced – 17.0%
- Mortality after the new pathway began being used – 8.9%

This improvement can also be seen in the hospital standardised mortality ratio (HSMR) for fractured hips – this is the number of people who have died given the population mix.

2008/09	Full year	Apr to Jun 2009	Jul to Aug 2009	Sep to Dec 2009
HSMR for fractured hip	175	101.8	130.3	116

All patient deaths are reviewed carefully to understand the outcome, with the aim of identifying whether or not improvements in care can be made in the future. This work can also help identify any errors in clinical coding used by the Trust.

The change in the Trust's performance around fractured hips was delivered through a combination of the following actions:

- Early priority given to anaesthetic pre-assessment, including pain management;
- Introduction of dedicated trauma list;
- The Trust's surgical division audits the management of patients with fracture neck of femur against the agreed care pathway;
- A care of the elderly physician with a specific interest in ortho-geriatrics was appointed, who joined the Trust on 1 April 2010.

This work will continue throughout 2010/11 and beyond, with the aim of changing the current clinical pathway so that patients with fractured hips get their operations within 36 hours. Results will continue to be monitored closely within the division and by the Trust Board.

Priority 3: increasing the percentage of patients who would recommend the trust

The question *Would you recommend this hospital to friends or family*? is particularly important to the Trust and its staff, as it acts as a proxy measure for overall patient experience and satisfaction of their care. During 2009/10, this question was asked of the Trust's patients more than ever before through the:

- Introduction of a regular quarterly postal satisfaction survey;
- Installation of 30 electronic tracking devices to obtain *real-time* feedback from patients in different locations around the Trust's four hospitals.

To date, over 13,000 people have responded to these initiatives and the results have been encouraging. For example, the postal surveys show consistently that 90% of patients would recommend the Trust's hospitals to their families and friends. Feedback provided through the *real-time* patient experience trackers show a very similar result. These findings are monitored every month by the Trust's *risk and quality committee*, as well as by the Trust Board.

Priority 4: improved stroke services

During 2009/10, many improvements to the Trust's stroke services were put in place. This is an area of care that the Trust knows is important to patients, which is why improving care for those with a stroke will remain a priority for the coming year.

One way of measuring improvements made in stroke care is to monitor the Hospital Standardised Mortality Ratio (HSMR) score for this specific group of patients. During 2009/10, the HSMR score for stroke improved as set out in the table below:

	2008/09	Apr to Jun 2009	Jul to Aug 2009	Sep to Dec 2009
HSMR for stroke	126.8	94.6	86.8	84.7

This suggests that as a result of improved clinical care made by the Trust's clinicians, there are fewer deaths from stroke in the Trust's hospitals than would be expected given the make-up of the local population. These figures will continue to be monitored carefully, particularly in evaluating the impact of the latest improvements that have been made to this important service.

The action taken by the Trust during 2009/10 have been:

- Stroke thrombolysis – use of specialist clot busting drugs on suitable patients within A&E – was introduced at the Lister hospital from November 2009;
- A hyper-acute stroke unit was opened at the Lister, with 12 beds providing high level neurological and cardiovascular monitoring for the first 24 hours of a stroke. After this immediate care patients are transferred to the Trust's acute stroke rehabilitation unit at the QEII hospital;
- Funding has now been agreed to appoint a new stroke physician during 2010;
- A high risk transient ischaemic attack (mini stroke) clinic seeing all patients and providing scans within 24 hours, started in February 2010.

Priority 4b: improved pneumonia and chronic obstructive pulmonary disease (COPD) service

Respiratory diseases account for 30 to 50% of all acute medical admissions. Referral pathways and guidelines ensure that appropriate patients are referred to clinical teams, including to specialist nurses when relevant for care and advice. The pathways have been reviewed and revised to improve communication, as well as remove delays and surplus paperwork, are being introduced during 2010/11.

Ready access to lung function, CT scanning and sleep studies for the further care of patients with COPD now exists in outpatient settings. Such patients are still admitted, however, following acute attacks. Their length of stay is average for the country, but work has started on an early supported discharge pilot.

Services have moved towards greater centralisation at the Lister during 2009. The intention now is to work further with primary care colleagues to enhance their ability to manage patients at home, thus avoiding needless hospital admissions.

The development of non-invasive nasal ventilation on the Trust's general wards, instead of in the intensive care units, for those in need of breathing support is just beginning. Training is being undertaken currently on general wards with the aim of providing better care for this group of patients. It is planned to introduce respiratory high dependency units that not only support people requiring non-invasive ventilation but also provide an area for closer observation of the most sick patients, for example those with breathing tubes.

The respiratory nurses work mainly within the hospitals to provide care, support and assessment to respiratory patients and offer out-patient clinic services. They also run a telephone information helpline and work closely with colleagues in the community to provide a seamless service.

The HSMR for COPD has improved from 150.2 in 2008/9 to 102.6 in 2009/10 (data to January 2010).

Priorities for 2010/11

The Trust's clinical improvement priorities for the coming year are:

Priority 1:	Priority 2:	Priority 3:	Priority 4:
Infection prevention and control	Effectiveness outcomes in cardiology	Patient experiences of end of life care	Continuing improvement in stroke services

Priority 1: infection prevention and control

This safety indicator will continue as a priority for 2010/11 because of its high national profile for patients and the wider public as a measure of confidence and safety. It is also considered to be a high priority by Hertfordshire county council's overview and scrutiny committee.

The aims of this year's plan will be to:

- Reduce the incidence of MSSA bacteraemias (blood infections);
- Achieve the 100% MRSA elective screening target set for 2010/11;
- Maintain hospital-acquired MRSA bloodstream and *C. difficile* infections below 2010/11 trajectories levels – 3 for MRSA bacteraemias and 63 for *C. difficile*.

Implementation of the Trust's infection prevention and control action plans will be monitored by the *infection control committee*, with assurance being provided on a monthly basis to the Trust Board's *risk and quality committee*. This will involve the use of graphical trend reports, with case reviews of MRSA and MSSA bacteraemias, *C. difficile* and Norovirus being presented.

Rates of MRSA bacteraemia and *C. difficile* infections will continue to be made available to the public on a monthly basis as part of the clinical quality dashboard – available in the Board's part one papers via the Trust's website (http://www.enherts-tr.nhs.uk).

The specific actions being taken in 2010/11 will be:

- Extending MRSA screening to all emergency patients;
- Commencing a new, higher specification cleaning contract (commenced on 1 April 2010);
- Implementing the Trust's *infection control assurance framework and annual programme*;
- Extending infection prevention and control education for all medical staff.

Priority 2: effectiveness outcomes in cardiology

The need for this clinical priority was identified for 2010/11 because of the drive across the East of England towards reducing the number of deaths from heart disease.

The Trust is in the process of seeking approval to build a second cardiac catheterisation laboratory. This means that it will be able not just to treat more patients quickly following a heart attack, but allow more patients to be treated locally who until recently have had to be referred to other centres, such as Harefield, due to lack of local capacity .

The aim of this year's plan will be to:

- Reduce waiting time for inpatient angiography/percutaneous coronary intervention (PCI) for patients with an acute coronary syndrome;
- Faster access to PCI for patients with a heart attack (called primary PCI), resulting in reduced door-to-balloon times (time from arrival in hospital to the point when a blocked artery is opened up);
- Reducing length-of-stay for primary PCI and acute coronary syndrome.

In terms of monitoring improvements, acute myocardial infarction (heart attack) will feature on the cardiology and Trust-wide clinical dashboard. Trends will be considered routinely via specialty and divisional board meetings. Compliance with national primary PCI guidelines is monitored on a monthly basis by the Trust Board, as well as by monthly cardiology internal audits.

Waiting times for angiography will be made available to the public on a monthly basis with the Board meeting papers via the Trust's website (http://www.enherts-tr.nhs.uk).

The main action being taken in 2010/11 will be the installation of a second cardiac catheterisation laboratory, which is subject to the full business case being approved by NHS Hertfordshire and NHS East of England.

Priority 3: improving patient experience of end-of-life care

The need to continue improving patients' experience of the end-of-life care provided in the Trust's hospitals was identified as a priority for 2010/11 for a number of reasons, including the national *End of life* strategy and the NHS East of England drive towards improved palliative care. It highlights the Trust's intention to better understand cancer and end-of-life care delivery from perspective of patients.

The Trust's clinical staff consider this objective to have great potential because of its application to many patients, along with the current relatively low level of engagement in the use of the *Liverpool care pathway*. Developed in Liverpool, the pathway is a planned programme of care to ensure that all dying patients, along with their relatives and carers, receive a high standard of care in the last days and hours of their lives. Based upon latest research, it guides staff in the delivery of both physical care (such as comfort and pain relief) and emotional care – especially around dignity and support.

The aim of the work programme will be to:

- Ensure advance care plans are completed for more than 50% of patients requiring end-of-life care;
- Make sure that the *Liverpool care pathway* is used for more than 75% of patients (anticipated deaths) approaching end-of-life;
- Seek patient views of carers of patients approaching end-of-life.

When it comes to monitoring for improvement, compliance with the *Liverpool care* pathway will be measured and monitored on the divisional dashboard; trends will be monitored via the divisional board meetings. Three key performance indicators will measure the divisional performance that relates to the directly quality of care:

- Spread of the *Liverpool care pathway*;
- Anticipatory prescribing for key symptoms that may develop in the last days of life;
- Compliance with completion of the *Liverpool care* pathway.

Progress with implementing the Trust's end-of-life strategy will be presented to the Trust Board meeting and be available, therefore via the Trust's website (http://www.enherts-tr.nhs.uk).

In terms of specific actions being undertaken during 2010/1, these will be the:

- Roll-out of advance care plan training across the Trust;
- Analysis and action relating to the carers/bereavement survey;
- Submission to next round of *Liverpool care pathway* national audit;
- Discharge of patients to their preferred place of care, documenting reasons if this is not possible;
- Improve GP notification of patient deaths;
- Audit of complaints relating to end-of-life issues within the Trust.

Priority 4: continuing improvement in stroke services
Given that a significant amount of change has been introduced at the Trust already, specifically towards the end of the 2009/10 year, this clinical area will continue as a priority for 2010/11 in order to monitor closely the resulting expected service improvements. It was also considered to be a high priority by the Hertfordshire Local Involvement Network (LINk).

The aim of the work will be to:

- Increase the number of stroke patients who spend 90% of their time on the Trust's stroke unit to more than 80% by March 2011;
- Increase the number of patients with high risk transient ischaemic attack who are treated within 24 hours, but are not admitted, to more than 60% by March 2011.

In terms of monitoring improvements, these indicators will be reported monthly to the Bedfordshire and Hertfordshire Heart and Stroke Network. They are also reviewed within the specialty and clinical division, as well as forming part of the indicator set monitored quarterly by the Trust's *risk and quality committee*. Progress against the aims will be reported in next year's *quality account* report.

The specific actions being pursued in 2010/11 will be to:

- Develop the stroke thrombolysis service to cover 24 hours every day;
- Participate in the regional tele-medicine service;
- Work towards centralisation of all stroke services on one site at the Lister;
- Work with community colleagues to re-brand/re-name the Trust's transient ischaemic attack clinic to become a place of immediate referral so that assessment and treatment, if necessary, can be started as soon as possible.

Statements of assurance from the Trust Board

Review of services
During 2009/10, the Trust provided and/or sub-contracted 27 NHS services; all the data available on the quality of care provided in each of these 27 services has been reviewed. The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust for 2009/10.

Clinical audit

During 2009/10, 32 national clinical audits and seven national confidential enquiries existed that covered NHS services provided by the Trust. During the year, the Trust participated in 81.3% and 86% respectively of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The eligible national clinical audits and national confidential enquiries, including those in which the Trust participated during 2009/10, are listed in the tables on the next page.

National clinical audits	Yes	No
VSSGBI national vascular database	✓	
Continuous, all patients		
NNAP – neonatal care	✓	
NDA – national diabetes audit (paediatric units only)	✓	
INARC CMPD – adult critical care units	✓	
National elective surgery PROMs – four operations	✓	
NIAP – adult cardiac interventions (coronary angioplasty)	✓	
NJR – hip and knee replacements	✓	
Renal registry – renal replacement therapy	✓	
NLCA – lung cancer	✓	
NBOCAP – bowel cancer	✓	
DAHNO – head and neck cancer	✓	
MINAP – myocardial infarction	✓	
Heart failure audit	✓	
NHFD – hip fracture	✓	
TARN – severe trauma	✓	
Intermittent samples of patients		
National kidney care audit (two days) – vascular access, patient transport	✓	
National audit of dementia	✓	
National comparative audit of blood collection – blood collection, use of red blood cells in children	✓	
College of Emergency Medicine – pain in children, asthma, fractured neck of femur	✓	
National sentinel stroke audit (2008/09 only)	✓	
National falls and bone health audit (2008/09 only)	✓	
British Thoracic Society – emergency oxygen, adult community acquired pneumonia	✓	
British Thoracic Society – NIV (adult, paediatric pneumonia, adult asthma, paediatric asthma and adult community acquired pneumonia)		✓
One-off, all patients		
National oesophago-gastric (stomach) cancer audit and outcomes	✓	
National mastectomy and breast reconstruction audit	✓	
Royal College of Physicians – continence care audit		✓

Note: some of the lines listed above contain more than one audit

National confidential enquiries	Yes	No
National Confidential Enquiry into Maternal and Child Health (CEMACH)		
CEMACH - head injury in children	✓	
CEMACH - obesity in pregnancy	✓	
CEMACH - national maternal and perinatal mortality surveillance	✓	
CEMACH - saving mothers' lives (mortality figures/action plan for CNST meeting)	✓	
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)		
NCEPOD - emergency and elective surgery in the elderly		✓
NCEPOD - surgery in children	✓	
NCEPOD - perioperative study	✓	

The reasons for non-participation in some of the available audits and confidential enquiries conducted during 2009/10 relate to insufficient resource being available, caused mainly by their late identification for forward planning purposes. A second reason was the unavailability of certain sets of medical notes.

During 2009/10, the Trust also participated in the following national clinical audits:

- National multiple sclerosis 360 degree audit;
- Royal College of Anaesthetists 4th National Audit Project (NAP4) – major complications of airway management in the UK;
- Emergency Airway Audit (CEM);
- National Radiotherapy Advisory Group (NRAG) – predication and recommendations of machine usage and requirements audit against current protocols for SpR clinical oncology;
- National Audit – cardiac rhythm 2009/10;
- NCAAG, Epilepsy 12 – quality and delivery of care for children and young people with suspected and diagnosed epilepsies;
- Older Peoples Experience of Falls Prevention Service (RCP);
- National Diabetes Inpatient Audit Day and *Think Glucose* campaign;
- National Audit on AAA;
- Peri-natal Transmission of HIV in England 2002-05 Audit – evaluation exercise;

The national clinical audits and confidential enquires in which the Trust participated, and for which data collection was completed during 2009/10, are listed below alongside the number of cases submitted to each audit/enquiry as a percentage of the number of registered cases required.

Audit title	Clinical audit % sample submitted
National Vascular Database	31 cases
National Neonatal Audit Programme (NNAP, Royal College of Paediatrics and Child Health, 2009/10)	100%
National Diabetes Audit (paediatric units only)	100%
Intensive Care National Audit and Research Centre (ICNARC, 2009/10)	100%
British Cardiac Intervention Society: Coronary interventions; coronary angioplasty	100%
National Joint Registry – hip and knee replacements	75%
Renal Registry	100%
NLCA – lung cancer	100%
NBOCAP – national bowel cancer (audit period 01.08.2009 to 31.07.2010)	100%
DAHNO – head and neck cancer	100%
MINAP – myocardial infarction	100%
NHFD National Hip Fracture Database	116/200 estimate*
National Kidney Care Audit – vascular access (2009/10)	100%
National Comparative Audit of Blood Collection	99%
National Comparative Audit – use of red blood cells in children	100%
Treatment of children in pain presenting in emergency department (limb fractures) Lister & QEII (CEM)	100%
The treatment of adults with moderate or severe asthma presenting in emergency departments (CEM)	84%
Management of fractured neck of femur in A&E (CEM)	100%
British Thoracic Society – emergency oxygen	100%
National oesophago-gastric (stomach) cancer audit and outcomes	100%
National Mastectomy and Breast Reconstruction Audit	0-25% category**
CEMACH – head Injury in children	100%
CEMACH – obesity in pregnancy	100%
CEMACH – perinatal mortality surveillance	100%
CEMACH – saving mothers' lives	100%
NCEPOD – surgery in children	100%
NCEPOD – perioperative study	66%

*NHFD – 200 is estimated total number of cases (Lister only – QEII not yet started) for 2009/10, however audit only started half way through year
**National Mastectomy and Breast Reconstruction Audit – total figure not known

The reports of 12 national clinical audits were reviewed in 2009/10 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Mastectomy and Breast Reconstruction Audit – a general surgeon (breast surgery) at QEII reported that action is being taken to ensure that breast reconstruction is discussed with every appropriate patient.

NCEPOD – the Trust's anaesthetics, theatres and critical care team reported that existing anaesthetic charts were being modified to comply with recommendations made in the report.

DAHNO Head and neck cancer – to improve data collection for the next audit

In addition, the Renal Registry audit results published during 2009/10 identified that the Trust's survival rate is the sixth best in the country. The National Diabetes audit confirmed that the Trust has been delivering a high standard of current practice.

The reports of 315 local clinical audits were reviewed in 2009/10 and the Trust intends to take the following actions to improve the quality of healthcare provided:

The management of foot osteomyelitis in patients with diabetes (diabetes and endocrinology)
New hospital guidelines have been introduced and a patient information leaflet is planned. A poster presentation of this audit was displayed at the Association of British Clinical Diabetologists at their annual conference last November 2009 and was also accepted for the Diabetes UK Conference in March 2010.

Audit of the management and outcomes of gastro-oesophageal cancer (gastroenterology)
The management and outcomes of gastro-oesophageal cancer between 2004 and 2006 was studied in a recent audit and the figures for treatment modalities mirror larger tertiary centres in the UK and our survival rates are comparable or if not better than centres with higher catchment populations and contrast favourably with the UK's *Improving Outcome Guidelines*. Two posters were presented in November 2009 at GASTRO 2009, organised by The United European Gastroenterology Federation (UEGF), and the World Gastroenterology Organisation (WGO), together with the World Organisation of Digestive Endoscopy (OMED) and the British Society of Gastroenterology (BSG). Data will continue to be collected to produce much needed five-year survival figures.

Specialist clinic for pre-school children with Downs Syndrome – parent satisfaction survey (child health)
The audit demonstrated a high level of satisfaction with the clinic which operates in east Hertfordshire only. As a result of the audit a clinic has recently started successfully in north Hertfordshire. The help of a psychologist is being sought and there are discussions about starting a clinic for school age children. Checklists for recording annual tests and referrals have also been introduced.

Audit of peri-operative fluid prescription (anaesthetics, theatres and critical care)
A new fluid policy has been implemented following the *British Consensus Guidelines on Intravenous Fluid Therapy for Adult Surgical Patients* (GIFTASUP) and a number of teaching sessions have been held for the trainees to encourage compliance.

Haemoglobinopathy screening audit (obstetrics and gynaecology)
All women are now seen pre and post testing by a Pegasus-trained counsellor within the Trust to prevent tertiary referrals. New guidelines are being implemented to ensure more clarity of required actions. There is to be more rigorous follow-up of fathers on a time frame of seven working days in line with new guidelines being introduced in March 2010.

Audits around end-of-life care (oncology)
Recent audits such as end-of-life complaints, the *National Care of the Dying and the Appropriateness of the Liverpool Care Pathway* (LCP) in elderly care, have been presented at general medicine meetings and have raised awareness of this important aspect of care, including the need for multidisciplinary team involvement and better training for all clinicians to ensure appropriate diagnosis of patients in their dying phase. The new LCP version 12, recently published for national implementation, is being customised to accommodate local practice within the Trust.

Children with autistic spectrum disorder (child health)
Following on from an audit of the management of children with autistic spectrum disorder, a family information leaflet has been produced listing a range of post autism diagnosis services for parents and families together with a comprehensive list of services for professionals, including diagnostic and other health services. This has been an agenda item within *the HCTP Strategic Stakeholder Group*.

The management of feverish children <5yrs (emergency medicine and child health)
A new sticker is to be put in the notes of all children <5 years with fever, with the 'traffic light system'.

Audit of laryngeal mask cuff pressures (anaesthetics, theatres and critical care)
Cuff manometers were purchased for every anaesthetic room so that all cuff pressures may be measured routinely and the occurrence of high pressures eliminated. A re-audit is underway.

Influenza and pneumococcal vaccination in patients on immunosuppressive disease-modifying anti-rheumatic drugs (DMARDs) (rheumatology)
Patients with rheumatological disorders on DMARDs are in greater danger of bacterial and viral infections, not only because of the medical therapy but also due to the disease itself. This audit suggested that the immunization message needed to be reinforced. Following this audit, practice has changed to highlight the importance of vaccination on the patient education clinic run by the rheumatology nurse.

Patient satisfaction survey – special care baby unit (child health)
Clinical support workers are being trained to help breastfeeding counsellor to give advice and support to new mothers. A multi-disciplinary discharge planning tool is being produced.

Acting on radiology results (renal medicine)
The completion of this audit has led to the patient safety document for the renal directorate incorporating these results. All renal patient vascular access related requests, reports and DNAs are dealt with exclusively by two named consultants. All other radiology results are acted upon by the requesting consultant.

Vascular access and tunnel vascular catheter (TVC) related infections (renal medicine)
As a result of this audit, new TVC care guidelines have recently been introduced.

Patient satisfaction survey – endoscopy outpatients (gastroenterology)
As a result of the audit, a photo board has been installed at the QEII; the audit form will be changed in the next audit and supplementary ethnicity data has been collected on both units.

The use of blood transfusion in neonates (child health)
Since carrying out the audit, a new blood transfusion proforma has been introduced.

Hand trauma (plastic surgery)
Following an audit, a hand trauma List is now being set up in the Lister's day surgery unit.

Documentation audit (intensive care)
A reminder sticker, emphasising key documentation points, is to be produced and used on each patient folder.

Thermal management (child health – neonates)
New posters and a flowchart on thermal management of newborn babies is to be produced for the Trust's maternity units. This audit is to be presented at the East of England Perinatal Network Clinical Governance meeting.

Management of medical thoracoscopy (respiratory medicine)
Patient survey showed high levels of satisfaction, with post-procedure pain control being the only issue raised. Literature is under review to see if change in pain relief practice is indicated. This audit has been accepted as a poster presentation at the National Lung Cancer Nurses Forum

Blood transfusion audit (anaesthetics, theatres and critical care)
Following this audit mandatory training on blood sampling for transfusion and blood administration was implemented.

Research and development
The number of patients receiving NHS services, provided or sub-contracted by the Trust, in 2009/10 who were recruited during the year to participate in research approved by a research ethics committee was 2,848. Patient recruitment into the United Kingdom Clinical Research Network (UKCRN) portfolio studies has risen dramatically over recent years as summarised below:

- 2007/08: 1,081 patients
- 2009/10: 1,644 patients

The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years; the Trust is on target to achieve this requirement. For 2010/11 onwards, the support funding received by the Trust for research will be related directly to patient recruitment figures.

During 2009/10, the Trust was involved in conducting 267 clinical research studies and used national systems to manage them in proportion to risk – with the vast majority being established and run under national model agreements. The National Institute for Health Research (NIHR) supported 149 of these studies through its research networks.

In the last three years, 455 publications have resulted from the Trust's involvement in research, helping to improve patient outcomes and experience across the NHS. The increasing level of patient participation in clinical research demonstrates the Trust's commitment to enhancing the quality of care offered and to making a contribution to wider health developments within the health service.

Goals agreed with commissioners
Through the *Commissioning for quality and innovation* (CQUIN) payment framework, which was introduced in 2009/10, a proportion of the Trust's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body in to which they have a contract, agreement or arrangement that was entered in to during the year for the provision of NHS services.

Further details of the agreed goals for 2009/10, as well as for the following 12 month period are available on request as follows:

Victoria Fisher, Trust Secretary
Tel: 01438 781594 (direct line)
E-mail: victoria.fisher@nhs.net

The CQUIN targets agreed for the Lister, QEII and Mount Vernon Cancer Centre are shown in the tables below, linked to their potential payments are given and confirmation of whether or not they were achieved.

The total potential payment of £1.4 million represents 0.5% of the Trusts overall clinical income for 2009/10; the total amount paid to the Trust was some £1.1 million.

CQUIN for the Lister and QEII hospitals				
Clinical area	**Action required**	**Payment (%)**	**Potential payment (£)**	**Achieved**
Healthcare acquired infection	Reduced infection rates and improved screening	15%	£200k	£200k
Contribution to national databases	Data submission	15%	£200k	£100k
VTE risk assessments	90% compliance in all specialties	5%	£70k	£70k
Mortality	Reduced HSMR Improved monitoring and action planning	15%	£200k	£200k
Improved discharge	Improved reporting and introduction of electronic system	20%	£270k	System change delayed to July 2010
Maternity	Increasing midwife numbers and implementation of national guidance	30%	£400k	£400k
Total	**-**	**100%**	**£1,340k**	**£970**

CQUIN for the Mount Vernon Cancer Centre				
Clinical area	**Action required**	**Payment (%)**	**Potential payment (£)**	**Achieved**
Healthcare acquired infection	Reduced infection rates and improved screening	15%	£24k	£24k
Contribution to national databases	Data submission	25%	£40k	£40k
VTE risk assessments	90% compliance in all specialties	5%	£8k	£8k
Mortality	Reduced HSMR Improved monitoring and action planning	10%	£16k	£16k
Improved discharge	Improved reporting and introduction of electronic system	5%	£8k	System change delayed to July 2010
Cancer waiting times	Referrals and treatment times	30%	£48k	£48k
Cancer standards	Treatment times	10%	£16k	£16k
Total	**-**	**100%**	**£160k**	**£152k**

Regulation

The Trust is required to register with the Care Quality Commission and its current registration status is *registered with no conditions*. The Commission has also not taken enforcement action against the Trust during 2009/10.

In addition the Trust is subject to periodic reviews by the Commission, the last one being the annual unannounced Hygiene Code inspection that took place on 24 November 2009. The Commission's assessment was that of the 15 hygiene code measures inspected, no concerns were found in all but one area – where the Commission identified a breach of the regulation and made a requirement of the Trust.

As a result, the Trust took action at the time to address the points made in the Commission's assessment and has ensured that it now has effective arrangements in place for the decontamination of equipment, including mattresses, and that these actions are detailed in the appropriate policies.

The Trust implemented effective arrangements for the ongoing monitoring of mattresses by 31 January 2010. Four days later (i.e. 4 February 2010), the Commission contacted the Trust to gain assurance that the requirement had been implemented. The outcome of this follow up process was that no evidence was found that the Trust had breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

The Trust has not participated in any special reviews or investigations by the Commission during 2009/10.

Data quality

The Trust submitted records between April 2009 and February 2010 to the *secondary uses service* for inclusion in the *Hospital Episode Statistics*, which are included in the latest published data. The percentage of records in the published data is set out below.

Where a patient's valid NHS number was included:

- 99.2% for admitted patient care;
- 98.4% for out patient care;
- 97.3% for accident and emergency care.

Where a patient's valid General Medical Practice code was included:

- 96.7%for admitted patient care;
- 99.2% for out patient care;
- 96.8% for accident and emergency care.

The Trust is required to score at least level two (out of three possible levels) in the 25 key measures within the information governance toolkit. The result achieved by the Trust for 2009/10 was level two, with an overall score of 76%.

During 2009/10, the Trust was subject to a *Payment by Results* clinical coding audit conducted by the Audit Commission. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 17.7% for primary diagnoses and 13.1% for primary procedures.

Review of quality performance

The Trust provides care from four hospitals:

- Lister Hospital, Stevenage (district general hospital);
- Queen Elizabeth II (QEII), Welwyn Garden City (district general hospital);
- Hertford County, Hertford (outpatient and diagnostic hospital);
- Mount Vernon Cancer Centre, Northwood (regional cancer centre).

The Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services, including A&E, maternity care and an urgent care centre, as well as regional services in renal medicine and plastic surgery.

It employs more than 5,000 staff, has an annual total budget of around £315 million and over 880 inpatient beds. In 2009/10, over 137,000 people attended A&E, more than 86,000 inpatient and day case patients were treated and over 107,000 first outpatient consultations were given.

Quality is an integral part of the Trust's business and engagement in quality can be seen at all levels – from Board commitment, as demonstrated by the Trust's objectives, to ward staff involved in the delivery of direct care and the monitoring of standards related to that care. Each of the Trust's directors has responsibility for the delivery of aspects of the quality agenda, which then becomes part of every day business through the implementation of operational plans and performance monitoring. Leads exist within every one of the Trust's clinical divisions and specialties, who have responsibility for the management and delivery of quality by their relevant teams. Between them, these arrangements provide the Trust with an accountability structure to support the delivery of quality across the organisation.

