

East and North Hertfordshire NHS Trust
*2013/14 annual report and
accounts*

28 May 2014

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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 the two former NHS trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and 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 the 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 Foundation 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 Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some two million people from across Hertfordshire, Bedfordshire, north-west London and parts of the Thames Valley.

The Trust's main 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 10.2% over the next ten years, with the most significant growth expected in people aged 45 to 74 years (although rates of increase in those aged 75 and over are likely to have the greatest impact in terms of health needs). Black and minority ethnic groups make up approximately 6% 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 and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,500 staff are employed by the Trust, which represents around 4,700 whole time equivalents. Its annual budget is approximately £360 million.

In the current economic climate, there is increased pressure on achieving both improved clinical quality and more efficient services. The ability of commissioners to manage patient activity, along with the capacity of NHS trusts to respond to these changes whilst at the same time preserving service quality and financial performance, remains a key component in any health economy's future success. It is this relationship that is at the heart of Hertfordshire's quality, innovation, productivity and prevention (QIPP) plan.

Chapter 2: chairman and chief executive's reports

Chairman's report

Over the last 12 months, managing change and rising expectations has continued to be at the heart of everything undertaken by the Trust and its staff.

Although the Francis report was published in February 2013, its recommendations – and the response of the Government to them - are having a far reaching impact on the NHS, as organisations such as the Trust seek to balance the requirement to provide high quality, safe and innovative clinical services that meet nationally set standards within the budget allocated. Whilst the Trust continues to meet these challenges, more remains to be done to realise the organisation's vision of becoming amongst the best performing NHS trusts in the English health service.

In the past year considerable progress has been made in delivering the Trust's *Our Changing Hospitals* programme. On its completion by October 2014, some £150 million will have been invested in creating the new Lister hospital – which will become a centre of specialist care for all the communities served by the Trust.

The Lister's new ward block, which along with the expanded emergency department and existing cardiology centre, creates a state-of-the-art emergency service that will transform the care of the most unwell patients. The new theatres block is the final piece of the jigsaw, which will ensure that there is sufficient capacity for all patients needing either emergency or planned surgery. At the same time, the work being undertaken by our colleagues in the East and North Hertfordshire Clinical Commissioning Group will see the New QEII Hospital opening in the Spring of 2015 – which is a very welcome development for local people.

These are hugely exciting developments and put our Trust at the forefront of providing some of the best hospital services to be found in the health service, balancing local access for routine hospital with access to highly specialist inpatient and emergency care through a transformed Lister hospital.

Back in 2007, when the *Delivering quality health care for Hertfordshire* consultation was underway, the promise made by the Trust's clinicians was that, although some in the county may have to travel further for specialist inpatient and emergency care, the service they would receive will be of a higher quality than available at either the Lister or QEII previously. The emerging evidence for those services that have been brought together already, such as at the Diamond Jubilee Maternity Unit and emergency surgery, show improving patient satisfaction, significantly improved mortality rates and reduced costs.

The Trust was also very willing to support the East and North Hertfordshire Clinical Commissioning Group in the decision to transfer the management and assets of the former Surgicentre from Clinicenta Ltd. This change was in the best interests of local patients, given the concerns raised about the quality of the facility's management by the Care Quality Commission and others. In taking on the management of the Surgicentre from 14 September 2013, the Trust was responding to the needs of the local health economy. It has been renamed as the Treatment Centre and has become an integrated part of the Lister hospital

Whilst new buildings and equipment are very important, the key to the Trust realising its vision of becoming *amongst the best* lies in the hands of its staff. Patients having a good experience of the care they receive in the Trust's hospitals has been taken very seriously by the Board for some years now. Even before the Francis report was published, the Trust has sought to improve engagement with all staff groups.

Evidence from across many sectors, including the NHS, shows a clear link between the level of staff engagement and the experience of those who use services provided. Where staff feel engaged, the quality of care rises and patients report greater satisfaction. The Trust's ARC programme, which started over two years ago, is a long-term programme that aims to a change to staff culture that will run along-side the new hospital facilities becoming available. ARC is founded on The Trust's ambition – to become amongst the best performing NHS organisations in the English health service –and is based on five core values:

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

Although much of the Trust's focus during 2013/14 has been on the changes taking place at the Lister and QEII, considerable effort has been put into securing the future of the Mount Vernon Cancer Centre. These very important services are run from facilities on the Mount Vernon hospital site, which is owned by the Hillingdon Hospitals NHS Foundation Trust. In effect, Hillingdon are the Trust's landlords.

Whilst some of the cancer centre's estate is modern and fit-for-purpose, this is not true for other buildings – especially the inpatient wards. For the Trust to secure the necessary funding to invest in new or upgraded facilities, it needs to reach agreement with Hillingdon for ownership of part of the Mount Vernon site to transfer to the Trust. Despite the efforts made by both sides, an agreement with Hillingdon has yet to be reached, although both parties continue to work towards a solution that benefits the needs of patients.

The Trust's plans to become a NHS foundation trust remain on hold following the Trust Development Authority's decision not to put us forward for consideration until the *Our changing hospitals* programme had been implemented fully and is working successfully. The Board remains committed to achieving NHS foundation status as this will cement further our links to a wide range of communities, and make us more accountable to local people.

In delivering our vision to become amongst the best performing NHS organisation in the English health service, the Trust's emerging five-year strategic plan is being built around three broad aims:

- Building the best services possible
- Delivering the safest services that can be achieved
- Creating excellent patient experience

In delivering these aims, the Trust's services will be transformed through:

- Driving for continuous improvement – saving more lives by keeping patients safer
- Excelling at customer service – taking action so patients always know what is happening
- Delivering outstanding care – working with partner organisations to take better care of vulnerable patients and those with long-term conditions
- Consolidating services – bringing together services to improve them and treating patients in better ways
- Improving cancer care – taking better care of people with cancer and building a plan to secure the future of the Mount Vernon Cancer Centre
- Taking care of the Trust's team – attracting and keeping the best staff, and taking care of them so that that they deliver great patient care

In realising the Trust's vision, our staff are core to everything that is undertaken, both currently and in the future. Much has been achieved over recent years, with the next 12 to 18 months amongst the most challenging ever faced by the Trust as we seek to transform services at both the Lister and QEII hospitals. I have full confidence in the ability of the Trust's staff to ensure that these changes are delivered successfully, whilst at the same delivering high quality care at all times for patients.

Ian Morfett
Chairman

Chief executive's report

The publication of the Francis Report has provided the NHS with a wake-up call and emphasised the need for us all to be focussed on meeting the needs of our patients. Despite the progress made in transforming the Trust's operational, clinical and financial performance since the late 2000s, enough evidence existed suggesting more could be done to improve both the quality of care received by patients and their experience of that care, consequently three years ago the Trust embarked on a major change programme.

Whilst a number of initiatives were set in train back in 2011 to address these important issues, one of the key areas has been a continued focus on organisational culture change. The Trust's ARC programme – which stands for *Accelerate, Refocus and Consolidate* – is a long term initiative to place patients and their needs at the heart of decision-making across the Trust.

The programme's aim is to help deliver the Trust's ambition of becoming *amongst the best performing organisations* within the English health service – based on an expanding evidence base, which includes the NHS, linking engaged and valued staff with better patient outcomes and experience.

The Trust's ambition – to become amongst the best performing NHS organisations in the English health service – is based on five core values:

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

The ARC programme, which involves the 500 or so clinical and non-clinical team leaders from across the Trust coming together every three months, aims to ensure that these values are kept at the heart of all the decisions taken and implemented – especially where this involves change for our staff.

Turning to the Trust's in-year performance, this annual report shows that despite the continuing economic pressures facing the NHS, 2013/14 was another good year for the Trust. Whilst very pleased with that outcome, which reflects the hard work of our staff, we can never be complacent – there are still areas where further improvement needs to be made, with further ones being set nationally – for example, the challenge posed by the move to 24/7 working for our senior doctors.

Operationally, we met virtually all waiting times and other standards set for all NHS trusts. This included A&E, where significant pressures were evident right through the winter months – although our performance in the final quarter (i.e. January to March 2014) was the best in the Trust's history.

Financially speaking, the Trust also met its main targets – albeit with a surplus of £0.1 million, which was lower than forecast at the start of the year. The principal reason for this outcome was the Trust being asked by the East and North Hertfordshire Clinical Commissioning Group to take over the management of the former *Surgicentre* on the Lister site from Clinicenta Ltd with effect from 14 September 2013.

Renamed the *Treatment Centre* and integrated fully with the Lister, the in-year effect on the Trust's finances was some £2.0 million, which resulted in the original year-end planned surplus dropping from £2.1 to £0.1 million. The costs incurred by the Trust, which will not be repeated in 2014/15 onwards, covered one-off legal and service-mobilisation expenditure, as well as the unit's under-utilisation that meant it was costing more to run than received in income from commissioners – a position that now no longer applies as the Trust team has the *Treatment Centre* working at full capacity.

Information provided by the Dr Foster organisation, as well as the NHS Information Centre, shows that the Trust's mortality rates have fallen again during 2013/14, thus building on a trend that has been in place since 2010. Today, our HSMR score continues to be below what would be expected given the Trust's size and patient case mix. That means increasing numbers of patients are receiving better outcomes following treatment in our hospitals.

Crucially, we can demonstrate that bringing our emergency and inpatient services together at the Lister has resulted in better patient experience and, critically, reduced mortality rates. Equally the numbers of people experiencing hospital-acquired infections, pressure ulcers and falls have all fallen significantly over the last 12 months. For example, the Trust's rate of infections caused by *Clostridium difficile* is now the fifth lowest of any NHS organisation in the country and the lowest when compared to all large acute NHS trusts.

Finally there is the feedback received from our patients. Whether from written correspondence, via the our Patient Advice and Liaison Services (PALS), comments left on the NHS Choices and Patient Opinion websites, directly via the Trust's Facebook and Twitter channels, or through our Friends and Family Test surveys, the vast majority of patients report positive experiences of the care provided by the Trust's staff. And where critical comments are made, these are always followed up and rectified whenever that is possible.

Whilst much of the Trust's focus has been on providing patients with timely, effective, high quality care, planning within its clinical divisions has been underway for some time to prepare for the opening of the Lister's new emergency department, ward and theatres blocks by October 2014. This is when the final inpatient and emergency services remaining at the QEII will transfer to the Lister, which will have had some £150 million invested to create effectively a new hospital that will become the centre for specialist care for everyone living and working in east and north Hertfordshire, as well as parts of Bedfordshire.

Outpatient, diagnostic, ante/post-natal services, along with a 24/7 local A&E service for non-life/limb-threatening injuries and illnesses, will carry on being available to local people from the existing QEII buildings from October 2014, prior to transferring across to New QEII Hospital being built by the East and North Hertfordshire Clinical Commissioning Group that is due to open in the Spring of 2015.

These important developments will complete the transformation of hospital services in Hertfordshire, as set out in the 2007/08 *Delivering quality health care for Hertfordshire* consultation. In total some £180 million of new facilities will have been created when the New QEII Hospital – the most significant investment in Hertfordshire's health service since the NHS was founded.

New buildings, however important, are only part of the picture. It is the services provided from them that really matter and the promise made back in 2007/08 was that local people would still use their nearby hospitals for routine care – for example outpatient appointments, scans and blood tests. By bringing together all specialist inpatient and emergency services in to the new Lister hospital, patients would experience a wider range of better quality treatments.

Today the Trust offers a 24/7 heart attack service at the Lister, with mortality rates for those surgical services already brought together showing significant reductions. Mothers using the Diamond Jubilee Maternity Unit report very high levels of satisfaction, with complaints at an all-time low. Those services that have been brought together already, such as maternity, have also shown that this helps to recruit and retain the very best staff.

The changes being made at the Lister and QEII also come at a crucial time in terms of the financial pressures facing the NHS. The next two years are set to become amongst the most challenging in NHS history, with the Trust required to reduce its costs by £47 million by 2015/16. Whilst not designed for this purpose, the consolidation process underway will contribute nearly half of those savings making the Trust's savings challenge easier to achieve than otherwise would have been the case.

In my report I have set out a picture of continued improved performance across all areas of activity within the Trust. Much has been achieved and much still needs to be done. It is really important, therefore, that I use this opportunity to recognise that at the heart of these improvements are our staff – and especially our clinical leaders. Our current positive position – and future prospects – reflects their dedication and hard work, for which I extend my thanks.

Nick Carver
Chief Executive

Chapter 3: NHS Constitution

The NHS Constitution was first published on 21 January 2009. It was one of a number of recommendations carried in *High Quality Care for All* – a report published on the 60th anniversary of the NHS that 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, what staff, patients and public can expect from the health service.

Following a period of extensive consultation, the Constitution was updated in March 2013 with improvements to a number of areas, including:

- Patient involvement
- Feedback
- Duty of candour
- End-of-life care
- Integrated care
- Complaints
- Patient information
- Staff rights, responsibilities and commitments
- Dignity, respect and compassion

Technical amendments were also made to ensure that the NHS Constitution was in line with changes made to the NHS following the introduction of the new health and care system on 1 April 2013.

In addition, as part of the Department of Health's initial response to the report into the failings at the Mid Staffordshire NHS Foundation Trust by Robert Francis QC, the Constitution was changed to reflect that the most important value with the NHS is for patients to be at the heart of everything done by 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.

Since 19 January 2010, all providers and commissioners of NHS are under a 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 continues to take seriously and seeks to demonstrate through the decisions it takes. The Trust undertakes regular monitoring of key performance indicators and quality metrics linked directly to key aspects of the Constitution's staff pledges, as well as appropriate patient legal rights.

Legal rights of patients and staff

On 8 March 2010, the Department of Health confirmed that from 1 April 2010, patients would get additional rights around waiting times under the NHS Constitution. This means that patients 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 does not 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, has 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 Constitution was updated in 2012 as part of a series of measures intended to highlight the importance of *whistleblowing* in the NHS. These measures included: an expectation that staff should raise concerns at the earliest opportunity; a pledge that NHS organisations should support staff when raising such concerns; and clarity around the existing legal right for staff to raise concerns about safety, malpractice or other wrong doing without suffering any detriment.

As outlined previously, 2013 saw further changes made to the Constitution in key areas such as: patient involvement and feedback; duty of candour; end-of-life care; integrated care; staff rights; complaint handling; patient information, responsibilities and commitments; and dignity, respect and compassion.

People who use health and care services have the right to be treated with respect, dignity and compassion by staff who have the skills and time to care for them and the Trust values fully align to the NHS Constitution – and work has continued throughout 2013/14 to ensure these are embedded including into the Trust's recruitment and appraisal processes - more detail is set out in chapter five of this annual report.

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 NHS Choices website at:

<http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx>

Chapter 4: future trends and projections

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable
- Objective 5: Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services
- Objective 6: Improve staff engagement and organisational culture to be amongst the best nationally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

Strategic change underway

Since April 2000, the Trust has provided emergency and planned acute services from its two district general hospitals in Hertfordshire – the Lister and QEII – with limited scope for economies of scale and without the critical mass required to introduce key service improvements.

Whilst some consolidation has been achieved, for fully efficient, modern and high quality services to be developed, all of the Trust's emergency and inpatient services will be brought together on to one site, the Lister, by October 2014, with outpatient and diagnostic services provided in two of the Trust's other hospitals – Hertford County and the New QEII Hospital being built by the East and North Hertfordshire Clinical Commissioning Group (scheduled to be ready by 2015). The New QEII Hospital will also have what is called a Local A&E service.

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. This has been managed through the Trust's *Our changing hospitals* programme, which is addressing the following clinical quality and efficiency challenges:

- 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 where more acute care is provided within 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, as well as 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 Trust's *Our changing hospitals* programme being delivered at the Lister has taken a phased approach to change, testing deliverability and flexibility at each stage. The following progress has been made to the year ending March 2014:

- Phase one – the Lister Surgicentre: financial close was reached in 2009 between the former primary care trust, NHS Hertfordshire, and its independent sector partner Clinicenta Ltd. – a wholly owned subsidiary of Carillion plc – with construction of the new £47 million facility completed in Spring 2011. Following initial delays, NHS Hertfordshire approved finally Clinicenta's operational plan that saw services commence fully from the Surgicentre in October 2011. The facility and service transferred back to the Trust in September 2013 following the decision to end Clinicenta's operation of the Surgicentre. The facility is now called the Treatment Centre.
- Phase two – maternity expansion: full business case approval for this £16.5 million NHS-funded scheme was achieved in August 2009, with construction completed in December 2010. The new maternity service commenced, on schedule, from October 2011, which is when all of the Trust's inpatient maternity and gynaecology services at the QEII transferred to the Lister. Ante and post natal services at Hertford County and the QEII were not affected directly by this service change.
- Phase three – multi storey car park: financial close was reached with the Trust's preferred bidder, VINCI Park, in June 2010. Work on building the new facility commenced in September 2010 and it opened for use by patients and staff in September 2011. The additional parking spaces, which include much improved provision for blue badge holders, will help support the transfer of inpatient and emergency services from the QEII to the Lister over the next few years.
- Phase four – full consolidation of all remaining emergency and planned acute hospital services: in 2010 the Trust refined the outline business case to reflect NHS Hertfordshire's refreshed commissioning strategy. Having been approved by the respective boards of the Trust, NHS Hertfordshire and NHS East of England in September 2010, the outline business was approved formally by the Department of Health and HM Treasury on 4 August 2011. Full business cases for the phase four projects have now been approved, with final reconfiguration of these services expected to be completed by October 2014 – a few months prior to the New QEII Hospital opening in Spring 2015.
- Phase four – the full business case for the Lister's new £19 million emergency department has been approved by the Trust, NHS Hertfordshire, East and North Hertfordshire Clinical Commissioning Group, NHS East of England, Department of Health and HM Treasury. Construction started in 2012 and the new facility will be completed by October 2014.
- Phase four – the full business case for the Lister's new £39 million ward and theatres blocks has been approved by the Trust, NHS Hertfordshire, East and North Hertfordshire Clinical Commissioning Group, NHS East of England, Department of Health and HM Treasury. Construction started in early 2013, with the new facilities set to be completed before October 2014.
- Phase four – the £2.0 million expansion of critical care services at the Lister was completed and opened during 2012.
- Phase four – work continued during 2012/13 on creating the Hertfordshire scanning centre at the Lister Hospital, which includes two new CT scanners and a second MRI scanner.

- Phase four – agreement reached with Macmillan to create jointly a new chemotherapy unit at the Lister, work on which is on plan to complete in June 2014.

In February 2013, NHS Hertfordshire confirmed that commercial close had been reached that will see the New QEII Hospital being built on the existing Howlands site in Welwyn Garden City by Spring 2015. Enabling works started in March 2013 to create new public and staff car parks, as well as site road layouts, that will come in to use from June 2013 while the New QEII Hospital is built.

The Trust's *Our changing hospitals* programme will be completed by the end of 2014, which is when all remaining emergency and inpatient care at the existing QEII hospital will have transferred to the Lister. The service model for the New QEII Hospital, which includes outpatient, diagnostic, ante/post natal and local A&E services, will then be delivered from the current buildings ahead of transferring to the new hospital in the Spring of 2015.

The Mount Vernon Cancer Centre has been a key component of the Trust since 2005, following which some £35 million of combined NHS and charitable investment has been made in developing its services. Whilst many of the centre's facilities have been transformed, including the installation of two new linear accelerators capable of providing intensity-modulated radiation therapy routinely to suitable patients, there remains a need for further investment.

Mindful of this need, the Trust's cancer services divisional team is implementing plans to maintain Mount Vernon to be amongst the best cancer centres nationally, with new research facilities, chemotherapy capacity and stereotactic body radio-surgery – the CyberKnife – introduced over recent years. The Trust is continuing to progress discussions with Hillingdon Hospitals NHS Foundation Trust regarding the ownership of land and buildings occupied by the cancer centre, with the aim of investing in Mount Vernon's inpatient wards.

The benefits of all of this investment for our patients and staff are already evident, with increasing levels of satisfaction being expressed by those using and working within these services and increasingly encouraging clinical outcome data.

The strategy's financial implications

In implementing its strategy, the Trust has had to raise the necessary funds to allow capital developments set out through the *Our changing hospitals* programme to take place. This financing is being accessed via the Department of Health – i.e. traditional NHS capital funding, involving a mixture of interest bearing debt and public dividend capital. The borrowing will be financed by savings released as services shift to the Lister site in accordance with the defined phases outlined above.

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 2011/12 and 2014/15, the Trust will deliver relatively modest net surpluses. Post configuration, the planned level of surplus will grow to around 1% of turnover

The Trust's development programme was based upon an indicative timetable that assumed business case approvals were achieved as per the programme milestones. Where these milestones have not been met, the Trust has revised its financial plans and managed the financial position through a combination of increased efficiency savings and the deferral of capital loans.

Achieving NHS foundation trust status

The Trust remains committed to achieving NHS foundation trust status – in particular the principle of being accountable to its local communities and membership – and continues to work towards achieving this ambition. In 2012/13, delays encountered in receiving approval for the final phase of the Trust's reconfiguration programme centred on the Lister hospital in Stevenage, along with changes to the financial surplus delivered, meant that the application was unable to progress to the final stages.

During 2013/14, the Trust has focused on the final stages of its reconfiguration programme – the aim of which is to achieve better clinical outcomes and experience for patients and to support a sustainable future. A revised foundation trust timeline will be agreed with the new Trust Development Authority during 2014 taking into account the new requirements from Monitor.

The Trust has continued to grow its public membership to over 10,000 members, as well as prepare for the role of governors, whilst also strengthening its governance arrangements as part of the Trust's preparations for achieving NHS foundation trust status.

Governors

Governors will be an important link between all of the Trust's hospitals and services, its members – public and staff – and local communities. They will help to make sure that the new foundation trust, once approved, acts in a way that is consistent with its objectives and that the Trust operates under the terms of its licence. In carrying out this role, governors will have statutory duties and powers delivered through three main roles:

- **Strategic** – governors will advise on the longer term direction of the foundation trust in order to help the Board of Directors determine its policies effectively;
- **Advisory** – governors will communicate the views and suggestions of their members, as well as the local community, to the Board of Directors;
- **Ambassadorial** – governors will feed back information on the Trust, its vision, values and strategy to members, local community and partner organisations.

The Council of Governors will be made up of 38 governors, 20 of whom will be elected by public members (public governors) and a further six elected by Trust staff (staff governors). The final 12 governors will be nominated by partner organisations (appointed governors). All of the Trust's governors will have the same duties and responsibilities.

Ahead of final authorisation to become a NHS foundation trust, the Trust has nine appointed governors operating in shadow. They have been invited to, and in several cases participated in, events, meetings and workshops held by the Trust. Some of them have also attended a development event for shadow appointed governors, run by the Foundation Trust Network, to better understand the governor role. They are also active members of the Trust's involvement committee.

During 2013/14, the Trust has continued to develop its foundation trust membership and implement a new engagement strategy to increase involvement of members, with the additional aim of also increasing nominations for prospective governors and in recruiting and involving young people, developing an innovative approach that is fun and interactive and geared towards showing them what the NHS can do for them.

For further information, please contact:

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Current service development plans

In October 2014 the Trust will deliver the final stage of the acute consolidation programme, representing a £150m capital investment at the Lister Hospital.

In addition to final stages of the longer-term strategic change being implemented by the Trust, which is due to be completed by October 2014 a number of other service development plans are also being pursued – some of which are part of region-wide changes being overseen by the local area teams of NHS England and the new Midlands and East Specialised Commissioning Group. All projects being pursued by the Trust are in line not just with the Trust's strategic framework, but also the commissioning intentions being followed by local commissioners. Some examples are listed below.

Renal dialysis – expansion in number of satellite unites

During April 2012, the Trust was informed by the former East of England Specialised Commissioning Group that its bids to operate, in partnership with its private sector specialist partner Diaverum, two new renal dialysis satellite units in Bedford and Harlow. These two new services, which opened to patients in March and August 2013 respectively, build on the Trust's successful track record of operating such units in St Albans and Luton linked to the central service based at the Lister.

Cardiology – 24/7 primary angioplasty service

Supported by local commissioners and the regional cardiology network, the Trust's business case to extend the current primary angioplasty service at the Lister to a full 24/7 service was approved in 2013 and the service is due to become operational in April 2014. Currently the Lister-based service operates during week day times only, with patients outside of these hours being taken to specialist units at Harefield and Papworth hospitals (both of which are outside Hertfordshire).

Specialist vascular surgery

During 2012, the East of England Specialised Commissioning Group (SCG), which now forms part of the new Midlands and East SCG, set out proposed changes for specialist vascular surgery. Following input from a number of sources, including reviews by external experts, the proposal developed during the year was for such specialist surgery to be brought together on to single hospital sites serving a wider catchment than the current arrangements. The driving factor was to improve survival rates for a very small group of patients where such surgery is often a matter of life or death. Whilst supportive of the rationale behind these proposed changes, the Trust was disappointed that for Hertfordshire the proposal currently is that the centre should be at Watford General Hospital and not the Lister. The Trust will continue to engage and work with commissioners to ensure that the quality of service provided on a 24/7 basis to its patients is maintained, especially for its renal inpatient unit.

Improving the Trust's information management and technology

The last financial year has seen the Trust's information management and technology capital programme focusing on the following key areas:

- *Infrastructure programme* – delivery of an infrastructure programme (PCs, laptops, printers, telecoms (VOIP) and video conferencing, along with a resilient network) to enable the IM&T service support efficient and effective patient care;
- *Clinical programme* – delivery of clinical programmes geared towards ensuring efficient and effective patient-centric care;
- *Trust WiFi programme* – empowerment of a mobile workforce to enable the access of information at point of care. This will also encompass patient Wi-Fi and guest Wi-Fi;
- *Mobile technological solutions programme* – solution that will encompass BYOD (*bring your own device*) and application development. Mobile technology implementation will enable the leverage of mobility as a means of driving high performance and ensuring competitive advantage;
- *Trust EPR programme* – implementation of an electronic patient record for the accurate capture of patient information in a digital format;
- *A business intelligence programme* designed to retrieve, analyse and report data effective and efficient delivery of patient care.

Delivering commissioning intentions

The Hertfordshire QIPP programme identifies the financial and service challenges facing the county's NHS over the next few years, when the growth in funding will reduce significantly. The Government's White Paper, [Equality and Excellence – Liberating the NHS](#), sets out a requirement of up to £20 billion (of savings that need to be made nationally by 2014/15). Hertfordshire's share of this QIPP challenge is £276 million over the same time period, of which the Trust's element sees £67 million needing to be saved in total by 2014/15. The latter includes savings arising from the Trust's *Our changing hospitals* strategic change programme, as well as its more mainstream annual cost improvement programmes (CIPs).

Within this plan, the Trust's main commissioners – the East and North Hertfordshire and Bedfordshire clinical commissioning groups – set significantly reduced levels of acute hospital patient activity from 2012 onwards. These commissioning intentions have been used to inform the Trust's capacity planning work, which in turn has defined the future configuration of hospital services at the Lister in particular.

At the same time, the Trust's clinicians are engaging with the East and North Hertfordshire and Bedfordshire CCGs to develop the new models of care that will be necessary to reduce the number of patients being referred for assessment and treatment in the Trust's hospitals. In pursuing this work, the Trust recognises that its involvement and leadership in a number of these key initiatives is essential for the successful delivery of Hertfordshire's overall QIPP programme.

Meeting the expectations of regulators

The Trust was registered fully with the Care Quality Commission (CQC), without compliance conditions, on 1 April 2010. The CQC has not taken enforcement action against the Trust during 2013/14 and has inspected the Trust on two occasions.

The CQC carried out a routine unannounced inspection of the Lister hospital on 5 and 6 September 2013, which was found to be compliant fully with the following standards:

- Outcome 4: Care and welfare of people who use services;
- Outcome 6: Co-operating with other providers;
- Outcome 7: Safeguarding people who use services from abuse;
- Outcome 13: Staffing;
- Outcome 16: Assessing and monitoring the quality of service provision.

The second inspection took place at the QEII hospital on 3 February 2014 and formed part of a national programme of themed inspections looking at the quality of dementia care. Following the inspection, the Trust received positive feedback and the final report confirms that the Trust is fully compliant with the following core standards:

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Co-operating with other providers
- Outcome 16: Assessing and monitoring the quality of service provision

As in previous years, the Trust continues to monitor compliance against all the essential standards of quality and safety on an on-going basis. During 2014/15, the Trust will seek to improve further upon this performance with regulators such as the Care Quality Commission, NHS Litigation Authority risk management standards and continue a programme of self-assessment against the standards required by Monitor.

Chapter 5: organisational development

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable
- Objective 6: Improve staff engagement and organisational culture to be amongst the best nationally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six.

This chapter of the annual report has been pulled together to reflect the work that is being undertaken by the Trust around organisational development, but also to provide a more consistent focus on the Trust's workforce and related area. In previous, annual reports workforce matters in particular have been somewhat dispersed, making it difficult to present a coherent picture of the work being undertaken around organisational development – an issue that took on additional performance following the publication of the *Francis Report* in February 2013, which set out a range of recommendations aimed at changing organisational culture within the NHS.

The Trust is going through a period of major change in both where and how its services are provided to patients. An example of changes that have taken place over the last year include:

- Creation of two new satellite renal dialysis units in Bedford and Harlow during 2013, where staff consultation supported by the Trust's human resources team has helped to enable the adjustment of staffing levels at the service's existing three dialysis units when patients are repatriated to the two new units which will be closer to where they live and/or work;

Examples of changes that are due to take place over the next year include:

- *Our changing hospitals* programme – the bringing together of the Trust emergency and inpatient services onto the redeveloped Lister hospital by October 2014; This is a significant change programme for the Trust and the consultation process with staff commenced in March 2014.
- The Trust has formed a consortium with six other NHS trusts, known as *Transforming Pathology Partnership* (TPP) to consolidate pathology services into a hub and satellite model covering all the partnership hospitals; TPP is hosted by the Cambridge University Hospitals NHS Foundation Trust (CUH). This new way of working for pathology staff will result in their TUPE transfer to one of two different organisations – CUH, as the host of TPP or Public Health England (PHE), as the provider of microbiology services. This transfer is planned for May 2014, following staff consultation in 2013. Under these new arrangements, the Trust will retain its own capability to provide emergency pathology services to its hospitals – the so-called *hot laboratory*.

Chapter five looks at four broad areas, namely the Trust's:

- Vision and values
- ARC programme – its aims and progress
- 2013 national NHS staff survey findings
- Response to the Francis Report

Vision and values

The Trust's vision is: *To become amongst the best*, which translates to becoming amongst the best performing organisations in the English health service. 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 and during 2013/14 has continued to implement a Trust-wide, long-term organisation development programme to embed these values further and develop a customer-focused culture.

All projects and reports brought to the Trust Board and its committees for approval must demonstrate how they will help the Trust achieve its vision and values.

The ARC programme

In December 2010 a steering group was established to drive forward an organisational culture change programme, resulting in greater emphasis being placed upon the need for an engaged workforce focused upon the experience of our patients. The programme was branded:

ARC – it's all about you

- **Accelerate** – quality, staff training, communication
- **Refocus** – on our patients, on our staff, on our values, on our partners
- **Consolidate** – services, patient pathways, our hospitals, our teams

The ARC name is underpinned with the strap line *It's all about you* – each and every staff member makes a difference.

ARC is a Trust-wide programme of activities to aid in delivering the highest quality of healthcare to patients whilst recognising that an engaged and effective workforce is essential in achieving this aim. Quarterly ARC briefing sessions with the Trust's clinical and non-clinical leadership have taken place to improve staff engagement. They also provide an invaluable forum for on-going, regular face-to-face communication between the Trust's leadership and executive directors.

Topics covered by the ARC sessions during 2013/14 included:

- The Francis Report
- New appraisal process
- Behaviours and values
- Health and well-being

During 2013/14, almost 2,000 attendances were recorded across the four sets of quarterly meetings. At the end of each session, those attending were charged with taking the programme out in to their teams so that staff working in frontline roles had the same opportunity to experience the ARC programme and – perhaps most importantly – consider changes that could be made locally that would help deliver improved standards of care and better patient experience.

Other key ARC programme activities during the year included: annual and monthly staff recognition schemes; leadership development (see chapter 10 for further information); new appraisal framework (again see chapter 10); and equality and diversity work, including a focus on behaviours and support for reducing workplace bullying.

Delivering excellence in customer care training

A key strand of work that has come out of the ARC programme was the recognition of the importance of customer care. Feedback from patients and their families/carers often highlight the impact – both positive and negative that staff can have when first encountered.

To improve the level of customer care that the Trust provides to its patients and visitors, a programme of training called *Delivering excellence in customer care* was launched across the Trust in February 2012. To date, around 2,400 members of the Trust's staff have completed this programme since its launch.

National 2013 NHS staff survey

As stated previously, the Trust's vision is *to be amongst the best*, i.e. to become one of the top quartile of acute trusts in England. Part of that ambition is to ensure that the Trust's staff view it as being one of the best places to work in the country. The results of the 2013 NHS staff survey, which was conducted in autumn 2013, highlighted key areas where the Trust is performing well compared to other acute Trusts and others where further improvement is needed.

There are 28 key findings in the survey linked to the national NHS staff pledges. In addition, there is an overall staff engagement score for which the Trust benchmarks as average for this, albeit with a small increase in the overall score compared to 2012.

The Trust's results showed 11 areas of strength, benchmarked against other acute Trusts (i.e. rated as being above average or in the top 20%):

- Staff recommending Trust
- Staff motivation at work
- Staff feeling satisfied with quality of care they are able to deliver
- Well structured appraisals
- Staff having health and safety training
- Availability of hand-washing materials
- Witnessing potentially harmful errors/near misses

- Staff experiencing physical violence from patients/public
- Staff experiencing physical violence from staff
- Staff experiencing bullying or abuse from patients/public
- Staff having equality and diversity training (best 20%)

A further six key findings are rated as average, with the following 11 rated as either being below average or in the bottom 20%:

- Staff agreeing that their role makes a difference to patients
- Work pressure felt by staff
- Effective team working
- Working extra hours (worst 20%)
- Support from immediate line managers
- Work related stress
- Reporting errors/near misses
- Staff experiencing bullying, harassment or abuse from staff
- Feeling pressure to attend work when feeling unwell (worst 20%)
- Good communication between senior managers and staff
- Believing the Trust provides equal opportunity for career progression/promotion

Results from the 2013 national survey, along with the Trust's own internal quarterly surveys, are communicated to staff through a variety of methods. The Trust is working in partnership with its management and staff side representatives to address issues of concern and develop action plans to make improvements where necessary during 2014/15. The March/April 2014 set of ARC meetings were used to engage leaders in considering what actions need to be taken to address the poorer performing aspects of the 2013 staff survey, as well as prepare for the staff consultations taking place during the Spring of 2014 to support the delivery of the Trust's *Our changing hospitals* programme.

Trust's response to the Francis report

The Francis report into the failings at Mid Staffordshire hospital was published in February 2013 and this was followed more recently by the Don Berwick report: *A promise to learn – commitment to act: improving the safety of patients in England*. Between them, these reports call for all NHS organisations to develop responses to their recommendations to bring about lasting improvements.

The Trust takes the issues raised in these reports extremely seriously and as part of its vision *To be amongst the best*, it is committed to ensuring the recommendations identified are applied across the Trust. The key lesson from the Francis report is that individually and collectively – and irrespective of their role within the organisation – every member of staff must redouble their efforts in striving to become amongst the best in providing the best possible care for patients.

The Trust's focus will remain, therefore, on placing the needs of its patients at the heart of everything it does, as well as ensuring that all staff operate in accordance with the Trust's values.

What has been done since the publication of the Francis and Berwick reports

The review process began at the Trust Board's February 2013 meeting, following which a number of steps have been taken to consider the impact of the reports' recommendations for the Trust and how these may improve patient care further.

This work included:

- Reviewing the Trust's position against all the 290 combined recommendations from the Francis and Berwick reports
- Looking at what was being done already and what could be done better
- Holding focus groups, listening to the views of staff, patients and foundation trust members
- Considering the responses from other organisations that impact on the Trust directly or indirectly
- Reviewing and re-launching the Trust's *Raising concerns at work* policy (whistle-blowing)
- Continuing to undertake a comprehensive review the Trust's staffing establishment each year, which includes taking action on the outcomes
- Continuing with the Trust's ARC programme for all clinical and non-clinical leaders
- Started delivering on the Trust's commitment to put every single member of its staff through customer care training, with some 2,300 people having attended this training thus far by 31 March 2014

The Trust has clear strategies and ambitions that support continued improvement to the delivery of patient care, including a: nursing and midwifery strategy; patient experience and carer strategy; improving patient outcomes strategy; engagement strategy; and quality governance and risk management strategy.

An action plan has been developed to ensure the Trust continues to improve, with the agreed actions monitored and report upon at least annually, through the risk and quality committee, to the Trust Board. This report is published on the Trust website:

<http://www.enherts-tr.nhs.uk/about-the-trust/our-publications/>

The Trust continues to put patients first and it will continue to monitor carefully what others say about services and encourage actively through involving patients, staff, commissioners, HealthWatch and other representatives in helping the Trust to identify ways it can keep improving.

Dealing with staff concerns

The importance of staff being able to raise concerns, especially around the quality of clinical care provided to patients, was a key recommendation made by Robert Francis QC. Whilst something that is considered in greater detail in chapter 10, it is important to note that the Trust's chief executive has reiterated to all staff their absolute duty to ensure patients receive the very best care and to take responsibility for dealing with, and addressing, any concerns they may have about the care provided. Fundamentally, they must not ignore such concerns or think they are for someone else to deal with – a core message is that the Trust's staff must never become *bystanders*.

Chapter 6: 2013/14 overview

This chapter's contents relate to the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable
- Objective 5: Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services
- Objective 6: Improve staff engagement and organisational culture to be amongst the best nationally

Further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14 is covered in this chapter.

The areas covered in this chapter are:

- Delivery of the Trust's corporate objectives for 2012/13;
- Operational, clinical and financial performance summary;
- Regulation and assessment-related information;
- Listening to patients' concerns;
- Education and training summary;
- Research and development overview;
- Clinical service changes during the year;
- FT membership activities.

Delivery of the Trust's corporate objectives for 2013/14

During 2013/14, the Trust worked to six strategic objectives, namely to:

- Improve continuously the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.
- Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.
- Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable.

- Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services
- Improve staff engagement and organisational culture to be amongst the best nationally.

The Trust set a number of stretching and challenging annual objectives for 2013/14 and met 22 out of 38 of these in full. In addition, 14 are met partially and this assessment has been made on progress evidenced to date and a full evaluation of the Trust's clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through risk and quality committee in the medical director's reports to the committee and Board during May through to July 2014.

Two objectives were not met during 2013/14, but in both cases their delivery has been outside the complete control of the Trust – namely the agreement of a memorandum of understanding with Hillingdon Hospitals NHS Foundation Trust regarding the Mount Vernon Cancer Centre site and delivery of requirements made by specialist commissioners following a review of vascular surgery service provision.

Progress made during the year in delivering each of the Trust's six strategic aims, along with their respective annual objectives, is set out in the tables on this and the next two pages.

Strategic objective 1: To improve the quality of all aspects of the Trust's services		
1.1	To improve patient outcomes thereby achieving a governance risk rating of 'amber/green', or better	Achieved
1.2	To reduce mortality and deliver HSMR and SHMI within the 'as expected' range or better <i>(Trust improvement priority 1)</i>	Achieved
1.3	To improve the safety and outcomes of patients by:	
	i) implementing the priorities set out in the Improving Clinical Outcomes strategy	*Achieved partly
	ii) delivering the agreed pathways to improve patient outcomes and ensure the achievement of the agreed CQUIN targets	Achieved
	iii) improving post-operative outcomes for high risk patients (deteriorating patient, frail elderly, co-morbidities) <i>(Trust improvement priority 3)</i>	Achieved
1.4	Have a zero tolerance approach to hospital acquired infection and comply with the hygiene code	Achieved
1.5	To deliver on the key priorities for 2013/14 agreed within the Quality Account priorities <i>(improving safety, improving clinical outcomes, staff development /engagement, improving patient experiences)</i>	*Achieved partly

Notes to annual objective one

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2014.

Strategic objective 2: To excel at customer service		
2.1	Achieve improved levels of GP satisfaction with Trust communication and services (measure clinical correspondence contract performance and GP survey/feedback)	Achieved
2.2	To implement the carer friendly hospital strategy	Achieved
2.3	To implement the patient and carer experience strategy and review identified priorities <i>(Trust improvement priority 5 - improving the experience of patients using our services)</i>	Achieved
2.4	To improve the administration processes and patient experience in relation to outpatients	*Achieved partly

Notes to annual objective two

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2014.

Strategic objective 3: To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.

3.1	To work with key partners and provide leadership to define and deliver year three of the Hertfordshire QIPP plan	Achieved
3.2	To enhance quality of life by reducing emergency admissions for acute conditions and enabling patients to stay at home (<i>Trust improvement priority 2</i>)	*Achieved partly
3.3	To improve In-patient Care of Diabetes (<i>Trust improvement priority 4</i>)	Achieved
3.4	To implement and deliver the 2013/14 milestones within the older persons strategy	*Achieved partly
3.5	To implement the dementia alliance framework	Achieved

Notes to annual objective two

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2014.

Strategic objective 4: To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable

4.1	To ensure the delivery of safe services at the QEII during the final phase of the consolidation programme, ensuring the effective management of patient safety and clinical risks associated with the delays to the phase 4 <i>Our changing hospitals</i> programme	Achieved
4.2	To approve the chemotherapy full business case	Achieved
4.3	To approve the pathology hot laboratory full business case	Achieved
4.4	To approve the Pathology Partnership joint venture and commence transformation of pathology services	*Achieved partly
4.5	Deliver the health records project in line with the approved full business case	*Achieved partly
4.6	To reach agreement with commissioners on pathways for services to be provided from the New QEII, including children's services, local A&E and rapid assessment	*Achieved partly
4.7	Ensure improvements in the stroke care pathway to deliver a hyper-acute stroke unit	*Achieved partly
4.8	To implement a 24/7 primary percutaneous coronary intervention (PPCI) service	*Achieved partly
4.9	Through targeted marketing ensure the maternity service is working to full capacity, 5,250 births	Achieved
4.10	To work with partners to deliver requirements of vascular review and to maintain the quality of services	Not Achieved
4.11	Explore with commissioners further opportunities for developing integrated care	*Partly Achieved
4.12	To improve the financial efficiency of the Trust and deliver the financial forecast and the cost improvement programme across the Trust for 2013/14	Achieved
4.13	To implement service line reporting, ensuring that it is used to inform decision making at all levels within the organisation demonstrating service improvement contribution	Achieved
4.14	To deliver on the milestones agreed with the Trust Development Authority to achieve authorisation as a NHS foundation trust	Achieved

Notes to annual objective four

4.4: Pathology Partnership services commenced on 1 May 2014

4.8: The 24/7 PPCI service went live on 28 April 2014

4.10: The Trust has continued to develop its vascular service in terms of quality and outcomes and during the course of 2013/14 has worked with both renal and vascular services to understand the implications of the specialist commissioners planned service changes and consider mitigation. It is understood that a commissioner-led programme board will be established at some point in the future to manage the service change across Hertfordshire on which the Trust will be represented by clinicians and senior managers

Strategic objective 5: To support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services

5.1	Agree a memorandum of understanding with the Hillingdon Hospitals NHS Foundation Trust (THHFT) regarding the Mount Vernon site development plan that will enable the development of a business case to address the cancer centre infrastructure including re-provision of the wards and clinical areas	Not achieved
5.2	Assess services provided by the cancer centre against the new cancer commissioning specification. Develop, agree and progress delivery of an action plan to support delivery of the specification	Achieved
5.3	Work collaboratively with clinical commissioners and cancer systems to support the development of the cancer centre	Achieved partly

Notes to annual objective five

5.1: It has currently not proved possible to identify a workable solution in terms of the MVCC clinical strategy and vision from a financial perspective and within THHFT current objectives.

5.3: Is achieved partly as this is dependent on the agreement of 5.1. During 2013/14, however, the division has continued to work with other providers to scope a future service model /clinical for discussion with commissioners.

Objective 6: To improve our staff engagement and organisational culture to be amongst the best nationally

6.1	Develop the detailed workforce strategy and delivery plan required to manage and deliver the phase 4 workforce skill mix changes and planned workforce reductions and pay savings in line with Phase 4, the Trust's foundation trust application and the Hertfordshire QIPP plan	Achieved
6.2	To implement a workforce recruitment strategy and reduce ward nurse vacancy rates to below 6.0%	Achieved partly
6.3	Increase the level of customer service and patient experience within the Trust, ensuring 90% of staff attend customer service training and focus on priority areas	Achieved partly
6.4	Ensure mechanisms and processes for staff to raise concerns are firmly established and a clear understanding of the issues in order to reduce bullying and harassment	Achieved

Notes to annual objective six

6.2: In 2013 the overall Trust vacancy rate fell to below 6%, although this was higher in nursing – in recent months the vacancy rate has been increased in line with the *Our changing hospitals* programme workforce plans. This is supported by recruiting into flexible work force positions.

6.3: Partly met – over 2,400 staff attended customer care training, with priority areas having included outpatient department, booking and portering staff (these areas have a higher percentage have been trained).

Further information

A more detailed analysis of the Trust's delivery of its corporate objectives is contained within the board assurance framework. This document is reviewed regularly by the Trust Board and is published in the relevant set of Board papers – which are published on the Trust's website (www.enherts-tr.nhs.uk). For further information, please contact:

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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	2013/14 planned	2013/14 Actual	% variance
A&E activity (attendances)	121,932	119,622	-1.9%
Outpatient activity (first appointments)	84,829	105,796	+24.7%
Elective activity (number of planned episodes of surgery/treatment)	28,585	31,221	+9.2%
Non-elective activity (number of emergency admissions)	38,854	40,138	+3.3%
Number of births	5,250	5,185	-1.2%

Patient access

In terms of existing nationals and local standards set for the Trust to achieve during 2013/14, a summary of the main patient access and clinical indicators is set out in the table below.

Standard	Standard	2013/14
18 weeks standard – admitted	≥90.0%	90.80%
18 weeks standard – non-admitted	≥95.0%	96.62%
18 weeks standard – open pathways	≥92.0%	94.84%
A&E four-hour wait	≥95.0%	95.70%
Two-week rapid access chest pain clinic wait	≥98.0%	100%
PPCI heart attack service – 150 min call to balloon time	≥80.0%	94.40%
Patients spending 90% hospital stay on specialist stroke unit	≥80.0%	72.71%*
Patients with high-risk TIA seen and scanned/treated within 24 hours	≥63.0%	69.82%*
Two-week maximum wait, referral to outpatient appointment (all cancers)	≥93.0%	97.80%*
Two-week wait – breast symptoms	≥93.0%	96.50%*
31-day diagnosis to treatment (all cancers)	≥96.0%	97.70%*
31-day second or subsequent treatment (anti-cancer drug)	≥98.0%	98.80%*
31-day second or subsequent treatment (surgery)	≥94.0%	96.80%*
31-day second or subsequent treatment (radiotherapy)	≥94.0%	97.50%*
62-day urgent referral to treatment (all cancers)	≥85.0%	85.50%*
62-day referral to treatment (from screening)	≥90.0%	92.10%*
Choose and Book slot issues	≤5.0%	10.99%
DNA (did not attend) rate – outpatients	≤7.2%	7.94%
New to follow-up outpatient appointment ratio	≤1.75	1.88
Pre-operative bed days	≤6.0%	5.02%
Delayed transfers of care (inpatients)	≤3.5%	3.19%
Cancelled operations	≤0.8%	0.81%

*Data only confirmed six weeks after month end – year-end outturn not confirmed until May 2014 for stroke standards and June 2014 for the Cancer standards

Overall the Trust's performance against standards set for it to be achieved during 2013/14 saw improvements on the previous year, although some areas saw performance slip slightly in comparison. Once again, a wide range of standards including those covering A&E waiting times, cancer care and cardiology were met. The timeliness for patients being treated with a high risk TIA (sometimes referred to as mini-strokes) improved by 19% on the previous year, however patients not attending for their outpatient appointments continues to be a challenge.

Areas of specific focus for 2013/14 include:

- Maintaining the Trust's A&E waiting times standard, with at least 95% of those attending the Trust's service being seen, treated and either admitted or discharged within four hours of arrival;
- Continuing to work with commissioners to reduce the level of issues with outpatient appointment slots coming through the *Choose and Book* system operated in those GP practices using this service on behalf of their patients;
- Building on the improving performance of the Trust's acute inpatient stroke service, which will continue to represent an area of considerable attention for the coming year in line with standards set by local commissioners. To ensure that this happens, the Trust continues to work closely with the Beds and Herts Heart and Stroke Network;

- Work to reduce the ratio of new to follow-up outpatient appointments, cancelled operations and the number of patients that do not attend (DNA) their outpatient appointment will continue to be a focus throughout this year

Clinical quality and patient experience indicators

In addition to the operational standards listed above, the Trust also worked to deliver a range of clinical indicators during 2013/14 – a summary of which are set out in the table below.

Healthcare quality indicator	2013/14 Standard	2013/14	2012/13 Outturn
MRSA blood infections (post 48 hours)	0	2	2
<i>Clostridium difficile</i> infections	≤14	14	13
Emergency MRSA screening compliance	≥95.0%	91.31%	90.8%
Adult inpatients undergoing VTE risk assessment	≥98%	98.32%	99.2%
Net promoter score (<i>Friends and Family Test</i>)	≥71.0	80.17	71.1
Falls resulting in serious harm	≤24	15	14
Pressure ulcers – grades two to four	≤120	45	113
Never Events	0	1	2
Serious dispensing drug errors	≤3	0	1
Administering drug errors	≤145	115	177
NPSA safety alerts outstanding	0	0	0
Hospital standardised mortality ratio (100 = expected NHS average)	≤94	88.96 ¹	92.5
Summary hospital-level mortality rate (100 = expected NHS average)	≤100	111.78 ²	111.4
Summary hospital-level mortality rate – adjusted for palliative care	≤95	100.43 ²	102.0

¹Rolling 12-month score, provided three months in arrears – means final 2013/14 position not known until at least July 2014

²Rolling 12-month score, provided six months in arrears – means final 2013/14 position not known until at least October 2014

Further discussion around the Trust's clinical quality and patient experience indicators is provided in chapter eight.

Trust's financial performance

At the end of March 2014, the Trust reported a year-end surplus of £0.109 million against a budget of £361 million. This was marginally better than the £0.1 million revised year-end forecast, although significantly less than the £2.1 million planned at the start of the year.

Looking back across the year, emergency admissions were over 6% higher than in 2012/13 and related income correspondingly showed a £3.0m increase versus plan. This is despite the fact that A&E attendance levels were actually slightly lower but with higher acuity levels resulting in more admissions. Elective activity levels were mixed with a high outpatient workload being partially offset by lower income from elective admissions.

Other financial-related issues of importance throughout the 12-month period were:

- The Trust met its external financing limit by achieving a year-end cash balance of £4.3 million against a requirement of no less than £4.0 million;
- The Trust's capital programme for the year totalled £39.0 million, of which £30.7 million related to phase four of the *Our changing hospitals* programme. Capital underspent against plan by £2.3 million, with some slippage on phase four that will catch up in 2014/15.
- The Trust delivered £16.4 million (90%) against its full-year cost improvement programme (CIP) target of £18.2 million.

Regulation and assessment-related information

Care Quality Commission registration

From 1 April 2010, the Trust has been registered formally with the Care Quality Commission under the Health and Social Care Act 2008 to provide the regulated activities at the specified locations set out in the table below.

Regulatory activity	Lister	QEII	MVCC	Hertford County	Bedford renal dialysis unit	Harlow renal dialysis unit
Treatment of disease, disorder or injury	ACS DSS CHC	ACS DSS CHC	ACS HPS* DSS	ACS DSS CHC	ACS	ACS
Surgical procedures	ACS	ACS	ACS			
Diagnostic and screening procedures	DSS	DSS	DSS	DSS	DSS	
Maternity and midwifery services	ACS CHC	ACS CHC		ACS		
Termination of pregnancies	ACS	ACS				
Family Planning Services	ACS	ACS		ACS		
Assessment or medical treatment of people detained under the Mental Health Act 1983	ACS	ACS	ACS			

During August 2013, an application was submitted to the CQC to register the Trust's new renal dialysis unit situated within the Princess Alexandra Hospital in Harlow. Following a registration assessment by the CQC, the Trust received approval of the application for registration and the unit opened to receive patients in August 2013.

Inspections and reviews

The CQC carried out a routine unannounced inspection of the Lister hospital on 5 and 6 September 2013, which was found to be fully compliant with the following standards:

- Outcome 4: Care and welfare of people who use services;
- Outcome 6: Co-operating with other providers;
- Outcome 7: Safeguarding people who use services from abuse;
- Outcome 13: Staffing;
- Outcome 16: Assessing and monitoring the quality of service provision.

During the two-day inspection, the CQC inspection team visited two care of the elderly wards, three surgical wards and the Hospital's stroke unit. Overall, the CQC found that people were happy with their care and treatment; they also spoke highly of the staff. The CQC reported that the Trust has a good and clear governance framework, along with a pro-active approach to dealing with areas for improvement.

The CQC also carried out an unannounced inspection of the QEII hospital on 3 February 2014. This was part of a national programme of themed inspections looking at the quality of dementia care and a team of five inspectors visited a number of wards as well as the A&E department at QEII. Following the inspection, the Trust received positive feedback and the final report confirms that the Trust is fully compliant with the following core standards:

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Co-operating with other providers
- Outcome 16: Assessing and monitoring the quality of service provision

As in previous years, the Trust continues to monitor compliance against all the essential standards of quality and safety on an on-going basis and has maintained a positive CQC Quality Risk Profile (QRP) and with the new CQC Intelligence Monitoring Report, progressing from a band three in October 2013 to a band five in March 2014. (*Bands range from one to six – the higher the band, the lower the risk profile.*)

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, who work closely with their complaints colleagues, aim to resolve issues locally, without the need for these concerns to be escalated to a more formal level. The teams also try to make initial contact with complainants who have written to the Trust to establish if their concerns can be addressed more effectively at a local level. During 2013/14, a total of 1,715 separate contacts were made with the Trust's PALS services – this includes those seeking direct help from the teams themselves, as well as via comment cards. The numbers using the Trust's PALS service during the year was broadly similar to that recorded in 2012/13 (1,728 separate contacts).

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 relevant concerns are directed initially through to the service in question to help facilitate the earliest possible resolution. Concerns of a more serious nature can be escalated to the appropriate line manager.

During the year, the Trust's PALS service saw an increase in the number of hours the service is staffed, which may well be reflected in the reducing number of formal complaints received detailed below.

Formal complaints and compliments

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

Principles for remedy

In 2007, the Parliamentary and Health Service Ombudsman published a report entitled *Principles for remedy*, which form the basis for how 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.

Principles for remedy was updated in [May 2010](#). Further information is available from the Parliamentary and Health Service Ombudsman's [website](#).

Dealing with complaints and compliments

During 2013/14, the Trust received 864 formal complaints – a reduction of over 10% on the number received the previous year. Given the continuing reconfiguration of services that have been taking place since 2012, along with the Trust's open encouragement of complaints being received, this is a pleasing outcome for the year. Overall, the majority of complaints reported to the Trust were of a low or moderate severity.

Everyone who makes a formal complaint is offered an opportunity to meet with relevant staff if they remain dissatisfied after receiving the Trust's investigation response. In 2013/14 there were 24 such meetings – six fewer than the previous year, which may indicate greater satisfaction with the initial complaint response. These meetings form part of what is known as the *local resolution* process.

In the 12 months to March 2014, a total of 17 people asked the Ombudsman (PHSO) to consider an investigation of their complaint, of which 12 related to complaints received in previous financial years. Following discussion with the Ombudsman's office, however, it became clear that some of these requests had not concluded the *local resolution* stage of the complaints handling process, so were passed back to the Trust for further action. However, during this year the criteria applied by the PHSO has been revised and unless local resolution is still on-going, all complaints received by the PHSO will be granted an investigation. As a result, the PHSO has only refused one request for investigation on the grounds that the request was *out of time*. Of the 16 investigations accepted, three have been upheld, one partially upheld and six not upheld; a further six are still under investigation.

In addition to these complaints, during 2013/14 the Trust received formally 144 letters and e-mails complimenting the standard of care provided by its staff. Another 65 people took the time to complete positive *comment cards*. This was in addition to the many hundreds of cards, notes, messages and small gifts that were given to ward staff directly.

Comments placed on NHS Choices

For some time now, patients and their family members/carers have been able to place comments about the care received at individual hospitals on relevant pages on the national *NHS Choices* website managed by the Department of Health, which also now appear on the independent *Patient Opinion* online service.

The total comments being made in this way is growing year-on-year, with 2013/14 seeing, on average, four to five being made each week across the Trust's four hospitals. Such means of online commentary are an increasing trend within healthcare, building on the success of such services as TripAdvisor in the holiday sector.