A series of *dashboards* are used routinely to measure quality. These dashboards are presentations of summary data that provide an *at a glance* view of performance against a number of indicators. The latter were developed based upon: national priorities; items of particular public interest; and the views of clinicians as to what is meaningful and measurable.

The Trust's *high-level dashboard* monitors 28 clinical indicators on a monthly basis. The *divisional dashboards* show 85 indicators, with the *specialty dashboards* holding 385 indicators. These dashboards are used on a rolling basis, thus enabling Trust staff to:

- Identify 12 months of results;
- Observe trends;
- See change take place;
- Identify actions to be taken.

This rich supply of data enables the Trust to have a good understanding of the quality delivered by each of its services.

The Trust's *risk and quality committee* oversees the delivery of the quality agenda. It is supported in this task by the *clinical governance strategy committee*, which comprises senior clinical representatives (consultants and matrons) with responsibility for implementing the quality agenda within their divisions.

There are a number of large scale significant improvements underway currently, as described previously in this chapter of the Trust's annual report and accounts for 2009/10. Many of the quality improvements being achieved, however, are undertaken everyday by the Trust's clinical teams – with some of this work described over the next few pages.

Measuring safety

Key highlights achieved by the Trust during 2009/10 were:

- Appointed a deputy medical director for patient safety;
- Continued the implementation of a 14-point *improving patient outcomes* action plan;
- Commenced the national *Leading improvement in patient safety* programme led by the NHS Institute for Innovation;
- Subscribed to the *Patient safety first* initiative;
- Introduced new observation charts that help to identify deteriorating patients;
- Launched the critical care outreach service to help care for very sick people on general wards and thus avoid admission to intensive care units;
- Enhanced blood transfusion training for all relevant staff;
- Implemented national safety alerts;
- Reported *never events* – a never event is a serious, and mostly preventable, patient safety incident that should not occur if strict preventative measures are in place. There are eight national never events such as leaving an instrument in place after surgery, or operating in the wrong place.

Safety indicator set

These indicators were chosen because of their significant impact on patients when they occur, with improvement initiatives having the potential for large scale benefits. These are set out in the table at the top of the next page.

Measure	2007/08	2008/09	2009/10	National average	Source
HCAI[1] – *Clostridium difficile*	354	108	82	79[2]	Infection[3] control
HCAI – MRSA bacteraemia	33	18	10	11.36[2]	Infection control
Serious untoward incidents (HCAI)	6	6	12	n/a	Datix[4]
Serious untoward incidents (non-HCAI)	12	10	13	n/a	Datix
Fractures following falls	13	16	14	n/a	Datix
Medication errors	1,067	1,169	810	n/a	Datix
Never events	0	0	1	n/a	Datix

[1] Healthcare acquired infection.
[2] Health Protection Agency data
[3] Trust data collected locally.
[4] Datix is the Trust's risk management software.

Examples of safety initiatives in action

Set out below are examples of the Trust's safety initiatives taken during 2009/10.

Pre-operative safety briefings

Two safety briefings were launched in February 2009: a safety briefing for individuals using the World Health Organisation checklist; and a theatre list safety briefing prior to the morning or afternoon schedule of operations. These lists aim to minimise errors during surgery by ensuring, for example, that *the operation site is marked correctly* and that *all equipment available is available*. The use and value of the theatre briefings, commonly known as *the team hug,* were audited in February and show that:

- The briefings are used *always* (21%), *usually* (39%) and *sometimes* (32%);
- The individual checklists are undertaken *always* (46%), *usually* (29%) and *sometimes* (15%).

Clearly these results show that further improvements are required. The audit identified areas for improvement, which will be implemented during 2010/11. On a more encouraging note:

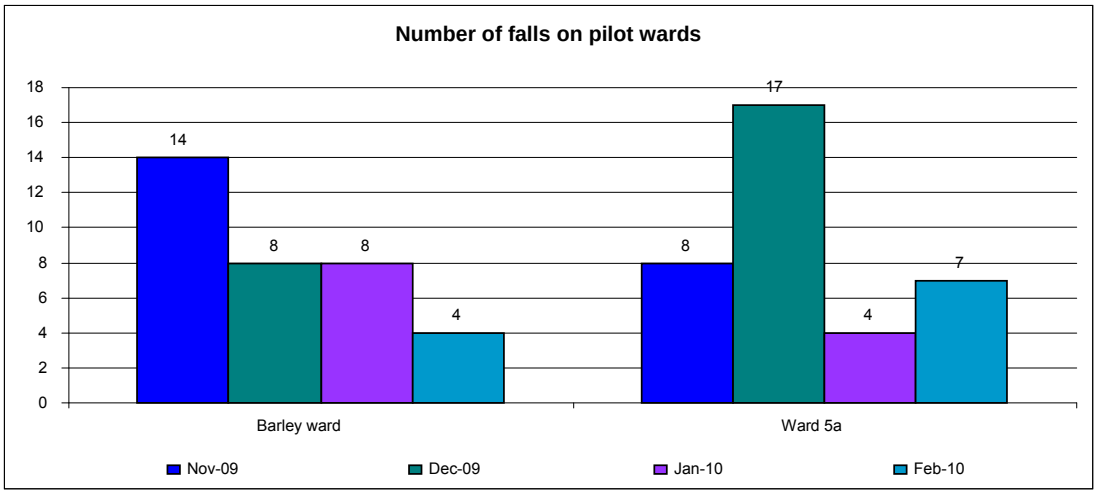
- 85% of participants stated that communication had improved;
- 89% reported a greater awareness of risks;
- 62% felt that it improved patient safety.

Reducing falls

Patient falls are the highest cause of patient safety incidents and accounting for 18.6% during the year. The majority of falls occur within the Trust's elderly care and orthopaedic wards. To this end a pilot started in February 2010 on the Lister's ward 5A (orthopaedics) and Barley ward (elderly care), which introduced:

- The *Simple Steps Programme* – includes more frequent monitoring, ensuring call bells and belongings are near to hand and making sure that appropriate footwear is worn;
- A pictorial poster to alert staff to specific patient needs, e.g. a picture of a *forget-me-not flower* if the patient has dementia.

The graph below shows outcomes for this work to date. While it is too early to make assumptions about progress, it is hoped that further data will demonstrate a continuation of the initial improvements seen.



Mortality rates

The Trust's crude mortality has improved from 2.16% in 2008/09 to 1.80% for the 2009/10 year-to-date (quarters 1-3).

The Hospital Standardised Mortality Ratio (HSMR) figure for 2008/09 was 115.6. Since then, it has reduced during 2009/10 – the year-to-date figure for April 2009 to January 2010 is to 92.4. This level of improvement in the Trust's HSMR score has exceeded the England average.

Mortality monitoring of every inpatient specialty has been rolled out across the Trust. Consultants now receive monthly mortality reports of patients who have died under their care, along with a copy of the *Dr Foster Consultant Outcomes Benchmarking Tool* that compares mortality and morbidity for their patients against national scores.

During 2010/11, mortality rates for individual specialty teams will be placed in the public domain, alongside the Trust figures that are published already. The Trust's general surgeons have volunteered to pilot this scheme, with data to be made public on a consultant-by-consultant basis.

Measuring effectiveness
Key achievements for the year were a:

- Review of mortality in all clinical specialties;
- Assessment of patients at risk of blood clots with the administration of the appropriate clotting prevention medication;
- Fall in the number of cardiac arrest calls following the development of the intensive care outreach service;
- Implementation of a protocol to operate on people with a fractured hip within 48 hours of the decision to operate.

A set of effectiveness indicators was chosen that apply to most clinical specialties, against which the Trust's performance during 2009/10 is set out in the table on the top of the next page.

Measure	2007/08	2008/09	2009/10	National average	Source
Hospital standardised mortality ratio (HSMR)	104.2	115.6	92.4[1]	100	Dr Foster
Crude mortality rate	2.13	2.1	1.86[1]	n/a	CHKS
Readmission rate	5.2%[2]	4.6%[2]	7.0%[1]	n/a	Dr Foster

[1] These are the year to date figures up to January 2010; final year figures will be available in summer 2010.
[2] Data collected by CHKS.

Examples of effectiveness initiatives in action
Set out below are examples of the Trust's effectiveness initiatives taken during 2009/10.

Prevention of blood clots
A national programme to prevent venous thromboembolism (VTE) was established during 2009/10 (VTEs are blood clots that may cause many deaths per year). The programme consists of a package of measures to assess patients at risk and to administer the appropriate blood thinning drug.

The Trust aimed to ensure that 90% of patients were assessed appropriately by September 2009. Risk policies and assessments for general surgery, medicine, maternity, renal and cancer patients were launched in the early part of the year, with audits undertaken to assess compliance during August and September 2009. The results shown in the table at the top of the next page shows that over 90% of the Trust's patients are now being assessed appropriately. A further audit planned for April 2010 will assess progress.

	%
Compliance at Lister and QEII	90.1%
Compliance at the Mount Vernon Cancer Centre	93.5%

One measure of success of the programme has been a reduction in the number of people referred to the Trust's anti-coagulation service for the treatment of blood clots. This indicator has been measured throughout the year to evaluate such changes, with the number of referrals made per month shown in the table at the top of the next page.

Month 2009/10	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Patients referred	3	2	3	3	2	2	8	6	3	0	1	9

It is still too early, however, to make exact judgements. As a result, this indicator will continue to be monitored throughout 2010/11.

Critical care out-reach service

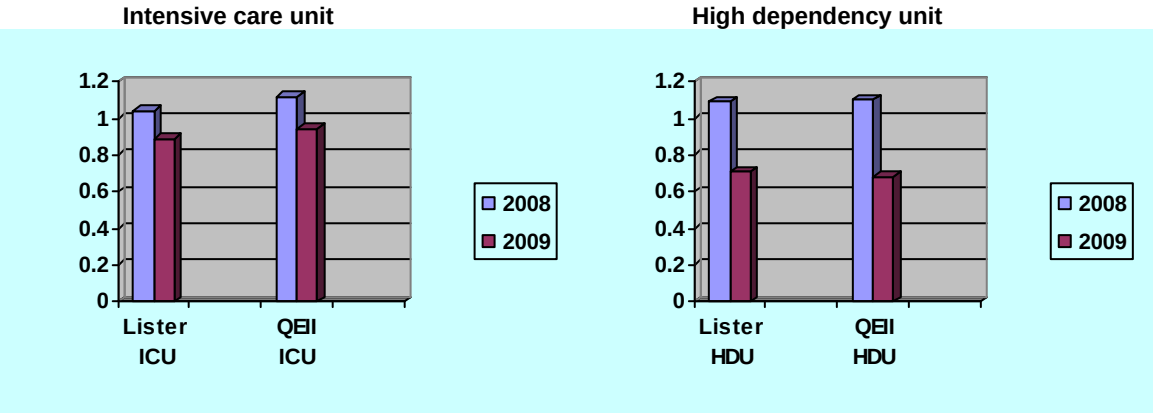
Critical care outreach is an approach being used by the Trust's staff to identify early patients at risk of developing critical illness. The aim is to begin treatment quickly to prevent further deterioration and thus improve their outcome. The Trust's *critical care outreach service* was established in January 2009 and during the year cared for 1,432 patients. The service:

- Follows up patients discharged from critical care (49% of 2009 activity);
- Assesses, facilitates and initiates early intervention for patients referred to the service who are identified by a trigger system based on observations – e.g. breathing rates (51% of 2009 activity);

The service is supported through a training programme on how to recognise the deteriorating patient and by enhanced escalation of concerns to senior staff through a standardised method of communication using certain prompts – known as SBAR (situation, background, assessment, recommendation).

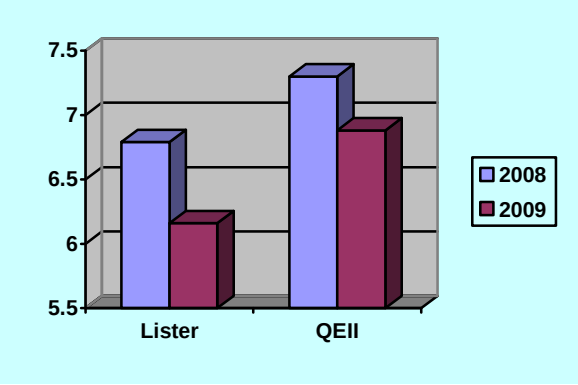
Due to an increase over the winter period in the number of patients admitted into intensive care, it has not been possible to evaluate the impact of the outreach service on critical care usage. Attempts to rescue patients more quickly, however, has resulted in a reduction in mortality – as shown in the graphs carried on the next two pages.

Reduction in standardised mortality ratio (SMR[1])

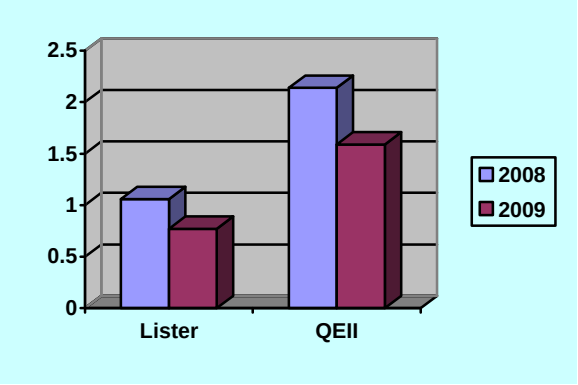


[1] Standardised mortality ratio – a figure less than 1 is better than the predicted outcome for the unit.

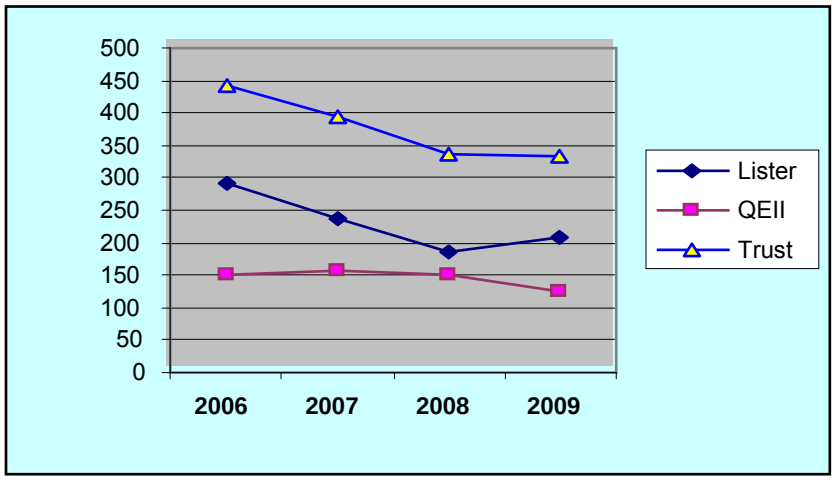
Reduction in length of stay in critical care units



Reduction in the number of patient transfers to other units



Reduction in number of cardiac arrest calls to Trust switchboards



Measuring patient experiences

Key achievements delivered during 2009/10 were:

- The *Productive Ward* initiative – programmes to improve ward efficiency in order to release more nursing time to care for patients have been implemented on half of the Trust's wards to date;
- *Productive Theatre* initiative has started;
- Postal satisfaction surveys started in July 2009 – approximately 1,500 newly discharged patients per quarter are asked to give their views on their care;
- Near-time data collection using 30 electronic *patient experience trackers* began in November 2009 – over 11,000 views have been received;
- A *patient experience steering group* to oversee trend and actions was established in July 2009;
- Ward audits examining *measures of care* are now undertaken routinely;
- Patient testimonials have been initiated to understand experiences of the whole journey of care.

Patient experience indicators, as set out in the table below, were chosen because of the breadth of assessment and the cross-referencing available to build up a bigger picture of what everyone considers important.

Measure	2007/08	2008/09	2009/10	National average	Source
Complaints – care	219	208	172	n/a	Datix[1]
Complaints – communication	295	418	326	n/a	Datix
PEAT – food	Acceptable	Good	Good	n/a	PEAT[2]
PEAT – cleanliness	Acceptable	Good	Good	n/a	PEAT
Survey – privacy	95	91	(92%) 93	n/a	(Postal survey) NPS[3]
Survey – cleanliness	79	81	(96%) 83	n/a	(Postal survey) NPS
Survey – respect and dignity	85	85	(88%) 86	n/a	(Postal survey) NPS
Survey – food	49	50	(86%) 50	n/a	(Postal survey) NPS
Survey – recommend trust	n/a	90.6%	90%	n/a	Trust survey

[1] Datix is the Trust's risk management software.
[2] Patient Environment Action Team.
[3] National inpatient survey (These figures are scores out of 100)

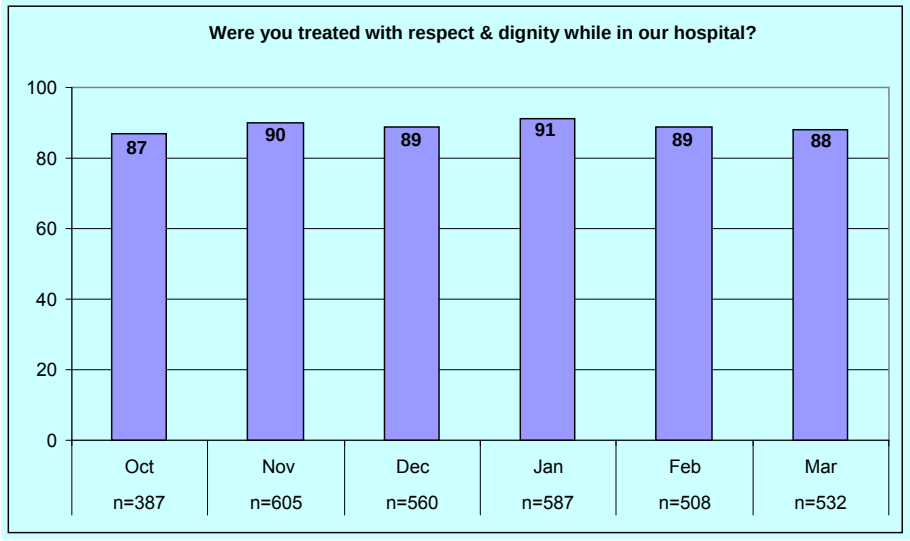
Examples of patient experience initiatives in action
Set out below are examples of the Trust's patient experience initiatives taken during 2009/10.

Near-time data collection
The Trust-wide patient experience tracker project began on 12 October 2009. Thirty trackers – hand-held electronic devices – were purchased to gather patients' views about five aspects of their care. The devices were placed in 30 wards and departments around the Trust's four hospitals.

The questions *Would you recommend this hospital/ward/department to your family and friends?* and *In your opinion, how clean is the hospital ward/department you are in?* were common to all 30 trackers. Other questions vary according to their location – inpatient, outpatient, A&E and maternity.

Between 400 and 550 responses each week are being returned, with a total of 11,645 patient responses to the end of March 2010. Feedback is acted upon by the relevant teams and overall performance is monitored centrally to ensure improvement targets are reached.

Respect and dignity scores consistently above 80%



Some of the other findings for 2009/10 are as set out in the table below:

2009/10	Patient groups	Dec	Jan	Feb	Mar
In your opinion, how clean is the hospital ward/department you are in?	All	80	84	79	80
Sometimes a member of staff will say one thing to you and another will say something quite different. Has this happened to you?	Inpatient and maternity	80	83	81	84
Did you receive enough information to enable you to make decisions about your pregnancy and birth?	Maternity	81	79	77	80
Did you have confidence and trust in the nurses looking after you?	A&E and urgent care centre	89	91	92	92

The main concerns of the Trust's patients relate to the issues of communication and information. The Trust has begun developing a more customer care focus for its staff, with enhanced training and the development of values. Information leaflets are undergoing a review across all clinical specialties and the Trust is seeking to achieve the national *Information Standard* by the end of 2010.

Experiences in outpatients

A national survey of outpatients undertaken by the Care Quality Commission in 2009 showed that the Trust improved in many areas, including the: length of time waiting for an appointment; and information received during a patient's appointment. There were concerns, however, around the processes for booking appointments – the latter has since been improved – and about the lack of information given in the outpatient department when appointments are delayed.

Results from the patient experience trackers used in outpatient departments during 2009/10 are shown in the table below.

2009/10	Patient groups	Dec	Jan	Feb	Mar
Overall, did you feel you were treated with respect and dignity while you were at the Outpatients Department?	Outpatients	90	94	92	89
Were you kept informed of any possible delays in your appointment time today?	Outpatients	73	84	79	74
If you had important questions to ask the doctor, did you get answers that you could understand?	Outpatients	85	90	89	86

New signs have been put up in clinics to inform patients of any delays and to provide names of the staff on duty. Results of the trackers are reviewed by staff at weekly meetings and customer care and communication is reinforced at all times. More in-depth surveys are scheduled for introduction in the summer of 2010.

Noise at night

The national inpatient surveys, along with the Trust's own quarterly postal surveys and the real-time patient experience trackers, all indicate the concern patients have regarding noise at night from staff and other patients. The Trust's *Silent nights* initiative has raised awareness amongst staff and quiet-closing bins have been installed on wards. Transfers at night have been minimised and call bells muted, where possible.

Results are improving, but there is still some way to go – as the table below demonstrates. In 2010/11, the *Goodnight* initiative for patients will aim to reduce noise from patients, for example through more considerate use of mobile phones.

2009/10	Patient groups	Dec	Jan	Feb	Mar
Have you been bothered by noise at night while in hospital?	Inpatient	69	70	69	75

Delivering same sex accommodation

The Trust declared compliance with delivering the national *same sex accommodation* initiative in December 2009. This means that same sex sleeping areas, bathrooms and toilet facilities are provided to protect patients from unwanted exposure, including casual overlooking and overhearing. Patients should not have to pass through opposite sex areas to reach their own facilities. £367,000 was spent in 2009/10 on building upgrades and an operational policy developed to report any breaches. To date, no non-justifiable breaches have been reported.

Performance against national priorities and national core standards

Target/standard	2007/08 actual	2008/09 actual	2009/10 target	2009/10 actual	Met
MRSA bacteraemia	33	18	22	10	✓
Clostidium difficile	354	108	159	82	✓
18 week standard – admitted	85.2%	91.5%	≥90%	91.4%	✓
18 week standard – non admitted	92.9%	95.7%	≥95%	96.1%	✓
A&E 4 hour wait	97.27%	98.03%	≥98%	98.57%	✓
13 week out-patient appointment	0%	0.02%	≤0.03%	0%	✓
26 week in-patient appointment	0%	0%	≤0.03%	0.01%	✓
Two-week wait for rapid access chest pain clinics	100%	99.8%	≥98%	100%	✓
Cancelled operations	2.4%	2.7%	≤0.8%	0.75%	✓
Cancelled operations rebooked within 28 days	95%	94.7%	≥95%	99.16%	✓
Delayed transfers of care	3.8%	3.66%	≤3.5%	4.2%	
Cancer – 2 week wait from urgent GP referral	100%	99.43%	≥93%	99.49%	✓
Cancer – 2 week wait from urgent GP referral (breast symptoms) – new from Jan 10	n/a	n/a	≥93%	95.64%	✓
31 day diagnosis to treatment (all cancer)	99.4%	98.8%	≥97%	98.93%	✓
31 day second or subsequent treatment (anti-cancer drug)	n/a	n/a	≥98%	98.86%	✓
31 day second or subsequent treatment (surgery)	n/a	n/a	≥94%	100%	✓
31 day second or subsequent treatment (radiotherapy)	n/a	n/a	≥94%	97.95%	✓
62 days from urgent referral to treatment (all cancers)	94.4%	93.53%	≥85%	89.22%	✓
62 days from referral to treatment (from screening)	n/a	n/a	≥85%	95.29%	✓
62 days from referral to treatment (from hospital specialists)	100%	100%	≥85%	100%	✓
PPCI heart attack service (150m call to balloon time)	n/a	n/a	≥85%	88.57%	✓

Regulation	2007/08 actual	2008/09 actual	2009/10 target	2009/10 actual	Met
Compliance with core standards	40 out of 43	42 out of 44	46	46 out of 46	✓

Engaging the public and staff in the Trust's clinical quality priorities

The clinical dashboards developed were shaped initially by the Trust's nursing and medical directors, based on national and organisational priorities and evolved further following consultation with the most senior clinical staff in the organisation – divisional chairs and clinical directors. Indicators from the *NHS indicators for quality improvement* were also used to guide the choice of local indicators. Ongoing evaluation of the indicators has occurred throughout the year at the Trust's *clinical governance strategy* committee. As a result, some changes to the indicators have been made.

Priorities have been discussed with the Trusts *involvement committee*, whose membership includes the Hertfordshire Local Involvement Network (LINk). They have also been discussed with the county council's overview and scrutiny committee.

The Trust recognises that consultation with a greater range of clinical staff, along with better liaison with external organisations, is required for 2010/11. This will help to better embed quality into everyday practices and respond more effectively to the views of the public.

Chapter 6: 2009/10 overview

This chapter of the annual report and accounts for 2009/10 looks at a range of important issues relating to the Trust's performance during the year – the majority of which are expanded upon in more detail in subsequent sections of the document. The areas covered in this overview are:

- The Trust's vision and values;
- Operational, clinical and financial performance summary;
- Regulation and assessment-related information;
- Listening to patients' concerns;
- Education and training summary;
- Research and development summary;
- Clinical service changes during the year;
- FT membership activities.

Vision and values

The Trust's vision is: *To deliver quality local healthcare that is valued and trusted*.

Underpinning its vision, the Trust works to the following core values:

- *We put our patients first;*
- *We work as a team;*
- *We value everybody;*
- *We are open and honest;*
- *We strive for excellence and continuous improvement*.

The Trust has satisfied itself that its vision and values are in line with the principles and values set out in the NHS Constitution.

Operational, clinical and financial performance summary

Before reviewing the Trust's performance against a wide range of national and locally set standards and targets, the tables below set out patient activity for the year.

Activity	2009/10 Planned*	2009/10 Actual*	% variance
A&E activity (attendances)	136,347	137,339	+0.7%
Outpatient activity (first appointments)	93,641	107,963	+15.3%
Elective activity (number of planned episodes of surgery/treatment	35,119	39,951	+13.8%
Non-elective activity (number of emergency admissions	41,782	46,482	+11.2%

* Planned figures exclude the Mount Vernon Cancer Centre

During the 12 months of 2009/10, the Trust has been declared fully compliant on each and every one of the 38 core standards set for the NHS under the *Standards for better health* initiative, and has maintained registration without conditions for HCAI. This includes the:

- Nine core standards relating to *safety*;
- Five core standards around *clinical and cost-effectiveness*;
- Fourteen core standards applying to *governance* arrangements;
- Two core standards set out under *accessible and responsive care*;
- Three core standards relating to the *care environment and amenities*;
- Five core standards around *public health* commitments;

Patient access

In terms of existing national standards that the Trust had to achieve during 2009/10, a summary of the key patient access and clinical indicators is set out in the table below.

Standard	National standard	2009/10 outturn
18 weeks standard – admitted	≥90.0%	91.4%
18 weeks standard – non-admitted	≥95.0%	96.1%
26-week inpatient standard	≤0.03%	2 (0.01%)
13-week outpatient standard	≤0.03%	3 (0.00%)
A&E four-hour wait	≥98.0%	98.57%
Two-week rapid access chest pain clinic wait	≥98.0%	100%
PPCI heart attack service – 150 min call to balloon time	≥85.0%	88.57%
Two-week maximum wait, referral to outpatient appt (all cancers)	≥93.0%	99.49%
Two-week wait – breast symptoms (new from January 2010)	≥93.0%	95.64%
31-day diagnosis to treatment (all cancers)	≥97.0%	98.93%
31-day second or subsequent treatment (anti-cancer drug)	≥98.0%	98.86%
31-day second or subsequent treatment (surgery)	≥94.0%	100%
31-day second or subsequent treatment (radiotherapy)	≥94.0%	97.95%
62-day urgent referral to treatment (all cancers)	≥85.0%	89.22%
62-day referral to treatment (from screening)	≥85.0%	95.29%
62-day referral to treatment (from hospital specialists)	≥85.0%	100%
Delayed transfers of care (inpatients)	≤3.50%	4.2%
Cancelled operations	≤0.80%	0.75%
Cancelled operations rebooked within 28 days	≥95.0%	99.44%
MRSA blood infections	22	10
Clostridium difficile infections	159	82

The Trust's performance against these standards during 2009/10 saw an improvement on the previous year, when it failed to achieve those set for delayed transfers of care and cancelled operations. The Trust's teams worked hard and were successful in delivering significant improvements against both of these standards, attaining the cancelled operations target for the first time ever. Working with its NHS and social services partners, the Trust also improved performance around delayed transfers of care – although not quite enough to achieve the standard for the full year.