The vast majority of comments received through NHS Choices are highly positive of the care and treatment received at the Trust's hospitals. Using a new five star rating system introduced in 2013/14, ratings for the Trust's hospitals are as follows:

- [Lister](#) – overall four stars based on a total of 235 ratings (cleanliness – four stars; staff co-operation – four stars; dignity and respect – four stars; involvement in decisions – four stars; and same sex accommodation four stars). Since the NHS Choices service started, the Lister has had 464 reviews.
- [QEII](#) – overall four stars based on 91 ratings (cleanliness – four stars; staff co-operation – four and a half stars; dignity and respect – four and a half stars; involvement in decisions – four and a half stars; and same sex accommodation four and a half stars). Since the NHS Choices service started, the QEII has had 284 reviews.
- [Hertford County](#) – overall four and a half stars based on 17 ratings (cleanliness – four and a half stars; staff co-operation – four and a half stars; dignity and respect – four and a half stars; involvement in decisions – four and a half stars; and same sex accommodation four and a half stars). Since the NHS Choices service started, Hertford County has had 48 reviews.
- [Mount Vernon Cancer Centre](#) – overall four and a half stars based on six ratings (cleanliness – four stars; staff co-operation – four and a half stars; dignity and respect – four and a half stars; involvement in decisions – four and a half stars; and same sex accommodation five stars). Since the NHS Choices service started, Mount Vernon has had 16 reviews.

The Trust responds individually to each and every message posted. Where possible, these comments are shared with the relevant teams to help them understand better the needs of their patients. Where someone leaving a comment is dissatisfied with the service received, the comment posted invariably invites them to contact the Trust via the general enquiries e-mail service accessible via the Trust's website. Whilst many do not choose to take this step, those that do are always followed up individually – including through the Trust's complaints handling team.

The level of commentary on the Trust's hospital services through NHS Choices compares very favourably with that of nearby NHS hospitals. Based on those involved in star grading system introduced in 2012, the only hospitals bordering the Trust that received a greater number of ratings than the QEII was for Princess Alexandra Hospital (four stars based on 104 ratings) and Watford General Hospital (three and half stars based on 102 ratings). None received greater than 110 ratings, with the exception of the Lister (235 ratings posted). The hospitals with the lowest level of ratings were Bedford (four and a half stars based on 79 ratings) and Addenbrooke's (four stars based on 83 ratings). Based on 87 ratings, the Luton and Dunstable hospital had three and a half stars.

Whilst it is difficult to draw any conclusions from the differences in levels of ratings made against different hospitals, it would seem that people in Hertfordshire appear more willing to use such services than perhaps those living in neighbouring areas. This seems to be particularly true of those being cared for at the Lister where the level of ratings left by patients and their relatives is running at between twice and five times the level of any other hospital locally. This may also reflect the switch in activity that has been taking place between the two hospitals since 2011/12.

Whatever the reason for this rating difference, it continues to provide the Trust with an important channel for direct patient feedback on the services provided through its hospitals.

Comments placed on social media channels/networks

The Trust now monitors a wide range of social media channels for commentary on its hospitals, related principally to Twitter and Facebook. Where relevant, the Trust will follow these comments up, either to pass on thanks to staff groups highlighted for praise or to seek further information where critical postings are made.

This approach has led to a steady rise in followers of the Trust's social media channels, thus increasing the means through which people can feed back about the hospital services they receive. In total, membership of these services stands at some 2,085 followers of the Trust's Twitter feed and nearly 2,800 people who receive the Trust's postings on its Facebook channels.

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 460 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 on wards to helping in specific outpatient areas and providing transport for patients, 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.

Education and training summary

The Trust continues to be committed to the development of all staff and recognises the importance of a workforce that is competent and fit for practice. During 2013/2014 the Trust has continued to focus on a wide range of training and education for both clinical and non-clinical staff, including:

- Development of a new non-medical statutory training programme, termed *Vital*
- An increased portfolio of clinical training for all staff including a focus on dementia and on-going development of simulation training
- An enhanced multi-professional approach to learning across clinical groups including allied health professionals and biomedical scientists
- A continued commitment to deliver a high quality learning environment for all pre-registration students
- Continued development of leadership programmes including a focus on change management in line with changes within the Trust's *Our changing hospitals* programme

Three Trust members have appointed *quality improvement fellows*. This is an initiative hosted by Health Education East of England and The Kings Fund to lead the development of service improvement projects that increase the quality of patient care

During 2013/14 the Trust continued to support national management graduate training schemes and regional senior leadership programmes. This included staff being awarded places on the NHS National Leadership Academy programmes, including Elizabeth Garret Anderson and Nye Bevan.

Research and development overview

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

During 2013/14, the Trust had some 250 active research studies recruiting around 2,000 participants; over 90% of these studies were funded externally. Patient recruitment into UK Clinical Research Network Portfolio studies has risen and been maintained over recent years. Up to the final quarter of 2013/4, 1,320 Trust patients had participated in these studies, with the number likely to rise as reporting is completed for the year. Over the last three calendar years, i.e. 2011 to 2013, researchers at the Trust contributed to around 500 publications in peer-reviewed journals.

Systems are in place within the Trust to ensure that the principles and requirements of the national research governance framework are applied consistently, through a full set of policies and standard operating procedures that have been ratified by the Trust. In connection with this, during 2013/14 the Trust hosted an MHRA Good Clinical Practice Inspection – which had a satisfactory outcome.

Before it can begin, each research proposal requires approval from both the National Research Ethics Service and from the Trust's multi-disciplinary R&D committees. These Trust committees include lay representation, with patient involvement in projects encouraged. The Trust's R&D board oversees research activity at all its hospital sites. A Trust-wide R&D strategy, including key performance indicators, has been implemented. This has encouraged new grant applications from Trust researchers addressing clinically important issues, and has also resulted in new clinical areas becoming research-active such as nursing, rheumatology and surgery.

Mount Vernon's academic partnership with the Royal Marsden and Institute of Cancer Research

At the Mount Vernon Cancer Centre, the academic partnership with the Royal Marsden NHS Foundation Trust and Institute of Cancer Research continues to be implemented. This involves the cancer centre's representation at the Biomedical Research Centre Committee, continuation of the academic alliance between each institution, and expansion of the translational research portfolio essential for delivering targeted cancer therapies.

The academic partnership research workforce training course, which is now entering its fourth year, continues to provide staff at all three partnership organisations targeted training for their research role. An internal education programme for oncology trial staff is also underway, providing additional training on the cancer centre's research standard operating procedures – which have now been fully aligned with those implemented at the Royal Marsden. Both research programmes provide research staff with access to training from research networks, industry, allied NHS Trusts and experts in their field.

The research and development office at Mount Vernon continues to be managed by three Royal Marsden staff members, supporting the partnership's aim to help the Trust further develop its oncology research programme. Following appointment of a lead statistician, Mount Vernon staff now have access to expert advice and support to further develop own account research.

To support the expansion of the cancer centre's translational research portfolio, a scientific research officer has also been appointed. The focus of this new role is to support tissue collection, storage and transfer of biological material to the Royal Marsden's centre of molecular pathology.

Lee Haynes Research Institute

When Sue Williams and Dave Haynes from Letchworth lost their son, Lee Haynes, to kidney disease in 2005 they vowed to keep his memory alive. They worked tirelessly to raise £55,000 to establish a new facility at the Lister hospital in Stevenage, the Lee Haynes Research Institute which will make it easier for medical staff to carry out vital clinical research. The new Lee Haynes Research Institute was opened officially on 28 February 2014. It includes offices, laboratory facilities and treatment rooms.

Medicines and Healthcare Products Regulatory Agency (MHRA) Inspection

An MHRA Good Clinical Practice Inspection took place at the Trust (in association with the West Hertfordshire Hospitals NHS Trust) between 24 and 27 September 2013, under its risk-based inspection programme. These inspections examine the systems used by organisations in the conduct of clinical trial research. They involve a brief tour of facilities, review of documentation and interviews with key personnel. A number of clinical trials are reviewed to examine how the organisation's trial procedures are applied.

From the Trust perspective, such an inspection involves a huge amount of preparation that impinges on the whole organisation. They can be stressful for those directly involved but represent a major opportunity for learning and development. The outcome of the Trust's inspection was satisfactory. There were no critical findings, but one major finding related to quality systems. The report has been responded to and an appropriate action plan put in place.

Academic Health Science Network

The Eastern Academic Health Science Network (EAHSN) came into operation in April 2013, with a remit to promote the adoption, diffusion and spread of innovation into and throughout the NHS. It is structured as a centre (the EAHSN) and four surrounding geographical *nodes*, involving partners from primary, secondary and tertiary care, academia, social care, public health, local government and industry.

Members of the Trust's executive team have major roles on the boards of both the EAHSN and the Hertfordshire and Bedfordshire *node*. Three initial areas of clinical priority have been identified: dementia and mental health; long term conditions (cardiac disease, cancer, diabetes, chronic respiratory diseases and stroke); and patient safety.

Seven clinical study groups (CSGs) have been set up covering each of these priority areas, with senior Trust clinicians having important roles in many of these CSGs. Several clinical projects have been funded by the EAHSN board, including a number in respiratory medicine, the CSG for which is led by Professor Thida Win.

Impacts of research – cancer

Clinical researchers at the Mount Vernon Cancer Centre continue to lead on national initiatives and research programmes. The portfolio of studies available to oncology patients has increased in volume and complexity compared with 2012/13, especially with regard to commercial studies, providing access to new agents and generating income to support the staffing infrastructure.

Increased research activity is reflected in the number of patients recruited to academic and commercial trials. Recruitment into academic studies at the end of the third quarter of 2013/4 approached 600, showing a 20% increase over that in the whole 2012/13. Around 50% of recruitment was into randomised studies. Growth in recruitment into commercial studies was at least as robust, with 80 patients having been recruited up to the end of the third quarter (75% of this recruitment being into randomised studies).

Funding awards in excess of £1.0 million to Professor Gordon Rustin has now resulted in a randomised trial confirming that the vascular targeting drug fosbretabulin (CA4P) has activity in ovarian cancer. Professor Rustin was the chief investigator (CI) of the original phase 1 trial of fosbretabulin that started in 1998 and of the first combination trials.

Dr Paul Nathan was CI of the first trial combining fosbretabulin with the VEGF inhibitor bevacizumab suggesting that they might be synergistic, through the VEGF inhibitor preventing cancer regrowth after fosbretabulin. Professor Rustin proposed a randomised trial of VEGF inhibitor alone versus VEGF inhibitor plus fosbretabulin. The GOG trial 1861 has just reported that the combination has met its primary objective of the combination improving progression free survival (HR 0.65).

Professor Rustin is joint CI of a trial comparing another VEGF inhibitor pazopanib alone, versus combining it with fosbretabulin in patients with relapsed ovarian cancer, which will start treating patients in June 2014. Thanks to the many patients recruited to clinical trials of fosbretabulin at Mount Vernon, it has now been shown that a vascular targeting agent has definite activity in ovarian cancer.

Dr Marcia Hall has been awarded support totalling some £0.6 million from CRUK and Boehringer Ingelheim for a trial of oral cyclophosphamide, with or without nintedanib, in advanced ovarian cancer starting in April 2014. This is a novel strategy of treating such patients with low dose chemotherapy, which is more tolerable and likely to be very effective in this setting.

Dr Nathan is CI of the COMBI-D and COMBI-AD cutaneous melanoma trials, the SUMIT ocular melanoma trial and the UKMCC-1 Merkel Cell Carcinoma trial. He has been awarded funding by CTAAC for the SELPAC ocular melanoma study and is chairing the UK guidelines group for management of ocular melanoma.

Mount Vernon's breast research team continue to provide a key leadership role in the treatment of breast cancer. Two global studies published in the New England Journal of Medicine (the CLEOPATRA and EMILIA studies), examined two new treatments for use in HER2 positive breast cancer. Dr David Miles was a key contributor and author on both articles and also a representative on the steering committee for EMILIA. The two studies have shown improvements in overall survival for women with this type of breast cancer using pertuzumab (CLEOPATRA study) and T-DM1 (EMILIA study).

Dr Andreas Makris is joint CI of the OPTIMA trial, which commenced in 2012. The pilot part of OPTIMA is funded by a £2 million grant from the HTA (Health Technology Assessment) and its main objective is to determine whether multi-parameter assays can be used in routine practice to spare some women with high-risk disease from undergoing chemotherapy.

Professor Peter Hoskin's work in radiotherapy continues to make significant impacts internationally. The FORT trial, presented at the American Society for Radiation Oncology and published recently in *Lancet Oncology*, explored the role of very low dose radiotherapy (4Gy) in follicular lymphoma. It demonstrated that this was inferior to standard dose (24Gy), thus establishing the latter as the international standard radiation dose for this condition. Based on this and the previous radiotherapy dose trial in lymphoma, Professor Hoskin has co-authored both national (British Society of Haematology) and international (ESMO) guidelines on the management of follicular lymphoma and is a current member of the NICE guideline development group in non Hodgkins lymphoma

The RAPID trial in which Professor Hoskin is a co-investigator is now submitted for publication and has already had a significant impact on the use of radiotherapy for early stage Hodgkin lymphoma. Professor Hoskin also co-authored the British Society of Haematology guidelines for Hodgkin lymphoma, which includes recommendations based on the RAPID results.

Updated analyses of Professor Hoskin's randomised trial of HDR brachytherapy continues to show an advantage for this approach in the radiotherapy for prostate cancer. As a result an increasing number of UK centres are adopting this approach, often with mentorship from the Mount Vernon team. Professor Hoskin has established a national database to standardise this treatment and it has been incorporated in the recent NICE guidelines. The HDR prostate monotherapy programme for which Professor Hoskin is the CI has led the field internationally in developing this new approach to prostate cancer treatment and is now incorporated in a national database to enable other UK centres to adopt this approach

Professor Hoskin is a co-investigator for the trials of Radium 223, a new agent for prostate cancer. The main results published in the *New England Journal of Medicine* have shown a significant survival advantage for this agent leading to its recent licensing and adoption by the Cancer Drugs Fund. Professor Hoskin was also local principal investigator for trials with abiraterone and enzalutamide, both of which are now established treatments for prostate cancer with positive NICE evaluations.

The Mount Vernon Cancer Centre has a longstanding international reputation for excellence and innovation in radiotherapy research. The Radiotherapy QA team at Mount Vernon leads the way in the UK for radiotherapy quality assurance in clinical trials. Radiotherapy trials are available across a wide range of disease sites, using many different treatment techniques and technologies. In the past year 30 patients have been enrolled into the PACE study in which treatment is delivered using the cyberknife facility. The success of the PACE study is partly due to dedicated research radiographer support, and in recognition of the value of the role, other similar radiographer roles are planned for the future.

Impacts of research – renal medicine

The Trust's renal service team continues both to contribute well to recruitment into national portfolio studies and generate portfolio studies. In the past year, the Trust has been the top recruiter in the Eastern region into renal studies on the portfolio.

Work on the technical aspects of dialysis has had a significant impact on clinical practice locally and beyond. This work includes studies of the adequacy of dialysis treatment, the importance of residual renal function, concepts of incremental haemodialysis and the clinical utilisation and long-term outcomes of haemodiafiltration. Studies in these areas have attracted funding from Kidney Research UK and the British Renal Society, with outcomes contributing to national and international guidelines for haemodialysis. Work is continuing in relation to the impact of metabolic rate, physical activity and comorbidity on the requirement for dialysis, and the mechanisms underlying micro-inflammation in dialysis patients.

The team also has a major interest in self-management in haemodialysis patients and work is continuing in the department supported by an NIHR RfBP grant. This work has influenced departmental strategy, which has embraced the shared dialysis care concept and its implementation. The work has also had a wider impact and has been presented in national conferences and workshops.

Previous work established the prevalence of a depression in dialysis patients, and its effects on outcomes. Research staff based in the Trust's renal unit currently are running a multi-centre pilot randomised controlled trial to determine the benefits of treatment of depression in this population. Further work is underway to unravel the constructs of depression in the South Asian population on dialysis. This work has been and is supported by grants from the British Renal Society, Kidney Research UK, and NIHR RfPB.

Adherence to the complex treatment schedules is a major problem in patients on dialysis. Work is on-going to understand and improve adherence to aspects of treatment including fluid management and phosphate control supported by grants from the British Renal Society.

The unit's work on conservative management of patients with advanced kidney disease and on end of life care in this setting, has had a significant influence in increasing the number of conservative management programmes throughout the UK and beyond. It has also contributed to a national policy documents including *End of life care in advanced kidney disease: a framework for implementation* and to Renal Association guidelines. This work has been supported by grants from the British Renal Society and NIHR RfPB.

Impacts of research – cardiology

The research profile of the Trust's cardiology team continues to increase. The unit continues to successfully support clinical trials, for example it was top UK recruiter in the X-VERT study, a large international clinical trial evaluating a novel oral anticoagulant, for which Professor Diana Gorog was UK chief investigator

During 2013/4 the first postgraduate cardiology MD was awarded by the University of Hertfordshire to one of its previous registrars for work carried out within the Trust.

Professor Gorog has led pilot studies of a novel blood test which can help identify patients at increased risk of heart attack. This may lead to treatments to reduce the risk of heart attack which is the major cause of death in the developed world. Heart attacks are caused by blocking of one of the arteries in the heart by a blood clot, but it is not understood fully why some people develop such blood clots and others do not. Nor is it understood why blood-thinning medications are effective in preventing recurrent heart attacks in many patients, but not in others, despite optimal treatment. Treating patients with strong blood-thinning agents runs the risk of major bleeding, so there is a real need to identify patients who are at greatest risk of arterial thrombosis (blood clot in an artery), to be able to target them specifically. The novel blood test (the global thrombosis test) can assess how quickly a patient's blood can form a clot and how easily it can dissolve such a clot.

Studies using this test have revealed that a significant proportion (23%) of patients who have been treated recently for acute coronary syndrome with a regime that included optimal use of blood thinners, remain prone to clot formation with clots resistant to dissolution. These patients were shown to be at high risk of a further cardiac event. In another study of patients with advanced kidney disease, a group at high cardiovascular risk, the group with abnormal results on this test, developed clots resistant to dissolution and were much more likely to suffer a heart attack or stroke in the next 12 months, than those with normal results.

The results of both these studies have been published in high-impact peer-reviewed journals. It is hoped that further research will help enable the team to identify treatments capable of correcting the abnormalities found on these blood tests and thus help reduce the occurrence of heart attack, stroke and cardiovascular death.

Impacts of research – nursing

The growth of research in nursing represents a major success. This is exemplified by a successful RfPB NIHR grant award with Cambridge University Foundation Trust for £301,145 for a study entitled *Characterising the experiences of men and women with learning disabilities following inpatient admission to general hospital*. Another RfPB submission relating to a study of noise at night on hospital wards is awaiting outcome.

Nurses have presented posters describing work carried out in the Trust at national conferences. They have also been at the forefront of increasing the profile of clinical research with patients and the general public, supporting and implementing *OK to ask* – a new campaign led by the National Institute for Health Research to encourage patients to ask their clinician about clinical research.

Clinical service developments during the year

During 2013/14, much of the Trust's attention continued to be placed on two major projects at the Lister – creating the hospital's new £19 million emergency department and the combined £39 million project that will see new ward and theatres/endoscopy blocks created at the hospital by October 2014.

Important clinical and service developments taking place during the year included:

- **April 2013** – the Trust's new satellite renal dialysis unit opened to its first patients, following a £1.5 million joint project with partners Diaverum. The unit has 10 dialysis stations, with sufficient capacity to add a further six as and when needed.
- **July 2013** – the new £3.0 million Lister Scanning Centre, which houses two state-of-the-art CT scanners – which complement one another in terms of their scanning capabilities – and an MRI scanner opened. A second MRI scanner has since been installed in an extension to the Scanning Centre that was created as part of the Lister's £150 million transformation in to the Trust's specialist centre for emergency and inpatient care by the end of 2014.
- **August 2013** – The first phase of the Lister's new £19 million emergency department, which will open fully by October 2014, completed – which included a state-of-the-art resuscitation unit.
- **August 2013** – the second of the Trust's two new satellite renal dialysis units, this time in Harlow, opened to patients. Again constructed in partnership with Diaverum and costing £1.5 million, the new unit has 12 dialysis stations.
- **September 2013** – the Trust took over the management of the former Surgicentre, following a decision made by the East and North Hertfordshire Clinical Commissioning Group to take the service back in to the NHS (up until that point, it had been run by Clinicenta Ltd., a wholly owned subsidiary of Carillion plc). The renamed Treatment Centre has since been integrated fully in to the Lister hospital and once again is working at full capacity.

- **October 2013** – a new £0.6 million ultrasound suite opened at the Lister, which was designed specifically to support GP referrals and outpatients.
- **February 2014** – following a successful bid made against a national Department of Health programme to improve maternity services, the Trust's Diamond Jubilee Maternity Unit at the Lister received £0.13 million for two new birthing pools in the midwife-led unit and work to the antenatal clinic.
- **April 2014** – after many months in the planning and following the successful recruitment of additional doctors, nurses and radiology technicians, the Trust's primary percutaneous coronary intervention (PPCI – the gold standard treatment for heart attacks) was expanded to become a 24/7 service.

Foundation trust membership report

Membership profile

The Trust has two membership constituencies – public and staff. Under the provisions of the Trust's Constitution, all members are eligible to vote for, or stand as, governors.

Public constituency

The Trust set itself a challenging target to secure and retain a public membership of 11,000 people by 31 March 2014. The composition of this membership is monitored against a range of criteria including age, gender and ethnicity to help us make it more representative of the local communities served by the Trust.

Public members are local residents who are aged 14 and over living in the following local authority defined areas:

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

The Trust has made significant progress in both recruiting and involving public members in 2013/14. By the end of the year, it had 10,835 public members in total – including 353 new young members aged between 14 and 16. Many of the new public members were recruited from communities the Trust had identified as a priority so that public membership better reflected the diversity of the communities served by the Trust's hospitals.

The Trust continues to offer prospective members flexibility in the ways they can get involved. Member satisfaction with involvement events, including the 2012/13 AGM attended by some 320 public members, staff and partners, consistently has been very strong throughout the year, averaging out at over 90%.

The Trust is offering more and varied opportunities for members to engage, sharing their views of services provided, what they think and becoming involved with the work of the Trust. A programme of workshops was delivered through the year that have sought member views on a variety of issues that are important to members ranging from end-of-life care, and sustainable developments to complaints and ward staffing levels.

The Trust has been particularly successful in recruiting and involving young people, developing an innovative approach that is fun and interactive and geared towards showing them what the NHS can do for them. The Trust's membership team has worked with these new recruits to help redesign the offer being made to young people to ensure the Trust stays relevant and continues to attract new young members. This work has been showcased as best practice at regional and national events across the country.

Additionally, the Trust has worked in partnership with the Healthwatch Hertfordshire to identify, brief and involve members in the patient-led assessments of the care environment (PLACE assessments), which have replaced the old patient environment action team (PEAT) inspections.

In the coming 2014/15 year, the engagement team aims to develop further the range and quality of the Trust's involvement programme for all members.

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. The total staff members as of 31 March 2014 stood at 5,548 staff members.

Governors – making a real difference in Trust decision-making

Governors will be a very important link between the Trust's hospitals and services, members and the local community, enabling the Trust to gather views from its members and at the same time feedback what is happening within the Trust. They will reflect members' interests and work with the Trust on their behalf to improve health services for the future.

Ahead of authorisation to become a NHS foundation trust, the Trust has secured nominations from many of the organisations selected to hold an appointed governor position on the Council of Governors. These individuals, who represent key partner organisations, have been participating in the work programme of the Trust's Involvement Committee in 2013/14 as a way to understand better the appointed governor role.

The Trust is also seeking to recruit 20 public governors, to be elected by the public membership, and is delighted that it has strong interest from members who are considering the role of governor. An additional six governors will be elected by Trust staff. Elections will take place for both public and staff members, to the new Council of Governors once the Trust's foundation trust application is moved forward to Monitor.

Contacting the Trust

Prospective and existing members can contact the Trust via the engagement team, by telephone or a dedicated e-mail address, to ensure that their enquiry is dealt with speedily and appropriately:

- Tel: 01438 284613;
- Email: ftmembership.enh-tr@nhs.net.

This contact information is published on the Trust's website (www.enherts-tr.nhs.uk) and in all relevant correspondence with members. Other regular contact opportunities are provided through member e-mail shots and at the Trust's annual general meeting.

Chapter 7: operational performance for 2013/14

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six.

In the previous chapter, the Trust's overall operational performance for 2013/14 was reviewed. Here the report seeks to provide further information on the Trust's operational management and performance.

Performance overview

The 2013/14 year represented one of significant success for the Trust's operational teams – which comprise doctors, nurses, other healthcare professionals, managers and support staff. As highlighted in the previous chapter, excellent progress was made against delivering the vast majority of patient access standards expected of the NHS, whilst also managing an effective efficiency savings programme.

Particularly pleasing was the Trust's continued success around achieving the standard for delayed transfers of care. Historically, this has been an area that have been extremely challenging for the Trust. For the fourth year running, and despite the seasonal winter pressures, the Trust delivered on this important standard.

Good progress also continued to be made in delivering against the national A&E and 18-weeks waiting times standards to ensure that patients receive their treatments in a timely and effective manner. The Trust's excellent performance in achieving cancer waiting times is worthy of particular note once again, with every standard met – which continues to represent a strong performance when compared with other cancer centres nationally.

The Trust's good operational performance during 2013/14 has been delivered during a period of reconfiguration and consolidation as the *Our changing hospitals* programme continues. The A&E team also partially relocated into part of the new emerging emergency department building in September 2013, although the project's final completion is not due until October 2014.

As outlined elsewhere in this report, however, much still needs to be done to achieve full reconfiguration of the Trust's inpatient and emergency services at the Lister by the end of 2014 – which sets the backdrop for the operational challenge facing the Trust over the next two years.

Whilst this work continues, opportunities are also being taken to focus on making improvements to existing services. Examples include the Trust's specialist stroke unit; although now based on a single site for the past two years and improvements having been made in its performance during 2013/14, more work needs to be done to ensure the Trust's performance meets national standards consistently

The year ahead will also represent a further year of significant challenge for Trust as its operational teams continue to improve performance further across all national standards in order to consolidate the organisation's position as one of the better performing NHS trusts in the health service. This is because such improved performance will need to be delivered at the same time as driving further efficiencies and delivering on major core elements of the Trust's strategic reconfiguration programme.

Part of this challenge will be to support the Trust's staff and public through these changes, but this is something in which the operational teams will continue to excel as they begin to deliver the significant improvements in patient care identified previously.

Management arrangements

The Trust's clinical services are organised into five divisions, each having a divisional chair – who is a senior clinician – and a divisional director – who is a full-time general manager. Between them, divisional chairs and directors provide leadership for their respective clinical services and teams; they also have regular interaction with the Trust's executive directors through membership of the Trust's divisional executive committee.

Service and financial performance issues are considered at the bi-weekly meetings of the Trust's executive committee. In addition, each division meets formally with the executive director team through a regular 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 Catherine Lemon, divisional chair Ella Ballatti, divisional director	Clinical haematology Mount Vernon Cancer Centre Oncology Palliative care
Medicine Dr Jon Baker, divisional chair* Aisling Bowman, divisional director <small>*Jon Baker is also the Trust's deputy medical director</small>	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 Dr Mike Chilvers, divisional chair John Fitzmaurice, 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 Rob Sattin/Dr Linda Struthers, divisional chairs Isobel Day, divisional director	Child health, include acute and community services Gynaecology Maternity/obstetrics Neonatal intensive care, including special care baby units
Clinical support services Dr Tim Walker, divisional chair Joanna Carter, 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 clinical commissioning groups (CCGs) locally and specialised commissioning groups (SCGs) regionally/nationally;
- 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 has developed longer-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. 2014/15). This information, along with comparisons against the previous year's performance, is set out below.

Activity	2013/14 actual	2014/15 planned
A&E attendances	119,622	118,282
Outpatients – first appointments	105,796	117,143
Outpatients – follow-up appointments	244,184	270,646
Elective inpatients (i.e. planned admissions)	10,030	10,560
Elective day cases	21,191	26,231
Average length of stay for elective patients (days)	2.4	2.4
Non-elective inpatients (i.e. emergency admissions)	40,138	40,723
Average length of stay for non-elective patients (days)	5.0	4.6
Births	5,185	5,400

Emergency preparedness – major incident plan

The Trust has a comprehensive major incident and mass casualties 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 and relevant legislation (Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2012).

The director of operations remains accountable to the Board through the *risk and quality committee* for emergency planning and preparedness and he discharges this duty through the head of emergency planning and resilience and the emergency planning committee. In addition, the use of the risk register and formal and informal tests, audits and training exercises are used to provide assurance on emergency preparedness. Annually the Trust participates in regional resilience exercises, working in partnership to ensure that as a health economy, the necessary resilience is in place to be able respond to an event.

Key hazards and risks to the Trust reflect national as well as local risks, and include an influenza pandemic, extreme weather and disruption to fuel supplies. The Trust is also subject to risks associated with high peaks in emergency activity, as well as its ability to manage those peaks safely.

The Trust has reviewed its major incident policy and hospital evacuation plan and developed a new training strategy to ensure that senior staff have access to and undertake major incident role specific training. The key priorities identified for the forthcoming year include to:

- Ensure that the hospital evacuation plan is ratified and then exercised;
- Implement the new training strategy for senior staff;
- Exercise the new major incident plan;
- Carry out a communications exercise;
- Foster working relationships with the new post-transition structures, in particular, NHS Hertfordshire and South Midlands
- Maintain and review the risk register in relation to emergency and business continuity planning;
- Embed business continuity plans;
- Continue to identify key risks and actions to mitigate, supported through addressing Hertfordshire's key objectives.

The Trust has assurance processes in place in monitoring its compliance with emergency preparedness legislation and guidance. The Trust continues to make progress in reviewing and updating policies, guidance and practices and in testing and exercising these arrangements both locally and nationally. The Trust continues to be well placed with other health organisations to manage major events.

For further information, please contact: Jude Archer, Company Secretary

Tel: 01438 314333

E-mail: jude.archer@nhs.net

Chapter 8: clinical performance for 2013/14

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

This chapter considers in more detail the Trust's performance during 2013/14. Unlike in previous reports, which focussed principally on reductions in hospital-acquired infections and improvements in the Trust's mortality rates, this year's report takes a wider look at performance around improving the quality of care and patients' experience of that care. The chapter also reflects on the Trust's performance around delivering commissioning for quality and innovation (CQUIN) and quality, innovation, productivity and prevention (QIPP) standards set for it by commissioners. A more detailed analysis of the Trust's clinical performance can be found in its 2013/14 Quality Account, will be available via the Trust's [website](#).

Reducing hospital-acquired infections

During the 12 months to the end of March 2014, the Trust recorded just two hospital-acquired blood infections (bacteraemias) caused by Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteria strains, along with 14 cases of infections due to the bacteria *Clostridium difficile*. The targets for these two important causes of hospital-acquired infections were none and 14 cases respectively.

Although the MRSA target was missed narrowly, the Trust remains amongst the best performing NHS organisations in the country and represent significant falls in hospital-acquired infections compared to just a few years ago. For example, the Trust's performance on preventing infections caused by *C. difficile* over the last 12 months places it as the fifth best in the country and when compared to large acute NHS trusts, the performance was the best in the English health service. This means that as a result of the Trust's proven infection prevention measures, its patients now have a very low chance of acquiring an infection that risks their recovery and discharge home.

Unlike previous years, the level of Norovirus infection outbreaks in 2013/14 was much lower than in previous years – something that was mirrored nationally. Where a Norovirus infection is suspected, the Trust's infection prevention team works with their clinical colleagues to contain the outbreak to individual wards or even bays within those wards. By minimising the numbers of staff, patients and their visitors accessing these areas, the virus' spread can be kept in check. Strict hygiene is enforced and as soon as the last symptomatic patient has gone 72 hours symptom-free, then the ward or ward area is deep cleaned thoroughly before reopening for new admissions. Symptomatic staff are sent home and told not to return to work until they too have been symptom-free for 72 hours.

Falling mortality rates

One of the single most important indicators when it comes to measuring the quality of NHS services is the mortality rate. Traditionally making comparisons between the performance of different hospitals has been difficult due to the health status of local populations, the complexity of services provided and the case mix of patients admitted for treatment.

Over the last decade or so, two mortality measures have been adopted across the NHS, namely the:

- Hospital standardised mortality ratio (HSMR) – data produced via the Dr Foster organisation;
- Summary hospital-level mortality indicator (SHMI) – data produced by the NHS Information Centre.

Both ratings are now used to help the public and clinicians compare and contrast the mortality rates, over time, of NHS trusts across the country. The average statistical score for two ratings is set at 100, with those organisations achieving scores of less than 100 considered to be better performing when compared to trusts of similar size and make up. Equally scores greater than 100 can suggest that a problem may exist that warrants further investigation.

Both HSMR and SHMI ratings should not be looked at in isolation – rather it is trends over time that give a better indication of likely performance.

HSMR

The most recent published data, for the rolling annual period from February 2013 to January 2014, is 88.96. Statistically speaking, this rating is better than the national position and represents a considerable improvement on the last three to four years, where the Trust's mortality was in line roughly with expected national levels.

SHMI

In use for around two years now, SHMI provides an overall rating that includes deaths following a patient discharges (up to 30 days), although unlike HSMR it does not make adjustment for palliative care. The Trust is one of a handful of hospital groups in the country that has an NHS hospice (Michael Sobell House at the Mount Vernon Cancer Centre), and is possibly the only hospital group to provide a seven-day-a-week palliative care service to local people. The combined effect of both these important factors is likely to cause SHMI scores to be higher than otherwise might be the case.

The Trust's most recently published SHMI score, which was for the 12 months to June 2013, was 111.76. This value is in the expected range for mortality on this measure. This is a large improvement on the same rolling period two years ago (for the 12 months ending in June 2011), when the Trust's score was measured at 120.27.

Reducing numbers of pressure ulcers

Harm caused to patients whilst in hospital can also be prevented by reducing the numbers of serious pressure ulcers (grade two to four). Not only are pressure ulcers painful and uncomfortable, they are more often than not entirely preventable through good nursing practice. Pressure ulcers can also be the reason why a patient's stay in hospital becomes extended.

By the end of February 2014, 43 hospital acquired pressure ulcers were recorded in the Trust's hospitals. This demonstrates a year-on-year improvement, as it is a further 62% reduction on the previous year's figure of 114. In addition to this on-going reduction in the number of hospital-acquired pressure ulcers, the Trust has not recorded an unavoidable grade four – the very worst pressure ulcer – since October 2011.

The Trust's tissue viability nursing team continues to support this improvement by innovative means, such as producing pressure ulcer free day reports for all inpatient areas for comparison and certificates signed by the director of nursing and chairman when clinical areas have achieved successfully pressure ulcer free day targets. This approach has proved to be a popular initiative with ward teams.

Preventing patient falls

When in hospital, patients can trip and fall. Often little or no injury results, but occasionally the consequences can be more serious – and in some cases even life-threatening. The Trust has worked to continually reduce the number of patient fall incidents and since March 2011 has reduced the number of patient falls by 52% (from 2058 March 2011 to 988 March 2014). The number of serious harm caused by falls for 2013/14 was 16 – three of which resulted in death. This is an area of patient safety that remains a continued focus for the Trust for the coming months and years.

Improving patient experience

The Trust's vision is to be amongst the best performing NHS Trusts in the country, with high quality care and excellent patient experience at its heart. The aim is to provide patients and their carers with the best possible experience whilst they are using the Trust's services. Some of the key initiatives that are in place to drive improvements in patient experience are outlined below.

Patient and carer experience strategy

The Trust's patient and carer experience strategy for 2012 to 2015 sets out seven key ambitions for improving patient experience:

- Ambition 1 – improve patient experience from start to finish of their journey
- Ambition 2 – improve patient experience of accessing hospital services
- Ambition 3 – improve communication with patients
- Ambition 4 – meet patients' physical comfort needs
- Ambition 5 – provide patients with emotional support needed whilst using Trust services
- Ambition 6 – respect needs of patients and recognise their individuality
- Ambition 7 – improve involvement of patients and carers

An evaluation of progress made during 2012/13 against delivering the strategy has been undertaken, which summarised the key actions towards achieving the seven ambitions. Key achievements noted were the Trust's: work with the charity *Kissing it Better*; support for the *Friends and Family Test*; collection of patient stories; and the development of divisional patient experience action plans.

Patient experience surveys

The annual inpatient experience survey is undertaken in all NHS acute hospitals and results published by the Care Quality Commission. The results of the annual inpatient survey undertaken in July 2012 were received in April 2013 and reflected the views of 342 patients. This is only a small percentage of the number of inpatients who receive treatment and care in the Trust each year.

The Trust monitors feedback from patients continually and uses this feedback to make changes and improvements to the services it provides. An electronic patient survey system is in place that enables patients to complete relevant surveys by the use of an iPad whilst they are in the hospital; these surveys can also be accessed via the Trust's web-site for completion by patients at home.

During 2013/14, 6,112 inpatients, 1,922 maternity patients, 4,156 outpatients and 434 A&E patients completed these surveys. Ward and department staff access the results of these surveys in real-time to enable prompt actions to be taken to address any problems areas. The highest performing areas of the electronic surveys are patients feeling they have been treated with respect and dignity and patients having a choice of food.

The Trust also surveys inpatients following their discharge home using questions that mirror the national inpatient survey. Staff have been telephoning patients when they have been discharged home following an emergency admission to hospital to discuss their hospital experience. They check that patients understand what to do if they have any concerns about their health, understand their medication and whether there are any outstanding issues, for example finding lost property or arranging for ward staff to contact the patient at home. A quarterly postal survey is undertaken for one month each quarter and an average of 2,200 patients are sent a paper survey to complete. The average response rate during 2013/14 was 32.5%.

The table below shows the Trust's performance against a range of patient experience indicators.

Patient experience indicator	2011/12 outturn		2012/13 outturn		2013/14 outturn
Food quality	52	▲	54	▼	52
Ward noise – other patients	56	▼	52	▲	54
Ward noise – staff	78	▶	78	▶	78
Patients' worries and fears	67	▼	64	▼	63
Pain control	88	▶	88	▶	88
Patient's awareness of danger signals	52	▲	53	▲	54
Understanding nurses	81	▼	80	▶	80
Understanding doctors	79	▼	77	▲	78
Awareness of medication side effects	46	▲	48	▼	46
Patients treated with dignity and respect	89	▲	90	▲	91

Each ward has a patient experience noticeboard, which is updated monthly with their latest patient experience survey results, along with *You said, we did* actions undertaken and its Friends and Family Test score (and number of responses).

Friends and Family Test

The Friends and Family Test question was implemented nationally across the NHS in April 2013 for inpatients and A&E, followed by maternity services from October 2013. Patients are asked the following question:

“How likely is it that you would recommend the ward/department/service to friends and family if they needed similar care or treatment?”

The question must be asked at or within 48 hours of the patients discharge from hospital. The inpatient wards have achieved an FFT score above the national average every month between April 2013 and February 2014 – the latest data available at this time of reporting.

Carers

The Trust is working to improve the experience of carers and hosted quarterly carers focus groups throughout 2013/14; a dedicated survey is also available to capture comments and suggestions from carers. A policy specifically to address the needs of carers has been developed by the Trust, which includes a carer's agreement that details the discussion with carers about how care will be provided to their relative or friend.

A carers page has been introduced on the Trust website, which has a wealth of information to support carers and details of benefits available to them.

Patient stories

Staff, including Board members and volunteers, have been trained in taking patient stories and these are undertaken and reported on a monthly basis. Staff and volunteers meet with patients from an area in which they do not usually work to listen to patients talk about their experience in hospital. The discussions are led by the patient and they are able to talk about any aspect of their experience.

The key themes from these patient stories are shared within the Trust and by the Board. Every Board meeting includes a patient story – this may be an audio recording or a patient and/or their relative attending in person to talk about their experiences.

Kissing it Better

The Trust continues its work with the charity *Kissing it Better*, with the aim of making a difference to patients. Through well-established links with North Herts and Oaklands colleges, student beauticians and hairdressers visit weekly as part of their timetable to provide hand and arm massages, manicures and hairstyling to patients. The initiative also hosts regular visits from Pets as Therapy (PAT) dogs and animal care students bring a selection of small animals to the children's ward. Singers, choirs and drama students have entertained patients.

During the first week of July 2013, year eight students from the Heath Mount School near Hertford refurbished the Strathmore garden area and repainted a mural along the walls. This was opened officially by a patient and the Trust's chairman at a garden party held on 5 July 2013.

Trust's 2013/14 CQUIN performance

A proportion of the Trust's income from its commissioners in 2013/14 was conditional on achieving specific quality improvement and innovation goals agreed through the commissioning for quality and innovation (CQUIN) payment framework.

The CQUIN framework is a way of improving quality by providing a financial incentive. The Trust receives either a full or part payment depending upon the results it achieves. The maximum potential value of the CQUIN payment to the Trust in 2013/14 amounted to approximately £6.3 million of which £5.7 million was received from the Trust's commissioners. The Trust main CQUINs for 2013/14 are set out in the table on the next page, together with their full monetary value and details of whether or not these quality improvements were met.

	CQUIN scheme	Percentage value with 100% scheme achievement	Actual scheme achievement	Percentage value awarded with actual achievement	Approximate value (£000s)
1	Friends and Family phased expansion	5%	100%	5%	320
2	NHS Safety Thermometer	5%	100%	5%	320
3	Diagnosis and care of dementia	5%	100%	5%	320
4	VTE risk assessment and root cause analysis	5%	100%	5%	320
5	Unscheduled care	25%	60%	15%	750
6	Customer focussed services	15%	100%	15%	750
7	Diabetes Care	15%	100%	15%	750
8	Hospital mortality	15%	100%	15%	750
9	Care of COPD patients	10%	100%	10%	500
	Other schemes with specialist commissioning				920
	Totals	100%	n/a	90%	5,700

Chapter 9: financial performance for 2013/14

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable
- Objective 5: Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services
- Objective 6: Improve staff engagement and organisational culture to be amongst the best nationally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

Review of 2013/14

During 2013/14, the Trust continued to maintain its strong financial position, delivering a surplus of £0.109 million (note 43.1). This is the seventh consecutive year of surplus dating back to 2006/07, although the original planned surplus of £2.1 million for the current year was reforecast mid-year to reflect the impact of the absorption of the Treatment Centre (formerly known as the Surgicentre).

In common with previous years, the Trust's clinical income ended the year substantially (£5.6 million) above plan. Emergency admissions were over 6% higher than in 2012/13 and related income correspondingly showed a £3.0 million increase versus plan. This is despite the fact that A&E attendance levels were actually slightly lower, but with higher acuity levels resulting in more admissions. Elective activity levels were mixed, with a high outpatient workload being offset partially by lower income from elective admissions. Activity levels (and income) at the Mount Vernon Cancer Centre were relatively stable, as were those for the Trust's maternity services.

The funding mechanism for emergency activity, where any over-achievement of the agreed plan is reimbursed at 30% of the national tariff, continues to be a significant pressure for the Trust, as do penalties for readmissions. In 2013/14 the total amount of funding withheld from the Trust under these two headings reached £9.5 million.

The Trust delivered cost improvements in 2013/14 of £16.394 million (90%) against a plan of £18.2 million.

During 2013/14, the Trust drew down long-term capital investment loans of £23.165 million and received £10.386 million of Public Dividend Capital from the Department of Health to support its strategic investments in the *Our changing hospitals* programme. There was some slippage in the year against largest phase four element of the programme, but this will catch up early in 2014/15 as the *Our changing hospitals* programme heads toward completion in October 2014.

Successful management of the Trust's capital programme and achievement of its revised planned surplus has ensured delivery of the Trust's breakeven duty, along with the other two statutory duties – i.e. not to exceed its external financial limit (EFL) and to achieve a 3.5% return on net relevant assets.

Capital spending

The Trust's total capital expenditure during 2013/14 was £39.025 million, with projects including:

- **Phase four of the *Our changing hospital* project – £30.7 million.** Phase four will complete the Trust's programme to bring all inpatient and emergency services on to a redeveloped Lister hospital site. The most significant items in 2013/14 related to works on: the new emergency department (£7.9 million – work on-going); additional theatre capacity (£9.4 million – work on-going); new ward block (£10.4 million – work on-going); minor schemes (£0.8 million) and improved chemotherapy facilities (£2.2 million – project on-going, in collaboration with Macmillan).

The Trust invested a further £0.8 million during 2013/14 on new information technology, £1.2 million on medical equipment and £5.9 million on estates maintenance. The Trust also received and spent additional funding as a consequence of three successful bids to the Department of Health: £186,000 to improve birthing environments; £128,000 to improve the maternity unit; and £140,000 for the Trust's renal service from the national nursing technology fund.

Financial implications of the Trust's *Our changing hospitals* programme

The Trust began planning and implementing its *Our changing hospitals* programme in 2009/10, which represents continued major capital investment until into 2015/16. The programme's outcome will result in a consolidation of acute inpatient and emergency services from the QEII on to the Lister site in October 2014.

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 loans (£63.588 million), Public Dividend Capital (£10.386 million) and operational capital funding. Other projects in the programme, including the creation of the Lister's Treatment Centre (formerly independent of the Trust, but acquired mid-year) and multi-storey car park, were funded by private sector partner organisations.

The Trust is expecting to draw down loans of £63.6 million from the Department of Health, the final instalment of which is due in June 2014; its repayment will be met through the greater efficiencies achieved from working off a single site. The financial risk to the Trust is represented by the £63.6 million Department of Health loan and the achievement of savings that allow for the servicing of that debt.

The Trust's development programme was based upon an indicative timetable that assumed business case approvals were achieved as per the programme milestones. Where these milestones have not been met, the Trust has revised its financial plans and managed the financial position through a combination of increased efficiency savings and the deferral of capital loans.

Looking to the future

Overall, 2013/14 was another important year in terms of consolidating the Trust's continued sound financial performance. It supported the progress being made towards achieving NHS foundation trust status and is key to 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 vital 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 detailed performance against this target for non-NHS creditors is set out in note 11 in the annual accounts shown below. Its overall performance in relation to the code was in line with the previous year with 78.6% of non-NHS trade invoices paid within target in 2013/14.

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

Chapter 10: workforce review

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

Workforce statistics

In the table below, a summary of workforce-related statistics is provided for 2012/13, alongside figures provided for the previous two years. The figures are the average for the years ending 31 March.

Activity	31 March 2014	31 March 2013	31 March 2012	31 March 2011
Staff employed (full time equivalents)	4,797.40	4,703.04	4,730.31	4,739.01
Vacancy rate	5.64%	8%	8%	8%
Turnover rate	10.63%	10.3%	10%	10%

During 2013/14, the Trust reduced its vacancy rate by year-end to 5.64% against a target of no more than 6%. There is still focused work continuing to improve the vacancy rate in clinical areas to bring them in line with the Trust's overall target. Recruitment campaigns are underway to recruit to qualified nursing staff. For 2014/15, the vacancy target for the Trust will be 5% across all staff groups.

Turnover rate for the Trust remained at around 10.63% at the end of 2013/14, which currently is in line with the existing workforce modelling undertaken to support the Trust's *Our changing hospitals* programme – although this will be reviewed as the Trust prepares to deliver the programme's final phases by the end of 2014.

Reducing sickness absence remains a key indicator for the Trust and performance during 2013/14 has been good. The average for the year was 3.39%, which compares favourably with the 4% average achieved by large acute NHS trusts across the country and the 3.9% rate recorded for Hertfordshire's health economy. The aim for 2013/14, is to maintain sickness absence below 3.5%, particularly for those areas within the Trust that are above this threshold currently; if achieved, this would place the Trust in the top 20% performing NHS organisations in the English health service.

Recruiting and retaining staff

The Trust's staff are its most important and valuable resource. The Trust cannot strive to deliver high quality, ever-improving services if it does not recruit and retain an excellent workforce. That is why the Trust works hard to ensure that its staff are trained, well-motivated and supported. The Trust continues to develop recruitment and retention strategies that underpin its core business of putting patients first and promoting the Trust as an employer of choice. The Trust enjoys 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. The Trust also works in partnership with the local community to develop pathways into employment for disadvantaged groups. Additional work was undertaken to review a number of workforce schemes associated with recruitment including streamlining the total recruitment process in order to reduce the gap between a member of staff leaving and their replacement starting in post. This work involved the procurement of a new recruitment system and the implementation of an electronic DBS system (previously CRB), all of which has contributed to reducing the length of time to recruit. The Trust is quite keen to continue this work of reducing the length of time that it takes to fill vacancies so that wards, departments and other areas can be staffed appropriately in order to deliver excellent patient care.

The Trust embarked on a challenging project to recruit approximately 160 new nursing staff (110 qualified and 50 unqualified) in 2013/14. A recruitment campaign was initiated that included jobs being advertised locally, holding numerous cohort recruitment days plus attendance at a dedicated job fair event in Ireland. As a direct result of these efforts, the Trust exceeded its target as in excess of 160 staff were offered posts, allowing the Trust to meet its 6% vacancy rate standard. The priority areas for recruitment were the Trust's emergency department, renal and inpatient ward services.

Additionally, significant work has been undertaken with NHS Professionals, the Trust's temporary staffing provider, to increase both the size of the staff bank and fill rates. There was a large scale project to auto enrol all eligible Trust staff to the bank in order to make it easier for staff to undertake additional shifts. NHS Professionals also undertook a recruitment drive to recruit nurses from the European Union to work at the Trust on a fixed term basis. The Trust continues to work with NHS Professionals on reducing the use of staff supplied by commercial agencies.

A highly skilled workforce

Developing a highly skilled workforce is key to excellent patient care. As well as delivering a comprehensive range of clinical and medical skills training the Trust provides a variety of staff development opportunities currently, including high quality programmes endorsed by the Institute of leadership and management (ILM). Leadership and management development programmes typically include: 360 feedback; coaching; skills development workshops; patient stories; observations of care; and service improvement projects. The Trust's programmes are open to, and accessed by, all staff groups.

The Trust also provides a range of leadership and management core skills development modules to meet specific individual needs of our managers and leaders. These include:

- Appraisal skills development
- Recruitment and selection skills development
- Core management skills for new managers

Additional management and leadership development initiatives available to staff include:

- Sisters fora and nurses days that run periodically throughout the year
- Preceptorship programmes, incorporating leadership development
- NHS graduate trainee scheme

During 2013/14, the following development opportunities were provided to the Trust's staff:

- Almost 800 managers trained in new appraisal process
- 46 completed an internal leadership and management development programme
- 80 attended bespoke leadership and management courses developed in partnership with the University of Hertfordshire including change leaders and handling challenging conversations
- Over 200 attended in house management skills courses
- 17 managers are accessing national leadership development programmes
- 81 newly qualified nurses trained in basic leadership skills awareness
- 23 ward leaders trained to conduct *patient stories* to gain valuable feedback from patients on their experience of being treated here

In 2013, a new line managers induction programme was launched incorporating an e-learning package, workshop and checklist/development planning process. A number of staff also undertook training to become an accredited coach and a coaching network has been established this year working with our partner organisations across Bedfordshire and Hertfordshire to offer a coaching service to our managers. Last year 14 staff accessed one-to-one coaching.

Appraisals and professional revalidation

Staff appraisals

The Trust's ambition, as stated regularly throughout this annual report, is to become amongst the best performing NHS organisations in the English health service. The Trust's results from the national 2013 NHS staff survey indicate that quality of appraisals continues to be a strength compared with other acute trusts.

Despite being amongst the better performing NHS organisations for the quality of appraisals, the Trust's end of year rate of around 70% was below its own target of 90% set for appraisal completion during 2013/14.

The Trust recognises the importance of regular appraisal for all staff and continues to closely monitor and take steps to achieve improved completion rates. As a result, in 2013/14 a new process for appraisals was designed and launched to further improve the quality of our appraisals and the consistency of ensuring they are completed.

The development and implementation of this new appraisal framework, process and policy was a key workforce initiative for 2013/14. The key changes are:

- New appraisal policy and revised documentation
- Improved ways of assessing achievement of work objectives and demonstration of the Trust's values and pay progression for staff will only be awarded for achievement of expected standards of performance
- Staff are expected to be compliant fully with all identified statutory training, in order to be awarded a pay progression (unless there is a valid reason for non-attendance)
- Appraisal dates are now aligned with the staff member's pay progression date
- Staff will have a mid-year review to monitor progress

Almost 800 managers were trained in 2013/14 to understand how to implement the new processes effectively with their staff.

Professional revalidation

Following national discussions that lasted for over a decade, the principle of revalidation for doctors was introduced across the English health service on 1 December 2012. This was preceded, in January 2011, by the appointment in each approved health organisation of the role of *responsible officer* (RO). The RO has overall accountability for the fitness to practise of all employed medical staff and, additionally, to ensure that there are appropriate systems in place both to test this and to deal with any staff subject to performance scrutiny.

The Trust continues to support the appraisal and revalidation process of its career-grade staff in line with the GMC's Revalidation procedure and to ensure they are fit to practice. The Trust's medical director is the responsible officer (RO) with overall responsibility for this function.

The administrative duties for the revalidation process in the Trust is co-ordinated by a revalidation officer and necessary information is provided by the medical staffing team on on-going *Maintaining High Professional Standards* investigations, disciplinary action or information that impacts on the revalidation process.

The Trust has a significant rate of compliance with the appraisal and revalidation process and a *failure to engage* policy for non-compliance that recommends disciplinary action.

Medical education and training

The directorate of medical and dental education provides an outstanding learning environment in the Trust. The education programme is governed by a robust governance structure, with a multi-professional education board co-ordinating educational activities across the Trust. The education, foundation board undergraduate and trainee in difficulty committees feed into the education board and have strong trainee participation.

Multi-professional education board members

Chairman and director of medical education
Clinical tutors (Lister, QEII and Mount Vernon)
Foundation training programme directors
Assistant director of nursing, education and research
Dental tutor
Undergraduate tutor
Education manager
Library manager

There are proposed changes to medical education nationally, with possible impact on training and workforce in the Trust. The education directorate is working with specialities and developing innovative ways of ensuring quality in medical education. Development of the multi-professional skills laboratory is a priority and approval of the second clinical skills trainer will strengthen this service. Transfer of library services to the Lister from the QEII, along with closer working with the educational department, will strengthen delivery of multi-professional education in the Trust. Workshops in collaboration with the University of Hertfordshire to train the trainers are on-going and are invaluable in accrediting the Trust's consultant workforce.

The quality assurance visits by Health Education East of England and the speciality schools have praised the strong educational structure and trainee involvement in delivery of training. The 2013 GMC trainee survey highlighted significant improvement in many areas in the Trust. The quality assurance visits, GMC survey and the Trust trainee survey results confirm that trainees are valued and there is commitment to education and active involvement at every level of the organisation.

The education directorate has strong links with several universities for medical education. There are strengthening ties with the Cambridge Medical School and historic links with the University College London for undergraduate education. The directorate also works closely with the University of Hertfordshire to improve educational standards.

The medical education directorate provides a dynamic educational environment with extensive educational opportunities for all medical staff. With all of the Trust's inpatient and emergency services being brought together on to the redeveloped Lister site by October 2014, the directorate will be better placed to support excellence in education.

Non-medical education and training (includes nursing, midwifery, allied health professions and biomedical scientists)

The Trust's non-medical education and training team has worked to deliver continuing profession development for a group of some 5,000 staff during 2013/14. This was achieved by using a wide range of innovative learning methods and opportunities that put the 6Cs (care, compassion, commitment, communication, courage and competency), along with the Trust's values, at the heart of education.

Examples of work undertaken by the team during the year include:

- Development of *listening forums* for nurses, midwives and clinical support workers, giving these staff an opportunity to listen to patient stories, Trust ambitions and news – and also have their own voices heard in return
- Supporting newly registered nurses progress from student to registered nurse with a preceptorship programme
- Working with local higher education institutes to ensure opportunities for educational programmes are aligned with Trust priorities and to develop staff and services using an approach that embraces imaginative ways of using existing funds
- Using a new approach to ward development that involves educators working clinically alongside staff to deliver training and practice development
- An increased focus on support and development of pre-registration training reflecting our commitment to prepare the workforce of the future

The support of Health and Social Care Level II and III apprentices continues at the Trust. This programme provides knowledge, skills and development for clinical support workers and provides nationally recognised qualifications for this staff group.

Examples of the non-medical education and training team's key achievements for 2013/14 were:

- As part of Health Education East of England's Performance and Quality Assurance Framework, non-medical education was reviewed against key performance indicators that support excellence and equip staff with the values, knowledge and skills to deliver high quality care. The Trust was rated *green* against all indicators, demonstrating the achievement of robust systems and practise to deliver a high quality environment.
- In March 2014 three team members presented posters, illustrating innovative methods of delivering education for quality care at the Royal College of Nursing Education Conference in Harrogate.

- Student nurse engagement with national initiatives including two final year student nurses becoming *care makers* and student nurses from the Trust being involved in Care Quality Commission inspections at other NHS trusts.

Equality and diversity

The Trust has an equality, diversity and human rights strategy covering 2011 to 2014, which sets out the short and long term objectives for meeting the requirements of the Equality Act 2010 (General and Specific Duties). This document can be found on the Trust's website.

The Trust's equality and diversity annual report, which was produced in June 2013 and presented to the Trust's risk and quality committee, contains the most recent data and summary of the Trust's workforce profile in terms of equality and diversity; it can also be located on the Trust's website.