The ability to continue to deliver the overall 18-weeks referral to treatment standards for both admitted and non-admitted patients was impressive, especially given the particularly difficult winter period and higher than normal level of Norovirus outbreaks in the last two quarters of the year, which affected the Trust's ability to admit patients. The latter also affected the Trust's A&E performance, but not sufficiently to prevent achievement of the 98.0% standard. Achievement of all the Trust's cancer-related targets, both existing and new, was a further highlight of the year.

Clinical quality indicators

In addition to these national standards, the Trust also delivered on a range of clinical indicators during 2009/10, which are set out in the table below.

Healthcare quality indicator	Trust's targets for 2009/10	2009/10 outturn	2008/09 Outturn
MRSA blood infections	18*	10	18
Clostridium difficile infections	108*	82	108
MRSA screening compliance	≥95.0%	95.63%	92.35%
Hand hygiene compliance	≥95.0%	95.52%	92.42%
Peripheral venous catheter compliance	≥95.0%	92.82%	89.50%
Central venous catheter compliance	≥95.0%	97.86%	90.08%
Urinary catheter compliance	≥95.0%	94.49%	91.80%
Crude mortality rate (% deaths per 100 admissions)	2.0%	1.80%	2.08%
Hospital standardised mortality ratio (100 = average)	100	92.4%	115.6
Trust postal inpatient survey – privacy respected	≥85.0%	92.0%	83.5%
Trust postal inpatient survey – ward cleanliness	≥85.0%	96.0%	81.0%
Trust postal inpatient survey – respect and dignity	≥85.0%	88.0%	85.0%
Trust postal inpatient survey – food	≥85.0%	86.0%	50.0%
Trust postal inpatient survey – recommend Trust	≥85.0%	90.0%	n/a

*Trust's own stretch targets, which were lower than the official standards it had to meet (22 MRSA blood infections and 159 C. difficile cases – both hospital-acquired)

Reflecting on the information contained in this table, particular attention is drawn to the reductions achieved in both the Trust's crude mortality rate (the percentage of patients dying for every 100 admitted) and the hospital standardised mortality ratio (HSMR) – a statistical device that is used to compared performances between different NHS trusts, where the figure 100 represents the expected average score.

Equally following a disappointing performance in the national inpatient survey, which was published during 2009 but covered a period roughly 12 months earlier, the Trust invested a great deal in developing patient experience information – both in real time through the use of patient experience trackers and quarterly postal surveys. While using the same key questions as in the Care Quality Commission's annual inpatient survey, the Trust's results provided a much more up-to-date picture from a great deal more patients than those chosen to participate in any national process. The improvement in patient experience scores, therefore, has been a very positive vindication of the efforts being made in this area.

Trust's finances

Finally, the Trust's financial performance for 2009/10. By the end of March 2010, the Trust delivered its agreed year-end surplus of £2.5 million – something that it forecast, month-on-month, would be achieved as the 2009/10 year unfolded. The surplus was delivered on a budget of some £313.3 million – thus representing just 0.75% of turnover.

Other financial-related Issues of note throughout the 12 month period have been:

- The conclusion of discussions with NHS Hertfordshire, which involved arbitration through NHS East of England, concerning payment for non-elective short stay activity;
- Coping with the impact that the adverse weather conditions experienced between December 2009 and February 2010 had on the Trust's income and expenditure so close to year-end;
- Overall, the higher levels of patient activity against the contracted plan agreed with NHS Hertfordshire at the beginning of the year, along with the additional expenditure incurred by the Trust in delivering that activity;
- Continued delivery of the Trust's cost improvement schemes (at 100% of target by year-end).

Regulation and assessment-related information

The Trust's principal regulator currently is the Care Quality Commission. During 2009/10, it has not needed to take enforcement action against the Trust. In addition, the Trust has not participated in any special reviews or investigations by the CQC during the year – other than the annual unannounced Hygiene Code inspection (see below for more information).

Registration with the Care Quality Commission

Under the Health and Social Care Act 2008, all organisations providing health care services, whether NHS or otherwise, have to register with the Care Quality Commission. During the second of 2009/10 the Trust went through the registration process for the services it provides from its four hospital sites, i.e. the Lister, QEII and Hertford County hospitals, as well as the Mount Vernon Cancer Centre. On 1 April 2010, the Trust learnt that it had been registered, without conditions, with the Commission. From 1 April 2009, the Trust also achieved registration, without conditions, for infection control – protecting patients, staff and others from known risks of acquiring an HCAI.

Hygiene Code inspection

Like all NHS organisations, the Trust is subject to periodic visits and reviews by the Care Quality Commission. The last such review was the annual unannounced Hygiene Code inspection, which took place on 24 November 2009. The Commission's subsequent assessment of the Trust was that of the 15 hygiene code measures inspected, no concerns were found in 14 of them. For just one measure around the cleaning and replacement of mattresses, the Commission identified a breach of the regulation and made a requirement of the Trust in terms of the issues needing to be addressed.

From the beginning of 2010, the Trust has ensured it uses effective arrangements for the decontamination of equipment, especially patient bed mattresses, and that these procedures are detailed in appropriate policies. The Trust was also able to confirm to the Commission that it implemented effective arrangements for the ongoing monitoring of mattresses by 31 January 2010.

On 4 February 2010, the Care Quality Commission contacted the Trust to gain assurance that the requirement it had issued following the previous November's Hygiene Code inspection visit had been addressed. The outcome of this work was that it found no evidence that the Trust has breached the regulation to protect patients, workers and others from the risks of acquiring a healthcare-associated infection.

Standards for better health declaration (2009/10)
The Trust is required to make a public declaration on its level of compliance with *Standards for better health* for the period between April 2009 and the end of March 2010. In November 2009, the Trust Board agreed its declaration of full compliance for 1 April to 31 October 2009, which was published subsequently on its website:

http://www.enherts-tr.nhs.uk/AboutTheTrust/AboutTrustBoardBoardPublications.html

For the first time ever, the Trust declared full year compliance for all core standards.

Annual health check results for 2008/09
The Care Quality Commission published the annual health results for all NHS organisations for 2008/09, through its national rating system, in October 2009. The assessment looked at the quality of services that the Trust provided to its patients, along with the quality of its financial management.

The Healthcare Commission's annual health check for 2008/09 showed a real improvement in the Trust's performance. With regards to its finances, delivering its projected year-end surplus for the second year in a row supported its *use of resources* rating improving from *fair* to *good*.

Analysis of this year's results also showed that the Trust missed out narrowly on rising to a *good* rating for its *quality of services*, which were continued to be rated as *fair* despite significant steps being made towards meeting existing and new national targets.

Of the 66 separate areas examined by the Care Quality Commission during 2008/09, which covers such important issues as waiting times, infection control and patient experience, the Trust delivered fully on 55 standards and almost met a further eight. This left just three standards that the Trust did not meet for the year. The percentage of standards achieved fully in 2008/09 rose to 83% from 76% recorded the year before.

Further information on the Trust's ratings for 2008/09 can be found on the Care Quality Commission's website at:

http://healthdirectory.cqc.org.uk/findcareservices/informationabouthealthcareservices/summaryinformation/searchfororganisation.cfm?cit_id=RWH&widCall1=customWidgets.content_view_1

2009/10 periodic review (replaces the annual health check)
The Care Quality Commission has made some changes to how it will publish a Trust's annual assessment on quality of services. The rationale for this is to ensure the Commission presents a clear picture of the quality of care provided by the NHS, in a year that they also register NHS and other healthcare organisations against essential standards of quality and safety.

Publication of the Trust's registration status will replace its score for delivering on core standards as the main way to share publicly that the Trust is meeting essential quality and safety standards. For its 2009/10 process, therefore, the Care Quality Commission will no longer score compliance with core standards;

This approach is being followed because registration outcomes were known by 1 April 2010, and will provide an earlier judgment of a Trust's compliance with essential standards than a core standards score alone. Trust declarations and any subsequent notifications of significant lapses will still be published, about which NHS organisations are required to inform the Commission.

The decision not to score the core standards' assessment means that there will no longer be an annual aggregated score for quality of services. Instead, the Care Quality Commission will publish three assessments during 2010:

- Registration status, which will be monitored continuously and updated (currently the Trust is registered, without conditions as of 1 April 2010);
- Achievement of national priorities in 2009/10, which will be scored;
- Quality of financial management in 2009/10, which too will be scored.

Listening to patients' concerns

Patient Advice and Liaison Service (PALS)
The Trust appreciates the importance of responding to patients' concerns and its Patient Advice and Liaison Service (PALS) continues to provide comprehensive support through a combination of permanent and voluntary staff. This allows patients, along with their carers, to voice concerns and raise issues, without having to make a written complaint.

The Trust's PALS teams, which work closely with their complaints colleagues, exist to prevent, wherever possible, the escalation of concerns to a more formal level. The number of people seeking help from the PALS teams continues to increase, rising by 23% in 2009/10 to a total of 2,338 – which is probably due to better awareness of the PALS teams' availability and role.

In addition to raising issues of concern, patients and visitors are also encouraged to use comment cards to highlight positive experiences of the Trust's services. Whenever appropriate, all patient concerns are directed initially through the service in order to facilitate the earliest possible resolution. Concerns of a more serious nature can be escalated to the appropriate manager.

During the year, the PALS service has been consolidated onto the two main acute sites at Lister and QEII Hospitals. Concerns and comment cards received at both Hertford County Hospital and Mount Vernon Cancer Centre are primarily dealt with either by volunteers or staff on site. If concerns that are more complex require attention, they are passed to staff at the QEII Hospital for investigation and resolution.

Formal complaints and compliments
The Trust values the views of its patients and/or their carers/families, not least in responding to complaints promotes improvements to the quality of care the Trust provides.

Following extensive national consultation that took place in 2008, a new NHS complaints procedure came into effect on from 1 April 2009. It has proved to be more customer-focused and has helped to improve better understanding of complaints within the Trust.

Principles for remedy
In 2007, the Parliamentary and Health Service Ombudsman published a report entitled *Principles for remedy*, which form the basis by which the Trust strives to put things right when they have gone wrong. *Principles for remedy* sets out good practice for NHS organisations dealing with patient complaints on the following issues:

- Getting it right;
- Being customer focused;
- Being open and accountable;

- Acting fairly and proportionately;
- Putting things right;
- Seeking continuous improvement.

First published on 11 October 2007, following a consultation that took place earlier that year, *Principles for remedy* was updated with minor amendments on 10 February 2009. Further information is available from the Parliamentary and Health Service Ombudsman's website: www.ombudsman.org.uk

Dealing with complaints and compliments in 2009/10

During 2009/10, the Trust received 864 formal complaints – a 19% reduction on the number received the previous year. The decrease in complaints can in part be attributed to the improvement in some of the services that lead to the high volume of complaints received the previous year.

Everyone who makes a formal complaint is offered an opportunity to meet with relevant staff if they remain dissatisfied after receiving the Trust's response. In 2009/10 there were 34 such meetings, 6 fewer than the previous year. Such meetings all form part of the 'local' resolution process.

In the 12 months to the end of March 2010, 14 patients referred their complaints to the Ombudsman. Of these two were accepted for further investigation, one of which resulted in a recommendation that a patient leaflet be produced for a specific procedure.

In addition to these complaints, during 2009/10 the Trust also received 135 letters and e-mails complimenting the standard of care provided by its staff. This was in addition to the many hundreds of cards, notes and small gifts that were given to ward staff directly.

Comments placed on NHS Choices

For some time now, patients have been able to place comments about the care received at individual hospitals on their corresponding pages on the national *NHS Choices* website managed by the Department of Health. While not large in number, probably between 50 and 100 being made annually across the Trust's four hospitals, the Trust responds individually to each and every message posted.

The role of the Trust's hospital volunteers

Volunteering within the Trust is an excellent example of the local community and NHS staff working together to improve services for patients. The role of hospital volunteers has always been an integral part of the NHS and the Trust is keen to involve members of the community wherever possible. The Trust opens its doors to approximately 700 volunteers, who offer their time, experience and knowledge for free.

There are almost as many reasons for volunteering within the Trust as there are volunteers. The common theme is that they all care about the NHS and the services it provides to their community. Volunteers play an important role in supporting the Trust's staff in providing high quality care to patients. Younger volunteers aiming for a career in the NHS find their work to be extremely useful for their university applications.

There is a variety of roles associated with being a hospital volunteer. From assisting with the meal service to helping in specific outpatient areas and working on hospital radio, the volunteers make an invaluable contribution. The Trust also has a number of volunteers associated with the regional specialist cancer services provided at Mount Vernon.

A review of the Trust's voluntary services carried out in 2009 showed that its volunteers felt supported by the staff and enjoyed their role thoroughly. Staff would appear equally to be enthusiastic about having volunteers in their departments and continue to provide them with new and interesting roles, which help to improve the patients' experience.

Education and training summary

The Trust has always recognised the importance of staff training and education. During 2009/10, it continued to focus on a wide range of internal training, including:

- Mandatory training, such as health and safety, fire safety and infection control;
- Clinical training, such as dementia, diabetes and palliative care;
- Developmental courses, including leadership and management, assertiveness skills, stress management and IT skills and systems

The Trust continued to progress its programme of conflict resolution training and also developed a number of e-learning packages. This enabled the Trust to provide staff with a mix of electronic and classroom-based training opportunities.

Four members of the Trust's staff successfully completed the second annual *Aspiring directors clinical leaders* programme last year; a further four are due to begin in June 2010. The Trust continues to play an active role in national management graduate training programmes.

Research and development summary

The Trust supports a strong and varied portfolio of research projects. Particular areas of strength include cancer research, renal medicine and urology, with the Trust providing excellent regional services that have achieved both national and international recognition.

During 2009/10 the Trust had 304 active research studies, of which 80% were funded externally. In 2009, researchers at the Trust produced 107 publications in peer-reviewed journals.

Patient recruitment into the *United Kingdom Clinical Research Network* portfolio studies has risen dramatically over recent years, with 1,576 Trust patients participating in these studies during 2009/10. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years; the Trust is on target to achieve this objective locally.

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, which have been ratified by the Trust. A record of all research being conducted is maintained and an annual report is submitted to the Department of Health.

Before it can begin, each research proposal requires approval from the *National Research Ethics Service* and by the Trust's multidisciplinary research and development committees. These Trust committees include lay representation, with patient involvement in projects encouraged widely.

The *Medicines and Healthcare Products Regulatory Agency* (MHRA) notified the Trust of a routine *good clinical practice* inspection in August 2009, with the visit itself taking place in December 2009. The inspection went well, resulting in no critical findings. Feedback from the inspectors was positive, particularly relating to the training of the Trust's research staff.

At the Mount Vernon Cancer centre, an academic partnership has been agreed with the Institute of Cancer Research and the Royal Marsden NHS Foundation Trust to help the Trust further develop its oncology research programmes. A new chemotherapy clinical trial unit opened in 2009/10 at the cancer centre allowing a greater number of patients to participate in research studies.

Impacts of Trust research activity

1) Early treatment of relapsed ovarian cancer based on CA125 level alone versus delayed treatment based on conventional clinical indicators. Results of the randomized MRC OVO5 and EORTC 55955 trials. Chief investigator – Prof Gordon Rustin, Mount Vernon Cancer Centre.

Prof. Rustin presented the first results of this randomised trial in relapsed ovarian cancer – early treatment based on CA125 levels alone vs. delayed treatment based on conventional clinical indicators. These results showed no evidence of a benefit from starting chemotherapy for relapsed ovarian cancer earlier (based on doubling of the blood marker CA125), compared to starting chemotherapy when signs or symptoms of tumour recurrence develop.

This research demonstrated that early treatment did not improve overall survival or quality of life. Researchers found that women who were treated as soon as their blood showed an abnormally high level of CA125 had chemotherapy five months earlier than those who were treated later. They did not live any longer than women who were treated later when they had symptoms of cancer. It was also found that women who were treated as soon as their blood showed an abnormally high level of CA125 needed re-treatment for the second relapse of their ovarian cancer five months earlier and received more than the standard total course of chemotherapy. Starting treatment earlier did not improve women's quality of life either.

This research is already leading to major changes in practice around the world, with fewer CA125 measurements and fewer courses of chemotherapy. The recommendations for influencing practice are set out below.

- Women can be reassured that:
  - there is no benefit from early detection of relapse by routine CA125 measurements;
  - even if CA125 rises, chemotherapy can be delayed until signs and symptoms of tumour recurrence.

- Women can be offered informed choices in follow-up:
  - no routine CA125 measurements but rapid access to CA125 testing if symptoms or signs of relapse;
  - regular CA125 testing.

The research team has suggested that doctors talk with women who have had ovarian cancer, so that they can decide for themselves whether they want their CA125 levels to be monitored or not. Some women may still want to have CA125 tests so that they can have an earlier warning that the cancer may be coming back. Others may choose not to have regular blood tests unless they have symptoms that they are worried about. Women can make these decisions knowing that delaying treatment will not make a difference to their quality of life or on how long they may live.

A full PowerPoint presentation and lay summary on this important research can be found at:

http://www.ctu.mrc.ac.uk/news_and_press_releases/news_archive/ov05_trial_asco_may_2009.aspx

2) NHS National end-of-life care programme and kidney care. End-of-life care in advanced kidney disease – a framework for implementation. Published by NHS Kidney Care.

This document was co-authored by Prof. Ken Farrington, who is a consultant nephrologist at the Lister. The Trust's renal team has previous and current research projects investigating conservative management of renal failure and end-of-life issues for renal patients, particularly with a patient-centred focus.

The overarching aim of the document has been to help people with advanced kidney disease make informed choices about their needs for supportive and end-of-life care. Key elements are the:

- Encouragement of timely recognition that the end-of-life phase is approaching;
- Sensitive communication with patients and carers;
- Holistic assessment, which includes the needs of carers;
- Joined-up planning and effective multi-professional working across boundaries linking kidney care, primary care, community care and palliative care services.

The framework aims to support clinical leadership by providing recommendations on measures to optimise end-of-life care for advanced kidney disease and for all treatment modalities.

The research theme is continuing in 2010/11 through ongoing projects, including *Planning for end-of-life care in dialysis patients – attitudes and perceptions* (Maria Da Silva Gane, Ken Farrington, Susan Cottam and David Wellsted). This research is being funded by *NIHR Research for Patient Benefit*.

Clinical service developments during the year

During 2009/10, much of the Trust's attention was placed on two major projects – the building of the Lister Surgicentre and the new women's and children's unit, both of which will open their doors from April and October 2011 respectively. This did not prevent, however, the Trust rolling out a number of other service developments during the year, including:

- **March/April 2009** – Routine screening of elective patients was one of the latest initiatives launched by the Trust to reduce even further rates of MRSA blood infections within its hospitals. The process being followed ensures that adults admitted to the Lister, QEII and Mount Vernon Cancer Centre for planned medical and surgical treatments are screened beforehand for the presence of MRSA on their skin or nostrils. Where it is found, these patients can then be treated with the aim of eradicating these bacteria prior to their treatment commencing, thus putting them – as well as other patients – at even lower risk of acquiring an infection.

- **April 2009** – An emergency heart attack treatment that opens up blocked arteries with a miniature balloon was launched at the Lister that already has saved the lives of people from across east and north Hertfordshire, as well as south Bedfordshire. The procedure's introduction, called primary angioplasty, means that the Lister will be one of just a handful of hospitals in the east of England to boast a fully operational heart attack service. Currently the service operates from 9.00am to 5.00pm weekdays, with patients being taken to alternative heart attack centres by blue light ambulance outside of these times. The success of the service's first year has helped support the development of an outline business case for a second cardiac catheter laboratory at the Lister, which will support its expansion over time.

- **April 2009** – The Lister hospital's newly upgraded renal unit opened its doors to patients at the end of April 2010. Around £750,000 has been invested in the unit, which has been relocated from its original site to one that is around 50 per cent larger. The move has allowed the number of dialysis stations to be increased from 20 to 25, meaning that an extra 25 to 30 patients can be treated on top of the 110 using the facility previously. It will also see the inclusion of four side rooms compared to just two before the new unit was created.

- **May 2009** – The Trust began overhauling patient bathrooms and toilets on many of the wards at the Lister and Queen Elizabeth II (QEII) hospitals, as well as the Mount Vernon Cancer Centre. This follows a successful bid to NHS East and North Hertfordshire for the £335,000 needed to do the work. On completion some weeks later, patients in single sex bays now have access to their own dedicated bathrooms and toilets, thus improving considerably their privacy and dignity – especially for older patients.

- **May 2009** – Thirty people were discovered to have bowel cancer during the first year of the bowel cancer screening programme (BCSP) in east and north Hertfordshire run by the Trust, even though they had no symptoms; all went on to receive specialist cancer treatment. A total of 36,897 stool testing kits were sent out in the post to people aged between 60 and 69 between March 2008 and March 2009, of which 21,478 were sent back (58%, which is a higher return rate than the national average of 52%). Of these, 389 tested positive for traces of blood in the stool sample (2% of the total number of kits returned), with the majority (357) taking the opportunity to visit their local hospital clinic to discuss the options available to them with the Trust's team of specialist bowel cancer nurses and consultants. Colonoscopy bowel examinations were then performed on 311 people, of which 114 were found to be normal, 116 had benign lumps called polyps (which can become cancerous but can also be removed during the procedure), and 30 were found to have cancer.

- **June 2009/February 2010** – Work to create a new £1.43m facility for cancer patients involved in chemotherapy trials at the Mount Vernon Cancer Centre began; the refurbished and expanded unit opened to its first patients in February 2010. Plans for the new unit, which were drawn up alongside the Cancer Treatment and Research Trust (CTRT), were approved by the Trust Board in March 2009. The development will see the Northwood site's existing chemotherapy facilities renovated and expanded so that patients undergoing standard treatment, as well as chemotherapy trials, are cared for in state-of-the-art surroundings. Money to fund the project was raised by the Trust's charity, *enhance herts*, through the dedicated *CTRT Appeal*.

- **July 2009** – The Trust's nationally renowned tertiary urology service, which is based at the Lister, held an official opening for the Hertfordshire Robotics Centre and its first state-of-the-art surgical robot. This leading-edge technology allows consultant urological surgeons to perform far more accurate and safer operations than is possible with conventional surgery, with patients making a faster recovery – often within 24 hours – and having fewer side effects that can affect their quality of life subsequently. Known as the da Vinci® robotic system, its installation and use was made possible through donations made by two Hertfordshire businessmen, Stef and Stelio Stefanou.

- **September 2009** – Working with *Service by Emergency Rider Volunteers (SERV)*, the Trust helped to launch a new service where volunteer motorcyclists are used to deliver night-time emergency blood supplies to both the Lister and QEII. SERV will be transporting the blood from National Blood Service centres in London between 7.00pm and 6.00am, 365 nights a year. The Trust uses between 800 and 1,200 bags of blood per month and receives a daily delivery from the National Blood Service. The new service avoids the need to use costly vans or taxis should a medical or surgical emergency arise.

- **October 2009** – the Trust, working its GP-led healthcare provider partner Assura Lea Valley LLP, opened new urgent care centre services at Hertford County and Cheshunt Community hospitals. Part of an 18-month pilot being run by NHS Hertfordshire, both centres operate on a walk-in basis and are open from 8.00am to 8.00pm, seven days a week. They can treat serious, but non-life-threatening, injuries like sprains and broken bones, infections and minor medical illnesses. The new service is designed to improve local access to care, whilst at the same time reducing unnecessary use of emergency hospital services – around 65 per cent of the work that goes through a typical A&E department could be dealt with in an urgent care centre. Since opening in October 2009, Hertford County's urgent care centre alone has seen and treated some 2,500 local people.

- **November 2009** – In a further improvement in stroke care, two wards at the Lister and QEII hospitals are now working together to offer an enhanced stroke service for the whole of east and north Hertfordshire. From November 2009, all patients with symptoms of a new stroke are taken, by emergency ambulance, to the Lister's A&E, where they are assessed and treated rapidly. They then go to a designated ward at the hospital (6A south), which has become a dedicated hyper-acute stroke unit. As soon as these patients have been treated and stabilised, they are then be transferred to the stroke-specific acute rehabilitation ward at the QEII. Where a patient arrives at A&E within three hours of the onset of stroke, they can be considered for stroke thrombolysis – the administration of specialist clot-busting drugs. Once they have had an urgent CT brain scan, this will help doctors to identify those who should be given thrombolysis to reduce the size and effects of the stroke.

  This is a specialist service that can only be provided by those with the correct skills and training, as well as in hospitals with rapid access to brain scanning facilities. Initially this new Lister-based service will be available between 9.00am and 5.00pm, Monday to Friday. The Trust plans to extend this to a full 24/7 service over the coming months and is working with the regional cardiac and stroke network to support this change.

- **February 2010** – The Trust announced formally that contracts had been signed, and construction work begun, that would see the latest stereotactic robotic radiotherapy technology from the United States being used to treat patients in the NHS, for the first time ever, from the autumn of 2010. Called a CyberKnife, the system uses real-time tracking capabilities to deliver high-dose radiation to tumours with pin-point accuracy – including those that move every time a patient breathes. It does not require the use of stabilising frames or uncomfortable breath-holding techniques, which have been required traditionally – thus making the whole radiotherapy process a much easier and comfortable experience for patients. Typically treatments using the CyberKnife are completed over one to five days.

- **March 2010** – The Trust's cardiology team was revealed as one of the best in the UK for implanting pacemakers. European guidelines recommend that 700 people in a million will need to be fitted with a pacemaker to regulate their heart beat every year. In the UK, the figure stands currently at 511. However, the Heart Rhythm Devices National Report, published in December 2009, showed that the Trust was implanting pacemakers at a rate of 716 per million – one of very few trusts in the UK to hit the European target. Data on pacemaker implantations is collated nationally every year. The Trust's pacemaker implant rate was the highest out of the four trusts in the Bedfordshire and Hertfordshire Network, which itself came out second highest in the UK.

- **March 2010** – A set of guidelines for treating diabetes patients in hospital, developed by one of the Trust's diabetes specialist nurses, has now been rolled out across the UK. Debbie Stanisstreet was asked by the Joint British Diabetes Societies Inpatient Care Working Group to lead a writing group creating guidance for nurses and doctors to spot and treat hypoglycaemia – low blood sugar levels which can be dangerous if not treated correctly. After 12 months, 14 drafts and much consultation with her colleagues and peers, Debbie presented the final document to a packed auditorium in Liverpool at the Diabetes UK annual professional conference.

- **March 2010** – According to national information published in March 2010, the Trust's three specialist renal dialysis units at the Lister, St Albans City and Luton & Dunstable hospitals together are providing the sixth best service in the country when it comes to annual survival rates. Not only are patients from across Hertfordshire and Bedfordshire living longer using this life-preserving service, the Trust's renal team have also been able to provide year-on-year improvements since 2002 at a rate that is higher the national average. The *Renal Registry* is published every year by the Renal Association, with the most recent report looking at 2008 comparative data from 71 separate dialysis services in NHS hospitals across the UK. Back in 2002, the Trust's adjusted annual survival rate stood at just over 86%, which by 2008 had risen close to 93%. Over the same period, the average survival rate for the UK as a whole went from just over 85% to around 88%.

Foundation trust membership report

Membership numbers

The Trust has two membership constituencies – public and staff. All members are eligible to vote for, or stand as, governors.

Public constituency

Public members are local residents who are over 14 and live in the following areas:

- Broxbourne;
- Central Bedfordshire and Luton;
- East Hertfordshire;
- North Hertfordshire and South Cambridgeshire;
- Mount Vernon Cancer Centre catchment area;
- Stevenage;
- Welwyn Hatfield.

Public constituency	
Total members at 1 April 2009	2,529
Net increase in members recruited during 2009/10	4,210
Total members at 31 March 2010	6,739

Staff constituency

The Trust's staff constituency has four classes:

- Consultants and doctors;
- Nursing and midwifery staff;
- Other clinical staff;
- Non-clinical staff.

Staff membership is an opt-out scheme, with this right being explained at induction as and when new staff join the Trust. To date, around 90 members – or 1.8% of the Trust's workforce – have chosen to opt out of membership.

Staff constituency	
Total members	4,955

Membership engagement

The Trust's foundation trust office team has worked hard to achieve the target it set itself to build a membership of 6,000 members by the end of 2009/10. In fact, due to a number of successful recruitment campaigns, the target was met several months ahead of schedule.

Membership composition is monitored against a range of criteria including age, gender and ethnicity to make sure that it is representative of the local communities served by the Trust.

Ahead of authorisation, the Trust has secured nominations from seven of the 12 organisations selected to have an appointed governor. These individuals have been invited to, and in several cases participated in, events, meetings and workshops held by the Trust including:

- *Involvement committee* meetings;
- *Delivering same sex accommodation* half-day event.