Key ethnicity data for this year shows the profile of the workforce as 70% white. This means that the Trust's ethnic representation is higher than that of the local communities served (as reflected in the 2011 Census, which recorded 80% white for these communities overall).

The Trust also adopted the equality delivery system (EDS) to help it meet Equality Act 2010 requirements and has been working on implementing this system throughout the organisation. Evidence on equality performance was gathered and presented for assessment to the Trust's first RAGP (red, amber, green, purple) panel in March 2012. This has provided the Trust with firm equality objectives, which were published in April 2012 on the Trust's website. Progress on delivering the scheme is monitored by the Trust Board, with action plans reviewed annually. The launch of the EDS2 in November 2013 has seen this work continue and engagement events to review our objectives and progress are being set up currently.

Progress has been made by leads against their equality delivery system actions. Examples of these include a:

- Review of local community demographics and protected characteristics identified through the newly developed engagement strategy
- Learning disability strategy and improvement plan is in place for the Trust and progress is being measured
- Increase in satisfaction levels across the protected groups, based on patient experience tracker results.

An annual review of progress on the equality delivery system has been drafted and an event to involve stakeholders is expected to take place in May 2014. This will be a collaborative approach from NHS organisations from across Hertfordshire and will showcase the regions progress since the equality delivery system's initial implementation.

Equality impact assessments

The Trust's equality and diversity lead receives copies of all the completed equality impact assessments. A summary list of those completed can be accessed through the Trust's staff intranet service (the *Knowledge Centre*) and the full copies of the assessments can be obtained directly from the equality and diversity lead. In addition:

- Trust policies are ratified at various groups, for example through Trust Partnership
- The Trust has a guide to assist managers in completing the equality impact assessment process that is available on the Trust's *Knowledge Centre* (The Trust's staff intranet service)

- The requirement to complete an equality impact assessment is reiterated by the Trust's divisional human resource managers with their respective divisional teams. Reminders are also sent periodically via several routes, including the weekly electronic *Trust Bulletin* and e-mails
- Clinical governance ensures all clinical policies have an equality impact assessment attached.

Raising issues of concerns 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 and when they arise. Whenever possible, the Trust will give feedback to the individual who raised the matter.

It had been identified that the existing policy needed updating. The policy was rewritten completely earlier in 2013, taking in to account concerns highlighted in the Francis Report. The policy was rewritten in early 2013, taking in to account concerns highlighted in the Francis Report; it was approved in May 2013 by the Trust's *audit committee*, but due to its significance was also submitted for approval by the Trust Board at its June 2013 meeting.

There has followed an extensive Trust-wide communication programme with posters, leaflets and training being delivered to raise the awareness amongst all staff. The training was delivered to a range of management and staff side representatives by Bevan Brittan's solicitors as they supported the Trust with the policy development to incorporate all of the Francis report recommendations promoting a culture of learning, sharing openness and transparency. Management guidelines to assist managers who are asked to respond to a concern raised under the raising issues of concern policy are available on the Trust's staff intranet service.

Chapter 11: staff, public, patient and GP engagement

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

Engaging with the Trust's staff

Informing and consulting staff

The Trust aims to ensure that staff at all levels of the organisation 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** – a monthly cascade briefing process, which reports discussions that take place on strategic issues taken in public session at Trust Board meetings;
- **Focus groups/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 sessions that anyone can attend, or to individual departmental and/or team meetings. This process was used during 2013/14 to engage staff in the consultation process being developed to support the workforce changes that will take place when all of the Trust's inpatient and emergency services are brought together at the Lister and the new service mainly outpatient and diagnostic model begins at the QEII from October 2014.
- **Workshops** – dedicated time where invited staff can debate specific issues relating to aspects of major strategic projects being worked on by the Trust. The ARC programme is a good example of this approach and forms part of the Trust's organisational development strategy. Each quarter, executives – including the chief executive – meet with around 500 of the Trust's clinical and non-clinical leadership in open discussion on various topics of importance to the Trust and its staff – see chapter five of this annual report.

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 staff intranet service has grown to become one of the single biggest sources of general information within the Trust. This format means that pages can be updated quickly to reflect new priority areas for the Trust. The chief executive also has an *AskNickCarver* service whereby all staff are able to pose questions to him directly around issues they would like to raise; the service is used consistently by the Trust’s staff.
- **Trust Bulletin** – a weekly newssheet issued through the Trust’s all staff e-mail service, carrying a wide range of operational information.
- **Our changing hospitals e-newsletter** – issued electronically on a periodic basis to all Trust staff, providing general updates on the Trust’s *Our changing hospitals* programme, along with links through to dedicated information pages on the Knowledge Centre.
- **Grapevine** – now published for the Trust’s staff, volunteers and public members, the Trust’s quarterly newsletter has been an unqualified success since its launch in 2003. Grapevine provides staff with a unique platform through which their contributions can be recognised by their colleagues.
- **Patient Safety Matters** – bi-monthly newsletter produced in-house at the Trust and issued electronically to all staff, with the aim of highlighting and promoting patient safety issues.

Trust Partnership

Running alongside all of these staff communication and involvement activities, the Trust also has a history of a positive partnership working relationship between staff and management side representatives through what is known locally as *Trust Partnership*. Meeting every month, the chair *Trust Partnership* alternates between the chair of staff side and the Trust’s director of workforce and organisation development.

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. Through *Trust Partnership*, staff side representatives are invited to sit on a wide range of committees and project groups – ranging from the likes of the equality and diversity committee through to various *Our changing hospitals* project groups.

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. The workforce and organisational development directorate funds two full time posts to enable strategic partnership working within the Trust.

Public and patient engagement

Health scrutiny committee

The Trust values the county’s health scrutiny committee and has continued to support and inform the committee’s work programme during 2013/14, including providing reports on our response to Francis, finance, patient experience, performance and mortality. The Trust always ensures that Board-level directors present the Trust’s contributions to the committee’s debates.

Healthwatch Hertfordshire

On 1 April 2013 Healthwatch Hertfordshire came into being as the successor organisation to the Hertfordshire Local Involvement Network (LINK). Regular meetings have taken place involving the Trust’s chairman and chief executive meeting with their opposite numbers in Healthwatch Hertfordshire.

The developing relationship between the Trust and Healthwatch Hertfordshire has been both positive and robust. The Trust has collaborated to develop and deliver the first patient leadership programme for Hertfordshire and Healthwatch Hertfordshire's chief executive sits on the Trust's involvement committee.

The Trust has also worked in partnership with Healthwatch Hertfordshire during 2013/14 in continuing to support local community groups, such as the Stevenage Health Involvement Partnership.

Involvement committee

The purpose of the Trust's involvement committee has been to provide a forum that enables stakeholders – and through them, the wider community – to be informed of, as well as involved in, the planning, monitoring and shaping of the Trust's services and to support continuous improvement in line with the organisation's strategic aims. It also allows members to share local priorities and identify areas that the group can work on collaboratively.

The committee's membership consists of managers from across the Trust, including clinical, nursing, strategic, engagement, governance and voluntary services, as well as representatives from Healthwatch Hertfordshire patient and member representation, as well as the Trust's shadow appointed governors. The make-up of the committee, therefore, helps to ensure a good spread of local community and service provider views are linked into the governance of the Trust.

The committee meets quarterly and the main duties are summarised under three themes:

- Membership – recruitment and engagement
- Public/patient experience
- Performance and service development

Local strategic partnerships

Local strategic partnerships (LSPs) in Hertfordshire still lead on much partnership working across the county designed to help improve the lives of people living in Hertfordshire. Local authorities and partners across the county are choosing to continue to work in partnership to deliver improved outcomes for local people. The Trust is contributing to this work enthusiastically, focussing on areas that the Trust and its members can support – such as the health and well-being agenda.

Hertfordshire public health board

The Trust sits on the new public health board for Hertfordshire, contributing to the development of health and wellbeing and public health interventions. The Board seeks to join up services and interventions across local government and health services to provide more effective support to local people seeking to lead healthy lifestyles.

Local authority relationships

The Trust maintains strong working relationships with all district and borough councils within east and north Hertfordshire, as well as central Bedfordshire and West Hertfordshire Districts including St. Albans. Representatives from the Trust often attend community-based meetings organised by these authorities. The Trust is committed to partnership working, which is underlined further through its active membership of local community groups and networks, as well as liaison with a growing number of external stakeholders.

Patient experience feedback

The Trust actively encourages patients and carers to tell us about their experience of our services. Patient experience data, including survey responses and Friends and Family Test scores, are monitored closely and a monthly patient experience dashboard compiled.

The Trust's patient and carer experience strategy for 2012 to 2015 sets out the seven key ambitions for improving patient and carer experience within the Trust. The patient experience committee, which has five patient representatives, monitors performance across the Trust and links into the Trust's board-level risk and quality committee and the Trust Board itself.

Feedback from patients and carers is encouraged through the use of patient experience surveys, the national Friends and Family Test, post-discharge telephone calls, discussions with staff and volunteers in the Trust's Patient Advice and Liaison Service (PALS) team, as well as written compliments or concerns. The Trust also welcomes comments through social media channels and websites such as NHS Choices and Patient Opinion. All this feedback is shared with the appropriate teams and used to make changes and improvements to services. Further information about this work is set out in chapter eight of this document.

Clinical commissioning group, GP and Local Medical Committee engagement

Clinical commissioning groups and GPs

Much work has been undertaken in the last twelve months to strengthen the relationship between the Trust, the newly-formed clinical commissioning groups (CCGs) and GPs. This work is in recognition of the need to provide a seamless service for patients between primary and secondary care and to make our services more visible. As well as regular attendance at CCG-led quality and assurance meetings, the Trust has contributed to a number of locality and CCG meetings, including Board meetings in public and training days for GPs.

Regular contact has also been established between the Trust's primary care customer relations manager and the local GP community, with visits to practices and localities to meet with GPs and practice staff taking place. Through this work, the Trust is able to enhance understanding of practices' experiences and perception of Trust services, as well as those offered by other providers within the area. This work has been supported by clinician-led visits to the Trust's emergency department, Treatment Centre and renal satellite sites, as well as departmental education events.

The *GP Update* newsletter was launched in March 2013 to provide necessary information to help GPs access the Trust's services more easily. The newsletter has received positive feedback, with GPs welcoming the additional communication from the Trust. A GP helpline service is also provided for resolution of mainly operational issues. Issues raised through this service are analysed and fed back to the Trust's clinical divisions for improvement planning in order to help prevent similar incidents from occurring.

The Trust's annual GP survey was conducted in November 2013, with double the number of respondents as in 2012. The survey gave GPs and practice managers an opportunity to voice their opinions on the Trust, its services and communication with the primary care community. Again, all this feedback is shared with the Trust's clinical divisions to help improve the quality of the services provided and, hence, patient experience.

Local Medical Council

The Trust has continued to develop its relationship with the Bedfordshire and Hertfordshire Local Medical Committee (LMC), with regular liaison meetings with the Trust's chief executive, and a presentation by the medical director at an area meeting. The Trust and LMC are also exploring ways that they can work together to ease communication difficulties between hospital clinicians and GPs.

Chapter 12: sustainability

This chapter's contents relate to part or all of the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

Environmental impact – context

In 2012 the carbon footprint of the health and care system was 32 million tonnes of CO₂ emissions, which represents 40% of the public sector in England. These 32 million tonnes were driven largely by emissions from:

- Procurement activities, including the commissioning of services and goods such as medical instruments and pharmaceuticals. These accounted for 72% of carbon emissions:
- Building energy, such as heating, cooling and lighting buildings and powering equipment. These accounted for 15% of carbon emissions; and
- Travel, including transport miles and patient, staff and visitor travel. These accounted for 13% of carbon emissions.¹

The Trust, along with the NHS, Public Health and Social Care is subject to a number of national and international carbon reduction schemes and targets including

- The Kyoto Protocol 2005
- The Climate Change Act 2008
- The NHS carbon reduction strategy 2009
- The European energy performance of buildings directive
- The carbon reduction commitment energy efficiency scheme
- The EU emissions trading scheme

The NHS carbon reduction strategy 2009 will be replaced in 2015 by the *Sustainable, resilient healthy people and places, a sustainable development strategy for NHS, public health and social care system*. This strategy sets out the following three goals based on the challenges presented by climate and environmental changes:

- **Goal 1: A healthier environment** – valuing and enhancing natural resources whilst reducing harmful pollution and carbon emissions. Contributing to the Climate Change Act, requires the NHS to reduce carbon emissions by 34% in 2020.

¹ Sustainable, Resilient, Healthy People and Places, Module Carbon Hotspots. The Sustainable Development Unit 2014.

- **Goal 2: Communities and services are ready and resilient for changing times and climates** – the focus is on multiagency and community planning to prepare for periods of extreme events such as floods, heatwaves, etc.
- **Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments** – every contact and decision counts towards helping people to be well can help build the medium and long term benefits of helping people to be well and reducing their care needs. Supporting communities and people to be independent and self-manage conditions and events.

The Trust's own *sustainable development strategy* sets out its response to the current demands for carbon reduction and covers the five year period from 2009 to 2014. In readiness for the implementation of the new NHS, public health and social care strategy in 2015, the Trust aims to review and update its own strategy in 2014/15 incorporating the themes and requirements of the new national strategy.

The Trust's current position

In 2009, the NHS carbon reduction strategy for England was published in response to the UK Climate Change Act. It established that the NHS should work towards a target of reducing its 2007 baseline carbon footprint by 10% by 2015 and that healthcare regulators should ensure that sustainability and the environmental impact of services are an integral part of quality standards.

The Trust commissioned independent energy consultants to establish the organisation's carbon footprint baseline (2007) and in accordance with NHS requirements. This position is reassessed every year to identify reductions in carbon associated with initiatives and changes in the Trust activities and the results, recorded in tonnes of CO₂ emissions (tCO₂e), are shown in the table below – note that figures for 2013/14 will not be available for some months yet due to the way these figures are calculated.

Scope	2007 baseline	2011/12	2012/13	2015 target
Procurement, estates, catering, wages, etc.	58,231	45,776	45,105	52,407
Utilities	16,382	16,222	15,344	14,743
Travel	8,309	8,189	8,226	7,479
Total footprint	82,922	70,187	68,675	74,629

The Trust has sustained its carbon reduction achievements in to 2012/13 and continues to exceed the target set to be achieved by 2015. This has largely been achieved following the successful installation of the Trust's new combined heat and power plant (CHP) in October 2012. Overall since 2007, carbon emissions at the Trust have reduced by 17.2%.

There is a lag period between the end of the financial year and final reporting of the utility figures for the carbon reduction commitment scheme, but early indications demonstrate that the CO₂ emissions associated with utilities for 2013/14 will be 15,205 tonnes – demonstrating the continued achievement of reductions in the Trust's CO₂ emissions. However, the transfer of the Treatment Centre building to the Trust and the new buildings being created at the Lister as a result of the Trust's *Our changing hospitals* programme have increased emissions and tax liability as the baseline reflects the Trust's 2007 footprint and, therefore, any new buildings and services impact directly on emissions and liabilities.

The Trust remains confident that it can continue to deliver further reductions and thus continue to exceed the NHS 2015 target.

On-going initiatives

Work had continued this year on the implementation of the Trust's green travel plan, focusing on the introduction of the Cycle2work, BikeBUDI and WalkBUDI schemes, as well as developing a process to enable staff to pay for bus season tickets via salary sacrifice. Dedicated car spaces for staff who car share have been created this year for those holding relevant permits and the number of these spaces will increase over the coming year as part of a series of measures to encourage staff not to use their car for travelling to work. A leaflet has also been developed with the County Council Passenger Unit promoting bus travel to Trust sites. These are being distributed to GP practices, health centres as well as hospital wards and departments.

Working with the Trust's procurement partner Hertfordshire Supply Management Confederation (HSMC), further carbon reduction initiatives have been implemented including:

- Mandatory supplier compliance with the HSMC sustainable procurement pack by all suppliers
- Recording of recycled and returned products and stock
- Introducing sustainability criteria in the contract evaluation process

The Trust continued to roll out dry mixed waste recycling and food waste recycling, with reductions being achieved in the overall tonnes of waste that are sent to landfill.

The Trust's engagement team encouraged over 50 attendees at the Trust AGM in September 2013 to either car share or use a coach to and from the venue. Sustainability across the Trust is promoted through the regular use of screensavers, as well as articles in staff news publications. Information on the staff intranet service, the *Knowledge Centre*, is being reviewed currently.

Other new schemes for 2013/14 include:

- Reducing the number of invoices from the same suppliers in catering, thus reducing paper waste and processing
- Recycling of shower heads across the Trust (c.1,200 over one year) rather than disposing of them as waste (all shower heads are replaced on an annual basis)
- Recycling of shrink wrap on pallets used by NHS Supply Chain, saving c.0.1 tonnes carbon per month (NHS Supply Chain is using the Trust as a case study for this scheme to encourage all NHS users to follow suit)

The Trust has also developed a climate change adaptation plan that considers the impact of known climate change on the Trust's sites and services. It is being used to support the development of plans and initiatives to meet these impacts over the coming years. The plan links to the Trust's emergency preparedness policies that are now in place and are reviewed on an annual basis.

In addition, it is anticipated that up to a further 37% reduction in CO₂ emissions will be achieved once all of the Trust's remaining inpatient and emergency services at the QEII transfer up to the redeveloped Lister site by the end of 2014.

Carbon reduction commitment energy efficiency scheme

Like all NHS organisations, the Trust is mandated to participate in the carbon reduction commitment scheme – with which it registered on 30 July 2010 and submits an annual report annually. For 2013/14, the Trust pays the carbon tax for the preceding year's (2012/13) emissions at a new cost of £12.00 per tonne. Based on the tonnes of carbon produced in 2012/13, the Trust's costs under the scheme were £159,817.

The impact of these costs on the Trust has been considered as part of the annual financial planning process and long-term financial model; they will continue to be monitored closely to ensure that all carbon emission reductions lead to a fall in the Trust's carbon tax spend.

The Trust is also registered for the EUETS (European Union Energy Trading Scheme) scheme for the operation of the energy centre. In 2012/13 the Trust paid 9,279 Euros (currently @ 4.58 Euros/tonne) in carbon tax for the EUETS scheme.

The total carbon emissions CRC/EUETS cost for the Trust for 2012/13 was £167,518, saving £27,000 on the previous year despite an increase in the carbon tax per tonne in year and a very cold winter that caused more energy to be used over a longer period of time.

Sustainable development management

The Trust has developed a Board-approved sustainability strategy and is confident of delivering its 2015 carbon reduction targets ahead of schedule. Delivery is monitored against an annual, detailed sustainable development management plan that is used to ensure that the required carbon emission reductions are achieved. These two documents are used by the Board to monitor progress and are available on the Trust's website.

The Trust registered for the *Good Corporate Citizen* scheme in 2010, which represents a valuable tool used to identify how the organisation contributes to sustainable development and ensuring that day-to-day activities support, rather than hinder, progress with sustainable development. In January 2013, the breadth and scope of the tool changed with more emphasis on integrating health and social care systems, sustainable models of care and strategies rather than a focussing on finite carbon reductions.

The Trust's initial baseline assessment against the scheme's new criteria in early 2013 showed that we were at the *Getting Started* stage; and our aim during 2013/14 was to reach the *Getting There* stage across all elements. Action plans to achieve this outcome complement the annual sustainable development management plan and are monitored and reported upon regularly through the Trust's sustainable development committee.

Good progress overall is being made towards achieving this target and this work will continue in 2014/15, with some elements of the scheme continuing to work towards reaching *Getting Started* standard and others moving ahead within the *Getting There* standard.

The Trust's return for the NHS Sustainability Report Framework for 2013/14 can be found in the appendix included at the end of this year's annual report and accounts (see page 158 onwards).

Chapter 13: governance and the trust board

This chapter's contents relate to the following Trust strategic objectives:

- Objective 1: Improve continuously the quality of the Trust's services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services
- Objective 2: Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction
- Objective 3: Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.
- Objective 4: Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable
- Objective 5: Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services
- Objective 6: Improve staff engagement and organisational culture to be amongst the best nationally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2013/14, please go to chapter six of this annual report

This section of the 2013/14 annual report is used to set out how the Trust is managed and decisions are made, along with 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 strategic development and workforce and organisational development (*from January 2014*) – and a non-executive director designate 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 have been, until 1 October 2012, appointed by a national body, the Appointments Commission, on behalf of the Secretary of State for Health. This function has been taken over by the NHS Trust Development Authority as of 1 October 2012. 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, with his/her main responsibilities being:

- 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;
- Ensuring 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 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 2013/14

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

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. In particular, the chairman attends all Board committees regularly although he is no longer a designated member. The committee attendance figures listed below do not take in to account these additional attendances; rather they reflect attendances that are *expected*.

Ian Morfett, chairman

Ian was appointed chairman from 1 April 2012, having previously been a non-executive director of the Trust from 1 August 2005 (reappointed in 2009) and vice chairman from 1 January 2011. He 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. Ian lives in Letchworth.

Committee membership: FTC, RC, CTC, IC

Attendance: Trust Board 11 out of 13; FPC 8 out of 11; RAQC 7 out of 11; RC 3 out of 3; CTC 4 out of 4, FTC 1 out of 1, IC 4 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 Morrision 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, FPC (core attendee), RAQC (core attendee), AC

Attendance: Trust Board 13 out of 13; FTC 1 out of 1; FPC 11 out of 11; RAQC 10 out of 11; AC 3 out of 6, IC 3 out of 4

Alison Bexfield, vice chairman

Alison started her career as a chartered accountant in public practice. She spent several years with KPMG, where she provided audit services across a number of healthcare organisations. Since 1998, Alison has been working for the BBC, initially in financial roles, but more recently with a wider governance and assurance remit. In this latter context, she was involved in implementing a new governance regime at the BBC, which saw the formation of the BBC Trust in 2007. Currently Alison is the BBC's head of internal audit. She has also served as an independent audit committee member on a number of audit committees. Alison was appointed a non-executive director on 1 February 2008 and re-appointed in 2012: she will serve on the Trust Board until 31 January 2016. Alison chairs the Board's *audit and remuneration committees*. From 1 April 2012, she was appointed vice chairman of the Trust Board. Alison lives in Letchworth.

Committee membership: AC, FPC, RC, FTC

Attendance: Trust Board 10 out of 13; AC 6 out of 6; FPC 9 out of 11; FTC 1 out of 1, RC 3 out of 3

Dyan Crowther, non-executive director

Dyan joined Network Rail as route director, London North Eastern in December 2004, from Arriva Trains Northern, where she had been its commercial director from March 2002 and managing director from October 2003. She took over the role of route director, Midland and Continental in May 2008 and became director of operational services in July 2010. She is now route managing director, London North Western. Prior to joining Network Rail, she held a number of strategic roles within the former infrastructure company, Railtrack, and has over 20 years' experience in the rail industry. Dyan lives near Baldock and was appointed as a non-executive director from 1 July 2010. She chairs the Board's *risk and quality committee*.

Committee membership: FTC, RAQC, RC

Attendance: Trust Board 9 out of 13; FTC 1 out of 1; RAQC 9 out of 11; RC 3 out of 3

Julian Nicholls, non-executive director

Julian has spent 20 years successfully managing substantial business-to-business services companies in the UK and Europe, most recently as group managing director of Reliance Security Group plc. He is currently chairman of Whitehill Pelham Ltd and a number of other companies, as well as advisor to a number of private equity-owned companies. During his early career he had senior roles in sales, marketing and business development in the computer industry, and prior to that spent some time working in Africa, the Middle East and South East Asia. Julian was appointed as a non-executive director from 1 July 2010 and chairs the Board's *finance and performance committee*. He lives in Barley, near Royston.

Committee membership: AC, FPC, RC, FTC

Attendance: Trust Board 11 out of 13; AC 6 out of 6; FPC 10 out of 11; RC 2 out of 3

Stuart Gavurin, non-executive director designate

Stuart spent over 20 years in private practice as a qualified accountant, but more recently as a commercial director with particular experience in finance, property development, investment, management and contract negotiation in the commercial, health and residential sectors. He has specialist knowledge of commercial legal affairs, with responsibility for setting up legal partnership arrangements between NHS bodies and the private sector. Stuart has been a Board member for a number of public and private organisations, including several NHS partnership companies, in both executive and non-executive capacities. He is an experienced executive and non-executive company chair and director. He lives in Bushey Heath and was appointed a non-executive director designate in August 2012. Stuart was appointed a non-executive director on 1 June 2013.

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

Attendance: Trust Board 11 out of 13; FPC 10 out of 11; RAQC 9 out of 11; CTC 4 out of 4; FTC 1 out of 1; RC 2 out of 3

Bob Niven, non-executive director

Bob, who lives in Hatfield, is a retired senior civil servant. He joined the civil service in 1974, having graduated from Oxford University with a BA in Politics, Philosophy and Economics, followed by an MA in Political Science from Michigan State University and a B. Phil in Management Studies from Oxford University. His final post on retirement in 1999 was director of equal opportunities legislation policy at the then Department for Education and Employment. Following his departure from the civil service, Bob became the chief executive of the Disability Rights Commission until September 2007. After a number of board appointments, including as chair of the Mental Health Helplines Partnership and at the Office of the Public Guardian, Bob served as the resident independent adviser to the Israeli Equal Employment Opportunities Commission under a two-year, EU-supported capacity-building project until February 2012. Bob was appointed a non-executive director designate on 1 September 2013 and was appointed a non-executive director on 6 January 2014.

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

Attendance: Trust Board 8 out of 8; RAQC 7 out of 7; AC 3 out of 3; CTC 3 out of 3; RC 2 out of 2

Karen Pettit, non-executive director

Karen has 25 years' experience in higher education institutions, including several as a senior member of the executive and school management team in the School of Health and Social Sciences at Middlesex University. She is currently the deputy dean of the School of Science and Technology at Middlesex. Responsible for curriculum development, learning, teaching and assessment for all programmes and collaborative partnerships within the School, she has also worked to establish effective monitoring of clinical safety within placements, user groups and audit of placement environments externally recognised by the Nursing and Midwifery Council and NHS London. Karen has a PhD from the University of Hertfordshire and lives in Hatfield. She was appointed a non-executive director in July 2012 and was on sabbatical, from 1 March 2013 to 31 October 2013, while acting as interim campus director of the University of Middlesex in Mauritius. Karen resigned from post on 31 October 2013.

Committee membership: RAQC, CTC, RC

Attendance: Not applicable: on an approved sabbatical 1 March 2013 to 31 October 2013 and then resigned from post

John Watson, director of operations

John joined the Trust in February 2013 from Ipswich Hospital NHS Trust, where he was director of operations for three years. Prior to this, he held acting director of operations and divisional manager posts at Kings College Hospital in central London. John has also completed the Public Service Leaders scheme, which included a two-day a week secondment to the Department of Health. Having started his NHS career in 1990, John has a BSc in social policy and economics and an MSc in health policy, planning and finance – both from the London School of Economics. He 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 (core attendee), RAQC (core attendee)

Attendance: Trust Board 12 out of 13; FPC 8 out of 11; RAQC 8 out of 11, AC 1 out of 6

Jane McCue, medical director

Jane has had extensive NHS experience working in almost twenty hospitals. She trained in surgery in London and Toronto and has been a consultant colorectal surgeon since 1996. She was medical director for the Trust from 2003 to 2007 and was appointed as its medical director again from April 2012. She was medical director for the Mount Vernon Cancer Network from February 2011 to March 2013. Jane led three major strategic reviews of surgery and planned care for the East of England Strategic Health Authority between 2007 and 2011 and was adviser to NHS London for its emergency surgery review. She is a member of the University of Hertfordshire Governing Board and Women in Surgery committee at the Royal College of Surgeons. She is a past council/committee member for the Association of Coloproctology, the Royal Society of Medicine Section of Coloproctology and the St Mark's Association.

Committee membership: EC, FTC, RAQC (core attendee)

Attendance: Trust Board 10 out of 13; FTC 1 out of 1; RAQC 8 out of 11

Angela Thompson, director of nursing

Angela took up the post of director of nursing, patient experience, and infection prevention and control at the Trust in 2011. Previously, she was assistant and then deputy chief nurse at Cambridge University Hospitals NHS Foundation Trust from 2007 to 2011, and lead for infection prevention and control from 2006 to 2010. She was also an advisor to Waikato District Health Board, Hamilton, New Zealand between 2006 and 2010. Angela is a registered general nurse (adult) and a registered sick children's nurse specialising in neonatal intensive care and care of the newborn. Her previous experience includes multi-disciplinary education, research, governance, patient safety and patient experience.

Committee membership: EC, FTC, RAQC (core attendee), FPC (attendee)

Attendance: Trust Board 10 out of 13; FTC 1 out of 1; RAQC 8 out of 11; FPC 8 out of 11

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 finance director since mid-2005. Previously, Paul held a similar role at Kent Ambulance NHS Trust, and prior to that 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, CTC, FPC (core attendee), AC (core attendee)

Attendance: Trust Board 13 out of 13; CTC 3 out of 4; FPC 11 out of 11; AC 6 out of 6.