In order to maximise engagement with public and staff members, a number of exclusive member talks from various clinical and non-clinical staff have been held on a wide range of subjects, including:

- Bowel cancer screening;
- *Pillcam* endoscopy;
- The Herford urgent care centre;
- The Trust's *Our changing hospitals* acute hospital service reconfiguration programme.

A variety of opportunities for involvement and input into service developments have also been offered to the Trust's members, including:

- Participation in a workshop regarding future car parking plans;
- Attending a website evaluation workshop ahead of a revamp of the Trust's website;
- Involvement in PEAT inspections;
- Invitation to be part of the Trust's patient information reader panel;
- Involvement in a patient experience workshop for the planning of the phase four project of the Trust's *Our changing hospitals* programme

Plans for 2010/11

The Trust is seeking to become authorised as a NHS foundation trust during 2010/11. In terms of members, the aim for the year is to achieve a membership of 8,000 – which is in line with the Trust's current membership strategy. The Trust will use opportunities provided through links within local communities to help meet its recruitment goals, with the focus increasingly moving towards increased engagement with existing and new members.

Contacting the Trust

Members can contact the Trust, via the membership office, by telephone or dedicated e-mail address. This ensures that their enquiry is dealt with speedily and appropriately:

- ftmembership.enh-tr@nhs.net;
- 01438 781846.

This contact information is published in the Trust's member newsletter, on the Trust's website (www.enherts-tr.nhs.uk) and in all other correspondence with members. Other regular contact opportunities are through:

- Member talks;
- The Trust's annual general meeting.

Chapter 7: operational performance for 2009/10

In the previous chapter, the Trust's overall operational performance for 2009/10 was reviewed. Here the report seeks to provide a more detailed look at that performance.

Performance management arrangements

The Trust's clinical services are organised into five clinical divisions. Each clinical division has a divisional chair, who is a clinician, and a divisional director, who is a manager. Between them, the divisional chairs and directors meet with the Trust's executive committee – the membership of which comprises all executive directors – at a monthly divisional executive committee meeting.

It is at these meetings 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 nurse 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 division meets routinely through a bi-monthly performance management system. While this places even greater responsibility for the performance of each division on to those running them, it also encourages them to take equal responsibility in empowering front line staff to develop their services using the NHS business planning processes.

Clinical division	Specialties
Cancer services Dr Peter Ostler, divisional chair David Govan, divisional director	Clinical haematology Mount Vernon Cancer Centre Oncology Palliative care
Medicine Dr Jon Baker, divisional chair Sharn Elton, divisional director	A&E Acute medicine Cardiology, including coronary care units Dermatology Diabetes and endocrinology Elderly medicine Emergency medicine Neurology Rheumatology Renal medicine, including dialysis Respiratory medicine

Clinical division	Specialities
Surgery Mr Nick James, divisional chair Kevin Nicholson, divisional director	Anaesthetics Audiology Breast surgery Colorectal surgery Critical care, including intensive care and high dependency units Ear nose and throat (ENT) Gastroenterology General surgery Oral and maxillofacial surgery (OMFS) Ophthalmology Plastic surgery Sterile services Theatres Trauma and orthopaedics Upper gastro-intestinal surgery Urology Vascular surgery
Women's and children's services Mr Rami Atalla/Dr Andy Raffles, divisional chairs Bernadette Herbert, divisional director	Child health, include acute and community services Gynaecology Maternity/obstetrics Neonatal intensive care, including special care baby units
Clinical support services Dr Thiagarajan Rajan, divisional chair Alison Rose, divisional director	Health records Outpatients Pathology Pharmacy Private patients Radiological imaging

Activity planning

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 the information available on activity plans is limited to the year ahead (i.e. 2009/10). This information, along with comparisons against previous years, is set out in the table on the next page.

Activity	2007/08 actual	2008/09 actual	2009/10 actual	2010/11 planned*
A&E attendances	133,767	136,786	137,339	135,429
Outpatients – first appointments	94,641	100,457	107,963	101,210
Outpatients – follow-up appointments	192,794	212,684	236,264	225,378
Elective inpatients (i.e. planned admissions)	10,508	14,007	11,195	10,979
Elective day cases	22,929	22,186	28,756	23,901
Average length of stay for elective patients (days)	3.4	2.5	3.1	3.0
Non-elective inpatients (i.e. emergency admissions)	41,219	42,920	46,482	46,720
Average length of stay for non-elective patients (days)	5.5	5.4	4.7	4.5
Births	5,917	5,881	5,756	5,750

*Excludes the Mount Vernon Cancer centre, as well as the Hertford and Cheshunt urgent care centres

Better standards for health – core standards

The Trust's performance against the core national standards expected to be achieved by all NHS organisations is set out in the tables below. Compliance for 2009/10 was declared at the end of October 2009, with performance maintained subsequently for the remainder of the year.

SAFETY: Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.	Full-year position 2009/10	Full-year position 2008/09
C1a: Protect patients through learning from patient safety incidents, etc.	Compliance	Compliance
C1b: Ensure patient safety notices, alerts are acted upon	Compliance	Compliance
C2c: Protect children by adhering to national child protection guidelines	Compliance	Compliance
C3: Protect patients by following NICE interventional procedures guidelines	Compliance	Compliance
C4a: Protect patients and staff by ensuring risk of infection is reduced [HCAI registration]	Compliance	Compliance
C4b: All risks linked to acquisition of medical devices are minimised	Compliance	Insufficient assurance*
C4c: All reusable medical devices are properly decontaminated [HCAI registration]	Compliance	Compliance
C4d: All medicines are handled safely and securely	Compliance	Compliance
C4e: Waste management is managed properly	Compliance	Compliance

*Standard was fully compliant before the end of the year

CLINICAL AND COST EFFECTIVENESS: patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.	Full-year position 2009/10	Full-year position 2008/09
C5a: Ensure the Trust conforms with NICE technology appraisals	Compliance	Compliance
C5b: Ensure that clinical care and treatment are under supervision and leadership	Compliance	Compliance
C5c: Ensure that clinicians update skills and techniques relevant to clinical work undertaken	Compliance	Compliance
C5d: Ensure that clinicians participate in regular clinical audit and reviews	Compliance	Compliance
C6: Health and social care organisations co-operate to meet patients' needs	Compliance	Compliance

GOVERNANCE: managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation	Full-year position 2009/10	Full-year position 2008/09
C7a: Apply sound clinical and corporate governance	Compliance	Compliance
C7b: Support all employees to promote economic, efficient and effective use of resources	Compliance	Compliance
C7c: Undertake systematic risk assessment and risk management	Compliance	Compliance
C7d: Financial management *(managed through separate use of resources assessment)*	n/a	n/a
C7e: Challenge discrimination and promote equality and human rights	Compliance	Compliance
C8a: Have in place processes for staff to raise concerns	Compliance	Compliance
C8b: Have in place organisational and personal development programmes	Compliance	Compliance
C9: Have in place a systematic approach to management of records	Compliance	Compliance
C10a: Undertake appropriate employment checks	Compliance	Compliance
C10b: Require that all professionals abide by code of professional practice	Compliance	Compliance
C11a: Ensure that staff are appropriately recruited, trained and qualified	Compliance	Compliance
C11b: Ensure that staff participate in mandatory training	Compliance	Compliance
C11c: Ensure that staff participate in further professional and occupational development	Compliance	Compliance
C12: Ensure that research follows research governance framework	Compliance	Compliance

PATIENT FOCUS: healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.	Full-year position 2009/10	Full-year position 2008/09
C13a: Ensure that staff treat patients, relatives and carers with respect	Compliance	Compliance
C13b: Ensure that appropriate consent is obtained	Compliance	Compliance
C13c: Ensure that patient information is treated confidentially	Compliance	Compliance
C14a: Ensure that patients, relatives and carers have appropriate Information	Compliance	Compliance
C14b: Ensure complainants are not discriminated against	Compliance	Compliance
C14c: Ensure that concerns are acted on appropriately	Compliance	Compliance
C15a: Ensure that patients have appropriate food and a choice of food	Compliance	Compliance
C15b: Ensure that patients nutritional and dietary requirements are met	Compliance	Compliance
C16: Ensure that information is available on services provided by the Trust	Compliance	Compliance

ACCESSIBLE AND RESPONSIVE CARE: Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.	Full-year position 2009/10	Full-year position 2008/09
C17: Patient and carer views are intrinsic to designing, planning and delivering services	Compliance	Compliance
C18: Equal access to all members of population is available	Compliance	Insufficient assurance*

*Standard was fully compliant before the end of the year

CARE ENVIRONMENT AND AMENITIES: care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes for patients.	Full-year position 2009/10	Full-year position 2008/09
C20a: Care is provided in a safe secure environment	Compliance	Compliance
C20b: Ensure that Trust is supportive of patient privacy and confidentiality	Compliance	Compliance
C21: Environment promotes effective care and optimum health outcomes [HCAI registration]	Compliance	Compliance

PUBLIC HEALTH: programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.	Full-year position 2009/10	Full-year position 2008/09
C22a: Co-operate with other NHS bodies, LA and other organisations	Compliance	Compliance
C22b: Removed for 2007/8 and reinstated from 2008/09	Compliance	Compliance
C22c: Make appropriate and effective contribution to local partnerships	Compliance	Compliance
C23: Ensure managed disease, health promotion & NSF's programmes	Compliance	Compliance
C24: Practiced plan in place to cover response to major incidents	Compliance	Compliance

Standards for better health – existing commitment and national priority indicators

The Trust's performance for these two groups of national indicators for 2009/10, along with what was achieved in each of the two preceding years, is set out in the tables below:

C7f: Existing commitment indicators	Current national target	2009/10*	2008/09	2007/08
Access to GUM clinics within 48 hours	n/a	n/a	n/a	n/a
Data quality for ethnic group – inpatients	≥85.0%	61.6%	61.1%	65.8%
Thrombolysis – 60 minute call-to-needle time	n/a	n/a	58.6%	n/a
PPCI – 150 minute call to balloon time	≥85.0%	88.57%	n/a	n/a
Delayed transfers of care	≤3.5%	4.2%	4.2%	3.8%
Four hour maximum wait in A&E	≥98.0%	98.57%	98.03%	97.30%
Maintain a maximum wait of 26 weeks for inpatients	≤0.03%	0.01%	0%	0%
Maintain a maximum wait of 13 weeks for an outpatient appointment	≤0.03%	0%	0.02%	0%
Three month maximum wait for revascularisation	≤0.1%	0%	0%	0%
Two-week wait access for rapid access chest pain clinics	≥98.0%	100%	99.8%	100%
Cancelled operations (% of elective workload)	≤0.8%	0.75%	2.38%	2.40%
Cancelled operations - those readmitted within 28 days	≥95.0%	99.44%	95.0%	95.2%

*Trust's predictions as Care Quality Commission thresholds for 2009/10 yet to be published

C19: National priority indicators	Current national target	2009/10*	2008/09	2007/08
Infant health and inequalities: smoking during pregnancy and breastfeeding initiative	Not yet stated	Special data collection	Under achieved	Under achieved
Experience of patients	n/a	Inpatient survey	Poor	Satisfactory
Participation in heart disease audits	Special data collection		Under achieved	Under achieved
Engagement in clinical audits	Special data collection		Achieved	n/a
Stroke care: % of patients spending 90% of hospital stay on a specialist stroke unit	≥70.0% (Q4 only)	Under achieved	Under achieved	n/a
Maternity hospital episode statistics: data quality indicators	≤15%	Achieved	Failed	n/a
MRSA bacteraemias	22	Achieved	Achieved	Under achieved
Clostridium difficile incidence	159	Achieved	Achieved	Achieved
18-week referral to treatment (RTT) target for admitted pathways	≥90%	91.4%	Achieved	n/a
18-week RTT data completeness for admitted pathways	≥90% to ≤110%	98.9%	Achieved	n/a
18-week RTT target for non-admitted pathways	≥95%	96.1%	Achieved	n/a
18-week RTT data completeness for non-admitted pathways	≥90% to ≤110%	93.8%	Achieved	n/a
All cancers: two week maximum wait from GP referral to first outpatient attendance	≥93%	99.59%	Achieved	Achieved
Two week wait - breast symptoms (target from 1 January 2010 – i.e. Q4 only)	≥93%	95.64%	n/a	n/a
31-day second or subsequent treatment (anti cancer drug treatments)	≥98%	99.86%	Achieved	Achieved
31-day second or subsequent treatment (surgery)	≥94%	100%	Achieved	Achieved
31-day second or subsequent treatment (radiotherapy treatments - target from December 2010)	≥94%	97.95%	n/a	n/a
31-day diagnosis to treatment for all cancers	≥96%	98.93%	Achieved	Achieved
62-day referral to treatment from screening	≥90%	95.29%	Achieved	Achieved
62-day referral to treatment from hospital specialist	≥90%	100%	Achieved	Achieved
62-day urgent referral to treatment of all cancers	≥85%	89.22%	Achieved	Achieved
NHS staff satisfaction	n/a	Achieved	Achieved	n/a
Access to health care for people with a learning disability	n/a	Special data collection	n/a	n/a
Additional SHA/Monitor risk rating indicator for 2009/10				
MRSA elective screening (all elective inpatients admissions)	≥100%	Achieved	n/a	n/a

*Trust's predictions as Care Quality Commission thresholds for 2009/10 yet to be published

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 QEII in Welwyn Garden City. The plan complies with Department of Health guidelines. During 2009/10, the plan did not need to be activated by the Trust.

In line with the requirement made of all NHS organisations across the country, the Trust developed and implemented a 'flu preparedness plan – which addressed business continuity in the face the swine 'flu pandemic declared in 2009 by the World Health Organisation.

Further information on both plans is available via:

Victoria Fisher, Trust Secretary
Tel: 01438 781 594 (direct line)
E-mail: victoria.fisher@nhs.net

Chapter 8: clinical performance for 2009/10

In chapter six of this annual report, the Trust's *quality account* for 2009/10 is set out in full. The *quality account* follows a relatively proscribed format in the areas it covers; it is also a requirement that it is made available separately through the national *NHS Choices* web pages, as well as on the Trust's own website.

Here, the Trust considers in more detail the Trust's performance during 2009/10 for two important clinical areas:

- Hospital-acquired infection rates;
- Mortality rates.

Hospital-acquired infections rates (MRSA bacteraemias and *Clostridium difficile*)

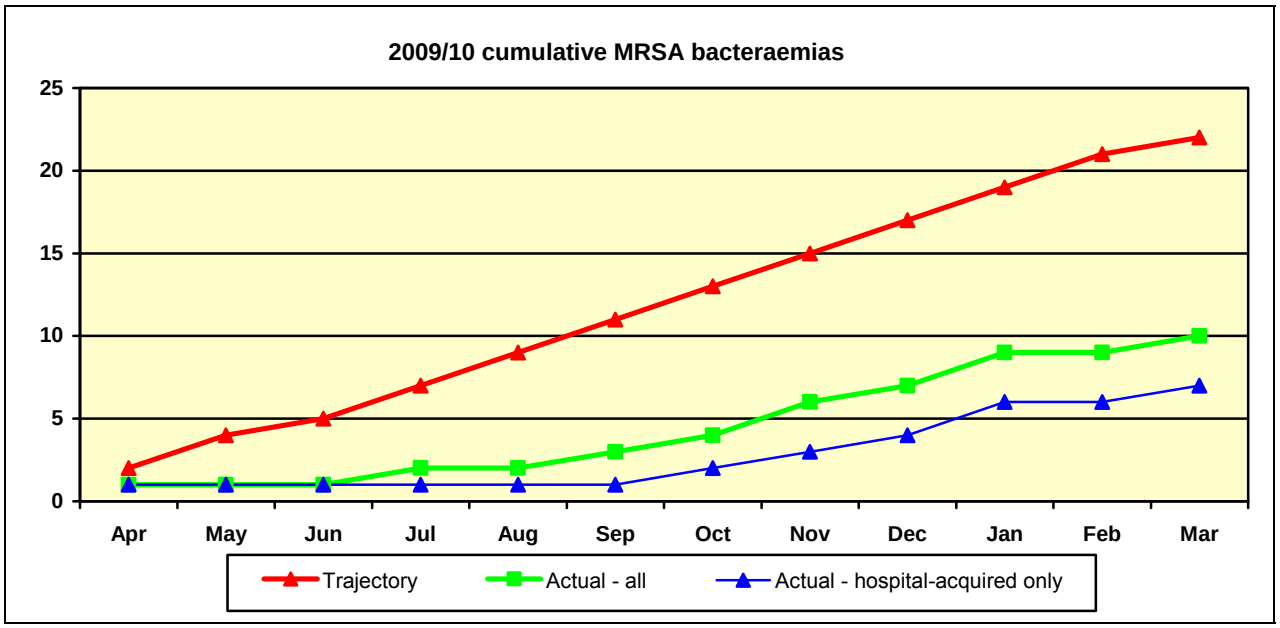
The Trust's performance up to March 2010 in relation to reducing MRSA bacteraemias (blood stream infections) and *Clostridium difficile* infections is shown in the tables below.

MRSA blood infections (Full year target 2009/10: 22 cases)	2008/09	2009/10	% ytd change
April to June	11	1	-90.9%
July to September	1	2	- 75.0%
October to December	1	4	-46.2%
January to March	5	3	-44.4%
Total (12 month period)	**18**	**10**	**-44.4%**

C. difficile infections (Full year target 2009/10: 159 cases)	2008/09	2009/10	% ytd change
April to June	38	16	-57.9%
July to September	24	22	-38.7%
October to December	23	20	- 31.8%
January to March	23	24	-24.1%
Total (12 month period)	**108**	**82**	**-24.1%**

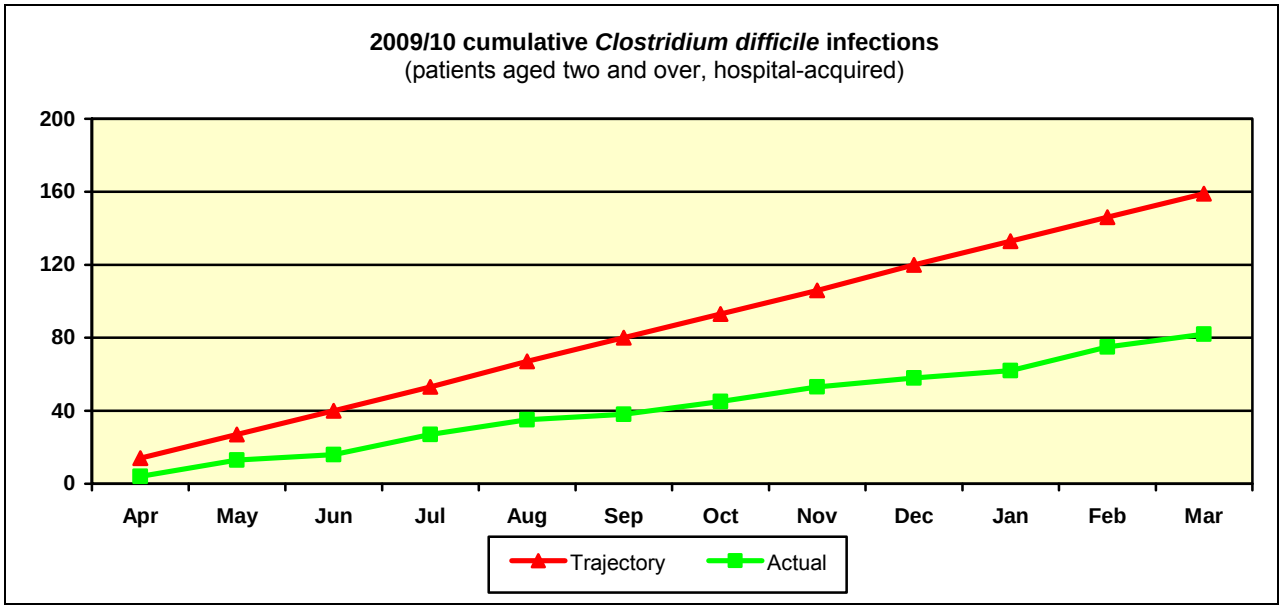
With regard to Trust's monthly target trajectory positions for both MRSA and *C. difficile*, these are shown in the graphs on the next page.

Although the formal targets set for the Trust, as part of the contracts agreed with NHS Hertfordshire and NHS East of England for 2009/10 are no more than 22 MRSA bacteraemias or 159 *C. difficile* infections, the Trust recognised that its performance is such that both were likely to be bettered. With this in mind, the Trust set its own in-year stretch targets of having no more than 18 MRSA bacteraemias or 108 *C. difficile* infections by the end of the year.



As can be seen from the graph above, in the 12 months since April 2009, the Trust has had just seven post-48 hours MRSA blood stream infections throughout the year. This ensued that the Trust delivered both the formal and its own full year-end positions – 22 and 18 blood infections cases respectively.

In relation to reducing *C. difficile* infections, during 2009/10 the Trust recorded just 82 cases – which was also below the formal and Trust's own stretch targets for the year (159 and 108 cases respectively). The graph showing the Trust's performance is set out below.



Mortality rates

Hospital mortality rates can be presented in rather an alarmist way, especially in the media. The resulting coverage often seems to forget that despite all the new technology and medical breakthroughs of recent years, people do die in hospital – every day, every month and every year.

Most of the time these deaths are unavoidable – the consequences of major trauma, such as road traffic accidents, as well as other serious conditions like heart attacks. Of course some people die because their illness is incurable; yet others have just come to the end of their life and the most important thing is that their death is dignified and respectful to their right for privacy.

The importance of measuring mortality rates

Not only do they help the Trust better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where improvements may need to be made. They can also help those people wishing to make a choice about the hospital where they may want to have their treatment. Accurate mortality data matters, therefore, to doctors and nurses, as well as to their patients.

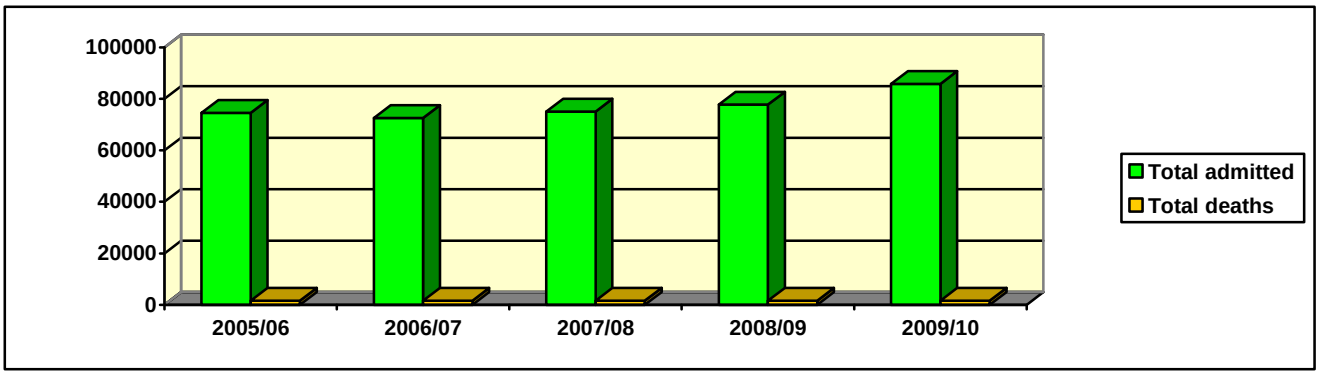
When it comes to measuring mortality rates, there are two main statistics used in the NHS:

- Crude mortality rates
- Hospital standardised mortality ratio (HSMR)

Crude mortality rates

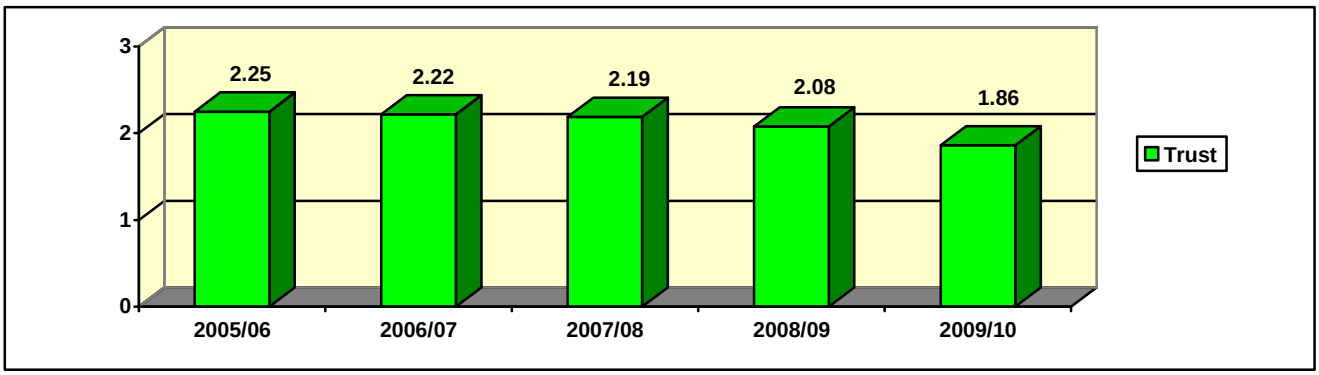
A hospital's crude mortality rate looks at the number of deaths that occur in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted.

What it describes best is how a hospital or Trust's mortality rate changes over time. In the case of the Trust's hospitals, the historical crude mortality rate is set out in the charts below.



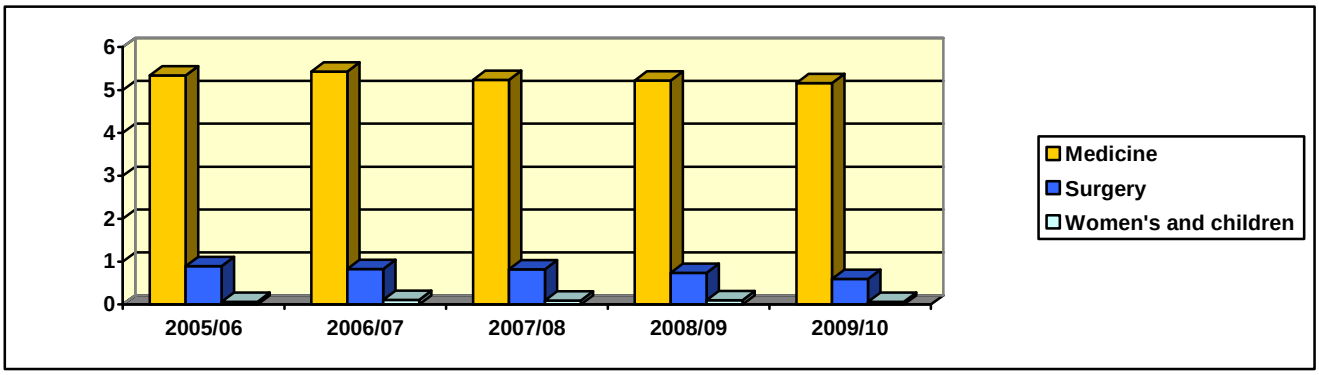
Total annual patients admitted and death by year

What this graph shows is that since 2005/06, the number of people being admitted to the Trust's hospitals has grown year-on-year from around 70,000 to just over 85,000 four years later. At the same time, the number of deaths recorded has remained at a very small number and, perhaps less obviously from the graph above, have been falling.



Crude mortality rate (% per 100 admitted) – the Trust

The graph above shows that over the last five years, the Trust's crude mortality rate has been falling as fewer patients die as an overall percentage of those that have been treated. If anything, that improvement appears to have speeded up since 2007/08, with the rate achieved for 2009/10 being below 2.0% for the first time.



Crude mortality rate (% per 100 admitted) – major clinical division

This final graph breaks down the Trust's crude mortality rates by its major clinical divisions – medicine, surgery and women's and children's services. What this shows is that the relative risk for surgery, despite public perceptions to the contrary, is much lower than that for general medicine.

During a period when the number of people being admitted to the Trust's hospitals has been rising year-on-year, those dying have been falling – both in absolute numbers and as a percentage of those admitted. In essence, fewer people overall are dying in the Trust's hospitals year-on-year.