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, sustainability, facilities and, from February 2013, workforce, 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, CTC, FPC (core attendee), RAQC (attendee)

Attendance: Trust Board 13 out of 13; CTC 2 out of 4; FPC 10 out of 11; RAQC 2 out of 11

Tom Simons, director of workforce and organisation development

Tom joined the Trust in February 2013, and has been a full board member since January 2014. He is responsible for staff recruitment, medical staffing, managing organisational and cultural change and leadership and management development. He also oversees the development and governance of the Trust's workforce. Before joining the Trust, Tom had extensive experience of leading large-scale organisational mergers including the recent merger of three acute hospital Trusts in London to create Barts Health NHS Trust. Before that, Tom held senior change management roles in the health sector. Tom holds a master's degree in human resource management and is a full member of the Chartered Institute of Personnel and Development. He is also vice-president of the healthcare people management association (HPMA) for the East of England.

Committee membership: EC, FPC (attendee), RAQC (core attendee)

Attendance: Trust Board 4 out of 4; FPC 11 out of 11; RAQC 11 out of 11.

	Title	Appointment date	Term(s) of office	Term of office ends
Ian Morfett	Chairman	1 April 2012	Four years	31 March 2016
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chairman	1 February 2008	Four years plus four years	31 January 2016
Dyan Crowther	Non-executive director	1 July 2010	Four years	30 June 2014
Julian Nicholls	Non-executive director	1 July 2010	Four years	30 June 2014
Karen Pettit	Non-executive director**	12 July 2012	Four years	Resigned 1 October 2013
Stuart Gavurin	Non-executive director designate*	15 August 2012	n/a	Ended 31 May 2013
	Non-executive director	1 June 2013	Two years	31 May 2015
Bob Niven	Non-executive director designate*	1 September 2013	n/a	Ended 5 January 2014
	Non-executive director	6 January 2014	Four years	5 January 2018
Jane McCue	Medical director	1 April 2012	Four years	31 March 2016
Angela Thompson	Director of nursing	30 August 2011	n/a	n/a
Paul Traynor	Director of finance	1 May 2009	n/a	n/a
John Watson	Director of operations	4 February 2013	n/a	n/a
Stephen Posey*	Director of strategic development	21 January 2008	n/a	n/a
Tom Simons*	Director of workforce and organisation development	02 January 2014	n/a	n/a

*Attend and participate in Trust Board meetings, but without voting rights.

**On approved sabbatical 1 March -31 October 2013

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, along with expenses incurred by directors in pursuing Trust work, is published on the Trust's website.

For further information, please contact:

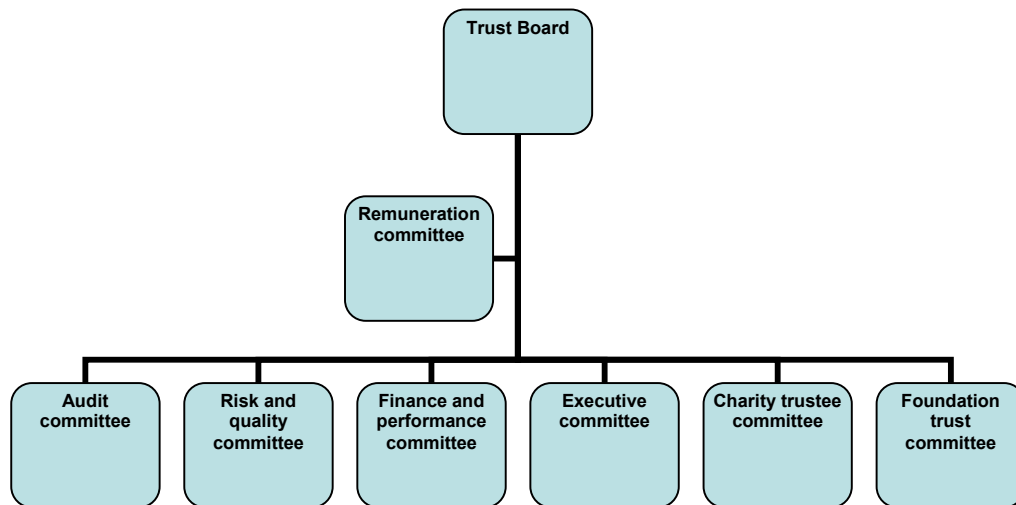
Jude Archer, Company Secretary

Tel: 01438 314333

E-mail: jude.archer@nhs.net

Governance structure

During 2008, the Trust Board adopted a system of line accountability through executive directors rather than through sub-committees; as a result, it revised its committee structure – see diagram on the next page. During 2012/13 an internal review of the Board's *audit, risk and quality, finance and performance* and *charity trustee committees* was undertaken to ensure they met their terms of reference and operated effectively in line with national guidance. Each committee undertakes an annual review to ensure that it continues to meet its terms of reference.



Executive directors are accountable directly to the Board committees. Each director has governance and assurance structures in place to deliver the respective areas of their responsibility.

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

The *risk and quality committee* meets monthly and 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 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 associate director for public affairs and the company secretary. This committee meets weekly and covers all major service, performance and organisational issues. Each fortnight it also meets with the divisional chairs and directors of the Trust's five 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 as part of the review in 2012, in order to meet the requirements under Monitor's code of governance, it revised its membership to three non-executive directors, thus ensuring it was constituted as an assurance committee to the Board. Its main role is to hold the executive to account for effective progress in managing financial, performance, strategic development, data quality and marketing strategy.

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 management of the Trust's clinical services are devolved into five clinical divisions:

- **Division of surgery** (divisional chair, Dr Michael Chilvers and divisional director, John Fitzmaurice)
- **Division of medicine** (divisional chair, Dr Jon Baker and divisional director, Aisling Bowman)
- **Division of clinical support services** (divisional chair, Dr Tim Walker and divisional director, Joanna Carter)

- **Division of cancer services** (divisional chair, Dr Catherine Lemon and divisional director, Ella Ballatti)
- **Division of women's and children's services** (divisional chairs, Mr Rob Sattin/Dr Linda Struthers and divisional director, Isobel Day)

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 2013/14, the Trust's external auditor was Grant Thornton UK LLP.

Private finance initiative (PFI) schemes

Since November 2004, the Trust has been involved in a PFI scheme in relation to the new Hertford County hospital – an £8.5 million scheme that was built, and is operated by Hertford PPP Health Services Limited. The scheme involves an annual unitary payment of approximately £1.2 million. This fee is payable until 2034, when the hospital reverts to NHS ownership. Further information is provided in note 37 of the accounts section. During the 2011/12 financial year, the Trust entered into a Public Private Partnership with Vinci Park to finance a new multi-storey car park on the Lister site. 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 2013/14 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 2013/14 accounts.

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 1.8 and valuation details under note 10.6 in the annual accounts contained in this report.

Special severance payments and exit packages

Special severance payments when staff leave public service employment are exceptional and will always require HM Treasury approval. The Trust has no delegated authority to make such payments unless so approved. No such payments were made during 2013/14.

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 45 measures, which cover:

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

For 2013/14, the Trust achieved the minimum level two compliance for all requirements in the information governance toolkit and thus achieved a *satisfactory* rating. Overall, the Trust's score was 86%, similar to the previous year.

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

The Trust reported one information governance serious incident to the Trust's commissioners and the Information Commissioner during 2013/14. This was a disclosure in error. In January 2014, 20 patients contacted the Trust via the appointment line to advise of receipt of multiple envelopes with multiple letters enclosed. The letters comprised duplicate copies of their audiology reminder letter, along with copies of other patients' reminder letters. A full investigation has been completed and the main learning identified was the importance of clear communication and acting on instruction; actions have been implemented to prevent reoccurrence, including additional training for staff.

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 national *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 the chief executive and executive directors. In addition when undertaking its nomination responsibilities, the committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate. It also considers succession planning arrangements for directors and other senior executives.

The *Remuneration committee* is a committee of the Trust Board, consisting of the chairman and all the non-executive directors. It is chaired by the vice chairman. The committee is supported by the chief executive, director of workforce and organisational development and the company secretary. The *Remuneration committee* aims to meet quarterly to fulfil its duties and it met three times during 2013/14. Details of directors' remuneration are given in the annual accounts.

Every year, the Board's *remuneration committee* considers the performance and 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 March 2013, the committee took into account a benchmarking report prepared by an external body.

The committee pays due consideration to what is happening in the financial environment and with its other employees when determining executive director's remuneration. 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.

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate. During 2013/14 the Trust recruited a new director of operations. Non-executive directors were involved in the recruitment of this post.

All the Trust's executive directors hold permanent contracts. The notice period for executive directors is generally three months, although it is six months in the case of the director of finance. There are no arrangements for termination payments or compensation for early termination of contract. The Trust is also 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 three and half days per week for the chairman.

Pay awards agreed nationally for other staff groups working at the Trust and the wider NHS, including staff on agenda for change contracts, medical and dental staff and very senior managers are determined by the Senior Salaries Review Body, which looks at senior salaries and pay conditions across the public sector.

Salary and pension entitlements of senior managers

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

Nick Carver
Chief Executive

Remuneration tables

Name and title	2013/14						2012/13					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Executive directors												
Nick Carver Chief executive	175-180	8	0	0	0	175-180	170-175	17	0	0	0	170-175
Paul Traynor Director of finance	130-135	92	0	0	0	140-145	135-140	40	0	0	0	135-140
Angela Thompson (from 30/08/11) Director of nursing	110-115	3	0	0	0	110-115	100-105	5	0	0	0	100-105
Neil Dardis (to 03/02/13) Director of operations	n/a	n/a	n/a	n/a	n/a	n/a	100-105	5	0	0	0	100-105
John Watson (from 04/02/13) Director of operations	105-110	0	0	0	0	105-110	15-20	0	0	0	0	15-20
Jane McCue Medical director	115-120	2	0	0	0	115-120	120-125	1	0	0	0	120-125
Stephen Posey Director of strategic development	105-110	56	0	0	0	110-115	100-105	46	0	0	0	105-110
Gregory Allen (from 03/10/11 to 24/02/13) Director of workforce and organisation development	n/a	n/a	n/a	n/a	n/a	n/a	90-95	54	0	0	0	95-100
Tom Simons (from 02/01/14) Director of workforce and organisation development	20-25	1	0	0	0	20-25	n/a	n/a	n/a	n/a	n/a	n/a

Name and title	2013/14						2012/13					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ian Morfett	20-25	0	0	0	0	20-25	20-25	0	0	0	0	20-25
Chair												
Alison Bexfield	6-10	0	0	0	0	6-10	6-10	0	0	0	0	6-10
Vice-chair												
Dyan Crowther	0	0	0	0	0	0	0	0	0	0	0	0
Julian Nicholls	6-10	0	0	0	0	6-10	6-10	0	0	0	0	6-10
Stuart Gavurin (from 15/08/12)	6-10	0	0	0	0	6-10	0-5	0	0	0	0	0-5
Douglas Smallwood (to 31/03/13)	n/a	n/a	n/a	n/a	n/a	n/a	6-10	0	0	0	0	6-10
Bob Niven (from 01/09/13)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Karen Pettit (to 31/10/13)	0	0	0	0	0	0	0-5	0	0	0	0	0-5

Notes to remuneration tables

- 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. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, having the effect of reducing the salary paid during 2012/13 and 2013/14.
- Dyan Crowther does not draw a salary from the Trust.
- Karen Pettit was on sabbatical from 01/03/13 until her resignation on 31/10/13 so did not draw a salary in 2013/14

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in 2013/14 was £177,500 (2012/13 – £172,500). This was 6.3 times (2012/13 – 5.9) the median remuneration of the workforce, which was £28,076 (2012/13 – £29,006). The increase multiple is a combination of a reduction in the median and an increase in the remuneration of the highest paid director.

In 2013/14, 20 employees (2012/13 – 21 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £11,905 to £264,932 (2012/13 – £14,153 to £226,983). The lowest paid employee is lower than reported for 2012/13 as the individual is part of a salary sacrifice scheme, which has had the effect of reducing pay. The highest paid employee in 2013/14 received a back-dated clinical excellence award increase that was effective from 1 April 2012, which had the effect of exaggerating the difference between the highest paid employee this year compared to 2012/13.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension 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 2014	Lump sum at aged 60 related to accrued pension at 31 March 2014	Cash equivalent transfer value at 31 March 2014	Cash equivalent transfer value at 31 March 2013	Real Increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver Chief executive	2.5-5	7.5-10	60-65	180-185	1,162	1,050	89	0
Paul Traynor Director of finance	0-2.5	0-2.5	35-40	115-120	601	566	23	0
John Watson Director of operations from 04/02/13	2.5-5	7.5-10	30-35	90-95	514	447	57	0
Stephen Posey Director of strategic development	0-2.5	5-7.5	20-25	65-70	275	241	29	0
Angela Thompson Director of nursing	0-2.5	5-7.5	40-45	120-125	785	707	62	0
Tom Simons Director of workforce and organisation development from 02/01/14)	0-2.5	n/a	5-10	n/a	61	42	18	0

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.

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

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

Real increase in CETV 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.

There are no lump sums to be disclosed in respect of Tom Simons as he is a member of the 2008 section of the NHS Pension scheme.

Off-payroll engagements

In line with national guidance, the two tables below set out off-payroll engagements with the Trust. For all off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2014	3
<i>Of which, the number that have existed:</i>	
- for less than one year at the time of reporting	1
- for between one and two years at the time of reporting	1
- for between two and three years at the time of reporting	1
- for between three and four years at the time of reporting	0
- for four or more years at the time of reporting	0

The Trust confirms that all existing off-payroll engagements have been subject to a risk based assessment as to whether assurance was required that the individual is paying the right amount of tax and, where necessary, that assurance was sought.

For all new off-payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements between 1 April 2013 and 31 March 2014	1
<i>Of which:</i>	
Number of new engagements that include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations.	0
Number for whom assurance has been requested	1
<i>Of which:</i>	
- assurance has been received	1
- assurance has not been received	0
- engagements terminated as a result of assurance not being received	0

	Number
Number of off-payroll engagements of board members, and or/senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	0

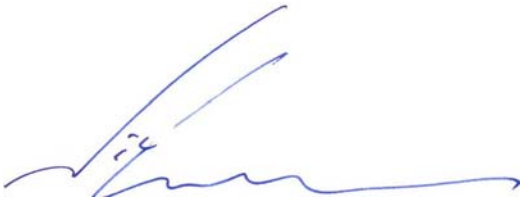
Chapter 14: annual accounts for 2013/14

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

The Chief Executive of the NHS Trust Development Authority 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 Chief Executive of the NHS Trust Development Authority. 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: 28 May 2014

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 which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

Date: 28 May 2014



Chief Executive

Date: 28 May 2014



Finance Director

Annual governance statement 2013/14

Insert name of organisation: East and North Hertfordshire NHS Trust
Organisation Code: RWH

Executive summary

The annual governance review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust has a programme that regularly monitors and tests various aspects of its governance and risk management structures to ensure they remain fit for purpose. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2014/15; these areas are highlighted within the main document below.

Overall, no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives.

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum.

In undertaking this role I, and my team, have developed strong links with the Trust Development Authority, local Clinical Commissioning Groups, and partner organisations.

2. The governance framework of the organisation

2.1 The purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of the East and North Hertfordshire NHS Trust,
- 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 2014 and up to the date of approval of the annual report and accounts.

2.2 Capacity to handle risk

The Trust has established clear leadership and accountability arrangements and from 1 April 2013 to 31 March 2014 the responsibility for ensuring that there is a comprehensive risk management and corporate governance systems in place has been delegated to the company secretary. In addition, I have delegated clinical governance and health and safety to the director of nursing, clinical governance and the co-ordination of the management of all clinical risks to the medical director, financial and IM&T risks to the director of finance, emergency planning to the director of operations, estates, security management and sustainability management to the director of strategic development, and workforce and organisational development to the director of workforce and organisational development.

Further detail on the individual director accountabilities are set out in:

- The Trust's Quality Governance and Risk Management Strategy
- Corporate Governance Assurance map
- The Trust's Annual Plan and
- Board Assurance Framework

The Trust has approved an assurance framework and quality governance and risk management strategy that ensures that:

- Leadership is given to the risk management process
- The principle risks to achieving the strategic and annual objectives are mitigated against effectively, reviewed and monitored
- 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 significant risks that impact on 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 appropriately managed throughout the organisation.

Each of the Trust's clinical divisions has a divisional (clinical) chair and a divisional director, who jointly are accountable for risk and governance. A process of review and challenge of divisional risks, as contained in the risk register, is conducted through the divisional performance review meetings. Areas of high risk are escalated to the *risk and quality committee* (RAQC) and the Trust Board. In addition each of the divisions attends RAQC on an annual basis for further scrutiny of their risk and governance processes.

The operational risk management team provides support and training to staff on risk management and the risk register. The health, safety and security team provides mandatory training on health and safety to all staff across the organisation. The company secretary ensures the Board receive support and training on risk management and during 2013, the Board continued a development programme to review key areas of strategic significance and potential risks facing the Trust in the future. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff through governance half days, patient safety newsletter, trust bulletin and the organisational development programme (ARC).

3. Risk assessment

3.1 Risk profile

Risk assessment is undertaken in line with the Trust's quality governance and risk management policy which sets out clear guidance on how risks should be identified, treated and managed. The key risks identified to the delivery of the strategic and annual objectives are developed in discussion with each executive director and in discussion with the Board and its committees. Each risk has a clear action plan and delivery is monitored through the assurance framework described below.

A full comprehensive record of the principle risks identified in 2013/14 and how these have been mitigated and reviewed is discussed at Trust Board each quarter in the public session.

These risks include:

- Risk of not meeting the *C. difficile* target was increased to **red** as the Trust had breached its performance trajectory during the year. This risk returned to **green** in March 2014 and the year-end target was delivered. This is covered further in section five of this statement.
- Risk that demand management does not reflect CCG commissioning intentions, leading to insufficient capacity and delivery of performance targets. The risk was increased to **amber** in October 2013 to take into account the additional capacity ward open and winter pressures. Mitigations are in place and the Trust is working jointly with its commissioners and partners. This will be an on-going focus in 2014.
- The risk of ability for the current IM&T infrastructure to support fully the technological changes required was increased in January to **amber** (previously **green**). The Trust has submitted applications to a number of national funding streams but recognises the risk of a lack of a co-ordinated approach and is reviewing the IM&T strategy.

Other operational key risks, including mortality and performance, that have been managed during 2013/14 are discussed in section five.

3.2 Risks escalated to the Board Assurance Framework (BAF) during 2013/14:

In September 2013, the risk that the transfer of the Treatment Centre services to the Trust impacts adversely on the overall performance and finance was added formally to the BAF. The risk reflects the service transfer of the Treatment Centre back to the Trust and the associated costs relating to this, the initial loss in operating costs at the time of the transfer and turning the service around to deliver an operational surplus in 2014. This has impacted on the Trust's ability to deliver the planned level of surplus for 2013/14; surplus forecast is now £0.1m. This risk reduced to **green** at year-end. (*cross reference to section five – review of economy, efficiency and effectiveness of the use of resources*). At this time the risk to the reputation of the Trust if Clinicienta performance is poor was closed.

Assurance framework ratings explained:

Red: A significant failure to mitigate a risk either through lack of controls identified (or poorly framed controls), with a high likelihood of the risk being realised in the short term.

Amber: On course to be mitigated, given the controls identified, but further work required in delivering the agreed actions.

Green: The risk has been mitigated as defined by the controls and actions identified. These risks will continue to be displayed on the framework so that assurances received can be kept up to date.

4. The risk and control framework

Quality governance and risk management is central to the effective running of the organisation and the Trust's ambition to *be amongst the best*.

The objectives of this strategy are:

- To achieve the Trust's strategic and operational objectives as defined in the integrated business plan and annual plan
- To maintain registration with CQC registration without compliance conditions
- To strengthen compliance with the quality governance framework and achieve a score of 0.5 or better
- To strengthen compliance with the Board governance assurance framework and maintain a green rating
- To achieve a year-on-year improved score on the assurance framework and risk management internal audit to achieve a *low risk* by end of 2014/15 (*rated currently as medium risk*)

The aims of this strategy are to:

- Support the delivery of the Trust's vision, values and strategic and annual objectives
- Provide a framework to support 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
- Have a clear operational and corporate structure which enables responsive and effective management and provides for appropriate escalation and delegation
- Provide a framework to support a consistent approach to quality governance and risk management
- Provide an open culture and proactive culture rather than reactive approach to quality governance and risk management, thus supporting a learning organisation
- Have a Board assurance framework (BAF) and risk register that is reflective truly of the risks faced
- Support compliance with regulatory bodies including, registration with the Care Quality Commission, Monitor (on gaining NHS foundation trust status), Health and Safety Executive and maintaining and improving compliance with NHS Litigation Authority's risk management standards and achieve year-on-year improvement in compliance with national standards, regulation requirements and accreditation schemes
- 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 ensure the organisation openly accepts the remaining risks.

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. The quality governance and risk management strategy also sets out the Board's appetite for risk.

4.1 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*. These are constituted as key assurance committees under Monitor's code of governance and an annual review of each of the committees is undertaken to ensure they continue to meet their terms of reference and requirements of the code.

In addition, the Board has established the *charity trustee committee* to provide assurance and support for its responsibility as a Corporate Trustee.

The assurance process as described below is reviewed by the Trust's *audit committee*, which provides an independent and objective review of the Trust's systems of internal control to the Trust Board and in doing so, holds the executive to account for the effectiveness of governance systems and the processes for managing risk.

The *finance and performance committee* (FPC) supports the governance structures and its main roles are to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. This includes:

- Overseeing the development and maintenance of the Trust's medium and long term financial strategy
- Reviewing and monitoring financial plans and their link to operational performance
- Overseeing financial risk management
- Scrutiny and approval of business cases and oversight of the capital programme
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise

The FPC will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T strategy for the Trust. It will ensure the Trust is prepared for the forthcoming major changes including delivering the Trust's *Our changing hospitals* programme and achieving NHS foundation trust status.

The *risk and quality committee* (RAQC), a formal committee of the Board, is chaired by a non-executive director. The purpose of the committee 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, 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 Trust's *finance and performance committee* will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny.

The principal objectives of the RAQC 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
- To 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
- To 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), Trust Development Authority (TDA) and ensure action is taken for compliance
- To monitor and advise the Board on compliance with the Hygiene Code

- To endorse, monitor and receive reports on the implementation of the Trust's key quality, clinical outcome, patient safety and patient experience strategies and indicators
- To provide regular risk management reports to the Trust Board
- To liaise with the *audit committee* and the *finance and performance committee*
- To receive, annually, divisional presentations on progress with divisional objectives, governance structures, quality, safety and risk
- To review the quality risk assessment of the cost improvement programme (CIP)
- To work with the *audit committee* when appropriate, and specifically in agreeing the annual internal audit plan and providing a review of effectiveness on clinical audit

Each executive director is accountable to the *risk and quality committee* for their defined areas of responsibility and has clear assurance systems and structures in place; these are reviewed annually with each director. Key committees supporting this process include:

- Clinical governance strategy committee
- Patient safety committee
- Patient experience committee
- Health and safety committee
- Emergency planning committee
- Infection control committee
- *Our changing hospitals* programme board

The purpose of the *charity trustee committee* (CTC) is:

- To ensure a robust strategy for delivery of the Charity aims and objectives.
- To champion the charity and its development, providing leadership both within the Trust and externally
- To provide stewardship of charitable resources and ensure compliance with relevant legislation, guidance and Trust policies.

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, *enhance herts* (registered charity no 1053338).

Directors' attendance at the Board and its Committees is recorded and monitored. A review of attendance during 2013/14 has not highlighted any issues. These are reported in full in the Trust's annual report (see chapter 13).

4.2 Board development

During 2013/14 the Board had a series of development sessions to consider key areas of strategic significance and risk, including information and technology, customer experience and satisfaction, impact on the workforce during large scale change, mortality, children's services, the Trust's next two year operating plan and training on undertaking patient stories. The Board also launched 'mission possible' (*back to the floor*) where each Board member visited and shadowed a member of staff or observed area of the Trust.

The expectation is that the sessions provide strategic focus to the organisation, enabling it to proactively respond to and support the achievement of strategic priorities for the local health economy in ways which are commercially and clinically effective for the Trust.

The Trust is compliant with the Corporate Governance Code and has developed the governance structures to ensure compliance with Monitor's code of governance on becoming a NHS foundation trust.

The Board has also reviewed its compliance against the Board governance assurance framework and quality governance framework. The self-assessment was evidence based and no areas of significant risk were identified. Actions are in place to ensure that the Trust continues to develop its systems in line with all the areas of good practice. This is reviewed at least annually.

4.3 Assurance framework and risk register

The 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 defined clearly 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 or safe service delivery
- **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, and managers are 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/external audit, for example from the Care Quality Commission, NHS Litigation Authority, or Health and Safety Executive notices, will be placed on the risk register
- **External guidance/alerts** – NICE, quality strategies, etc. that are not yet implemented
- **Results of feedback** – learning from patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices, etc.

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.

5. Review of the effectiveness of risk management and internal control

Care Quality Commission

The Trust was registered fully with the Care Quality Commission (CQC), without compliance conditions, on 1 April 2010. The CQC has not taken enforcement action against the Trust during 2013/14 and has inspected the Trust on two occasions.

The CQC carried out a routine unannounced inspection of the Lister hospital on 5th and 6th September 2014. The Lister hospital was found to be compliant fully with the following standards:

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Co-operating with other providers
- Outcome 7: Safeguarding people who use services from abuse
- Outcome 13: Staffing
- Outcome 16: Assessing and monitoring the quality of service provision

The second inspection took place on 3 February 2014 and formed part of a national programme of themed inspections looking at the quality of dementia care. This inspection took place at QEII hospital. Following the inspection, the Trust received positive feedback and the final report confirms that the Trust is compliant fully with the following core standards:

- Outcome 4: Care and welfare of people who use services
- Outcome 6: Co-operating with other providers
- Outcome 16: Assessing and monitoring the quality of service provision

During August 2013, an application was submitted to CQC to register the Trust's new renal dialysis unit situated within the Princess Alexandra Hospital in Harlow. Following a registration assessment by CQC, the Trust received approval of the application for registration and the unit opened to receive patients in August 2013.

As in previous years, the Trust continues to monitor compliance against all the essential standards of quality and safety on an on-going basis and has maintained a positive CQC quality risk profile (QRP) and with the new CQC intelligence monitoring report, progressing from a band three in October 2013 to a band five in March 2014. (*Bands range from one to six, with the higher the band the lower the risk profile.*)

During 2014/15, the Trust will seek to improve further upon this performance with regulators such as the Care Quality Commission, NHS Litigation Authority risk management standards and, continue a programme of self-assessment against the standards required by Monitor.

Clinical audit

The *risk and quality committee* and *audit committee* considered the assurances on clinical audit following an evidence-based self-assessment against the criteria stated in the Audit Committee Handbook 2010. The self-assessment demonstrates that the Trust's clinical audit processes are compliant, and that there are plans in place to continue to strengthen these. It is clear that processes and monitoring have led to a continued improvement in clinical audit activity across the Trust. Approximately 82% of the clinical audit programme (566 clinical audits) and an additional 18% (121 clinical audits) that were approved in year have been completed or are in progress for 2013/14.

Information governance

The assurance framework and risk register include 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 2013/14 the Trust achieved the minimum level two compliance for all requirements in the information governance toolkit and achieved a *satisfactory* rating. Overall the Trust's score has been maintained in 2013/14.

The Trust has reported one information governance serious incident to the Information Commissioner Officer relating to patients from an audiology clinic receiving a follow-up clinic reminder letter containing multiple letters for the same clinic leading to a breach of confidentiality affecting approximately 146 patients. A full investigation had been completed and actions implemented to mitigate the risk of reoccurrence. Information governance training remains a priority for the Trust and the e-learning package is supported by an increased number of face-to-face training sessions delivered on the Trust's statutory and mandatory training day and a number of other training and awareness activities across the organisation.

Performance

The Trust has maintained a consistently strong performance against a number of key indicators and delivered a quarterly risk rating of amber/green with the exception of quarter three that was amber/red. This rating was triggered by the 62 day cancer wait to first treatment in quarter three and *Clostridium difficile* in all quarters.

The Trust has a zero tolerance approach to avoidable hospital acquired infections and continues to remain compliant with the requirements of the Hygiene Code. During 2014/15, there were 14 cases of *C. difficile* against a target of 14. Root cause analysis has been completed on all cases and actions taken. Of the *C. difficile* cases, six community acquired cases were identified post 72 hours.

The pressures on the A&E standard have continued in 2013/14, although the Trust delivered 95% performance for the year. In January 2014 the Trust ran a *Breaking the Cycle* initiative to seek to combat winter pressures, improve patient flow within the Trust's inpatient wards and patient safety and outcomes. This was successful and the Trust is looking to take forward key learning points to support sustainable change, including: daily consultant ward rounds by 11.00am; role of the ward liaison officer; and real-time information.

Mortality

The Trust's has continued to reduce mortality and the year-to-date performance shows SHMI improved to within the *as expected* range (111.8) and HSMR improved to the *better than expected* range (90.8).

Mortality monitoring includes reviewing all deaths and *alerts* that show higher than expected mortality with certain diagnoses. The Trust received one CQC mortality outlier alert in 2013, which related to acute bronchitis. A full clinical and coding review was undertaken and the findings and actions have been reported to the CQC, which has now closed the alert. This matter continues to be monitored through the *risk and quality committee*.

Reducing mortality remains an improvement priority for the Trust in 2014/15 and the Trust's operating plan and clinical outcomes strategy sets out the required priorities and actions.

Pensions

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 into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. An assessment against the criteria stated in the Equality Delivery Scheme has been undertaken and the EDS objectives have been agreed and published.

Sustainability

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

Review of economy, efficiency and effectiveness of the use of resources

The Trust has a clear framework ensuring the effective monitoring and control of the use of Trust resources. Financial monitoring, performance monitoring and workforce information is scrutinised through the Trust's performance monitoring framework. Internal and external audit provide scrutiny to the key processes that have been applied to ensure that resources are used economically, efficiently and effectively. The *finance and performance committee* and Board provide scrutiny and challenge to ensure the Trust effectively mitigates and manages the risks to deliver the Trust's strategic and annual objectives.

The Trust delivered a surplus in 2013/14, maintained its financial risk rating of two and delivered 90% of its CIP programme. However the planned surplus of £2.1m was reduced to £0.1m as a result of the financial impact of the transfer of the Treatment Centre back to the Trust in October 2013. This has been monitored by the *finance and performance committee* and Board and the facility is now delivering an operational surplus.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The formulation of the Quality Account 2013/14 has been led by the Trust's head of quality and patient safety on behalf of the medical director and was designed to meet all relevant Department of Health and Monitor requirements. It provides a *look-back* against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a look forward to future priorities. The account includes a section on mandated topics, for example clinical audits, and reports against the achievement of national standards.

The 2013/14 and 2014/15 priorities for improvement were identified for a range of reasons including feedback on survey data, a review of clinical outcomes and following input from staff, key external stakeholders and involvement committee. For 2013/14 these were:

- Improving safety for older people
- Improving clinical outcomes (relating to stroke and surgery)
- Improving patient experiences
- Staff development/engagement

Significant progress has been made against the majority of the quality account priorities, with less progress in others. The Trust recognises that this is likely given the high level of ambition set.

An overview of 2013/14 shows that we have made on the current priorities include:

- Reduced the number of inpatient falls
- Reduced the number of avoidable pressure ulcers
- Introduced regular nutrition audits
- Improved clinical outcomes including stroke and mortality
- received encouraging feedback from patients and carers about their experience but recognise there is more to be achieved
- Increased the number of staff who would recommend the Trust as a place to work

The priorities for 2014/15 are:

- Improve safety – safety thermometer
- Improve safety – medications
- Improve outcomes – mortality
- Improve clinical outcomes – stroke
- Improve experiences – communication
- Improve experiences – reduce delays

Throughout the year the Trust ensures on-going engagement with the Health and Well Being Board, Health Scrutiny Committee and commissioners. The Trust will continue to monitor performance against priorities, including by the use of floodlight scorecards at ward, divisional and Trust level.

Francis Inquiry

The Francis report which looked into the failings at Mid Staffordshire hospital was published in February 2013 and this was followed by the Don Berwick report, *A Promise to Learn - Commitment to act: Improving the Safety of Patients in England*. They call for all NHS organisations to develop responses to the recommendations to bring about lasting improvements. The East and North Hertfordshire NHS Trust takes the issues raised in the reports extremely seriously and as part of our vision to “be amongst the best” is committed to ensuring the recommendations identified in both reports are applied across the Trust. The key lessons from the Francis report, is that individually and collectively, whatever their role within the Trust, every staff member must redouble their efforts in striving to become amongst the best in providing the best possible care for patients.

The Trust’s focus will remain, therefore, on placing the needs of its patients at the heart of everything it does, as well as ensuring that all staff operate in accordance with the Trust’s values. Set out below are the actions undertaken by the Trust since the publication of the Francis Inquiry and Don Berwick reports.

The review process began at the Board’s February 2013 meeting, following which a number of steps have been taken to consider the impact of the recommendations for the Trust and how these may further improve patient care.

- We have reviewed ourselves against all the 290 recommendations in the Francis Inquiry and those in the Berwick report.
- We have looked at what we are already doing and what we could do better.
- We have held focus groups listened to the views of our staff, our patients and our members.

- We have considered the responses from other organisations that directly or indirectly impact on us.
- We have reviewed and re-launched our *raising concerns at work policy* (Whistle-blowing).
- We have continued to undertake a comprehensive review of our staffing establishment each year and taken action on the outcomes.
- We have continued our ARC programme for all clinical and non-clinical leaders.
- We have commenced our commitment to put every single member of its staff through customer care training. Over 2,300 staff attended this training so far.
- We have clear strategies and ambitions that support continued improvement to the delivery of patient care including nursing and midwifery strategy, patient experience and carer strategy, improving patient outcomes strategy, engagement strategy and quality governance and risk management strategy.

The Trust has developed an action plan to ensure it continues to improve and will monitor itself against the agreed actions and report on this at least annually through the *risk and quality committee* to Trust Board. This information is published on the Trust website.

The Trust continues to put patients first and will continue to monitor carefully what others say about its services and actively encourage and involve patients, staff, commissioners, HealthWatch and other representatives in helping to identify ways the Trust can keep improving.

6. Significant issues

There no significant control issues to report.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the *audit committee* and the *risk and quality committee* and a plan to address weaknesses and ensure continuous improvement of the system is in place.

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit (HoIA) provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of internal audit's work.

The opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary.

The head of internal audit, 1 April 2013 to 31 March 2014, overall opinion is:

Our opinion is based on our assessment of whether the controls in place support the achievement of management's objectives as set out in our individual assignment reports.

The Trust has completed the programme of internal audit work for the year ended 31 March 2014 with the exception of two reviews – service assurance statement and workforce planning. For both outstanding reviews fieldwork has been completed and we are in the process of finalising the work in conjunction with Trust management. Our completed work identified low, moderate and high rated findings. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and/or effectiveness of governance, risk management and control.

The key factors that contributed to our opinion are summarised as follows:

- High risk report ratings issued in relation to cancer wait times, business continuity and access policy for the Treatment Centre; and
- We issued high risk findings within the following reports – safeguarding and risk management.

The Trust's internal audit programme is directed to areas of *high risk and where individual weaknesses have been identified the executive director lead has ensured comprehensive action plans have been put in place to address these and evidence collated to support implementation. There were no *critical risk findings identified during 2013/14.

**The Internal Auditor's define a high risk as "there is considerable risk that the system will fail to meet management's objectives. Significant improvements are required to improve the adequacy and / or effectiveness of governance, risk management and control". A critical risk is defined as where "the systems have failed or there is a real and substantial risk that the systems will fail to meet management's objectives. Immediate action is required to improve the adequacy and / or effectiveness of governance, risk management and control."*

The areas identified as high risk and the actions taken are summarised below:

- Business continuity - The review highlighted a number of areas for improvement including that a formal comprehensive programme of business continuity plan testing is currently not in place. The report recognises that some business continuity testing has taken place within regular training exercises and where the plans have been invoked to address events. Actions are in place to address the findings and a formalised plan is being developed which includes information technology.
- Cancer data quality – The review concluded that there was generally a sound process to monitor the progress of patients along key pathways and to prioritise those patients at risk of breaching national standards. Some concerns were identified about the Trust's ability to properly and fully record evidence for adjustments made to the pathways and reported waiting times. The Access Policy has been reviewed in line with the recommendations and an internal audit programme is being established.
- Safeguarding – safeguarding training is below the 95% target and the Trust's electronic staff record (ESR) system cannot identify non-compliant individuals reliably. The Trust has an ESR project in place to address the recording issues and enable self-service function. At the end of March 2014, safeguarding adult training was at 86% and safeguarding children is at 79%. There is a higher compliance level in the high risk areas and compliance is monitored monthly through the Board committees.

- Risk management – The review highlighted that all fields on the the risk register database are not being fully completed and reviewed within the timeframe. Steps are in place to address this with the individual areas identified with clear monitoring and escalation.
- Access policy for the Treatment Centre – This reviewed was designed to provide a gap analysis between the Trust's established access policy and that of the Treatment Centre under its previous ownership. The review identified a number of gaps in the Treatment Centre's policy, processes and recording and staff awareness. The Treatment Centre was transferred to the Trust in September 2014 and actions have been taken to address the findings and implement the Trust's access policy.

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 the external auditors, the Care Quality Commission inspections, the quality risk profile and intelligence monitoring report, the self-assessment against the CQC essential standards of quality and safety.

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 Monitor's quality governance framework 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*, the *risk and quality committee* and the *finance and performance 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 a robust assurance framework. This has enabled the Board to identify its strategic and annual 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
- the *finance and performance committee* highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the *risk and quality committee* for further scrutiny, 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 ensures that all senior staff, clinical and other, through various meetings and review processes, including bi-monthly performance reviews with each clinical division, are held to account in all areas for delivery against finance, performance, quality, governance and risk issues

- 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. This is supported by the positive CQC inspections and recent internal audit reports
- The evidence-based self-assessment review against the Department of Health Board Governance Assurance Framework and Monitor's Quality Governance Framework

Conclusion

The overall opinion is that no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives.

My review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2014/15.

Accounting officer: Nick Carver

Organisation: East and North Hertfordshire NHS Trust

Signature



Date

28 May 2014

Independent auditor's report to the directors of the East and North Hertfordshire NHS Trust

We have audited the financial statements of the East and North Hertfordshire NHS Trust for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise group and Trust statement of comprehensive income, the group and Trust statement of financial position, the group and Trust statement of cash flow, the statement of changes in taxpayers' equity and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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 on pages 82 and 83
- Table of pension benefits of senior managers and related narrative notes on pages 84 and 85
- Pay multiples narrative on page 84

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 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in April 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of directors and auditors

As explained more fully in the Statement of Directors' Responsibilities in respect of the accounts, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and East and North Hertfordshire NHS Trust as at 31 March 2014 and of the group's expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with the Trust Development Authority's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; and/or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and auditors

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2013, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2014.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2013, we are satisfied that in all significant respects the East and North Hertfordshire NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

Delay in certification of completion of the audit

We cannot conclude the audit formally and issue an audit certificate until we have completed the work necessary to provide assurance over the Trust's annual quality accounts. We are satisfied that this work does not have a material effect on the financial statements or on our value for money conclusion.

Paul Dossett
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP

28 May 2014

Data entered below will be used throughout the workbook:

Trust name	East and North Hertfordshire NHS Trust
This year	2013-14
Last year	2012-13
This year ended	31 March 2014
Last year ended	31 March 2013
This year commencing:	1 April 2013
Last year commencing:	1 April 2012

Accounts 2013-14

Details of Links

	Name of Note	Linked to		any other issues/notes
		Form	subcodes	
	Statement of Comprehensive Income	TRU01	sc100-sc200	
	Other Comprehensive Income	TRU01	sc250-sc330	Added additional row for 'Other Gains/losses' to template Rows do not match FMAs as IFRIC 12 rows reported on 1 line only in accounts
	Reported Financial Performance	TRU01	sc350-sc355	
	Statement of Financial Position	TRU02	sc100-sc490	
	Statement of Changes in Taxpayers Equity	TRU03	sc100-sc350	
	Statement of Cashflows	TRU04	sc100-sc640	
Note 1	Accounting Policies		N/A	
Note 2	XYZ pooled budget (optional)		N/A	
Note 3	Operating Segment		N/A	
Note 4	Income generation activities	TRU05	sc400-sc420	
Note 5	Revenue from patient care activities	TRU05	sc100-sc230	Calc to sum DH/other NHS spend not included. Separate analysis of Finance/Operating lease in Other Operating Revenue not included
Note 6	Other operating revenue	TRU05	sc250-sc370	
Note 7	Revenue		N/A	Other' figure is different to FMAs as TRU06 includes change in discount rate in the 'Other' total, but this is shown on a separate row in accounts proforma. Accounts forms also exclude the DH requirement for an analysis of Depreciation and amortisation between gov/donated and other assets
Note 8	Operating Expenses	TRU06	sc100-sc430	
Note 9	Operating Leases	TRU08	sc100-sc330	Analysis slightly diff format on TRU08 In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and Wages' row and prior year feeds to this row.
Note 10.1	Employee Benefits	TRU09	sc100-sc420	
Note 10.2	Average Staff Numbers	TRU09	sc460-sc560	
Note 10.3	Staff Sickness absence and ill health			Sickness absence figures will be supplied separately after draft accounts deadline in Cabinet Office format
Note 10.3	retirements	TRU09	sc570-sc594	
Note 10.4	Exit Packages	TRU10	sc100-sc270	
Note 10.5	Exit Packages Disclosures	TRU10	sc280-sc350	NEW table for 2013-14
Note 10.6	Pension costs (narrative disclosure)		N/A	
Note 11	Better Payment Practice Code	TRU09	sc600-sc670	
Note 12	Investment Revenue	TRU11	sc100-sc210	
Note 13	Other Gains and Losses	TRU11	sc211-sc300	
Note 14	Finance Costs	TRU11	sc310-sc420	
Note 15.1	Property, Plant and Equipment	TRU12	sc100-sc1090	
Note 15.2	Property, Plant and Equipment prior year	TRU12	sc630-sc1045	Prior year analysis of purchase/lease differs
Note 16	Intangible fixed assets	TRU13	sc100-sc390	
Note 16.2	Intangible fixed assets prior year	TRU13	sc480-sc840	Prior year analysis of purchase not linked
Note 17	Analysis of impairments and reversals	TRU14	sc100-sc960	
Note 18	Investment property	TRU15	sc100-sc190	
Note 19	Commitments	TRU15	sc200-sc220	
Note 19.2	Other Capital Commitments	TRU19	sc340-sc370	
Note 20	Intra-Government and other balances	TRU15	sc230-sc340	

Note 21	Inventories	TRU15	sc620-sc750	No Prior-year table on FMA or accounts for this
Note 22.1	Trade and Other Receivables	TRU16	sc200-sc490	
Note 22.2	Receivables past their due date but not impair	TRU16	sc500-sc530	No Prior_year table on FMA forms so will need to be completed manually
Note 22.3	Provision for impairment of receivables	TRU16	sc540-sc660	No Prior_year table on FMA forms so will need to be completed manually
Note 23	NHS LIFT investments	TRU21	sc450-sc570	
Note 24.1	Other Financial Assets - Current	TRU16	sc1400-sc1411	No prior year balances except closing and current year figures will have to be calculated
Note 24.2	Other Financial Assets - Non-current	TRU16	sc1240-sc1391	No prior year figures on FMA forms and 3 new rows introduced to table in current year
Note 24.3	Other Financial Assets - Non Current - Capital	N/A		Not linked as not on FMA forms. FREM requirement though
Note 25	Other current assets	TRU16	sc800-sc820	
Note 26	Cash and Cash Equivalents	TRU16	sc857-sc950	
Note 27	Non-current assets held for sale	TRU15	sc800-sc1030	
Note 28	Trade and Other Payables	TRU17	sc110-sc370	
Note 29	Other Liabilities	TRU17	sc400-sc480	
Note 30	Borrowings	TRU17	sc500-sc750	
Note 31	Other Financial Liabilities	TRU17	sc850-sc930	
Note 32	Deferred Revenue	TRU17	sc950-sc1030	
Note 33	Finance lease obligations as lessee	TRU18	sc100-sc320	
Note 34	Finance lease receivables as lessor	TRU18	sc330-sc810	
Note 35	Provisions	TRU19	sc100-sc250	
Note 36	Contingencies	TRU19	sc290-sc330	
Note 37	PFI and LIFT - additional information	TRU20	sc100-sc580	
Note 38	Impact of IFRS treatment - current year	TRU20	sc510-sc650	
Note 39	Financial Instruments: Financial Assets and Li	TRU21	sc100-sc350	Note: Additional narrative disclosure required in accounts on Financial Risk Management
Note 40	Events after the end of the reporting period	TRU21	sc400	Note: Additional narrative disclosure required in accounts
Note 41	Related party transactions	N/A		
Note 42	Losses and special payments	TRU22	sc100-sc390	Prior-year is not linked for this Note as not on FMA forms
Note 43.1	Breakeven performance	TRU25	sc100-sc280	
Note 43.2	Capital cost absorption rate	N/A		
Note 43.3	External financing	TRU25	sc330-sc380	
Note 43.4	Capital resource limit	TRU25	sc545-sc600	
Note 44	Third party assets	n/A		

**Statement of Comprehensive Income for year ended
31 March 2014**

	NOTE	2013-14 £000s	2012-13 £000s	Group 2013-14 £000s	Group 2012-13 £000s
Gross employee benefits	10.1	(227,011)	(222,544)	(227,011)	(222,544)
Other operating costs	8	(132,963)	(135,344)	(133,887)	(136,502)
Revenue from patient care activities	5	316,720	285,862	316,720	285,862
Other Operating revenue	6	48,593	64,681	49,271	65,525
Operating surplus/(deficit)		5,339	(7,345)	5,093	(7,659)
Investment revenue	12	28	31	108	103
Other gains and (losses)	13	0	0	0	0
Finance costs	14	(2,498)	(1,865)	(2,498)	(1,865)
Surplus/(deficit) for the financial year		2,869	(9,179)	2,703	(9,421)
Public dividend capital dividends payable		(3,127)	(3,237)	(3,127)	(3,237)
Transfers by absorption - gains		40,425	0	40,425	0
Transfers by absorption - (losses)		(18,014)	0	(18,014)	0
Net Gain/(loss) on transfers by absorption		22,411	0	22,411	0
Retained surplus/(deficit) for the year		22,153	(12,416)	21,987	(12,658)
Other Comprehensive Income		2013-14 £000s	2012-13 £000s		
Impairments and reversals taken to the Revaluation Reserve		(14,665)	(34,541)	(14,665)	(34,541)
Net gain/(loss) on revaluation of property, plant & equipment		6,208	13,992	6,208	13,992
Net gain/(loss) on revaluation of intangibles		0	0	0	0
Net gain/(loss) on revaluation of financial assets		0	0	117	277
Other gain/(loss) (explain in footnote below)		0	0	0	0
Net gain/(loss) on revaluation of available for sale financial assets		0	0	0	0
Net actuarial gain/(loss) on pension schemes		0	0	0	0
Other Pension Remeasurements		0		0	
Reclassification Adjustments					
On disposal of available for sale financial assets		0	0	0	0
Total Comprehensive Income for the year*		13,696	(32,965)	13,647	(32,930)
Financial performance for the year					
Retained surplus/(deficit) for the year		22,153	(12,416)		
Prior period adjustment to correct errors and other performance adjustments		0	0		
IFRIC 12 adjustment (including IFRIC 12 impairments)		0	0		
Impairments (excluding IFRIC 12 impairments)		781	12,658		
Adjustments in respect of donated gov't grant asset reserve elimination [if required]		(414)	290		
Adjustment re Absorption accounting		(22,411)	0		
Adjusted retained surplus/(deficit)		109	532		

*[Insert explanation re adjustments made to accounting outturn to arrive at reported performance.
Note that prior year performance is not re-assessed following accounting restatements]*

The notes on pages x to xx form part of this account.

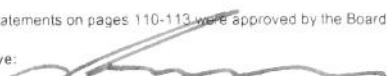
Statement of Financial Position as at
31 March 2014

		31 March 2014	31 March 2013	Group 31 March 2014	Group 31 March 2013	Group 1 April 2012
NOTE	£000s	£000s	£000s	£000s	£000s	£000s
Non-current assets:						
Property, plant and equipment	15	184,701	140,280	184,701	140,280	166,633
Intangible assets	16	4,708	4,388	4,715	4,399	3,859
Investment property	18	0	0	0	0	0
Other Investments - Charitable				2,905	2,809	2,550
Other financial assets		0	0	0	0	0
Trade and other receivables	22.1	1,436	1,485	1,436	1,485	1,325
Total non-current assets		190,845	146,153	193,757	148,973	174,367
Current assets:						
Inventories	21	4,890	4,864	4,890	4,864	4,738
Trade and other receivables	22.1	40,073	23,277	39,972	23,867	20,571
Other financial assets	24	0	0	0	0	0
Other current assets	25	0	0	0	0	0
Cash and cash equivalents	26	4,289	10,099	4,741	10,318	10,260
Total current assets		49,252	38,240	49,603	39,049	35,569
Non-current assets held for sale	27	0	0	0	0	0
Total current assets		49,252	38,240	49,603	39,049	35,569
Total assets		240,097	184,393	243,360	188,022	209,936
Current liabilities						
Trade and other payables	28	(49,785)	(39,283)	(49,803)	(39,619)	(41,252)
Other liabilities	29	(203)	(203)	(203)	(203)	(203)
Provisions	35	(363)	(194)	(363)	(194)	(456)
Borrowings	30	(275)	(241)	(275)	(241)	(169)
Other financial liabilities	31	(140)	(135)	(140)	(135)	(40)
Working capital loan from Department	30	0	0	0	0	0
Capital loan from Department	30	(2,509)	(1,561)	(2,509)	(1,561)	(1,038)
Total current liabilities		(53,275)	(41,617)	(53,293)	(41,953)	(43,158)
Net current assets/(liabilities)		(4,023)	(3,377)	(3,690)	(2,904)	(7,589)
Non-current assets plus/less net current assets/liabilities		186,822	142,776	190,067	146,069	166,778
Non-current liabilities						
Trade and other payables	28	0	0	0	0	0
Other Liabilities	31	(5,420)	(5,623)	(5,420)	(5,623)	(5,826)
Provisions	35	(899)	(961)	(899)	(961)	(1,079)
Borrowings	31	(7,711)	(7,875)	(7,711)	(7,875)	(8,173)
Other financial liabilities	30	(2,891)	(3,030)	(2,891)	(3,030)	(1,167)
Working capital loan from Department	30	0	0	0	0	0
Capital loan from Department	30	(54,351)	(34,271)	(54,351)	(34,271)	(22,899)
Total non-current liabilities		(71,272)	(51,760)	(71,272)	(51,760)	(39,144)
Total Assets Employed:		115,550	91,016	118,795	94,309	127,634
FINANCED BY:						
TAXPAYERS' EQUITY						
Public Dividend Capital		161,980	151,139	161,980	151,139	151,534
Retained earnings		(83,636)	(105,787)	(83,636)	(105,787)	(95,329)
Revaluation reserve		37,207	45,664	37,207	45,664	68,171
Charitable Funds Reserve				3,245	3,293	3,258
Other reserves		0	0	0	0	0
Total Taxpayers' Equity:		115,550	91,016	118,795	94,309	127,634

The notes on pages 114 to 157 form part of this account.

The financial statements on pages 110-113 were approved by the Board on Wednesday 28th May 2014 and signed on its behalf by

Chief Executive:



Date:

3rd June 2014

**Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2014**

	Pre Consolidation					Public Dividend capital £000s	Retained earnings £000s	Group Revaluati on reserve £000s	Charitabl e Funds Reserve £000s	Other reserves £000s	Total reserves £000s
	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s						
Balance at 1 April 2013	151,139	(105,787)	45,664	0	91,016	151,139	(105,787)	0	45,664	0	91,016
Changes in taxpayers' equity for 2013-14											
Retained surplus/(deficit) for the year		22,153			22,153		22,153				22,153
Net gain / (loss) on revaluation of property, plant, equipment			6,208		6,208			6,208			6,208
Net gain / (loss) on revaluation of intangible assets			0		0			0			0
Net gain / (loss) on revaluation of financial assets			0		0			0			0
Net gain / (loss) on revaluation of available for sale financial assets			0		0			0			0
Impairments and reversals			(14,665)		(14,665)			(14,665)			(14,665)
Other gains/(loss) (provide details below)			0		0			0			0
Transfers between reserves		0	0		0		0	0			0
Transfers under Modified Absorption Accounting - PCTs & SHAs		0	0		0		0	0			0
Transfers under Modified Absorption Accounting - Other Bodies		0	0		0		0	0			0
Reclassification Adjustments											
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0		0	0	0	0			0
Transfers between Revaluation Reserve & Retained Earnings in respect of assets transferred under absorption		0	0		0		0	0			0
On Disposal of Available for Sale financial Assets			0		0			0			0
Reserves eliminated on dissolution	0	0	0		0	0	0	0			0
Originating capital for Trust established in year	0				0			0			0
New PDC Received - Cash	15,940				15,940	15,940					15,940
New PDC Received/(Repaid) - PCTs and SHAs Legacy items paid for by Department of Health	0				0	0					0
PDC Repaid In Year	(5,100)				(5,100)	(5,100)					(5,100)
PDC Written Off	0				0	0					0
Transferred to NHS Foundation Trust	0	0	0		0	0		0			0
Other Movements	0	0	0		0	0		0			0
Revaluation and impairment of Charitable fund assets											
Charitable Funds Adjustment						(166)		3,245			3,079
Net Actuarial Gain/(Loss) on Pension					0	0		0			0
Other Pensions Remeasurement					0	0		0			0
Net recognised revenue/(expense) for the year	10,841	22,153	(8,457)	0	24,537	10,841	21,987	(8,457)	3,245	0	27,616
Transfers between reserves in respect of modified absorption - PCTs & SHAs		0	0		0		0	0			0
Transfers between reserves in respect of modified absorption - Other Bodies		0	0		0		0	0			0
Balance at 31 March 2014	161,980	(83,634)	37,207	0	115,553	161,980	(83,800)	37,207	3,245	0	118,632
Balance at 1 April 2012	151,534	(95,329)	68,171	0	124,376	151,534	(95,329)	68,171	0	0	124,376
Changes in taxpayers' equity for the year ended 31 March 2013											
Retained surplus/(deficit) for the year		(12,416)			(12,416)		(12,416)				(12,416)
Net gain / (loss) on revaluation of property, plant, equipment			13,992		13,992			13,992			13,992
Net gain / (loss) on revaluation of intangible assets			0		0			0			0
Net gain / (loss) on revaluation of financial assets			0		0			0			0
Net gain / (loss) on revaluation of assets held for sale			0		0			0			0
Impairments and reversals			(34,541)		(34,541)			(34,541)			(34,541)
Movements in other reserves			0		0			0			0
Transfers between reserves		1,958	(1,958)		0		1,958	(1,958)			0
Release of reserves to Statement of Comprehensive Income			0		0			0			0
Reclassification Adjustments											
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0		0	0	0	0			0
Transfers between Revaluation Reserve & Retained Earnings Reserve in respect of assets transferred under absorptio		0	0		0		0	0			0
On Disposal of Available for Sale financial Assets			0		0			0			0
Reserves eliminated on dissolution	0	0	0		0	0	0	0			0
Originating capital for Trust established in year	0				0			0			0
New PDC Received	4,942				4,942	4,942					4,942
PDC Repaid In Year	(5,337)				(5,337)	(5,337)					(5,337)
PDC Written Off	0				0	0		0			0
Transferred to NHS Foundation Trust	0	0	0		0	0		0			0
Other Movements in PDC In Year	0				0	0		0			0
Revaluation and impairment of Charitable fund assets											
Charitable Funds Adjustment						(242)		3,293			3,051
Net Actuarial Gain/(Loss) on Pension					0	0		0			0
Net recognised revenue/(expense) for the year	(395)	(10,458)	(22,507)	0	(33,360)	(395)	(10,700)	(22,507)	3,293	0	(30,369)
Balance at 31 March 2013	151,139	(105,787)	45,664	0	91,016	151,139	(106,029)	45,664	3,293	0	94,067

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED

31 March 2014

Group

	NOTE	2013-14 £000s	2012-13 £000s	2013-14 £000s	2012-13 £000s
Cash Flows from Operating Activities					
Operating Surplus/(Deficit)		5,339	(7,345)	5,339	(7,345)
Depreciation and Amortisation		7,664	7,919	7,664	7,919
Impairments and Reversals		781	12,658	781	12,658
Other Gains/(Losses) on foreign exchange		0	0	0	0
Donated Assets received credited to revenue but non-cash		(1,173)	(269)	(1,173)	(269)
Government Granted Assets received credited to revenue but non-cash		0	0	0	0
Interest Paid		(2,077)	(970)	(2,077)	(970)
Dividend (Paid)/Refunded		(3,155)	(3,241)	(3,155)	(3,241)
Release of PFI/deferred credit		0	243	0	243
(Increase)/Decrease in Inventories		(26)	(126)	(26)	(126)
(Increase)/Decrease in Trade and Other Receivables		(19,447)	(233)	(19,447)	(233)
(Increase)/Decrease in Other Current Assets		0	0	0	0
Increase/(Decrease) in Trade and Other Payables		10,232	6,839	10,232	6,839
(Increase)/Decrease in Other Current Liabilities		(203)	(203)	(203)	(203)
Provisions Utilised		(224)	(414)	(224)	(414)
Increase/(Decrease) in Provisions		331	8	331	8
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows				233	(439)
Net Cash Inflow/(Outflow) from Operating Activities		(1,958)	14,866	(1,725)	14,427
CASH FLOWS FROM INVESTING ACTIVITIES					
Interest Received		28	31	28	31
(Payments) for Property, Plant and Equipment		(37,474)	(24,678)	(37,474)	(24,678)
(Payments) for Intangible Assets		(1,458)	(1,616)	(1,458)	(1,616)
(Payments) for Investments with DH		0	0	0	0
(Payments) for Other Financial Assets		0	0	0	0
(Payments) for Financial Assets (LIFT)		0	0	0	0
Proceeds of disposal of assets held for sale (PPE)		2,700	394	2,700	394
Proceeds of disposal of assets held for sale (Intangible)		0	0	0	0
Proceeds from Disposal of Investment with DH		0	0	0	0
Proceeds from Disposal of Other Financial Assets		0	0	0	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0	0	0
Loans Made in Respect of LIFT		0	0	0	0
Loans Repaid in Respect of LIFT		0	0	0	0
Rental Revenue		484	0	484	0
NHS Charitable Funds - net cash flows relating to investing activities				0	0
Net Cash Inflow/(Outflow) from Investing Activities		(35,720)	(25,869)	(35,720)	(25,869)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		(37,678)	(11,003)	(37,445)	(11,442)
CASH FLOWS FROM FINANCING ACTIVITIES					
Public Dividend Capital Received		15,940	0	15,940	0
Public Dividend Capital Repaid		(5,100)	(394)	(5,100)	(394)
Loans received from DH - New Capital Investment Loans		23,165	18,093	23,165	18,093
Loans received from DH - New Revenue Support Loans		0	0	0	0
Other Loans Received		0	0	0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		(2,137)	(6,199)	(2,137)	(6,199)
Loans repaid to DH - Revenue Support Loans		0	0	0	0
Other Loans Repaid		0	0	0	0
Cash transferred to NHS Foundation Trusts		0	0	0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		0	0	0	0
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		0	0	0	0
NHS Charitable Funds - net cash flows relating to Financing activities					
Net Cash Inflow/(Outflow) from Financing Activities		31,868	11,500	31,868	11,500
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		(5,810)	497	(5,577)	58
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		10,099	9,602	10,318	10,260
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0	0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		4,289	10,099	4,741	10,318

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 2013-14 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 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE/SOCNI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the SOCNE/SOCNI.