Hospital standardised mortality ratio (HSMR)

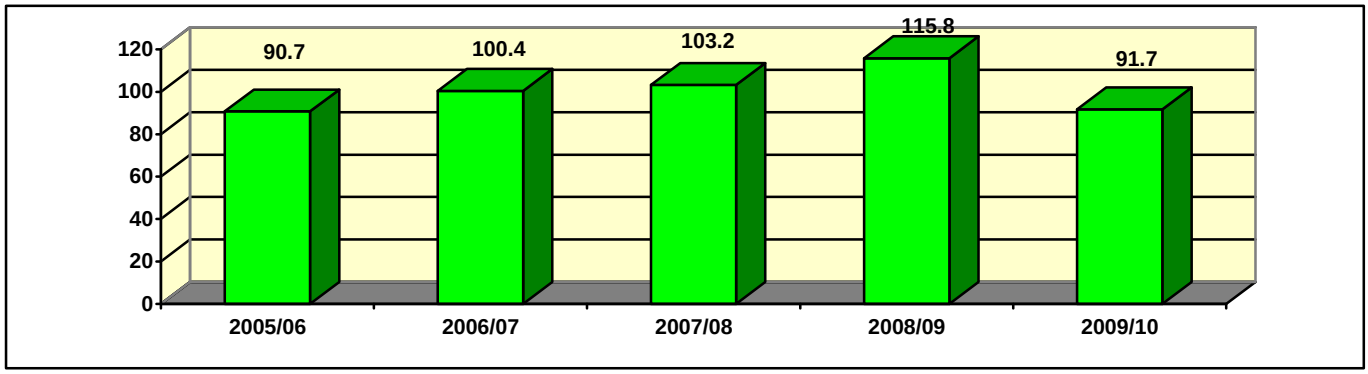
While crude mortality rates are very important, it is very hard to use this information to compare and contrast what's happening between different hospitals and NHS trusts. This is because every hospital is different, both in the treatments and operations that it offers and the make-up of its local population.

A hospital that carries out higher-risk operations, such as organ transplants, or has a higher number patients who are elderly and/or come from areas of greater poverty, will have a crude mortality rate that is very different from one that does not provide such higher-risk operations and whose local population is generally younger and more affluent.

This is why several years ago statisticians interested in comparing mortality rates between hospitals sought to find a new statistical device to allow them to do just that. The one now used most commonly is called the hospital standardised mortality ratio – or HSMR for short.

The HSMR scoring system works by taking a hospital's crude mortality rate and adjusting it for a wide variety of factors – population size, age profile, level of poverty, range of treatments and operations provided, etc. The idea is that by taking these facts in to account for each hospital, it is possible to calculate two scores – the average mortality rate that would be expected for NHS hospitals of a particular type and the observed rate for an individual hospital within that group.

The Trust's main hospitals – the Lister and QEII – are described as district general hospitals. Nationally the expected HSMR score for such hospitals is set as a score of 100. It is important to remember that this figure does not represent deaths – it is just a baseline number that statisticians use against which to compare observed performances. The Trust's published HSMR scores for the last few years are set out in the chart below.



Trust's annual overall HSMR score (100 = NHS average)

When thinking about HSMR scores, it is tempting to view these figures simplistically. In the past, some people have been led to believe that a Trust with a score of, say, 115 has 15% more deaths than average, while one with a score of 95% has 5% less deaths on average. Not only is this an over-simplification, it is also probably an entirely wrong conclusion to draw.

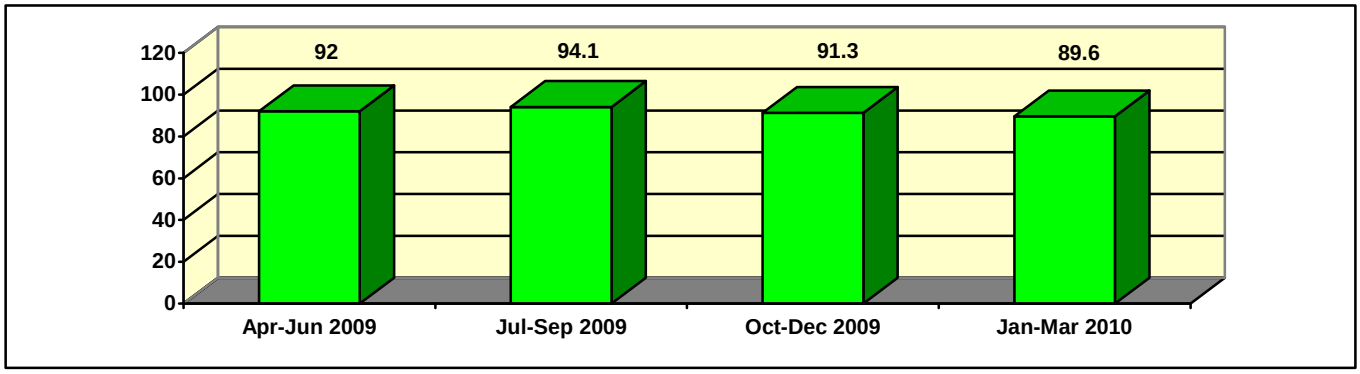
There are several reasons why any individual HSMR score needs to be treated with caution, namely:

1. *The quality of the clinical coding* – every clinical procedure undertaken in the NHS has its own unique code and unless these are used properly on our computer records, this can have a direct skewing effect on the resulting HSMR score. Indeed until recently this was an important issue behind the changes in the Trust's own HSMR scores it received during 2009/10, which related in part to inadequate clinical coding – an issue that has now largely been resolved;

2. *Where a patient dies* – compared to other parts of the country, Hertfordshire has fewer hospice beds or community-based services that help people to be with their families and loved ones when they die. As a result, more people end up dying in the Trust's hospitals when that does not need to happen. Again this can affect the HSMR score adversely.

3. *Clinical quality issues* – thankfully not a big issue for the Trust, but this is the one that most people get concerned about. Running a service where more patients may be dying than would be expected is a key clinical quality issue to which the Trust pays particular attention. A rising HSMR for a particular clinical procedure is an early warning indicator that something might not be right. In most cases it proves to be caused by a coding or other non-clinical issue. But sometimes, it can be a pointer to something more serious, which then allows the Trust to take corrective action quickly.

Below is a chart showing the HSMR scores achieved by the Trust for each quarter in 2009/10, with the overall score being 91.7 – which compares favourably to the 115.8 score received in 2008/09, although this figure will be revised as part of the annual rebasing of all HSMR scores that occurs annually. The scores gained came during a period when the Trust focussed on improving the quality of its clinical coding, as well as tackled one or two clinical areas – for example around surgery for elderly patients with fractured necks of their femur (upper leg) bones.



Trust's quarterly HSMR scores for 2009/10

Interpreting and using HSMR scores

The most important thing to remember when looking at HSMR scores is that they no longer deal with actual deaths, but rather whether or not what is recorded against an individual hospital looks to be above or below average. And the important word here is *looks*. Why? Because experts in using the HSMR scoring system always give a big health warning about how it should be used and interpreted.

For example, scores well above 100 suggest that there may be a need to investigate whether or not there is an underlying clinical problem that should be addressed. This does not mean that people can or should assume that a real problem exists. It could just be that the data on which the calculation was based was not as accurate as it could have been. Such a high score, however, could also point to a specific clinical issue that needs attention. Until investigated thoroughly, therefore, it is often impossible for anyone to tell what the true reason is behind a lower or higher than expected HSMR score.

Working through the Trust's HSMR scores

For each of the three years to 2007/08, the Trust's annual HSMR score has been recorded at or around the national average that would be expected for district general hospitals such as the Lister and QEII. During 2008/09, however, the Trust began to notice that its quarterly HSMR score was rising and needed to be investigated.

This important work was carried out and what was uncovered was a significant deterioration in the quality of the data recorded against patients treated at the Trust's hospitals. While this had no direct effect on the quality of care they received, it did skew adversely the resulting HSMR score. Once this data entry problem was fixed, the Trust's HSMR rating began to improve quite quickly.

That is not the whole story, however. By improving the quality of the Trust's data, it did allow one or two clinical areas where the HSMR score was still higher than it should have been to be uncovered – for example for patients with broken hips, where the death rate was higher than expected. By looking at the clinical pathways involved, changes were made that had a real impact on the chances that this vulnerable and often frail group of patients had in not just surviving their surgery, but going on to recover a good quality of life afterwards.

Future developments: Trust HSMR scores by clinical specialty

Currently the Trust publishes HSMR data annually and quarterly, but for the organisation as a whole. It is now moving towards publishing the same data by major specialty. So a patient about to have an operation can look at the HSMR score for the team looking after them – and not just the average result for the Trust overall.

The Trust hopes to be in a position to publish such date from later in 2010/11, once it is confident that the information being provided is reliable and accurate.

Chapter 9: financial performance for 2009/10

Review of 2009/10

During 2009/10, the Trust continued to maintain its strong financial position, delivering a third year with a surplus of £2.5 million (excluding an impairment of £21.8m, further detail on page 92). This is despite between a 10 to 15% growth in patient activity during the year. The £2.5 million surplus was in line with the NHS East of England target and satisfied, therefore, the Trust's statutory breakeven duty.

At the start of 2009/10, the Trust agreed financial contracts with its primary care trusts (PCTs) that reflected the number and type of patients treated in the previous year. This level of activity translated into its hospitals running at full capacity – as measured in terms of beds, operating theatre availability and time, particularly doctors – throughout the year.

The upturn in the numbers of patients being referred throughout 2009/10 meant that the Trust had to incur additional cost to provide extra capacity and other resources needed to treat all of these patients, whilst at the same time maintaining key national waiting time performance standards – including the 18-week referral to treatment targets.

In the early part of the year, therefore, the Trust was at risk of spending more on treating each patient than it was receiving in income from the PCT. Consequently, all clinical teams have again had to work hard to review all aspects of their service to bring marginal costs down below the national *Payment by Results* tariff price earned for each patient treated. This process redesign was crucial in delivering the financial target by year-end.

The Trust is clearly the *hospital of choice* for many local residents and it will be interesting to see if patient numbers continue to rise into 2010/11, when the local PCT – NHS Hertfordshire – has made clear its intentions for a very marked reduction in referral levels.

During 2009/10, the Trust was also able to spend capital up to the level of its depreciation provision. This was achieved successfully, thus ensuring delivery of the remaining two statutory duties on top of its breakeven requirement, namely not to exceed its external financial limit (EFL) and to achieve a 3.5% return on net relevant assets.

Capital spending

The total capital expenditure in the year was £14.1 million, with projects including:

- **Maternity new build – £4.2 million**. Major works began in year with the start of the Maternity project. The scheme involves the provision of a new maternity building which will facilitate the consolidation of maternity services on to the Lister site. This project represents phase 3 of the trust's *Our Changing Hospitals* programme

- **Planning and enabling works for phase 4 of the *Our changing hospital* project – £2.7 million**. This started in year, with extensive preparation work undertaken prior to the anticipated major construction that will commence over the coming financial years.

- **Electrical infrastructure upgrade – £1.9 million**. Major electrical upgrade of the Lister site commenced in-year which will be completed in 2011/12, this work will provide the required power supply to service the site on the completion of the Trust's *Our Changing Hospitals* capital investment programme.

- **General maintenance – £0.5 million**. General maintenance schemes were undertaken across the Trust's sites, with the most significant project being the replacement of lifts in the tower block on the Lister site. Other smaller projects were more routine in nature and included road repairs, flooring repairs and electrical testing.

In addition to the above, the Trust also used its capital spending to invest in new medical equipment, including:

- Anaesthetic machines – £150,000;
- Nasendoscopes and stack system with chemotherapy pumps – £100,000;
- Dialysis machines – £80,000;
- Floor standing microscope – £81,000.

The final element of the Trust's capital spend during 2009/10 was on information technology, most notably:

- **Chemotherapy e-prescribing system – £408,000**. The system progressed in-year, which when completed will convert the prescribing system from a paper-based to an electronic system; go live is expected in early 2010/11.

- **Mount Vernon IT infrastructure upgrade – £577,000**. The IT infrastructure has been upgraded at the Mount Vernon site in order cope with the major IT projects being undertaken on site during 2009/10 and into 2010/11.

- **Install of new PAS system at Mount Vernon – £389,000**. A new PAS system has been installed at Mount Vernon to bring it in line with other Trust sites.

Financial implications of *Our changing hospitals* programme

The Trust began planning and implementing its *Our changing hospitals* programme in 2009/10, which represents a major capital investment by the Trust over the next five years. The programme's outcome will result in a consolidation of acute inpatient and emergency services from the QEII onto the Lister site.

The total Trust investment involved in this work is estimated to be £88 million, which will be financed through a combination of Department of Health loan and operational capital funding. The Trust is expecting to draw down loans of £77 million from the Department of Health, the repayment of which will be met through the greater efficiencies achieved from working off a single site. The financial risk to the Trust is represented by the £77 million Department of Health loan and the achievement of savings that allow for the servicing of that debt.

Looking to the future

Overall, 2009/10 was an important year in terms of consolidating the Trust's recent good financial performance. It supported the progress being towards achieving NHS foundation trust status and is key to the future plans to invest and modernise the Trust's hospital facilities, particularly at the Lister.

The NHS, along with the rest of the economy, will face increasingly tough and challenging financial planning assumptions in the new financial year and beyond. Sound financial management, therefore, remains key to ensuring that the Trust's resources continue to be used as effectively as possible.

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 95% 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 note 11 in the annual accounts shown below.

The Trust has also signed up to the Government's *prompt payment code*.

Chapter 10: workforce review

Workforce statistics

In the table below, a summary of workforce-related statistics is provided for 2009/10, alongside figures provided for the previous two years.

Activity	31 March 2010	31 March 2009	31 March 2008
Staff employed (full time equivalents)	4770.48	4506	4256
Vacancy rate	7.79%	8.5%	13.0%
Turnover rate	8.87%	8.7%	11.6%
Sickness rate	5.27%	5.7%	5.6%

During 2009/10, the Trust maintained is success from the year previously in reducing vacancies and improving retention; new cohort recruitment continued during the year for newly qualified nurses and support workers.

Sickness levels were below the East of England averages and further work during the last quarter of 2009/10 saw further improvements.

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 an excellent 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 2009/10 the Trust continued with cohort recruitment for a range of key nursing roles, facilitating the recruitment and induction of these staff groups, ensuring a significant reduction in our vacancy rates and increasing the numbers of healthcare staff.

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.

A highly skilled workforce

The Trust is committed to having a highly skilled and flexible workforce and achieves this through continued investment in the personal development of its staff. In 2009/10, the Trust supported its staff in various training programmes and an increased emphasis was placed on all staff completing the annual appraisal process, which helps identify development needs.

Set out below is a summary of some of the Trust's training achievements:

- 66 staff began National Vocational Qualifications (NVQs) in local colleges and universities. The staff were from a wide range of departments and specialities, including nursing support, sterile services, pathology and administration;
- 1,386 members of staff attended IT skills and systems related training courses, with 900 trained on the new PAS system;
- There were 594 attendances on in-house management development courses. This includes 108 managers at various levels who completed, or are in the process of completing, comprehensive leadership and management development programmes.
- 430 members of staff attended in-house personal skills development courses or completed e-learning programmes.

Medical education and training

The Trust's *medical education board* is the body that oversees education and training in the Trust; it is also the official channel for communication with the deaneries and colleges. The board's membership is set out in the table below.

Medical education board	
Chairman and director of medical education	John Saetta
Clinical tutors	Shahid Khan Indu Sockalingam Deepak Jain Di Harvey Jeanette Dickson (Mount Vernon Cancer Centre)
Undergraduate tutors	Sigismund Wilkey Mary Lynch
Associate clinical tutor	Amin Salem
Centre manager	Christine Crick
Foundation programme representation	FY1 – Lily Li FY2 – Ann Mulroy

The Trust has 314 training posts and there are active postgraduate centres run by the clinical tutors at the QEII and Lister hospitals, as well as the Mount Vernon Cancer Centre. The well-stocked medical libraries contain facilities for CD-ROM and online literature searches.

The Trust has an established education committee, comprising clinical tutors, consultant staff and other senior staff, that oversees and plans for high quality multi-disciplinary education and training throughout the organisation. All consultants are required to contribute to the Trust's education programmes for junior medical staff.

Very close links exist between the Trust and University College London Hospital, the Royal Free, Imperial College School of Medicine (Charing Cross, Chelsea and Westminster, St Mary's and Hammersmith hospitals) and Addenbrookes (Cambridge) in respect of linked pre-registration house officer posts, the teaching of medical students and rotational training posts.

Nursing and midwifery education and training

Mandatory training remains a priority for the department. The programme was redesigned in 2009 to provide an acute care, theatre, midwifery and general pathway. Clinical skills training are offered to the trust as part of the internal training programme. Newly registered nurses continue to be offered a preceptorship programme called *first steps* this is provided in partnership with the University of Hertfordshire.

Clinical support workers employed into the Trust from 2009 are employed as apprentices in Health and social care. The Trust has exceeded the East of England SHA target for 2009/10.

Quality clinical leadership remains a high priority within nurse education and significant progress has been made within our organisation when supporting County and SHA initiatives. 11 managers completed the Effective leader programme in 2009/10

Apprenticeships

The Trust is working in partnership with training providers to support staff within bands one to four to undertake apprenticeships relevant to their job role and in doing so striving towards meeting the skills pledge.

Apprenticeships were first implemented in the Trust August 2009 for all new clinical support workers recruited into band two positions and existing clinical staff who did not already posses a level two qualification. These clinical support workers are employed into a vacancy on a one-year fixed term apprenticeship contract and are interviewed prior to the end of their contract subject to conditions to gain a substantive post. Apprenticeships are now also being promoted in non clinical areas.

Apprenticeships commenced between August 2009 and April 2010		
Health and social care	110	Level two
Health award	24	Level three
Business and administration	6	Level two
Customer care	15	Level two/three

Development routes for clinical staff are in place, progressing onto a foundation degree (assistant practitioner). The key drivers for this are *Modernising Healthcare Careers*, reducing supply of registered professionals and the NHS' QIPP agenda.

Targets for the East of England for band one to four in 2011 are:

- 518 apprenticeships;
- 300 foundation degree (of which 45 are in Hertfordshire).

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 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 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.

Equal opportunities

It is the Trust's policy 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 diversity 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.

During 2009/10 a series of training events were held to support staff in undertaking equality impact assessments.

Disability policy

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

To use the *Two Ticks Standard* 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 implementation 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 wellbeing of staff. During 2009/10 achievements included an effective staff vaccination campaign to support the Trust's swine flu response; support for the changes in the Trust Absence Management Policy; and work to develop a Health and Well-being Strategy.

Health and safety

It is the Trust's policy to do all that is reasonably practical to provide a safe and healthy work 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. This work is supported through relevant training, information instruction and supervision of staff, as well as the monitoring of any third party contactors.

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 required to attend this training, which is delivered to a nationally agreed syllabus. The Trust is now in its fourth year of delivering such training.

Whistle-blowing policy and procedure

The Trust has a whistle-blowing 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 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 steps to deal with such issues, as they arise. Whenever possible, the Trust will give feedback to the individual who raised the matter.

Chapter 11: staff, patient and public engagement

Engaging with the Trust's staff

Informing and consulting staff

The Trust aims to ensure that 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:

- **Trust Brief** – monthly cascade briefing process, which reports discussions that take place on strategic issues taken in public session at Trust Board meetings;

- **Quarterly open staff briefings** – quarterly meetings open to all staff and held on each of the Trust's four hospitals sites through which the executive team presents and discuss major strategic issues – especially the on-going *Our changing hospitals* programme. Those attending are expected to carry the discussion back to their teams;

- **Road shows/briefings** – where the views and input of staff is required on specific projects and changes, the Trust seeks to take issues out to them – either in full, open-house session 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.

To support strategic messages delivered through the above communication 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:

- **The Knowledge Centre** – the Trust's new Intranet service has grown to become one of the single biggest sources of general information within the Trust;

- **Trust Bulletin** – weekly newssheet issued by all staff e-mail, carrying a wide range of operational articles;

- **Our changing hospitals e-newsletter** – issued roughly every month electronically to all Trust staff, provide general updates on the *Our changing hospitals* programme, providing links through to dedicated information pages on the Trust's Intranet service, the Knowledge Centre;

- **Grapevine** – published by staff, for staff, the Trust's bi-monthly staff newsletter has been an unqualified success since its launch in 2003. Grapevine provides staff with a unique platform to recognise the contribution of their colleagues.

- **Patient Safety Matters** – bi-monthly newsletter produced in-house at the Trust and aimed at highlighting and promoting patient safety issues.

In addition, the annual staff awards, which is now in its fifth year, is one of the main means through which the trust also 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 staff side representatives and the Trust's director of human resources, Trust Partnership meets every month.

This very important forum is used to discuss and agree a wide range of issues, including new and updated trust policies and change management issues. In December 2008 staff side and management representatives undertook a review of partnership working and jointly agreed a number of further improvements.

The Trust's chief executive and other directors also meet with staff side representatives regularly to brief them in more detail on strategic issues, as well as on the organisation's clinical, operational and financial performance.

Listening to staff

The 2009 NHS staff survey, published by the Care Quality Commission, found that we are in the best performing 20% of trusts in the following areas:

- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver;
- Percentage having well-structured appraisals in the last 12 months;
- Staff satisfaction;
- Staff motivation at work;
- Percentage of staff agreeing that they have an interesting job;
- Work pressure felt by staff;
- Trust commitment to work/life balance;
- Percentage feeling that there are good opportunities to develop their potential at work.

However, there are four areas in particular where more work is required:

- Percentage receiving health and safety training in the last 12 months;
- Percentage suffering work-related injury in the last 12 months;
- Percentage of staff experiencing physical violence from other staff in last 12 months (3% of respondents);
- Percentage experiencing discrimination at work.

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

Patient and public engagement

Overview and scrutiny

The nature of the relationship between the Trust and the Hertfordshire county council's health scrutiny committee is subject to legislative guidance. The law gives powers to local authority overview and scrutiny committees to consider issues affecting the health of local people and to call the NHS to account on behalf of local communities.

The primary aims of health overview and scrutiny committees are to ensure that:

- Health services reflect the views and aspirations of local communities;
- All sections of local communities have equal access to services;
- All sections of local communities have an equal chance of a successful outcome from services

The National Health Service Act 2006 (section 244) and the NHS Next Stage Review, May 2008 place a statutory duty on NHS bodies to consult the local authority's overview and scrutiny committee on proposals for any substantial development of health services in the local authority area or for a substantial variation in the provision of the service. These regulations, although the same in requirement, replace section 7 of the Health and Social Care Act 2001.

Recent examples of work with the county council's health scrutiny committee include the Trust's participation in two workshops to brief newly elected members of the committee on the NHS in Hertfordshire and the introduction of Quality Accounts plus hosting visits from committee members to both the Mount Vernon Cancer Centre and the Lister Hospital, the latter to scrutinise implementation of the Delivering Quality Healthcare for Hertfordshire strategy.

Section 242 of the NHS Act 2006, part 1, explains the duty to make arrangements for involvement. While it does not set out how that involvement should work, it is clear that users may be involved by *"…being consulted, or by giving information, or in other ways, either directly or by representatives."* Engagement, consultation and participation are all words that can be used to describe different types of involvement activity.

Hertfordshire LINk

In April 2008, the Government replaced Patient and Public Involvement Fora (PPIs) with new Local Involvement Networks (LINks). The Hertfordshire LINk was established early in 2008, with a formal launch following in November 2008.

LINks were introduced to help communities influence the care they receive, with their role including:

- Providing everyone in the community – from individuals to voluntary groups – with the chance to say what they think about local health and social care services, for example what is working and what is not;
- Giving people a chance to influence how services are planned and run;
- Feeding back to the NHS what people have said about services so that things can be changed, where necessary

Representatives of Hertfordshire LINk have regular meetings with members of the Trust's senior management team, as well as being able to attend Trust Board meetings as they see fit. Hertfordshire LINk also has an active role on the Trust's involvement committee.

Membership of LINk is available to all and the board includes strong voluntary sector membership, as well as individuals. LINk members are encouraged to join local groups and the LINk aims to work with such local groups on issues of importance to them – and not just duplicate existing activities. The objective is to add influence to local people's voices.

The relationship between the LINk and the Trust is important in terms of enriching involvement with the local community.

Involvement committee

The Trust's involvement committee has reviewed the way in which it works, establishing a number of topic groups in order to deliver the aims of the involvement strategy. Committee membership includes a wide range of representatives, including Trust staff, patients and foundation trust members, as well as representatives from Hertfordshire LINks, local authorities and organisations from the voluntary sector.

The involvement committee's work includes:

- Extending and embedding involvement from staff, patients, carers and the public in decisions affecting the development or provision of the Trust's services;
- Seeking to involve those groups who may traditionally be less likely to access clinical services or respond to invitations to become involved;
- Seeking to provide people with appropriate information to support effective involvement;
- Providing feedback to let people know the outcome of their involvement;
- Evaluating and seeking continually to improve the quality of the Trust's involvement work;
- Striving to further improve patient experience

Local strategic partnerships

Local strategic partnerships (LSPs) are responsible for developing sustainable community strategies (SCS), which are strategic plans for those involved in providing services within a district to help improve the lives of people living in the area. Achievement of this strategy is measured against a set of national indicators.

The Trust is a member of several district LSPs, including North Hertfordshire, Welwyn Hatfield's Welhat Alliance and East Hertfordshire. The Trust contributes to the development of all SCSs locally, including the county-wide plan of *Herts Forward*.

The Trust maintains strong working relationships with all district and borough councils within east and north Hertfordshire, as well as increasingly south Bedfordshire. Representatives from the Trust often attend community-based meetings organised by these authorities. The Trust is committed to partnership working, which is further underlined through its active membership of local clinical networks.

Annual report and accounts – public consultation

Consultation process

As in each of the three previous years, the Trust conducted a consultation on the contents of its annual report for 2008/09, with the aim of helping to improve further the content of, and access to, the 2009/10 report. On 8 December 2009, the Trust issued its questionnaire – via e-mail and as a hard copy to those who do not use e-mail – to 160 people, including:

- Trust and other NHS staff locally;
- Foundation trust members;
- Patient group representatives;
- Local authority councillors
- MPs;
- Newspaper editors.

The deadline for response was set as 15 January 2010.

Consultation findings

The response rate, at eight out of 160, was 5.0% – which is slightly higher than in previous annual report consultations undertaken in each of the last three years. While the low numbers involved would suggest that it is important not to draw too many hard and fast conclusions, the responses suggest that:

- Overall people appeared happy with the report's content – including those who had only reviewed it as part of the consultation process;
- As was the case last year, there was no preference from respondents suggesting additional routes as to how the report should be disseminated other than those used already (hard copy mailing, e-mail PDF attachment and PDF file on Trust website);
- No suggestions were made about additional formats required other than those available already (normal and large print versions);
- Last year there was some suggestion that more attention could be paid to the clarity of the writing. This year respondents praised the report for its accessibility.

Actions for 2009/10 annual report

Following this year's consultation, the following actions are now being pursued in terms of developing the 2009/10 annual report:

1. Broadly speaking, the annual report meets people's information needs although some wanted more summary information earlier in the report – while this year's report has been restructured to meet this need, the publication of a separate and much shorter annual review document later in 2010 will deliver this improvement completely.

2. Key topics people said they wanted covered for 2009/10 are:

    - Quality for patients, including *Patient Choice* and outcomes
    - Future projects, including *Our changing hospitals* and related programmes
    - Progress made against national standards and priorities
    - Infection prevent and control, including cleanliness
    - Finance and its impact on services
    - Progress towards FT status
    - New treatments and technology
    - Staffing arrangements

These requests have been borne in mind in the writing of the annual report and accounts for 2009/10.

Chapter 12: sustainability

Environmental impact

Each year the NHS produces more than 18 million tonnes of CO_2 from:

- heating, cooling and lighting buildings;
- powering equipment; procuring goods and commissioning services;
- sending waste to landfill;
- patients, staff and visitor travel.

This represents 25% of total public sector emissions in England and 3.2% of total carbon emissions overall. The Trust is taking steps to control its energy use, taking into consideration the NHS carbon reduction strategy that was published at the end of May 2008. These efforts will result in a number of benefits, including:

- More energy efficient buildings, which will improve conditions for patients and staff;
- Achievement of mandatory government targets;
- Improved future service developments;
- A focus for planned capital and maintenance expenditure.

It is known that organisations that publish their achievements receive positive feedback from stakeholders and the local community. It is also worth noting that such initiatives cut across departmental boundaries and foster an inclusive atmosphere, which can lead to improvement in staff morale.

Many healthcare organisations are already feeling the value of these benefits, but there is another reason why action should be considered. The global environment is being damaged irrevocably by the burning of fossil fuels, which supply an increasing demand for resources. The UK, together with many of the world's governments, has pledged to curb reliance on fossil fuels so that carbon emissions can be cut to a sustainable level.

National and international targets

The Kyoto Protocol 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 2008/09. In addition, the UK has set a domestic goal to reduce emissions by 20% by 2010, with a further goal of 60% by 2050.

In April 2001 the Secretary of State for Health wrote to all 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 overleaf.

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)

The Climate Change Act 2008

This Act sets a target to be achieved by the year 2050 for the reduction of targeted greenhouse gas emissions of at least 80% lower than the 1990 baseline targets, along with a 26% reduction by 2020. The baseline means the aggregate amount of net UK emissions of carbon dioxide for that year, and the net UK emissions of each of the other targeted greenhouse gases for the year.

NHS carbon reduction strategy

Meeting these targets is a legal requirement and governance arrangements of all organisations will need to demonstrate how this is being measured, monitored, and managed. The NHS carbon reduction strategy has been developed in response to the need to take action on climate change and in consultation with the NHS and other organisations.

Widespread support has given the NHS a mandate to implement this strategy across every aspect of the health service in England. The NHS has a carbon footprint of 18 million tonnes CO_2 per year, which comprises energy (22%), travel (18%) and procurement (60%). Despite an increase in efficiency, the NHS has increased its carbon footprint by 40% since 1990. This means that meeting Climate Change Act targets of a 26% reduction by 2020 and a further 60% by 2050 will be a significant challenge.

The strategy establishes that the NHS should have a target of reducing its 2007 carbon footprint by 10% by 2015. This will require the current level of growth of emissions to not only be curbed, but the trend to be reversed and absolute emissions reduced. Interim NHS targets will be needed to meet the government targets.

Every NHS organisation should sign up to the *Good Corporate Citizenship Assessment Model* and produce a Board-approved sustainable development management plan – which the Trust has now done.

The NHS should set itself interim targets and trajectories to meet the provisions of the Climate Change Act. In the first instance, this should be set at 10%, as a minimum, of the 2007 levels by 2015. Carbon reduction and sustainable development are corporate responsibilities and should be an inherent part of each organisation's performance and governance mechanisms.

Healthcare regulators should ensure that sustainability and the environmental impact of services are an integral part of quality standards. Strategic health authorities and regional government offices should ensure that:

- The NHS delivers carbon reduction through its commissioning frameworks;
- The NHS delivers on its sustainability commitments within local area agreements;
- Sustainable development regional networks in the NHS are developed further to deliver on this agenda.

Carbon reduction commitment (CRC)

This scheme was implemented from April 2010 and any estate that uses more than 6,000MWh per year – equivalent to an annual electricity bill of £500,000 – will have to work within the CRC. As the Trust's current total electricity usage is above this threshold, all of its hospital sites will fall within the CRC. All energy, except for transport fuels, will be covered, such as electricity, gas, fuel and oil.

During a planned introductory phase, starting in April 2010, all allowances will be sold at a fixed price. From April 2013, allowances will be allocated through auctions, with a diminishing number of credits available over time. At the end of each year, the Trust's performance – based mainly on absolute carbon reductions since the start of the scheme – will be summarised in league tables outlining the best and worse performers in terms of carbon emissions and reduction.

In order to avoid creating an additional financial burden, revenues generated through the initial sale of credits will be recycled back to participants, with NHS trusts receiving payments from the Government in relation to their first emissions, plus or minus a bonus or penalty dependent on the Trust's position in the league table. Present estimates of carbon cost are around £12.00 per tonne. This will be applied to the carbon content of: gas, heating oil and grid supplied electricity. Predicted site costs for the Lister, for example, are £72,000 per annum.

EU emission trading scheme

It is a statutory requirement for NHS installations of 20 megawatts or more thermal capacity per site to register with DEFRA. Eighty-three NHS trusts are now registered, but the Trust's sites currently fall below this limit. The scheme works on a carbon trading basis. 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, depending on their performance.

European energy performance of buildings directive (EPBD)

The EPBD took effect in 2006 and will be implemented through *Building Regulations*. One of the main changes 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; and existing buildings when they undergo substantial refurbishment.

In addition, all public buildings that are over 1,000 m^2 (i.e. most of the Trust's estate) will need to display an energy label – the o*perational rating* – for the public to see. The Government has 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 source, including: wind; wave; tidal; solar; thermal; photo-voltaic (PV); hydro-generation; geothermal; and biomass (energy from forestry or crops). All of these technologies are applicable to the healthcare sector and there are various financial incentives to encourage organisations to introduce these.

What is the Trust's current position?

In February 2010, the Trust's Board approved a sustainability strategy, which was followed subsequently in March 2010 by the establishment of the Trust's sustainability development committee. The aim of the latter is to lead the delivery of the Trust's carbon reduction strategy and delivery of the sustainability objectives.

In terms of the Trust's energy consumption, it has seen a 38% increase in the cost paid for electricity at Lister hospital over the past two years; with a 0.1% reduction in consumption (GJ). The QEII has seen a 48% increase in the cost paid for electricity, with a 4% reduction in consumption.

This anomaly in rates at which both hospitals have been charged for the use of electricity was uncovered recently. It has since been established that inadvertent overcharging was taking place due to a fault in the supplier's systems. This has now been resolved and the Trust will be receiving a rebate for this overcharge going back six years. Both hospital sites are now paying the same for rate for electricity usage.

In relation to gas, here has been a 40% increase in the cost paid for gas at Lister over the past two years; with a reduction in consumption of 4%. The QEII has seen the cost paid for gas increase by 35% over the past two years, whilst there has also been a 3.8% increase in consumption.

Over the past two years the Trust has experienced a year-on-year reduction in CO_2 emissions, which equates to a 12% reduction overall. Detailed energy surveys have been carried out for the Lister and QEII sites in 2003 and 2005 respectively; these enabled baselines to be set and to identify efficiency measures. The Trust complied and registered with the CRC scheme from April 2010.

The Trust procures its energy and utilities through PASA, which acts on behalf of approximately 90% of NHS organisations. It ensures, through economies of scale and a flexible purchasing strategy, the very best price for utility procurement is achieved. There is an obligation for 10% of the electricity supply purchased to come from a renewable resource, as required by the Government target set for March 2008, which the Trust meets.

The Trust invested £1.7 million in 2009/10, with a further £2.1 million approved investment in 2010/11, for energy infrastructure upgrade work to both provide greater security of energy supply and improve the efficiency of energy provision at the Lister. Plans have also been developed during 2009/10 for the development of a combined heat and power plant at the Lister, which on their final approval will become operational in 2012 and deliver an estimated 14% reduction to the Trust's total carbon consumption/emissions.

Chapter 13: 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, two further executive directors – for human resources and strategic development – participate in board meetings but do not have voting rights.

The Trust Board is responsible for the leadership of the Trust, setting its strategic direction, defining its objectives and monitoring its performance. 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 by a national body, the Appointments Commission, on behalf of the Secretary of State. The normal term of office served by the chairman and non-executive directors is four years, renewable for a further four-year period. The executive directors are appointed by the Board on permanent contracts.

The role of the NHS trust board

The Board's role includes:

- **Looking ahead** – the Board is responsible collectively for shaping the strategy, vision and purpose of the Trust. It holds the organisation to account for the delivery of its strategy and ensures value for money.

- **Leadership and control** – a key role of the Board is to provide active leadership to the Trust within a framework of prudent and effective controls, ensuring that risks to the organisation and the public are managed and mitigated effectively.

- **Collective responsibility for performance** – the Board defines the Trust's objectives and ensures that the necessary financial and human resources are in place for the organisation to meet those objectives. The Board also monitors management performance.

- **Setting and maintaining values** – in setting the Trust's values and standards, the 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's role is key in creating the conditions for overall board and individual director effectiveness. The main responsibilities of an NHS chair are:

- Providing leadership to the Board, ensuring its effectiveness in all aspects of its role, and taking responsibility for setting its agenda;
- Ensuring the provision of accurate, timely and clear information to directors and other stakeholders;
- Ensure effective communication with all stakeholders;
- Arranging the regular evaluation of the performance of the board, its committees and individual directors, including the Chief Executive;
- Facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

The role of non-executive directors

The non-executive directors on an NHS board bring their expertise and experience, as well as their particular knowledge as a member of the community, to the work of the board. Their focus is strategic and impartial, providing an independent view that is removed from the day-to-day running of the organisation. Their main responsibilities include:

- Helping to plan for the future growth and success of the organisation;
- Helping the board ensure it is working in the public interest;
- Making sure that the management team meets its performance targets;
- Making sure that the finances of the organisation are managed properly, with accurate information;
- Serving on important board committees.

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, as well as scrutiny of performance, 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. Together with the chief executive, the chairman and non-executive directors appoint all other executive directors and determine their remuneration.

The Trust Board 2009/10

This section of the annual report provides details of Board members as well as of other non-voting directors, including their Board committee membership.

Key to principal committee membership

AC – Audit committee
EC – Executive committee
FTC – Foundation trust committee
FPC – Finance and performance committee
RAQC – Risk and quality committee
RC – Remuneration committee
CTC – Charity trustee committee (formerly TIC – Treasury and investment committee)

Notes to Committee attendance

1. The executive committee (EC) is a weekly meeting that is attended by all executive directors, unless absent from the Trust.
2. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. The committee attendance figures listed below do not take in to account these additional attendances; rather they reflect attendances that are *expected*.

Richard Beazley, chairman

Appointed Chairman of the Trust on 1 April 2002, in 2006 Richard was reappointed for a second term which was extended to run until 30 September 2011. He is a former chief executive, international lawyer and economist. He became a solicitor in 1974 and spent 25 years working in the oil industry, including 21 years with the Mobil Oil Corporation. Of those 25 years, he spent 12 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 chairs the *Foundation trust committee* and the *Remuneration committee*. He lives in Standon, near Ware.

Committee membership: FTC, RC, CTC
Attendance: Trust Board 11 out of 11; FTC 4 out of 5; RC 2 out of 2; CTC 3 out of 4

Nick Carver, chief executive

The chief executive is the accountable officer for the Trust and carries full responsibility for its performance, as well as for leadership of the executive team. Nick was appointed as the Trust's chief executive in November 2002, having been 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 joining the national management trainee scheme. Prior to becoming an NHS chief executive, Nick was director of operations and nursing at the Royal United Hospitals NHS Trust in Bath. He has also worked at the Morriston Hospital in Swansea, the Singleton Hospital in 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. He sits on the national advisory group for NHS emerging leaders.

Committee membership: EC, FTC, FPC, CTC
Attendance: Trust Board 11 out of 11; FTC 5 out of 5; FPC 6 out of 11; CTC 3 out of 4; RAQC 8 out of 12; AC 2 (as required)

Alison Murray, non-executive director and vice-chair

Currently Alison is an adviser on research projects for applied service developments. She has experience of working in various NHS trusts – especially in developing acute services for older people, stroke services and 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 Department of Employment and as a university officer in personnel at the University of Cambridge. Alison chairs the Trust's *Risk and quality committee* and is the Trust's vice-chair. Alison was reappointed from 1 December 2007 and her current term of office ends on 30 June 2010. She lives in Ashwell, near Baldock.

Committee membership: FTC, RAQC, RC

Attendance: Trust Board 9 out of 11; FTC 2 out of 5; RAQC – 11 out of 12; RC 1 out of 2

Stephen Brooker, non-executive director

A chartered accountant, Stephen has a variety of business and charitable interests, as well as chairing the Audit Committee of the Law Society of England and Wales until 31 December 2009. He is an adviser on finance, strategy and governance to a number of British and international charities. Stephen has been a partner in Ernst & Young, director of finance of the British Red Cross and, until May 1997, bursar and fellow of Emmanuel College, Cambridge. During 2009, Stephen was appointed to the House of Commons audit committee with effect from 1 July 2010. He was reappointed as a non-executive director of the Trust in 2006, with his current term of office running from 1 January 2007 to 31 December 2010. He is chairman of the Trust's *Audit committee*.

Committee membership: AC, FTC, RC, CTC

Attendance: Trust Board 8 out of 11; AC 7 out of 7; FTC 3 out of 5; RC 1 out of 2; CTC 3 out of 4

Ian Morfett, non-executive director

Ian teaches at University College London, developing programmes in leadership and management. Until 2006, he was the deputy director of the *Better Regulation Executive* within the Cabinet Office, where he worked with stakeholders to identify and reduce the negative impact of regulation on business. Prior to that, Ian worked for BT for 30 years, most recently as managing director of strategy and business development for BT Wholesale – the network and carrier services arm of BT. He has also been group director of regulatory affairs for BT and has held a number of senior roles covering finance, commerce and customer service. Appointed non-executive director from 1 August 2005, Ian was reappointed in 2009 and his current term of office runs to 31 July 2013. Ian chairs the Trust's *Finance and performance committee*. He lives in Letchworth.

Committee membership: FTC, FPC, RAQC, RC

Attendance: Trust Board 11 out of 11; FTC 2 out of 5; FPC 11 out of 11; RAQC 8 out of 12; RC 2 out of 2

Michael Gibbons, non-executive director

Formerly a board director of Powergen, Michael has held a wide variety of commercial and public appointments during his career. Among other appointments he is chairman of the Regulatory Policy Committee, chairman of the UK National Committee of the World Energy Council, a director of the Carbon Capture and Storage Association and a director of the Hertfordshire Family Mediation Service Ltd. Between 2002 and 2008, Michael was a member of the Better Regulation Commission and its predecessor body, working with policy makers to reduce unnecessary regulatory and administrative burdens. He is currently a member of the High Level Group of Independent Stakeholders set up to advise the European Commission on reducing administrative burdens. Michael lives in Tewin and was appointed non-executive director from 1 June 2007; he was due to serve until 31 May 2011, but resigned with effect from 30 April 2010 because he is moving away from the area. He chaired the *Charity trustee committee* (formerly the *Treasury and investment committee*).

Committee membership: AC, FTC, FPC, RC, CTC

Attendance: Trust Board 9 out of 11; AC 6 out of 7; FTC 5 out of 5; FPC 5 out of 11; RC 1 out of 2; CTC 4 out of 4

Alison Bexfield, non-executive director

A charted accountant and the chief financial adviser to the BBC Trust, Alison provides its trustees with financial and corporate governance expertise. She also sits as an independent member of the audit committee of the Medical Research Council. Previously, Alison worked for seven years within the BBC's group finance function and, prior to that, for ten years as an auditor within public practice for Touche Ross (now Deloittes) and KPMG, including several years managing healthcare audits in both public and private sectors. Alison was appointed from 1 February 2008 and is due to serve until 31 January 2012. She lives in Letchworth.

Committee membership: AC, FTC, RAQC, RC

Attendance: Trust Board 10 out of 11; AC 5 out of 7; FTC 1 out of 5*; RAQC 11 out of 12; RC 2 out of 2

*Although FTC membership was extended to all Board members, it was recognised that Alison's existing commitments with the BBC would prevent her from attending the majority of FTC meetings.

James Quinn, medical director

A practising ear, nose and throat (ENT) surgeon with the Trust, James was appointed medical director from 1 April 2007. Prior to this, he was deputy medical director with a remit for clinical efficiency, and had been clinical director for surgical specialties for three years. James trained in ENT surgery in London and Cambridge and was appointed as an ENT consultant covering the former East Hertfordshire and North Hertfordshire NHS Trusts in 1998. He has a specialist interest in ear surgery and balance disorders.

Committee membership: EC, FTC, FPC

Attendance: Trust Board 8 out of 11; FTC 2 out of 5*; FPC 0 out of 11*; RAQC 9 out of 12

*Meetings held on Wednesdays clash with James' clinical commitments

Sue Greenslade, director of nursing

Appointed director of nursing in September 2008, Sue is also the Trust's director of infection prevention and control (DIPC). After qualifying as a general registered nurse, she held a number of posts in district general and London hospitals. A former director of nursing, patient services and governance at Hillingdon Hospital NHS Trust, Sue was the East of England Strategic Health Authority's deputy chief nurse from 2007 to 2008.

Committee membership: EC, FTC, FPC

Attendance: Trust Board 8 out of 11; FTC 3 out of 5; FPC 6 out of 11; RAQC 6 out of 12

Paul Traynor, director of finance

Paul was appointed as the Trust's finance director in May 2009. He joined from Dartford and Gravesham NHS Trust, where he had been its finance director since mid-2005. Previously Paul held a similar role at Kent Ambulance NHS Trust, prior to which he held a number of senior finance positions in both acute hospitals and primary care trusts. He joined the NHS in 1990 and completed his accountancy qualification in 1995.

Committee membership: EC, FTC, FPC, CTC

Attendance: Trust Board 9 out of 10; FTC 4 out of 5; FPC 9 out of 10; CTC 3 out of 4; RAQC 5 out of 11; AC 6 out of 6

Neil Dardis, director of operations

Neil was appointed as the Trust's director of operations in June 2008, following a period as deputy director of operations. Previously, he held several senior general management roles within the Trust, including leading its surgical services. Neil has also held several senior management roles in acute teaching hospitals. He is responsible for the effective delivery of high quality and accessible services for patients across all four of the Trust's hospitals and ensuring that these services meet national and local performance and quality standards. Neil has management responsibility for over 3,000 front line staff through the leadership of the Trust's five clinical divisions and their senior managerial and clinical teams.

Committee membership: EC, FTC, FPC

Attendance: Trust Board 9 out of 11; FTC 9 out of 10; FPC 8 out of 10; RAQC 9 out of 12

Stephen Posey, director of strategic development

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 trusts, the Department of Health, strategic health authorities and primary care trusts across the East of England. Stephen has lead director responsibility for business development, partnerships, involvement, and sustainability as well as strategic development. He is responsible for delivery of the Trust's *Our changing hospitals* programme to consolidate acute services at the Lister hospital. This forms part of the Hertfordshire-wide *Delivering quality health care for Hertfordshire* (DQHH) programme.

Committee membership: EC, FTC, FPC, TIC

Attendance: Trust Board 11 out of 11; FTC 5 out of 5; FPC 8 out of 11; CTC 4 out of 4; RAQC 9 out of 12

Janet Lynch, director of human resources and organisational development

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 over five years. Prior to that, she had held a similar post at Riverside Community Healthcare NHS Trust in west London. Janet originally joined the NHS in 1986 on a personnel management training scheme with the former Mersey Regional Heath Authority. She then held a range of human resources posts in health organisations in the North-west.

Committee membership: EC, FTC, FPC

Attendance: Trust Board 10 out of 11; FTC 3 out of 5; FPC 8 out of 11; RAQC 10 out of 12

John Webster, director of corporate development

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. John has held a number of senior management roles within acute trusts, health authorities and the Department of Health. Before joining the Trust, he had been the performance lead for the former Midlands and Eastern region of the Department of Health and Social Care. John left the Trust in November 2009 on secondment to NHS Harrow as its chief operating officer.

Committee membership: EC, FTC

Attendance: Trust Board 5 out of 6; FTC 3 out of 4; RAQC 4 out of 5; AC 3 out of 5

	Title	Appointment date	Term(s) of office	Term of office ends
Richard Beazley	Chairman	1 April 2002	Four years, plus four years, plus 18 months	30 September 2011
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Murray[1]	Vice Chairman	1 August 2000	Four years plus two years plus seven months	30 June 2010
Alison Bexfield	Non-executive director	1 February 2008	Four years	31 January 2012
Stephen Brooker[1]	Non-executive director	17 April 2000	Four years plus four years	31 December 2010
Michael Gibbons	Non-executive director	1 June 2007	Four years	30 April 2010 (resigned)
Ian Morfett	Non-executive director	1 August 2005	Four years plus four years	31 July 2013
Neil Dardis	Director of operations	6 June 2008	n/a	n/a
Sue Greenslade	Director of nursing	22 September 2008	n/a	n/a
James Quinn	Medical director	1 April 2007	Four years	31 March 2011
Paul Traynor	Director of finance	1 May 2009	n/a	n/a
Janet Lynch[2]	Director of human resources	1 October 2007	n/a	n/a
Stephen Posey[2]	Director of strategic development	21 January 2008	n/a	n/a
John Webster[2]	Director of corporate development	7 July 2007	n/a	8 November 2009

[1]Originally joined the Trust as non-executive directors in 2000: the terms of office given above date from the first appointment by the Appointments Commission, which took responsibility for public appointments to the NHS and their terms of office in 2001.
[2]Attend and participate in Trust Board meetings, but without voting rights.

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; alternatively, a copy can be supplied on request.

For further information, please contact:

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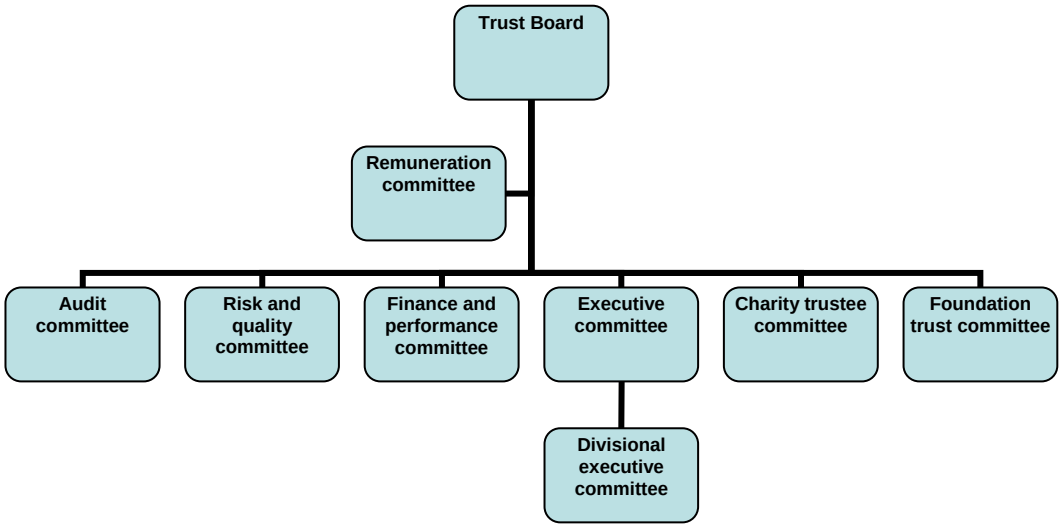
Governance structure

During 2008 the Trust Board adopted a system of line accountability through executive directors rather than through sub-committees, and it revised its committee structure – see diagram below.



The *Risk and quality committee* has a membership of three non-executive directors who hold the executive to account for effective progress in managing risk, ensuring compliance and improving quality.

The *Audit committee* holds the executive to account for the effectiveness of governance systems and the processes for managing risk.

The Trust's *Executive committee* comprises all executive directors and is also attended by the director of strategic estates, the director of business development and partnerships, the head of public affairs and the Trust Secretary. This committee meets weekly and covers all major service, performance and organisational issues. Once a month it also meets with the divisional chairs and divisional directors of the clinical divisions.

In addition, each division meets with the executive on a bi-monthly basis through the performance review system introduced in 2007-08 as part of the performance management framework.

The *Finance and performance committee* meets monthly and provides a forum for detailed discussion of financial and performance issues, as well as for reviewing the Trust's financial strategy and monitoring the capital programme.

The *Charity trustee committee* provides stewardship of the Trust's charitable funds on behalf of the Board, which is the corporate trustee, and is responsible for the charity's strategy. The committee was renamed in January 2010, having formerly been known as the *Treasury and investment committee*.

In 2008/09, the Board streamlined the management of the Trust's clinical services into five clinical divisions:

- **Division of surgery** (divisional chair, Mr Nick James and divisional director, Kevin Nicholson);
- **Division of medicine** (divisional chair, Dr Jon Baker and divisional director, Sharn Elton);
- **Division of clinical support services** (divisional chair, Dr Rajan Thiagarajan, and divisional director, Alison Rose);
- **Division of cancer services** (divisional chair, Dr Peter Ostler and divisional director, David Govan);
- **Division of women's and children's services** (divisional chairs, Mr Rami Atalla/Dr Andy Raffles and divisional director, Bernadette Herbert).

External auditor

Owing 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. It appoints auditors from its own staff, as well as from private firms of auditors. For 2009/10, the Trust's external auditor was Grant Thornton UK LLP.

The Audit Commission mandated additional work in 2009/10 on behalf of the Trust, relating to the implementation of International Financial Reporting Standards. The cost of this work has been disclosed separately under *Other auditor remuneration* in the accounts included within the body of this report.

Private finance initiative (PFI) schemes

Currently the Trust is involved in one PFI scheme, which is the new Hertford County hospital that opened its doors to patients in November 2004. The hospital is an £8.5 million PFI scheme, which was built, and is operated, by Ryhurst Ltd. The scheme involves an annual unitary payment of approximately £1 million. This fee is payable until 2034, when the hospital reverts to NHS ownership. Further information is provided in note 23 of the accounts section. The capital investment associated with the Trust's plans to reconfigure its acute hospital services will be funded through Trust borrowing.

Fixed assets

As set out in note 1 of the 2009/10 accounts section, fixed assets are stated at the lower of replacement cost and recoverable amount. An annual review is carried out 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 2009/10 accounts.

Transition to International Financial Reporting Standards

The Trust has adopted *International Financial Reporting Standards* (IFRS) in preparing this year's annual accounts along with all other NHS bodies. This will harmonise the principles used by all public bodies enabling more informed comparison and adoption of best practice from the corporate sector.

The impact of this change on operational costs has been modest, improving the position by £38,000 in-year. The more significant effect has been the accounting policy changes required to balance sheet accounting in connection with the revaluation of assets, as explained further below.

In accordance with Department of Health policy, the Trust valued its land and building assets using modern equivalent asset methodology (MEA). This change in estimation technique reduced the asset values shown on the balance sheet by £70 million. IFRS states if values fall below their historical cost, the shortfall should be charged to the operational costs of the organisation in the year of revaluation. As such, in 2009/10 the Trust has recorded an impairment cost of £21.8 million that forms part of retained deficit total for the year shown under the annual accounts section of this report in the *Statement of Comprehensive Income*.

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Although the scheme is a defined benefit scheme, it 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. The cost to the NHS body, therefore, of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The full accounting policy can be viewed under note 1.7 and valuation details under note 9 in the annual accounts contained in this report.

Information governance

All NHS trusts are required to carry out an annual self-assessment against information governance requirements defined in the *Connecting for Health* information governance toolkit. The latter seeks assurance on all aspects of information relevant to the Trust's business and comprises a total of 60 measures, which cover:

- Information governance management;
- Confidentiality and data protection;
- Information security;
- Clinical information assurance;
- Secondary use;
- Corporate information assurance

The Trust Board has endorsed Paul Traynor, director of finance, as the *board-level senior information risk owner*.

For 2009/10 the Trust achieved a 'green' rating against the Information Governance Toolkit with minimum level 2 compliance for all statement of compliance measures. The Trust self-reported one Information Governance Serious Untoward Incident (SUI) relating the Data Protection Act to the Information Commission Office in December 2009 and following investigation the case was closed in March 2010 stating no regulatory action to be taken. The Trust has an SUI action plan in place to implement the lessons learnt and mitigate the risks of reoccurrence; this is monitored by the IG steering group:

Summary of other personal data-related incidents in 2009/10		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	1
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secure NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	17
V	Other	28

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 (Board-level 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 the chairman and all the non-executive directors. Remuneration for executive directors does not include any performance-related bonuses and none of them receive 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. In 2009, the committee took into account a benchmarking report prepared by Capita Health Service Partners.

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

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.

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.

Nick Carver
Chief Executive

Salary and pension entitlements of senior managers

The salary and pension entitlement of the members of the Trust Board are set out on the tables over the next two pages.

Remuneration

Name and title	2009/10			2008/09		
	Salary	Other remuneration	Benefits in kind	Salary	Other remuneration	Benefits in kind
	(bands of £5000)	(bands of £5000)	Rounded to the nearest	(bands of £5000)	(bands of £5000)	Rounded to the nearest
	£000	£000	£00	£000	£000	£00
Executive directors						
Nick Carver	160-165	0	9	155-160	0	9
Chief executive						
Wendy Hull	15-20	0	25	135-140	0	93
Director of finance (01/4/09 to 12/5/09)						
Paul Traynor	125-130	0	66	0	0	0
Director of finance (5/5/10 to 31/3/10)						
Sue Greenslade	100-105	0	1	50-55	0	0
Director of nursing						
John Webster	55-60	0	8	90-95	0	8
Director of corporate development (1/4/09 to 9/11/09)						
James Quinn	50-55	0	3	45-50	0	2
Medical director						
Neil Dardis	100-105	0	4	95-100	0	3
Director of operations						
Stephen Posey	95-100	0	4	85-90	0	3
Director of strategic development						
Janet Lynch	95-100	0	3	90-95	0	4
Director of human resources						
Non-executive directors						
Richard Beazley	25-30	0	0	20-25	0	0
Chairman						
Alison Murray	6-10	0	0	5-10	0	0
Vice-chair						
Stephen Brooker	6-10	0	0	5-10	0	0
Michael Gibbons	6-10	0	0	5-10	0	0
Ian Morfett	6-10	0	0	5-10	0	0
Alison Bexfield	6-10	0	0	5-10	0	0

Notes to remuneration table

Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. The medical director's remuneration quoted in the table above relates to senior manager duties only. Please note that the director of nursing's salary figures for 2009/10 reflect a full year salary; while the figures shown in 2008/09 are for part-year only.

Pensions benefits

Name and title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2010	Lump sum at aged 60 related to accrued pension at 31 March 2010	Cash equivalent transfer value at 31 March 2010	Cash equivalent transfer value at 31 March 2009	Real increase in cash equivalent transfer value	Employers contribution to stakeholder pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Nick Carver	0-2.5	0-2.5	45-50	135-140	853	762	53	0
Chief executive								
Wendy Hull	0	0	50-55	170-175	0	0	0	0
Director of finance (1/4/2009 to 12/5/2009)								
Paul Traynor	5-7.5	15-20	30-35	90-95	430	320	85	0
Director of finance (5/5/2009 to 31/3/2010)								
Sue Greenslade	2.5-5	12.5-15	35-40	110-115	641	518	98	0
Director of nursing								
Neil Dardis	0-2.5	2.5-5	15-20	50-55	206	173	24	0
Director of operations								
Stephen Posey	0-2.5	5-7.5	10-15	40-45	168	127	35	0
Director of strategic development								
Janet Lynch	0-2.5	2.5-5	25-30	80-85	466	404	42	0
Director of human resources								
John Webster	0-2.5	0-2.5	10-15	40-45	238	206	13	0
Director of corporate development (1/4/2009 to 8/11/2009)								

Notes to pensions table

As non-executive members of the Board do not receive pensionable remuneration, there are no entries in respect of pensions for these individuals. This also applies to the medical director; in the same way remuneration for this role is not pensionable and thus this post is not listed above. The *NHS Pensions Agency* has stated that if a member is over retirement age or receiving their NHS pension, they are not entitled to transfer their benefits. Wendy hull is now receiving her NHS pension and, therefore, no cash-equivalent transfer value (CETV) has been provided and no material change in pension benefits has occurred.

A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the *Institute and Faculty of Actuaries*

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

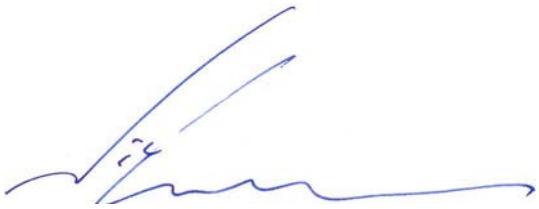
Chapter 14: annual accounts for 2009/10

Statement of the chief executive's responsibilities as the accountable officer of the Trust

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

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

Signed .  Chief Executive

Date: 27 May 2010

Statement of directors' responsibilities in respect of the accounts

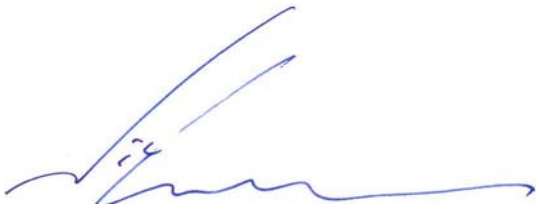
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised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

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the 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

Date: 27 May 2010  Chief Executive

Date: 27 May 2010 Finance Director

Summarisation schedules (TRUs) for the East and North Hertfordshire NHS Trust

Summarisation schedules numbered TRU01 to TRU35 plus Freetext are attached.

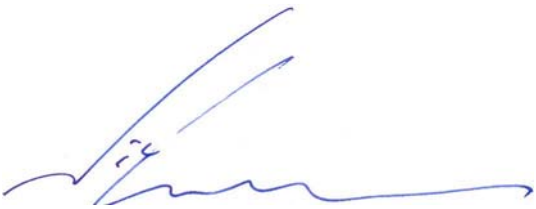
Director of Finance Certificate

I certify that the attached summarisation schedules have been compiled from and are in accordance with the financial records maintained by the trust and with the accounting standards and policies for the NHS approved by the Secretary of State.

Date: 27 May 2010 Finance Director

Chief Executive Certificate

I acknowledge the attached summarisation schedules, which have been prepared and certified by the director of finance, as the summarisation schedules which the trust is required to submit to the Secretary of State.



Date: 27 May 2010 Chief Executive

Statement of internal control

Scope of responsibility

The Board is accountable for internal control. As the 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 other partner organisations.

From April 2009 to October 2009, the responsibility for ensuring that there is a comprehensive risk management system in place was delegated to the director of corporate development, who was also responsible for corporate and information governance. Due to organisational changes, from October 2009 these responsibilities have been delegated to the director of finance. In addition, I am supported by: the director of nursing and clinical governance and the medical director for clinical governance and the co-ordination of the management of all clinical risks; the director of finance for financial and IM&T risks; the director of operations for emergency planning; and the director of human resources for health and safety and security management.

More detail on the individual director accountabilities are set out in the Trust's *risk management strategy*.

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 only provide, therefore, reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

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

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

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;
- Staff are trained and equipped to manage risk in a way appropriate to their authority and duties.

The *assurance framework* provides the Trust with a comprehensive method for the effective and focused management of the risks to ensure the delivery of the Trust's annual and strategic objectives. Through this framework, the Board gains assurance from the appropriate executive director that risks are being managed appropriately throughout the organisation.

Each of the Trust's clinical divisions has a divisional (clinical) chair and a divisional director, who are accountable jointly for risk and governance. A process of review and challenge of divisional risks, as contained in the Trust's *risk register*, is conducted through divisional performance review meetings. Areas of high risk are escalated to the *Risk and quality committee* and the Trust Board.

Support and training to staff is provided through a dedicated clinical governance support unit, as well as via non-clinical risk managers.

The risk and control framework

Objectives

The overall objective of the *risk management strategy* is to enable the achievement of the Trust's operational and strategic objectives. The delivery of a first-class service requires the Trust to take responsibility for the appropriate and effective management of its risks, in such a way that informed business decisions are taken to improve safety and quality. The Trust's *risk management strategy* reflects the principles set out in the Trust's corporate objectives and specifically seeks to:

- Maintain and seek continually to improve the quality of healthcare provided by the Trust through the minimisation of risk;
- Identify and control risks that may adversely affect the Trust's operational ability;
- Develop a fair and just culture;
- Provide and maintain a safe and secure environment for patients, staff and visitors;
- Encourage and support innovation and service developments within a framework for risk management;
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer of risk; otherwise to ensure that the organisation openly accepts the remaining risks;
- Create awareness throughout the Trust of the importance of actively managing risk;
- Ensure risk management systems and processes are clear and understood by all staff;
- Develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role.

Through a process of risk identification, assessment, learning and control, the organisation maintains a dynamic *corporate risk register* that informs the *board assurance framework* and, thereby, provides assurance both to the Board and to the community we serve.

Board assurance and reporting

The Trust Board has established three committees to discharge its responsibilities on Board assurance. These are the: *Audit committee*; *Risk and quality committee* and the *Finance and performance committee*.

The *Risk and quality committee*, which is a formal committee of the Board, is chaired by the Trust's vice-chair. Its purpose is to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of: clinical and corporate risk; clinical governance; clinical effectiveness; research governance; financial risk; information governance; health and safety; staff governance; and patient and public safety. The committee also ensures that the Trust has an effective management and clinical governance framework that includes the assessment and monitoring of quality indicators, which drive forward the development of quality of services and care, patient safety and patient experience.

The principal objectives of the *Risk and quality committee* are to:

- Provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused;
- Review and monitor the *board assurance framework* and the *corporate risk register*, ensuring appropriate action is taken to mitigate risks where possible and advising the Board where acceptance of risk may need to be considered;

- Monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS Litigation Authority (NHSLA), Clinical Negligence Scheme for Trusts (CNST), Health and Safety Executive (HSE), strategic health authority (SHA), the risk elements of the Auditors Local Evaluation (ALE), and ensure action is taken for compliance;
- Monitor and advise the Board on compliance with the Hygiene Code;
- Endorse, monitor and receive reports on the implementation of the Trust's key quality, clinical outcome, patient safety and patient experience strategies and indicators;
- Provide regular risk management reports to the Trust Board;
- Liaise with the Trust's *Audit committee* and the *Finance and performance committee*.

Each of the Trust's executive directors is accountable to the *Risk and quality committee* for their defined areas of responsibility and has clear assurance systems and structures in place. Key committees supporting this process include the:

- Clinical governance strategy group;
- Health and safety committee;
- Emergency planning committee;
- Information governance steering group;
- Infection control committee.

Assurance framework and risk register

The Trust's *assurance framework* identifies which of the organisation's aims and objectives may be at risk because of inadequacies in the operation of controls, or where the Trust has insufficient assurance. At the same time it: encompasses the *control* of risk; provides structured assurances about where risks are being managed effectively; and ensures that objectives are being delivered. This allows the Board to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care.

The *assurance framework* links to the Trust's *corporate risk register*, which provides a record of all identified risks to the organisation. Each risk is aligned with a corporate objective to facilitate a clear means of assessing compliance. The *Risk and quality committee*, with additional oversight provided by the *Audit committee*, determines whether or not any risks from the *corporate risk register* should be transferred to the *assurance framework*. This approach is clearly defined in the Trust's risk register policy.

The *corporate risk register* is populated with risks arising from sources throughout the organisation, specifically:

- **Business and service delivery plans** – i.e. principal risks to the Trust achieving key performance standards;
- **Adverse incident forms** – if it is apparent from an adverse event form, or subsequent investigation into the adverse event, that there is a significant risk, then it will be transferred to the *risk register*;
- **Health and safety risk assessments** – Health and safety risk assessments are a legal obligation for the Trust, with managers being responsible for ensuring these assessments are undertaken. Any risk identified from these assessments will be included on the *risk register*;
- **Local risk assessments** – where local assessments have identified risks;
- **External assessment/audit** – significant risks identified by any internal and/or external audit, e.g. Healthcare Commission, NHS Litigation Authority, HSE notices, will be placed on the *risk register*;

- **External guidance/alerts** – NICE, NSFs, etc. that are not yet implemented;
- **Results of feedback** – Learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices, etc.

The assurance process, as described above, is reviewed by the Trust's *Audit committee*, which holds the executive to account for the effectiveness of governance systems and the processes for managing risk.

The Trust's *Finance and performance committee* supports the governance structures, providing a forum for detailed discussion of financial and performance issues, as well as for reviewing the Trust's financial strategy and monitoring the capital programme.

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

The Trust has in place established 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.

Control measures

The *assurance framework* and *risk register* 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. For 2009/10, the Trust achieved a *green* rating against the *Information Governance Toolkit*, with minimum level two compliance for all statement of compliance measures. The Trust self-reported one information governance serious untoward incident (SUI) relating to the data protection act to the Information Commission Office in December 2009; following investigation, the case was closed in March 2010 stating no regulatory action to be taken. The Trust has a SUI action plan in place to implement the lessons learnt and mitigate the risks of reoccurrence; this is monitored by the Trust's information governance steering group.

The Trust's *Policy of policies* sets out the requirements for equality impact assessments (EIA). EIAs undertaken for policies and services development consultations are considered and published on the Trust website. Training on EIAs has been provided to support the embedding of this process.

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

The Trust identified a number of data quality risks, particularly relating to clinical coding during 2009 and the Trust Board supported and commissioned a number of external assurances. This has resulted in the development of a new *information strategy* and the action plan from the strategy is monitored by the *Finance and performance committee*.

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 updated accurately in accordance with the timescales detailed in the regulations

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

The Trust has an established assurance process to ensure that it complies with the *NHS Core Standards for Better Health*. Each core standard has an identified accountable lead executive director and standard lead. *Standards for Better Health* compliance reports are completed for each of the core standards and an established process is in place for the mid-year compliance declaration and exception reporting. The *Risk and quality committee* has held directors to account, and has requested and received reports on specific standards during the declaration year; this has been informed by the internal and external reviews, *board assurance framework*, *risk register* and internal assurance map.

The Trust is compliant fully with the *NHS Core Standards for Better Health*.

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 Trust's 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.

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:

Based on the work undertaken in 2009/10, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk. Where individual weaknesses have been identified, comprehensive action plans have been put in place to address these and evidence collated to support implementation.

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 and the Care Quality Commission and the core standards self-assessment declaration.

Further evidence is provided by a range of audit reports including clinical audit, internal audit and external audit. In addition, the process undertaken by the Trust Board and management to assess the organisation's position against the Care Quality Commission's core standards and new registration standards are sources of evidence and assurance for me.

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, the *Audit committee* and the *Risk and quality committee*. A plan to address weaknesses and ensure continuous improvement of the system is in place.

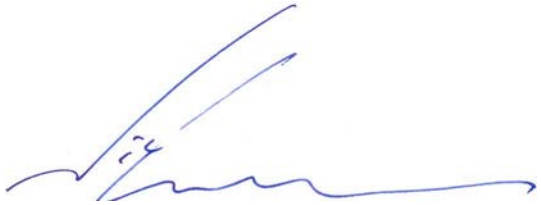
In order to establish, maintain and review the effectiveness of the system of internal control, the Board has adopted an *assurance framework*. This has enabled the Board to identify its strategic objectives, the high level risks associated with those objectives, and the controls and assurances available for managing and monitoring those risks.

The processes adopted to maintain and review the effectiveness of the system of internal control include:

- The Board regularly reviews the Trust's objectives and receives reports on key matters of concern;
- The *Audit committee* provides an independent and objective review of the Trust's system of internal control and comments where appropriate on the overall risk management process;
- The *Risk and quality committee* provides assurance on the progress of all areas of risk management;
- Following the introduction of a new risk management database in 2009, I am confident that executive directors, senior managers of the Trust and identified risk leads are engaged fully in maintaining and reviewing the effectiveness of the system of internal control;
- The *Finance and performance committee* highlights the major financial risks to the Board and to the *Risk and quality committee*, while providing proactive risk management within the areas of activity covered by its own remit;
- Internal audit, through its annual audit plan, provides assurance and comment on matters related to internal control;
- The Board has appointed a senior information risk owner, who is supported by an information governance steering group, to provide information governance assurance via the information governance toolkit submission and IGSoC;
- the Board and all senior staff, clinical and other, are, through various meetings and review processes, including bi-monthly performance reviews with each clinical division, involved in the self-assessment process required as part of the *Standards for Better Health* compliance declaration and Care Quality Commission registration;
- The Trust has maintained ALE scores of at least level three for all five themes, which indicates that the Trust is "….consistently above minimum requirements − performing well.".

I have identified no significant control weaknesses that could prejudice the Trust's services or service users, its strategic objectives, reputation or financial stability.

My review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives.

27 May 2010 **Date**  **Chief Executive**

Independent auditors' report to the Board of Directors of the East and North Hertfordshire NHS Trust

Opinion on the financial statements

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

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes; and
- the table of pension benefits of senior managers and related narrative notes on page.

This report is made solely to the Board of Directors of the 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 49 of the Statement of Responsibilities of Auditors and of Audited Bodies published by the Audit Commission in April 2008.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the 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 subject to audit have been prepared properly 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 within the Directors' report, included in the Annual Report, is consistent with the financial statements.

We review whether the directors' Statement on Internal Control reflects compliance with the Department of Health's requirements, set out in 'Guidance on Completing the Statement on Internal Control 2009/10' issued in February 2010. 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 unaudited part of the Remuneration Report and the remaining elements of the Directors' report. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of audit opinion

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

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

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report subject to audit 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 subject to audit.

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 2010 and of its income and expenditure for the year then ended;
- the financial statements and the part of the Remuneration Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England; and
- information which comprises the commentary on the financial performance included within the Directors' report, included within the Annual Report, is consistent with the financial statements.

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

Directors' responsibilities

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

Auditor's responsibilities

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, the East and North Hertfordshire NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2010.

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.

Paul Winrow

Senior Statutory Auditor,
for and on behalf of Grant Thornton UK LLP.

Grant Thornton House
Melton Street
London
NW1 2EP

27 May 2010

Data entered below will be used throughout the workbook:

Trust name:	**East and North Hertfordshire NHS Trust**
This year	2009/10
Last year	2008/09
This year ended	31 March 2010
Last year ended	31 March 2009
This year commencing:	1 April 2009

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Revenue			
Revenue from patient care activities	3	**297,007**	274,241
Other operating revenue	4	**34,305**	34,834
Operating expenses	6	**(344,405)**	(299,287)
Operating surplus (deficit)		**(13,093)**	9,788
Finance costs:			
Investment revenue	12	**22**	482
Finance costs	13	**(1,121)**	(1,153)
Surplus/(deficit) for the financial year		**(14,192)**	9,117
Public dividend capital dividends payable		**(5,028)**	(8,065)
Retained surplus/(deficit) for the year		**(19,220)**	**1,052**
Other comprehensive income			
Impairments and reversals		(66,238)	(34,227)
Gains on revaluations		16,338	261
Receipt of donated/government granted assets		3,635	726
Reclassification adjustments:			
- Transfers from donated and government grant reserves		(622)	(380)
Total comprehensive income for the year		**(66,107)**	**(32,568)**

Explanatory Note

The retained deficit shown above includes an impairment of £21.8m that resulted from the change in estimation technique used to value the Trust's Land and Building assets. Excluding this technical adjustment the Trust achieved a surplus of £2.5m. Further background on this change is contained on page 94 of the annual report. Please see below a summary reconciliation.

Description	**2009/10 £000's**	**2008/09 £000's**
Retained surplus/(deficit) for the year	(19,220)	1,052
Add back impairment loss in year	21,758	
Adjusted surplus/(deficit) for the year	**2,538**	**1,052**

Further detail on the makeup of the 2009/10 surplus can be seen on page 150 of these accounts under note 27.1 Breakeven Performance. Further narrative on the Trust's financial performance for 2009/10 is contained in Chapter 9 of the Annual Report

The notes on pages 118 to 154 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010

	NOTE	**31 March 2010** £000	31 March 2009 £000	1 April 2008 £000
Non-current assets				
Property, plant and equipment	14	**135,706**	196,373	233,051
Intangible assets	15	**3,743**	3,108	0
Trade and other receivables	19	**1,736**	1,843	1,308
Total non-current assets		**141,185**	201,324	234,359
Current assets				
Inventories	18	**4,270**	4,198	3,641
Trade and other receivables	19	**21,649**	13,123	16,870
Cash and cash equivalents	20	**3,761**	1,250	3,040
		29,680	18,571	23,551
Total current assets		**29,680**	18,571	23,551
Total assets		**170,865**	219,895	257,910
Current liabilities				
Trade and other payables	21	**(31,825)**	(19,697)	(23,254)
DH Working capital loan		**(1,560)**	(1,560)	(1,560)
DH Capital loan		**(272)**	0	0
Borrowings	22	**(226)**	(173)	(161)
Provisions	24	**(184)**	(172)	(250)
Net current assets/(liabilities)		**(4,387)**	(3,031)	(1,674)
Total assets less current liabilities		**136,798**	198,293	232,685
Non-current liabilities				
Borrowings	22	**(8,591)**	(8,817)	(8,989)
DH Working capital loan		**(1,560)**	(3,120)	(4,680)
DH Capital loan		**(6,400)**	0	0
Provisions	24	**(1,296)**	(1,298)	(1,357)
Total assets employed		**118,951**	185,058	217,659
Financed by taxpayers' equity:				
Public dividend capital		**145,034**	145,034	145,034
Retained earnings		**(84,872)**	(66,647)	(69,345)
Revaluation reserve		**51,101**	102,110	137,700
Donated asset reserve		**7,688**	4,554	4,255
Government grant reserve		**0**	7	15
Total Taxpayers' Equity		**118,951**	185,058	217,659

The financial statements on pages 112 to 116 were approved by the Board on 26/5/2010 and signed on its behalf by:

Signed  (Chief Executive) Date: 27 May 2010

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Balance at 31 March 2008							
As previously stated	145,034	(24,087)	96,837	4,255	15	0	222,054
Prior Period Adjustment	0	(45,258)	40,863	0	0	0	(4,395)
Restated balance	145,034	(69,345)	137,700	4,255	15	0	217,659
Changes in taxpayers' equity for 2008/09							
Total Comprehensive Income for the year:							
Retained surplus/(deficit) for the year	0	1,052	0	0	0	0	1,052
Transfers between reserves	0	1,679	(1,679)	0	0	0	0
Impairments and reversals	0	0	(34,172)	(55)	0	0	(34,227)
Net gain on revaluation of property, plant, equipment	0	0	261	0	0	0	261
Receipt of donated/government granted assets	0	0	0	726	0	0	726
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(372)	(8)	0	(380)
Reserves eliminated on dissolution	0	(33)	0	0	0	0	(33)
Balance at 31 March 2009	145,034	(66,647)	102,110	4,554	7	0	185,058

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Gov't grant reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2009/10							
Balance at 1 April 2009	145,034	(66,647)	102,110	4,554	7	0	185,058
Total Comprehensive Income for the year							
Retained surplus/(deficit) for the year	0	(19,220)	0	0	0	0	(19,220)
Transfers between reserves	0	1,006	(1,006)	0	0	0	0
Impairments and reversals	0	0	(66,238)	0	0	0	(66,238)
Net gain on revaluation of property, plant, equipment	0	0	16,224	114	0	0	16,338
Receipt of donated/government granted assets	0	0	0	3,635	0	0	3,635
Reclassification adjustments:							
- transfers from donated asset/government grant reserve	0	0	0	(615)	(7)	0	(622)
Reserves eliminated on dissolution	0	(11)	11	0	0	0	0
Balance at 31 March 2010	145,034	(84,872)	51,101	7,688	0	0	118,951

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**(13,093)**	9,788
Depreciation and amortisation		**6,078**	6,873
Impairments and reversals		**21,757**	1,183
Transfer from donated asset reserve		**(615)**	(372)
Transfer from government grant reserve		**(7)**	(8)
Interest paid		**(1,121)**	(1,123)
Dividends paid		**(5,028)**	(8,066)
(Increase)/decrease in inventories		**(72)**	(557)
(Increase)/decrease in trade and other receivables		**(8,419)**	3,212
Increase/(decrease) in trade and other payables		**10,343**	(2,161)
Increase/(decrease) in provisions	24	**10**	(166)
Net cash inflow/(outflow) from operating activities		**9,833**	8,603
Cash flows from investing activities			
Interest received		**22**	482
(Payments) for property, plant and equipment	14	**(18,133)**	(9,154)
Net cash inflow/(outflow) from investing activities		**(18,111)**	**(8,672)**
Net cash inflow/(outflow) before financing		**(8,278)**	(69)
Cash flows from financing activities			
Loans received from the DH		**6,790**	0
Other loans received		**5,850**	0
Loans repaid to the DH		**(1,678)**	(1,560)
Capital element of finance leases and PFI		**(173)**	(161)
Net cash inflow/(outflow) from financing		**10,789**	(1,721)
Net increase/(decrease) in cash and cash equivalents		**2,511**	(1,790)
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**1,250**	3,040
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	20	**3,761**	1,250

NOTES TO THE ACCOUNTS

1. Accounting Policies

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

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

Accounting estimates associated with this set of accounts are explained in the relevant section.

1.4 Key sources of estimation uncertainty

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

Estimation techniques in the following areas and are explained in more detail under the relevant note.

The estimation of partly completed spells - note 1.5 page 119

Provision for impairment of receivables - note 1.5 page 119

The estimation of the "holiday pay accrual" under employee benefits - note 1.6 page 119

The valuation of fixed assets - note 1.9 page 120

In the calculation of provisions - note 1.19 page 125

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

1.5 Revenue

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

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

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

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

The Trust provides against an impairment of receivables, this figure is stated in note 19 Trade Receivables on page 143 of the accounts. The figure is derived from all outstanding balances relating to overseas visitor debtors over 60 days, and all Non NHS debtors over 180 days.

The Trust also holds a provision for unsuccessful claims and doubtful debts relating to the NHS Injury Cost Recovery Scheme as stated above. This is calculated at 7.8% of outstanding debtor balances.

1.6 Employee Benefits

Short-term employee benefits

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

The cost of annual leave carried forward is estimated using an average cost per staff category. A significant sample of actual annual leave to be carried forward is obtained from departments and then extrapolated as a fair representation of the Trust as a whole, the average cost per staff group is applied to arrive at an estimated cost.

1.7 Retirement benefit costs

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

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

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

1.8 Other expenses

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

it is held for use in delivering services or for administrative purposes;

it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;

it is expected to be used for more than one financial year;

the cost of the item can be measured reliably; and

the item has cost of at least £5,000; or

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

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

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

Valuation

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

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair Values are determined as follows:

Land and non-specialised buildings – market value for existing use

Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury has agreed that NHS trusts must apply these new valuation requirements by 1 April 2010 at the latest.

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

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

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

Subsequent expenditure

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

1.10 Intangible assets

Recognition

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

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

the technical feasibility of completing the intangible asset so that it will be available for use

the intention to complete the intangible asset and use it

the ability to sell or use the intangible asset

how the intangible asset will generate probable future economic benefits or service potential

the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it

the ability to measure reliably the expenditure attributable to the intangible asset during its development

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

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

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

1.11 Depreciation, amortisation and impairments

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

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

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.12 Donated assets

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

1.13 Government grants

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

1.14 Non-current assets held for sale

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

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

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

1.15 Leases

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

The trust as lessee

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

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

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

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

The trust as lessor

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

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

1.16 Private Finance Initiative (PFI) transactions

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

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

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

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

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

Services received

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

PFI Asset

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

PFI liability

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

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

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

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

Lifecycle replacement

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

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

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

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

1.17 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.18 Cash and cash equivalents

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

1.19 Provisions

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

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

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

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

1.20 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 24.

1.21 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.

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

1.22 EU Emissions 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.

1.23 Contingencies

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

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

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

1.24 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are no longer recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

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

Held to maturity investments

The Trust has no held to maturity investments

Available for sale financial assets

The Trust has no available for sale financial assets

Loans and receivables

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

Current receivables are held at book value and are expected to be recovered within one year. No current receivables are discounted at 2.2% per annum, except where the difference between fair value and book value is not considered material, in this case book value would be used.

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

1.25 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are no longer recognised when the liability has been discharged, that is, the liability has been paid or has expired.

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

Financial liabilities at fair value through profit and loss

The Trust currently has no contracts containing embedded derivatives.

1.26 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.

1.27 Foreign currencies

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

1.28 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 29 to the accounts.

1.29 Public Dividend Capital (PDC) and PDC dividend

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

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

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

1.30 Losses and Special Payments

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

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

1.31 Subsidiaries

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

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

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

IAS 27 (Revised) Consolidated and separate financial statements

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

Amendment to IAS 39 Eligible hedged items

IFRS 3 (Revised) Business combinations

IFRIC 17 Distributions of Non-cash Assets to Owners

IFRIC 18 Transfer of assets from customers

1.33 Accounting standards issued that have been adopted early

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

1.34 Research and Development

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

2. Operating segments

East and North Herts NHS Trust provides only Healthcare services. The services are managed and resourced as one business unit, divisions in reporting are for management purposes only. Capital resource allocations are distributed based on the operational and strategic need of the whole organisation. Services are provided largely for Primary Care Trusts and as such provide the same level of risk for each service area. Therefore the Trust considers a single segment reporting to be the most appropriate reporting format.

3 **Revenue from patient care activities**	**2009/10**	2008/09
	£000	£000
Primary care trusts	**290,776**	238,617
Department of Health	**0**	29,024
Non-NHS:		
Private patients	**4,112**	4,576
Overseas patients (non-reciprocal)	**239**	123
Injury costs recovery	**1,355**	1,329
Other	**525**	572
	297,007	**274,241**

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

4 **Other Operating Revenue**	**2009/10**	2008/09
	£000	£000
Education, training and research	**15,778**	16,493
Transfers from Donated Asset Reserve	**615**	372
Transfers from Government Grant Reserve	**7**	8
Non-patient care services to other bodies	**12,222**	11,820
Income generation	**2,946**	2,691
Other revenue	**2,737**	3,450
	34,305	34,834

5 **Revenue**	**2009/10**	2008/09
	£000	£000
From rendering of services	**331,312**	309,074
From sale of goods	**0**	0

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

6 Operating Expenses

	2009/10 £000	2008/09 £000
Services from other NHS Trusts	**6,808**	7,918
Services from PCTs	**4,045**	4,163
Services from other NHS bodies	**49**	27
Services from Foundation Trusts	**1,311**	391
Purchase of healthcare from non NHS bodies	**5,025**	3,297
Directors' costs	**1,132**	1,171
Other Employee Benefits	**212,863**	195,632
Supplies and services - clinical	**50,006**	46,716
Supplies and services - general	**8,243**	7,951
Consultancy services	**1,511**	1,313
Establishment	**5,333**	4,527
Transport	**3,202**	2,997
Premises	**9,449**	10,004
Provision for impairment of receivables	**(82)**	66
Depreciation	**5,179**	6,828
Amortisation	**899**	45
Impairments and reversals of property, plant and equipment	**21,757**	1,183
Audit fees	**220**	225
Other auditor's remuneration	**16**	15
Clinical negligence	**5,452**	2,981
Education and Training	**905**	866
Other	**1,082**	971
	344,405	299,287

7 Operating leases

7.1 As lessee

The trust leasing arrangements have been classified as operating leases, therefore all associated costs are charged to the Income Statement in the accounting period to which it relates

Payments recognised as an expense	**2009/10 £000**	2008/09 £000
Minimum lease payments	**4,396**	3,237
Total	**4,396**	3,237

Total future minimum lease payments	**2009/10 £000**	2008/09 £000
Payable:		
Not later than one year	**3,456**	3,193
Between one and five years	**8,874**	9,651
After 5 years	**208**	1,779
Total	**12,538**	14,623

8 Employee costs and numbers

8.1 Employee costs

	2009/10			2008/09		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**182,889**	**162,702**	**20,187**	166,520	147,913	18,607
Social Security Costs	**13,805**	**13,511**	**294**	14,011	13,672	339
Employer contributions to NHS Pension scheme	**17,749**	**17,595**	**154**	16,217	16,071	146
Employee benefits expense	**214,443**	**193,808**	**20,635**	196,748	177,656	19,092
Of the total above:						
Charged to capital	507			531		
Employee benefits charged to revenue	213,936			196,217		
	214,443			**196,748**		

8.2 Average number of people employed

	2009/10			2008/09		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**708**	**669**	**39**	675	641	34
Administration and estates	**983**	**947**	**36**	958	862	96
Healthcare assistants and other support staff	**1,131**	**993**	**138**	922	831	91
Nursing, midwifery and health visiting staff	**1,655**	**1,521**	**134**	1,633	1,475	158
Nursing, midwifery and health visiting learners	**7**	**7**	**0**	6	6	0
Scientific, therapeutic and technical staff	**554**	**520**	**34**	618	579	39
Total	**5,039**	**4,658**	**381**	4,812	4,394	**418**
Of the above:						
Number of staff (WTE) engaged on capital projects	**0**			**0**		

8.3 Staff sickness absence

	2009/10 Number
Days lost (long term)	0
Days lost (short term)	0
Total days lost	**42,100**
Total staff years	**4,639**
Average working days lost	9.08
Total staff employed in period (headcount)	0
Total staff employed in period with no absence (headcount)	0
Percentage staff with no sick leave	**0.0%**

8.4 Management Costs	**2009/10 £000**	**2009/10 %**	**2008/09 £000**	**2008/09 %**
Management costs	14,739	4.45%	12,947	4.19%
Income	331,312		309,074	

9. Pension costs

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against notional assets as at 31 March 2004
Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

Annual Pensions

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

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

Pensions Indexation

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

Lump Sum Allowance

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

Ill-Health Retirement

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

Death Benefit

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

Additional Voluntary Contributions (AVCs)

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

Transfer Between Funds

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

Preserved Benefits

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

Compensation for Early Retirement

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

10 Retirements due to ill-health

During 2009/10 there were 5 (2008/09, 5) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £406k (2008/09: £130k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11 Better Payment Practice Code

Better Payment Practice Code - measure of compliance	**2009/10**		2008/09	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**79,243**	**93,228**	76,977	84,591
Total Non NHS trade invoices paid within target	**67,963**	**78,756**	67,889	76,601
Percentage of Non-NHS trade invoices paid within target	**86%**	**84%**	88%	91%
Total NHS trade invoices paid in the year	**2,937**	**35,943**	3,216	39,201
Total NHS trade invoices paid within target	**1,242**	**15,128**	1,905	25,262
Percentage of NHS trade invoices paid within target	**42%**	**42%**	59%	64%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

12 Investment revenue

	2009/10	2008/09
	£000	£000
Interest revenue:		
Bank accounts	22	482
Total	22	482

13 Finance Costs

	2009/10	2008/09
	£000	£000
Interest on loans and overdrafts	**328**	319
Interest on obligations under PFI contracts:		
- main finance cost	**667**	679
- contingent finance cost	**126**	0
Total interest expense	**1,121**	998
Other finance costs	**0**	155
Total	**1,121**	**1,153**

14. Property, plant and equipment

2009/10:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	73,039	102,325	0	1,577	36,812	113	11,078	2,714	227,658
Additions purchased	0	2,248	0	7,708	1,884	0	621	140	12,601
Additions donated	0	17	0	3,350	213	0	0	43	3,623
Reclassifications	0	1,071	0	(1,072)	1	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	(1,234)	0	(1,234)
Revaluation/indexation gains	0	16,338	0	0	0	0	0	0	16,338
Impairments	(36,746)	(29,492)	0	0	0	0	0	0	(66,238)
At 31 March 2010	**36,293**	**92,507**	**0**	**11,563**	**38,910**	**113**	**10,465**	**2,897**	**192,748**
Depreciation at 1 April 2009	0	0	0	0	22,406	107	7,231	1,541	31,285
Disposals other than by sale	0	0	0	0	0	0	(1,179)	0	(1,179)
Impairments	0	21,757	0	0	0	0	0	0	21,757
Charged during the year	0	1,564	0	0	2,462	3	900	250	5,179
Transfer to Foundation Trust	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2010	**0**	**23,321**	**0**	**0**	**24,868**	**110**	**6,952**	**1,791**	**57,042**
Net book value									
Purchased	36,293	66,417	0	9,153	11,697	3	3,502	1,021	128,086
Donated	0	2,769	0	2,410	2,345	0	11	85	7,620
Total at 31 March 2010	**36,293**	**69,186**	**0**	**11,563**	**14,042**	**3**	**3,513**	**1,106**	**135,706**
Asset financing									
Owned	**36,293**	**62,616**	**0**	**11,563**	**14,042**	**3**	**3,513**	**1,106**	**129,136**
Private finance initiative	**0**	**6,570**	**0**	**0**	**0**	**0**	**0**	**0**	**6,570**
Total 31 March 2010	**36,293**	**69,186**	**0**	**11,563**	**14,042**	**3**	**3,513**	**1,106**	**135,706**

Prior year:

2008/09:	Land	Buildings excluding dwellings	Dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	102,951	106,862	0	1,070	37,973	111	15,103	2,586	266,656
Additions purchased	0	3,205	0	1,305	1,144	0	1,162	205	7,021
Additions donated	0	(35)	0	76	598	0	6	0	645
Reclassifications	0	407	0	(869)	210	0	(2,114)	(1)	(2,367)
Disposals other than by sale	0	0	0	0	(3,808)	0	(3,079)	(123)	(7,010)
Revaluation/indexation gains	0	(31)	0	(5)	695	2	0	47	708
Impairments	(29,912)	(4,315)	0	0	0	0	0	0	(34,227)
At 31 March 2009	**73,039**	**106,093**	**0**	**1,577**	**36,812**	**113**	**11,078**	**2,714**	**231,426**
Depreciation at 1 April 2008	0	0	0	0	22,843	102	9,284	1,376	33,605
Disposals other than by sale	0	0	0	0	(3,822)	0	(3,072)	(116)	(7,010)
Revaluation/indexation gains	0	0	0	0	420	2	0	25	447
Impairments	0	894	0	0	289	0	0	0	1,183
Charged during the year	0	2,874	0	0	2,676	3	1,019	256	6,828
Depreciation at 31 March 2009	**0**	**3,768**	**0**	**0**	**22,406**	**107**	**7,231**	**1,541**	**35,053**
Net book value									
Purchased	73,039	100,484	0	1,501	11,928	6	3,826	1,118	191,902
Donated	0	1,841	0	76	2,478	0	14	55	4,464
Government granted	0	0	0	0	0	0	7	0	7
Total at 31 March 2009	**73,039**	**102,325**	**0**	**1,577**	**14,406**	**6**	**3,847**	**1,173**	**196,373**
Asset financing									
Owned	**73,039**	**96,475**	**0**	**1,577**	**14,406**	**6**	**3,847**	**1,173**	**190,523**
Private finance initiative	**0**	**5,850**	**0**	**0**	**0**	**0**	**0**	**0**	**5,850**
Total 31 March 2009	**73,039**	**102,325**	**0**	**1,577**	**14,406**	**6**	**3,847**	**1,173**	**196,373**

14. Property, plant and equipment (cont.)
The land and building assets held by the Trust were revalued in year using modern equivalent assets valuation methodology, in accordance with DH guidance. The revaluation was carried out by an independent qualified valuer. The effective date for the valuation was 1st April 2009.

The building assets using MEA and valued in component parts as required under International reporting standards.

Basis for Valuation
East and North Herts NHS Trust has revalued its land and building assets during 2009, as at a valuation date of 1st April 2009, in line with HM Treasury adopted standard approach to valuation based on modern equivalent assets. The trust will record the new values in the annual accounts for the year ending 31st March 2010.

Professional valuations were carried out by DTZ Project and Building Consultancy, 1 Colmore Square, Birmingham, B4 6AJ 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.

Existing Use Value of the properties has been primarily derived using the Depreciated Replacement Cost (DRC) approach because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the entity.

In certain circumstances the Existing Use Value has been derived from comparable recent market transactions on arm's length terms. This has been in respect of non specialist properties.

Existing Use Value is defined in UKPS 1.3 of the Red Book and in undertaking the valuations our surveyors have applied the conceptual framework of Market Value, which is detailed in PS3.2 together with the supplementary commentary which is included in items 2-5 of UKPS 1.3. Under UKPS1.3 the term "Existing Use Value" is defined as follows:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

Definition of MEA

Modern equivalent assets - A structure similar to an existing structure with an equivalent productive capacity, which could be built using modern materials, techniques and designs. Replacement cost is the basis used to estimate the cost of constructing a modern equivalent asset.

The economic lives of fixed assets range from:

	Min life (years)	Max life (years)
Software Licences	3	8
Licences and trademarks	2	8
Patents	0	0
Development Expenditure	5	8
Buildings exc dwellings	19	90
Plant & Machinery	5	20
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	7	10

15. Intangible assets

2009/10:	Computer software - purchased	Computer software - internally generated	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2009	607	0	386	0	3,654	4,647
Additions purchased	277	0	68	0	0	345
Additions internally generated	0	0	0	0	1,203	1,203
Additions donated	0	0	12	0	0	12
Disposals other than by sale	(4)	0	(18)	0	(81)	(103)
Gross cost at 31 March 2010	**880**	**0**	**448**	**0**	**4,776**	**6,104**
Amortisation at 1 April 2009	160	0	122	0	1,257	1,539
Disposals other than by sale	(1)	0	(5)	0	(71)	(77)
Charged during the year	206	0	236	0	457	899
Amortisation at 31 March 2010	**365**	**0**	**353**	**0**	**1,643**	**2,361**
Net book value						
Purchased	459	0	83	0	3,133	3,675
Donated	56	0	12	0	0	68
Total at 31 March 2010	**515**	**0**	**95**	**0**	**3,133**	**3,743**

Prior year:

2008/09:	Computer software - purchased	Computer software - internally generated	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2008	0	0	0	0	0	0
Additions purchased	194	0	26	0	498	718
Additions donated	79	0	1	0	0	80
Reclassifications	334	0	359	0	3,156	3,849
Gross cost at 31 March 2009	**607**	**0**	**386**	**0**	**3,654**	**4,647**
Amortisation at 1 April 2008	0	0	0	0	0	0
Reclassifications	134	0	121	0	1,239	1,494
Charged during the year	26	0	1	0	18	45
Amortisation at 31 March 2009	**160**	**0**	**122**	**0**	**1,257**	**1,539**
Net book value						
Purchased	361	0	261	0	2,397	3,019
Donated	86	0	3	0	0	89
Total at 31 March 2009	**447**	**0**	**264**	**0**	**2,397**	**3,108**

15. Intangible assets (cont.)

The trust account for intangible fixed assets in accordance with IAS 38. All intangible assets with a value of over £5000 and amortised on a quarterly basis over its economic useful life. The Trust does not consider that its Intangible fixed assets have an active market, and therefore use book value as a prudent indicator of fair value intangible assets.

The trust does not hold intangible assets with an indefinite useful life.

15.2 Revaluation reserve balance for intangible assets	2009/10 £000	2008/09 £000
At 1 April	**2**	0
Changes	**(2)**	2
At 31 March	**0**	2

16. Impairments

The Trust has revalued its land and building assets using MEA as previously stated in the accounts, in accordance with DH Guidance.

The MEA revaluation of the Trust's land and building assets, used for carrying out Trust activity. The revaluation created a significant impairment of £73m overall, of which £22m was charged to the Income statement in year and is reflected in the overall deficit reported.

Details of basis for valuation is included under note 14

17. Capital commitments

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

	31 March 2010 £000	31 March 2009 £000
Property, plant and equipment	**12,015**	772
Total	**12,015**	**772**

The capital commitments figures shown above largely relate to the Trust's Maternity new build project totalling £16.4m. The commitment remaining on the scheme amounts to £11m and is due for completion during 2011. The project is funded through a Department of Health capital investment loan and payable over 25 years from when the loan was first utilised in September 2009.

The other commitments relate to smaller projects commenced in 2009/10 and will be completed in 2010/11.

18. Inventories

18.1. Inventories

	31 March 2010	31 March 2009
	£000	£000
Drugs	**1,286**	**1,365**
Consumables	**2,887**	**2,763**
Energy	**97**	**70**
Total	**4,270**	4,198

19.1 Trade and other receivables

	Current		**Non-current**	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
NHS receivables-revenue	**13,716**	7,773	**526**	546
Non-NHS receivables-revenue	**1,927**	2,514	**0**	1,472
Provision for the impairment of receivables	**(372)**	(728)	**(193)**	(175)
Prepayments and Accrued income	**5,056**	2,055	**0**	0
VAT	**270**	279	**0**	0
Other receivables	**1,052**	1,230	**1,403**	0
Total	**21,649**	13,123	**1,736**	1,843

The year on year increases in NHS receivables, relates to over performance against activity invoices to PCTs that remain outstanding at year end, amounting to £5.4m.
Please note that Non NHS accrued income for 2008/09 has been included under Non NHS receivables (£308k) rather than under prepayments and accrued income.

19.2 Receivables past their due date but not impaired	31 March 2010 £000	31 March 2009 £000
By up to three months	**11,933**	4,129
By three to six months	**396**	418
By more than six months	**224**	631
Total	**12,553**	**5,178**

The increase year on year on debts outstanding up to three months relates to issue described under 19.1.

19.3 Provision for impairment of receivables	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**(903)**	(864)
Amount written off during the year	**256**	27
Amount recovered during the year	**0**	4
(Increase)/decrease in receivables impaired	**82**	(70)
Balance at 31 March	**(565)**	(903)

The Trust has reviewed its aged debt during 2009/10 and took the decision to write off debt not expected to be recovered but had been provided for in the bad debt provision, as such write offs in 2009/10 were significantly higher than in 2008/09.

The provision for impairment of receivables is calculated based on the likihood of recovery. As such all non NHS debt over 180 days and all overseas patient debt over 60 days reflecting the risk in the recovery of this category of debt. Also within the figures quoted includes a provision relating to the NHS Injury cost recovery scheme to reflect the risk of write offs over a significant period, this is calculated at 7.8% of total receivables under this category.

20. Cash and cash equivalents	31 March 2010 £000	31 March 2009 £000
Balance at 1 April	**1,250**	3,040
Net change in year	**2,511**	(1,790)
Balance at 31 March	**3,761**	1,250
Made up of		
Cash with Office of HM Paymaster General	**3,488**	970
Commercial banks and cash in hand	**273**	280
Cash and cash equivalents as in statement of financial position	**3,761**	1,250
Cash and cash equivalents as in statement of cash flows	**3,761**	1,250

21. Trade and other payables	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
NHS payables-revenue	**3,577**	3,775	**0**	0
Non NHS trade payables - revenue	**9,981**	11,603	**0**	0
Non NHS trade payables - capital	**2,612**	744	**0**	0
Accruals and deferred income	**8,541**	1,508	**0**	0
Social security costs	**2,087**	4	**0**	0
Tax	**2,575**	0	**0**	0
Other	**2,452**	2,063	**0**	0
Total	**31,825**	19,697	**0**	0

Please note that Non NHS accrued expenditure figure for 2008/09 has been included under Non NHS trade payables -revenue (£7095k) rather than under prepayments and accrued income which is the case for 2009/10.

22. Borrowings	Current		Non-current	
	31 March 2010 £000	31 March 2009 £000	31 March 2010 £000	31 March 2009 £000
Loans from:				
Department of Health	**1,832**	1,560	**7,960**	3,120
PFI liabilities	**226**	173	**8,591**	8,817
Total	**2,058**	1,733	**16,551**	11,937

The figures in the table above relate to the trust's outstanding loans and long term liabilities. The Department of Health section relates to two loans, which are explained below.

The first, the Trust's working capital loan commenced on 22nd March 2007 and is payable over 5 years, final settlement of the loan will be made in March 2012. The interest rate charged is fixed at 5.45% and the loan repayments are made twice a year typically in September and March.

The second relates to a capital investment loan obtained in order to fund a major capital project and commenced 2nd September 2009. The loan is payable over 25 years, final settlement of this loan will be made in September 2034. The interest rate is fixed at 4% per annum for the funds drawn down at 31st March 2010. The interest rate for this loan is fixed at the National loan fund rate prevailing at the date the loan is utilised. The loan repayments are made twice a year typically in September and March

The PFI liability above relates to the Hertford County Hospital PFI scheme which commenced in November 2004. In accordance with IFRS this scheme was brought on to the balance sheet, recognising both the asset and the liability the scheme represents. The loan repayments are made monthly and carries an implicit interest rate of 7.59%. The scheme is scheduled to run until March 2033.

23. Private Finance Initiative contracts

23.1 PFI schemes on-Statement of Financial Position

The Trust has one PFI scheme, this relates to Hertford County Hospital. The hospital largely provides outpatient and therapy services to the local community. The facility became operational on 1st November 2004 with a contract period of 28.5 years. The contract is due to end 31st March 2033.

The contract is paid in the form of an annual unitary charge that covers repayment of capital, cost of financing and service costs. The future commitment of the elements at 31st March 2010 are as follows.

	£000
Capital	8,817
Lifecycle replacement Costs	4,549
Interest	9,512
Contingent Rental	10,350
Service	2,735

The Lessor is obligated to maintain Hertford County Hospital for the period of the contract. Life cycle capital replacement costs are incurred by the lessor as part of the required routine maintenance, these costs are part of the annual unitary charge, charged monthly. This element is subsequently capitalised as a capital enhancement of the asset in the year the costs are incurred.

The contingent rental costs relates to the effects of inflation on the finance charge over the period of the contract. The cost is charged annually to the Income statement under finance costs.

The Trust are financially committed to the PFI scheme for the term of the contract stated above.

The terms of the contract are such that the asset becomes a Trust property at the end of the PFI contract period. The fair value of the current asset will be review annually to ensure carrying values are appropriately recorded.

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

	31 March 2010 £000	31 March 2009 £000
Not later than one year	**878**	840
Later than one year, not later than five years	**3,337**	3,350
Later than five years	**14,114**	14,980
Sub total	**18,329**	19,170
Less: interest element	**(9,512)**	(10,180)
Total	**8,817**	8,990

23.2 Charges to expenditure

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £87k (prior year £87k).

The trust is committed to the following annual charges

	31 March 2010 £000	31 March 2009 £000
PFI scheme expiry date:		
Later than five years	**2,735**	2,821
Total	**2,735**	2,821

24. Provisions

	Current		Non-current	
	31 March 2010	31 March 2009	**31 March 2010**	31 March 2009
	£000	£000	**£000**	£000
Pensions relating to other staff	**109**	111	**1,247**	1,202
Legal claims	**75**	61	**49**	96
Total	**184**	172	**1,296**	1,298

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Restructuring**	**Continuing care**	**Equal pay**	**Agenda for change**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
At 1 April 2009	0	1,313	157	0	0	0	0	0	**1,470**
Arising during the year	0	122	101	0	0	0	0	0	**223**
Used during the year	0	(79)	(104)	0	0	0	0	0	**(183)**
Reversed unused	0	0	(30)	0	0	0	0	0	**(30)**
Unwinding of discount	0	0	0	0	0	0	0	0	**0**
Transfers in year	0	0	0	0	0	0	0	0	**0**
At 31 March 2010	0	1,356	124	0	0	**0**	**0**	0	**1,480**
Expected timing of cash flows:									
In the remainder of the spending review period to 31 March 2011	0	109	75	0	0	0	0	0	**184**
Between 1 April 2011 and 31 March 2016	0	349	49	0	0	0	0	0	**398**
Between 1 April 2016 and 31 March 2021	0	442	0	0	0	0	0	0	**442**
Thereafter	0	456	0	0	0	0	0	0	**456**

Pensions relating to other staff: This provision is for the constructive obligation with the NHS Pensions Agency relating to staff that have 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. The Trust is invoiced quarterly to reflect payment s made on behalf of the trust by the Pension agency, this cost is charged to the provision.
Legal Claims: This provision is for the constructive obligation under the Litigation to Third Parties Scheme (LTPS). The balance as at 31st March 2009 is as advised by the Litigation Authority taking into consideration the probability as to the outcome of each claim.
£45.7m is included in the provisions of the NHS Litigation Authority at 31/3/2010 in respect of clinical negligence liabilities of the trust (31/03/2009 £39m).

25. Contingencies

25.1 Contingent liabilities	2009/10 £000	2008/09 £000
Equal pay cases	**0**	0
Other (specify)	**(54)**	(64)
Amounts recoverable against contingent liabilities	**0**	0
Total	**(54)**	(64)

£54k of the 2009/10 (£64k 2008/09) net contingent liability relates to Liabilities to Litigation Authority Third Parties Scheme. The value is calculated by NHS Litigation authority on a claim by claim basis and communicated to the Trust via an annual report.

26. Financial Instruments

26.1 Financial assets	At fair value through profit and loss	Loans and receivables	Available for sale	Total
	£000	**£000**	**£000**	**£000**
Receivables	0	13,123	0	**13,123**
Cash at bank and in hand	0	1,250	0	**1,250**
Total at 31 March 2009	0	14,373	0	**14,373**
Receivables	**0**	**23,721**	**0**	**23,721**
Cash at bank and in hand	**0**	**3,761**	**0**	**3,761**
Total at 31 March 2010	**0**	**27,482**	**0**	**27,482**

26.2 Financial liabilities	At fair value through profit and loss	Other	Total
	£000	**£000**	**£000**
Payables	0	19,697	19,697
PFI and finance lease obligations	0	4,680	4,680
Other borrowings	0	8,990	8,990
Total at 31 March 2009	0	33,367	33,367
Payables	**0**	**33,986**	**33,986**
PFI and finance lease obligations	**0**	**8,817**	**8,817**
Other borrowings	**0**	**9,792**	**9,792**
Total at 31 March 2010	**0**	**52,595**	**52,595**

26.3 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

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

Liquidity risk

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

27. Financial performance targets

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

27.1 Breakeven Performance

As per the national guidance the values in the tables below in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

	UK GAAP 2005/06 £000	UK GAAP 2006/07 £000	UK GAAP 2007/08 £000	UK GAAP 2008/09 £000	IFRS 2009/10 £000
Turnover	246,307	270,257	286,332	309,074	331,312
Retained surplus/(deficit) for the year	(22,379)	(1,527)	2,003	2,070	(19,220)
Adjustment for:					
Adjustments for Impairments	0	0	0	0	21,758
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	(38)
Other agreed adjustments	8,557	22,379	0	0	0
Break-even in-year position	(13,822)	20,852	2,003	2,070	2,500
Break-even cumulative position	(23,100)	(2,248)	(245)	1,825	4,325

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

	2005/06 %	2006/07 %	2007/08 %	2008/09 %	2009/10 %
Materiality test (I.e. is it equal to or less than 0.5%):					
Break-even in-year position as a percentage of turnover	-5.61%	7.72%	0.70%	0.67%	0.75%
Break-even cumulative position as a percentage of turnover	-9.38%	-0.83%	-0.09%	0.59%	1.31%

27.2 Capital cost absorption rate

For 2009/10 the trust was required to absorb the cost of capital at a rate of 3.5% of Actual relevant net assets. The rate is calculated as the percentage, relating to dividends paid on public dividend capital, totalling £5,028k for this financial year, bears to the actual average relevant net assets of £143,655k, that is 3.5% (prior year 4.0%)

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

27.3 External financing

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

	£000	**2009/10 £000**	£000	2008/09 £000
External financing limit		**10,827**		2,007
Cash flow financing	8,278		230	0
External financing requirement		**8,278**		230
Undershoot/(overshoot)		**2,549**		1,777

27.4 Capital Resource Limit

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

	2009/10 £000	2008/09 £000
Gross capital expenditure	**17,784**	8,535
Less: donations towards the acquisition of non-current assets	**(3,635)**	(725)
Charge against the capital resource limit	**14,149**	7,810
Capital resource limit	**14,405**	7,850
(Over)/Underspend against the capital resource limit	**256**	40

28. 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:

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:

Related Party Organisation	Code	Income £000's	Expenditure £000's	Debtors £000's	Creditors £000's
Strategic Health Authorities					
East of England Strategic Health Authority	Q53	12,443	20	144	0
Primary Care Trusts					
Barnet PCT	5A9	2,190	6	57	0
Bedfordshire PCT	5P2	21,814	0	908	0
Berkshire East PCT	5QG	1,431	0	199	0
Brent Teaching PCT	5K5	1,394	0	0	0
Buckinghamshire PCT	5QD	2,008	0	217	0
East and North Hertfordshire PCT	5P3	204,028	5,505	7,098	870
Harrow PCT	5K6	3,320	0	94	0
Hillingdon PCT	5AT	5,569	64	69	13
Luton PCT	5GC	4,724	0	472	0
North East Essex PCT	5PW	1,419	0	26	0
South East Essex PCT	5P1	16,152	0	229	0
West Hertfordshire PCT	5P4	29,713	24	1,990	18
NHS Trusts					
The Hillingdon Hospital NHS Trust	RAS	390	10,163	333	2,121
West Hertfordshire Hospital NHS Trust	RWG	833	1,881	233	202
Other NHS bodies					
NHS Business Services Authority	ST1450	0	1,662	0	0
NHS Litigation Authority	ST1150	0	5,643	0	0
NHS Blood and Transplant	033NBT	0	2,070	0	46
Foundation Trusts					
Hertfordshire Partnership NHS Foundation Trust	RWR	2,136	25	14	42
Luton and Dunstable Hospital NHS Foundation Trust	RC9	253	1,790	572	163

In addition, the trust has had a number of material transactions with other government departments and other central and local authority bodies. The Pensions agency is the largest other central government body the trust has had transactions with, and this entirely involves the payments of employees and employers pension contributions. The transactions with local authorities although not material in the context of the above disclosures, relate in the main to the payment of business rates.

29. Third Party Assets

The Trust held £3k cash and cash equivalents at 31 March 2010 (£3k - at 31 March 2009) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

30. Intra-Government and Other Balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	1	0	2,283	0
Balances with Local Authorities	123	0	1,156	0
Balances with NHS Trusts and Foundation Trusts	13,716	526	3,577	0
Intra Government balances	13,840	526	7,016	0
Balances with bodies external to Government	7,809	1,210	24,809	0
At 31 March 2010	**21,649**	**1,736**	**31,825**	**0**
Balances with other Central Government Bodies	2	0	0	0
Balances with Local Authorities	229	0	0	0
Balances with NHS Trusts and Foundation Trusts	7,773	546	3,744	0
Intra Government balances	8,004	546	3,744	0
Balances with bodies external to Government	5,119	1,297	15,953	0
At 31 March 2009	13,123	1,843	19,697	0

31. Losses and Special Payments

There were 2,495 cases of losses and special payments (2008/09: 654 cases) totalling £268,915 (2008/09: £35,993) accrued during 2009/10.

32. Transition to IFRS

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Government grant reserve £000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**(50,676)**	**90,942**	**0**	**0**
Adjustments for IFRS changes:				
Private finance initiative	(5,641)	1,896	0	0
Others (specify)	(1,058)	0	0	0
Adjustments for:				
UK GAAP errors	(9,272)	9,272	0	0
Taxpayers' equity at 1 April 2009 under IFRS:	**(66,647)**	**102,110**	**0**	**0**

	£000
Surplus/(deficit) for 2008/09 under UK GAAP	**0**
Adjustments for:	2,070
Private finance initiative	(196)
Others (specify)	(822)
Surplus/(deficit) for 2008/09 under IFRS	**1,052**

The UK GAAP errors of £9.3m stated above relate to building asset negative revaluation reserves incorrectly offset against Land. The error was identified during the 2008/09 annual accounts process. Negative revaluation reserves are not permitted under IFRS and as such the negative reserves have been transferred to I&E reserves as a prior period adjustment.

The IFRS transition has affected the I&E account in two ways. The Hertford County Hospital PFI scheme was required to be included on the balance under the new accounting standards, resulting in a deterioration of £196k to the I&E position. The second item relates to the removal of a long term debtor previously on the balance sheet under UK GAAP. The debtor has historically been written down on a straightline basis to the I&E account, at £71k per annum. This adjustment has been reverse as part of the IFRS conversion process, and therefore has improved the I&E position by this amount.

The IFRS transition of the Trust's asset register identified a number of negative revaluation reserves amounting to £893k not permitted by IAS 16, as such the negative reserves have been charged to the Income statement.