During the year 2013/14 the Trust absorbed an asset titled "The Independent Sector Treatment Centre". This was absorbed from East and North Hertfordshire Clinical Commissioning Group. The value for this on absorption was £40,425k which was impaired by £18,014k to £22,411k. This asset is now called the Lister Treatment centre.

1.4 Charitable Funds

For 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with NHS Trust's own returns is removed. Under the provisions of IAS 27 *Consolidated and Separate Financial Statements*, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 *Presentation of Financial Statements*, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust Charitable Funds have been consolidated within this set of Accounts.

1.5 Pooled Budgets

The Trust has no pooled budgets.

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

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

There are no critical judgements or estimations that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.6.2 Key sources of estimation uncertainty

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

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

The estimation of partly completed spells - note 22.1

Provision for impairment of receivables - note 22.3

The valuation of property, plant and equipment - note 15.3

The calculation of provisions - note 35

1.7 Revenue

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

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

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

1.8 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, except for bonuses earned but not yet taken which is not accrued for at the year end on the grounds of immateriality. No accruals are necessary in respect of annual leave earned but not taken as staff have not been permitted to carry forward annual leave since 2011-12.

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

Retirement benefit costs

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

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

1.9 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.

1.10 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 impairment.

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

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.

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 that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. 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.

1.11 Intangible assets

Recognition

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

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

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it

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

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

Measurement

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

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

1.12 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 life.

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

1.15 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.

1.16 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 and individually 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.

1.17 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)

1.18 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.

1.19 Cash and cash equivalents

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

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

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

1.20 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 (2.35% for employee early departure obligations).

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

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

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

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 35.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

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

1.24 Contingencies

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

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

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

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

1.25 Financial assets

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

Financial assets are initially recognised at fair value.

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

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

1.26 Financial liabilities

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

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

Financial guarantee contract liabilities

The Trust currently has no financial guarantee contract liabilities

Financial liabilities at fair value through profit and loss

The Trust currently has no contracts containing embedded derivatives

Other financial liabilities

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

1.27 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.

1.28 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.

1.29 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 44 to the accounts.

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

1.30 Public Dividend Capital (PDC) and PDC dividend [NHS trust only]

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.

1.31 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).

1.32 Subsidiaries

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

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

From 2013-14, the Trust consolidates the results of East and North Hertfordshire NHS Trust Charitable Funds over which it considers it has the power to exercise control in accordance with IAS27 requirements.

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

1.33 Joint operations

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

Under this heading, the Trust is involved in a Transforming Pathology Partnership with a number of other NHS parties.

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.

1.35 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. pooled budget

The Trust has no pooled budgets

3. Operating segments

The East and North Hertfordshire NHS Trust provides healthcare services only. 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 Clinical Commissioning Groups, in 2012/13 Primary Care Trusts and as such provide the same level of risk for each area. Therefore the Trust considers single segment reporting to be the most appropriate reporting format. Details of revenue from the single segment are disclosed in notes 3 and 4.

In 2013/14 income from transactions with Clinical Commissioning Groups amounted to £328 million (Primary Care Trust Income 2012/13 £307 million) which accounted for 90% of total income (2012/13 88%).

4. Income generation activities

The trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care, however none of those activities have a full cost exceeding £1m or was otherwise material.

5. Revenue from patient care activities

	2013-14 £000s	2012-13 £000s
NHS Trusts	323	0
NHS England	77,467	0
Clinical Commissioning Groups	233,044	0
Primary Care Trusts		280,369
Strategic Health Authorities		0
NHS Foundation Trusts	0	0
Department of Health	0	0
NHS Other (including Public Health England and Prop Co)	272	0
Non-NHS:		
Local Authorities	0	132
Private patients	3,168	3,340
Overseas patients (non-reciprocal)	437	382
Injury costs recovery	1,146	975
Other	863	664
Total Revenue from patient care activities	316,720	285,862

The increase in 2013/14 is due to the Trust takeover of the Lister Treatment Centre mid-year £10m, growth in outpatient services £10m and costs passed directly through to commissioners (high cost drugs and patient transport services - £5m).

6. Other operating revenue

	2013-14 £000s	2012-13 £000s
Recoveries in respect of employee benefits	3,363	4,020
Patient transport services	0	0
Education, training and research	18,487	16,936
Charitable and other contributions to revenue expenditure - NHS	0	0
Charitable and other contributions to revenue expenditure -non- NHS	0	0
Receipt of donations for capital acquisitions - NHS Charity	1,173	269
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies	17,766	34,734
Income generation	2,320	2,222
Rental revenue from finance leases	0	0
Rental revenue from operating leases	484	0
Other revenue	5,678	7,344
Total Other Operating Revenue	49,271	65,525
Total operating revenue	365,991	351,387

The main elements of the decrease in Other Operating Revenue was lower Transitional Relief in respect of the Treatment Centre from £14m in 2012/13 to £5m in 2013/14.

Operating operating revenue includes for 2013/14 £678k and for 2012/13 £844k consolidated charity revenue

7. Revenue

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

8. Operating expenses

	2013-14 £000s	2012-13 £000s
Services from other NHS Trusts	5,393	4,945
Services from CCGs/NHS England	0	-
Services from other NHS bodies	53	121
Services from NHS Foundation Trusts	4,866	1,860
Services from Primary Care Trusts	-	0
Total Services from NHS bodies*	10,312	6,926
Purchase of healthcare from non-NHS bodies	3,754	3,195
Trust Chair and Non-executive Directors	49	52
Supplies and services - clinical	58,594	58,320
Supplies and services - general	19,081	20,006
Consultancy services	862	534
Establishment	4,940	3,493
Transport	823	897
Premises	14,985	12,151
Hospitality	0	-
Insurance	0	-
Legal Fees	0	-
Impairments and Reversals of Receivables	(4)	275
Inventories write down	0	0
Depreciation	6,526	6,856
Amortisation	1,138	1,063
Impairments and reversals of property, plant and equipment	781	12,648
Impairments and reversals of intangible assets	0	10
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	0
Impairments and reversals of investment properties	-	0
Audit fees	137	131
Other auditor's remuneration [detail]	0	1
Clinical negligence	8,114	6,939
Research and development (excluding staff costs)	0	0
Education and Training	1,037	943
Change in Discount Rate	0	0
Other	2,758	2,062
Total Operating expenses (excluding employee benefits)	133,887	136,502
Employee Benefits		
Employee benefits excluding Board members	226,028	221,803
Board members	983	741
Total Employee Benefits	227,011	222,544
Total Operating Expenses	360,898	359,046

*Services from NHS bodies does not include expenditure which falls into a category below

9 Operating Leases

The Trust's leasing arrangements have been classified as operating leases excluding PFI, therefore all associated costs are charged to the Statement of Comprehensive Income in the accounting period to which they relate.

9.1 Trust as lessee				2013-14	2012-13
	Land £000s	Buildings £000s	Other £000s	Total £000s	£000s
Payments recognised as an expense					
Minimum lease payments	0	0	0	4,201	4,131
Contingent rents	0	0	0	0	0
Sub-lease payments	0	0	0	0	0
Total	0	0	0	4,201	4,131
Payable:					
No later than one year	0	0	3,703	3,703	3,853
Between one and five years	0	0	10,145	10,145	8,302
After five years	0	0	268	268	4,228
Total	0	0	14,116	14,116	16,383
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

The Trust does not act as a lessor.

10 Employee benefits and staff numbers

10.1 Employee benefits

	2013-14		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	194,645	174,217	20,428
Social security costs	15,032	15,032	0
Employer Contributions to NHS BSA - Pensions Division	19,550	19,550	0
Other pension costs	0	0	0
Termination benefits	0	0	0
Total employee benefits	229,227	208,799	20,428
Employee costs capitalised	2,216	2,216	0
Gross Employee Benefits excluding capitalised costs	227,011	206,583	20,428

	2012-13		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2012-13			
Salaries and wages	190,755	170,613	20,142
Social security costs	14,445	14,289	156
Employer Contributions to NHS BSA - Pensions Division	19,029	18,917	112
Other pension costs	0	0	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	224,229	203,819	20,410
Employee costs capitalised	1,685	1,606	79
Gross Employee Benefits excluding capitalised costs	222,544	202,213	20,331

In 2012-13 there were rows for 'other post-employment benefits' and 'other employment benefits'. These are now included within the 'Salaries and wages' row.

10.2 Staff Numbers

	2013-14			2012-13
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	721	695	26	700
Ambulance staff	0	0	0	0
Administration and estates	993	984	9	1,003
Healthcare assistants and other support staff	435	279	156	330
Nursing, midwifery and health visiting staff	2,233	2,079	154	2,279
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	749	730	18	717
Social Care Staff	1	1	0	0
Other	8	8	0	18
TOTAL	5,140	4,777	363	5,047
Of the above - staff engaged on capital projects	32	32	0	37

10.3 Staff Sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total Days Lost	41,889	40,544
Total Staff Years	4,772	4,730
Average working Days Lost	8.78	8.57
	2013-14 Number	2012-13 Number
Number of persons retired early on ill health grounds	6	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	325	374

10.4 Exit Packages agreed in 2013-14

Exit package cost band (including any special payment element)	2013-14			2012-13		
	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	0	.....	.....	0	0	0
£10,000-£25,000	0	0	0	0	0	0
£25,001-£50,000	0	.....	.....	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	0	0	0	0	0	0
Total resource cost (£000s)	0	61,306	61,306	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

In order to respect the confidentiality of individuals, numbers are rounded to the nearest ten, and numbers less than five are represented by "...".

10.5 Exit packages - Other Departures analysis

	2013-14		2012-13	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	61,306	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	3	61,306	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

10.6 Pension costs

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

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

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

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

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

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

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

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

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

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

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

11 Better Payment Practice Code

11.1 Measure of compliance

	2013-14 Number	2013-14 £000s	2012-13 Number	2012-13 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	68,401	158,097	71,842	111,726
Total Non-NHS Trade Invoices Paid Within Target	53,735	110,883	55,056	77,690
Percentage of NHS Trade Invoices Paid Within Target	78.56%	70.14%	76.63%	69.54%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,960	28,479	3,070	36,234
Total NHS Trade Invoices Paid Within Target	1,767	12,942	1,681	19,288
Percentage of NHS Trade Invoices Paid Within Target	59.70%	45.44%	54.76%	53.23%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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

	2013-14 £000s	2012-13 £000s
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

12 Investment Revenue

	2013-14 £000s	2012-13 £000s
Rental revenue		
PFI finance lease revenue (planned)	0	0
PFI finance lease revenue (contingent)	0	0
Other finance lease revenue	0	0
Subtotal	<u>0</u>	<u>0</u>
Interest revenue		
LIFT: equity dividends receivable	0	0
LIFT: loan interest receivable	0	0
Bank interest	108	103
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Subtotal	<u>108</u>	<u>103</u>
Total investment revenue	<u>108</u>	<u>103</u>

Investment revenue includes for 2013/14 £80k and for 2012/13 £72k consolidated charity revenue.

13 Other Gains and Losses

	2013-14 £000s	2012-13 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	0
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0
Gain/(Loss) on disposal of Financial Assets other than held for sale	0	0
Gain (Loss) on disposal of assets held for sale	0	0
Gain/(loss) on foreign exchange	0	0
Change in fair value of financial assets carried at fair value through the SoCI	0	0
Change in fair value of financial liabilities carried at fair value through the SoCI	0	0
Change in fair value of investment property	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	<u>0</u>	<u>0</u>

14 Finance Costs

	2013-14 £000s	2012-13 £000s
Interest		
Interest on loans and overdrafts	1,572	970
Interest on obligations under finance leases	1	0
Interest on obligations under PFI contracts:		
- main finance cost	608	617
- contingent finance cost	298	199
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Total interest expense	<u>2,479</u>	<u>1,786</u>
Other finance costs	0	0
Provisions - unwinding of discount	19	26
Total	<u>2,498</u>	<u>1,812</u>

15.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
2013-14									
Cost or valuation:									
At 1 April 2013	34,963	74,617	0	13,304	46,789	113	11,163	3,314	184,263
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	0
Additions of Assets Under Construction				31,094					31,094
Additions Purchased	0	3,642	0		1,886	0	702	243	6,473
Additions Donated	0	77	0		123	0	6		206
Additions - Government Granted	0	0	0		0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	0	0	(1,593)	1,593	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	0	0	0	0	0
Upward revaluation/positive indexation	1,321	4,887	0	0	0	0	0	0	6,208
Impairments/negative indexation	0	(14,664)	0	0	0	0	0	0	(14,664)
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	36,410	0	0	4,015	0	0	0	40,425
At 31 March 2014	36,284	104,969	0	42,805	54,406	113	11,871	3,557	254,005
Depreciation									
At 1 April 2013	0	0	0	0	32,960	113	8,432	2,478	43,983
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	436	0	0	345	0	0	0	781
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Charged During the Year	0	1,889	0		3,489	0	926	222	6,526
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	15,744	0		2,270	0	0	0	18,014
At 31 March 2014	0	18,069	0	0	39,064	113	9,358	2,700	69,304
Net Book Value at 31 March 2014	36,284	86,900	0	42,805	15,342	0	2,513	857	184,701
Asset financing:									
Owned - Purchased	36,284	80,225	0	42,805	15,219	0	2,507	857	177,897
Owned - Donated	0	77	0	0	123	0	6	0	206
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	6,598	0	0	0	0	0	0	6,598
PFI residual- interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2014	36,284	86,900	0	42,805	15,342	0	2,513	857	184,701

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	13,303	31,715	0	0	480	143	0	23	45,664
At 31 March 2014	13,303	31,715	0	0	480	143	0	23	45,664

Additions to Assets Under Construction in 2013/14

	£000's
Land	0
Buildings excl Dwellings	31,094
Dwellings	0
Plant & Machinery	0
Balance as at YTD	31,094

15.2 Property, plant and equipment prior-year

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
2012-13									
Cost or valuation:									
At 1 April 2012	37,571	136,946	0	12,196	47,516	113	10,486	3,197	248,025
Additions - Assets Under Construction				5,512					5,512
Additions - purchased	92	9,101	0		1,259	0	484	77	11,013
Additions - donated	0	15	0	21	0	0	193	40	269
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	6,017	0	(4,425)	(1,592)	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	(2,700)	(42,123)	0	0	(394)	0	0	0	(45,217)
Revaluation & indexation gains	0	13,992	0	0	0	0	0	0	13,992
Impairments	0	(34,791)	0	0	0	0	0	0	(34,791)
Reversals of impairments	0	250	0	0	0	0	0	0	250
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	34,963	89,407	0	13,304	46,789	113	11,163	3,314	199,053
Depreciation									
At 1 April 2012	0	0	0	0	29,410	113	7,491	2,255	39,269
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		0	0	0	0	0
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	0	12,584	0	0	281	0	101	19	12,985
Reversal of Impairments	0	(63)	0	0	(190)	0	(71)	(13)	(337)
Charged During the Year	0	2,269	0		3,459	0	911	217	6,856
Transfer to NHS Foundation Trust	0	0	0		0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2013	0	14,790	0	0	32,960	113	8,432	2,478	58,773
Net book value at 31 March 2013	34,963	74,617	0	13,304	13,829	0	2,731	836	140,280
Purchased	0	74,432	0	13,283	10,916	0	2,523	726	101,880
Donated	0	185	0	21	2,913	0	208	110	3,437
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	0	74,617	0	13,304	13,829	0	2,731	836	105,317
Asset financing:									
Owned	34,963	67,643	0	13,304	13,829	0	2,731	836	133,306
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	6,974	0	0	0	0	0	0	6,974
Total at 31 March 2013	34,963	74,617	0	13,304	13,829	0	2,731	836	140,280

15.3 (cont). Property, plant and equipment

In 2013/14 the Trust received donated assets from East and North Hertfordshire NHS Trust Charitable Fund £161K.

The land and building assets held by the Trust were revalued in year using the modern equivalent assets valuation methodology, in accordance with DH guidance and International Financial Reporting Standards. The revaluation was carried out by an independent qualified valuer. The effective date for the valuation was 1st April 2013.

Basis for Valuation

The Trust has revalued its land and building assets during 2013, as at a valuation date of 1st April 2013, 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 2014.

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.

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 UKPS 1.3 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 tangible fixed assets range from:

	Min life (years)	Max life (years)
Buildings exc dwellings	19	90
Dwellings	20	90
Plant & Machinery	5	20
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	7	10

There have been no changes to asset lives/residual values other than those advised by the independent valuer during their review on a MEA basis.

There have been no write-downs to recoverable amount or any reversals of write-downs.

Property is held at existing use value and is not materially different from its open market value.

16.1 Intangible non-current assets

	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
2013-14						
At 1 April 2013	0	1,887	858	0	6,631	9,376
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0
Additions - purchased	0	103	314	0	0	417
Additions - internally generated	0	0	0	0	1,041	1,041
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions - leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments charged to reserves	0	0	0	0	0	0
Reversal of impairments charged to reserves	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	0	1,990	1,172	0	7,672	10,834
Amortisation						
At 1 April 2013	0	646	513	0	3,822	4,981
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	305	111	0	722	1,138
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	0	951	624	0	4,544	6,119
Net Book Value at 31 March 2014	0	1,039	548	0	3,128	4,715
Asset Financing: Net book value at 31 March 2014 comprises:						
Purchased	0	1,039	548	0	3,128	4,715
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0
Total at 31 March 2014	0	1,039	548	0	3,128	4,715

Intangible non-current assets includes for 2013/14 £7k consolidated charity assets.

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2013	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0
At 31 March 2014	0	0	0	0	0	0

16.2 Intangible non-current assets prior year

	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
2012-13						
Cost or valuation:						
At 1 April 2012	0	972	733	0	6,059	7,764
Additions - purchased	0	919	125	0	0	1,044
Additions - internally generated	0	0	0	0	572	572
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	<u>0</u>	<u>1,891</u>	<u>858</u>	<u>0</u>	<u>6,631</u>	<u>9,380</u>
Amortisation						
At 1 April 2012	0	496	419	0	2,993	3,908
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	3	1	0	29	33
Reversal of impairments charged to operating expenses	0	(1)	0	0	(22)	(23)
Charged during the year	0	148	93	0	822	1,063
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2013	<u>0</u>	<u>646</u>	<u>513</u>	<u>0</u>	<u>3,822</u>	<u>4,981</u>
Net book value at 31 March 2013	0	1,245	345	0	2,809	4,399
Net book value at 31 March 2013 comprises:						
Purchased	0	1,237	339	0	2,809	4,385
Donated	0	8	6	0	0	14
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	<u>0</u>	<u>1,245</u>	<u>345</u>	<u>0</u>	<u>2,809</u>	<u>4,399</u>

Intangible non-current assets includes for 2012/13 £11k consolidated charity assets.

16.3 Intangible non-current assets

The Trust accounts for intangible fixed assets in accordance with IAS 38. All intangible fixed assets with a value of over £5,000 are 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 fixed assets with an indefinite useful life.

The economic lives of intangible fixed assets range from:

	Min life (year)	Max life (years)
Software purchased	3	8
Licences and trademarks	2	8
Development Expenditure	5	8

17 Analysis of impairments and reversals recognised in 2013-14

	2013-14 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	781
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	781
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Property, Plant and Equipment charged to SoCI	781
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Intangibles charged to SoCI	0
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Financial Assets charged to SoCI	0
Non-current assets held for sale - impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total impairments of non-current assets held for sale charged to SoCI	0
Total Impairments charged to SoCI - DEL	781
Total Impairments charged to SoCI - AME	0
Overall Total Impairments	781
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

18 Investment property

	31 March 2014 £000s	31 March 2013 £000s
At fair value		
Balance at 1 April 2013	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Additions Through Subsequent Expenditure	0	0
Other Acquisitions	0	0
Disposals	0	0
Property Reclassified as Held for Sale	0	0
Loss from Fair Value Adjustments - Impairments	0	0
Loss from Fair Value Adjustments - Reversal of Impairments	0	0
Gain from Fair Value Adjustments	0	0
Transfer to other NHS Foundation Trust	0	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	0	0
Other Changes	0	0
Balance at 31 March 2014	0	0

19 Commitments

19.1 Capital commitments

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

	31 March 2014 £000s	31 March 2013 £000s
Property, plant and equipment	20,759	39,126
Intangible assets	0	0
Total	20,759	39,126

19.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession

	31 March 2014 £000s	31 March 2013 £000s
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

20 Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other Central Government Bodies	23,717	0	5,292	0
Balances with Local Authorities	154	0	0	0
Balances with NHS bodies outside the Departmental Group	13	0	0	0
Balances with NHS Trusts and Foundation Trusts	3,937	0	5,191	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	0	0	0	0
At 31 March 2014	27,821	0	10,483	0
prior period:				
Balances with other Central Government Bodies	7,691	0	168	0
Balances with Local Authorities	90	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	15	0
Balances with NHS Trusts and Foundation Trusts	1,779	0	5,838	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	6,518	1,485	15,850	0
At 31 March 2013	16,078	1,485	21,871	0

21 Inventories	Drugs £000s	Consumables £000s	Work in Progress		Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
			£000s	£000s					
Balance at 1 April 2013	1,656	2,951	0	257	0	0	4,864	0	
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0			0	0	0	0	
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	
Additions	0	111	0	0	0	0	111	0	
Inventories recognised as an expense in the period	(30)	(15)	0	(40)	0	0	(85)	0	
Write-down of inventories (including losses)	0	0	0	0	0	0	0	0	
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	0	0	
Transfers (to) Foundation Trusts	0	0	0	0	0	0	0	0	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	
Balance at 31 March 2014	1,626	3,047	0	217	0	0	4,890	0	

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
NHS receivables - revenue	16,576	8,713	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	9,765	0	0	0
Non-NHS receivables - revenue	3,516	3,170	1,699	1,699
Non-NHS receivables - capital	0	2,700	0	0
Non-NHS prepayments and accrued income	6,015	6,518	0	0
Provision for the impairment of receivables	(578)	(689)	(263)	(214)
VAT	1,385	163	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	3,293	3,292	0	0
Total	39,972	23,867	1,436	1,485
Total current and non current	41,408	25,352		
Included in NHS receivables are prepaid pension contributions:	0			

The great majority of trade is with Clinical Commissioning Group's (CCG;s), as commissioners for NHS patient care services. As CCG's are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Trade and other receivables includes for 2013/14 -£101k and for 2012/13 £590k consolidated charity receivables.

22.2 Receivables past their due date but not impaired

	31 March 2014 £000s	31 March 2013 £000s
By up to three months	11,338	6,666
By three to six months	6,036	642
By more than six months	2,324	470
Total	19,698	7,778

22.3 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
Balance at 1 April 2013	(903)	(679)
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	
Transfers under Modified Absorption Accounting - Other Bodies	0	
Amount written off during the year	58	51
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	4	(275)
Transfer to NHS Foundation Trust	0	
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	
Balance at 31 March 2014	(841)	(903)

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non NHS debt has been analysed at dunning level and all overseas patient debt not on repayment plan has been provided for. 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 has been increased from 10.5% to 12.6% of total receivables under this category this financial year.

23 NHS LIFT investments

The Trust has no Lift investments.

24.1 Other Financial Assets - Current

	31 March 2014 £000s	31 March 2013 £000s
Opening balance 1 April	0	0
Transfers (to)/from Other Public Sector Bodies in year	0	0
Other Movements	0	0
Closing balance 31 March	<u>0</u>	<u>0</u>

24.2 Other Financial Assets - Non Current

	31 March 2014 £000s	31 March 2013 £000s
Opening balance 1 April	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Additions	0	0
Revaluation	0	0
Impairments/reversals taken to Revaluation Reserve	0	0
Impairment/reversals taken to SoCI	0	0
Change in Fair Value through SoCI	0	0
Transferred to current financial assets	0	0
Disposals	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0
Total Other Financial Assets - Non Current	<u>0</u>	<u>0</u>

25 Other current assets

	31 March 2014 £000s	31 March 2013 £000s
EU Emissions Trading Scheme Allowance	0	0
Other Assets	0	0
Total	<u>0</u>	<u>0</u>

26 Cash and Cash Equivalents

	31 March 2014 £000s	31 March 2013 £000s
Opening balance	10,318	9,821
Net change in year	(5,577)	497
Closing balance	<u>4,741</u>	<u>10,318</u>
Made up of		
Cash with Government Banking Service	4,281	10,005
Commercial banks	0	94
Cash in hand	8	0
Current investments	452	219
Cash and cash equivalents as in statement of financial position	<u>4,741</u>	<u>10,318</u>
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	<u>4,741</u>	<u>10,318</u>
Patients' money held by the [organisation], not included above	<u>0</u>	<u>0</u>

27 Non-current assets held for sale

The Trust has no Non-current assets held for sale.

28 Trade and other payables

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
NHS payables - revenue	2,356	2,285	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	8,127	3,736	0	0
Non-NHS payables - revenue	12,031	6,404	0	0
Non-NHS payables - capital	4,820	60	0	0
Non-NHS accruals and deferred income	15,143	13,520	0	0
Social security costs	2,048	2,641		
VAT	0	0	0	0
Tax	2,403	2,446		
Payments received on account	0	0	0	0
Other	2,875	8,527	0	0
Total	49,803	39,619	0	0
Total payables (current and non-current)	49,803	39,619		

Included above:

to Buy Out the Liability for Early Retirements Over 5 Years	0	0
number of Cases Involved (number)	0	0
outstanding Pension Contributions at the year end	2,827	(2,533)

Trade and other payables includes for 2013/14 £18k and for 2012/13 £336k consolidated charity payables.

29 Other liabilities

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
PFI/LIFT deferred credit	0	0	0	0
Lease incentives	0	0	0	0
Other [specify]	203	203	5,420	5,623
Total	203	203	5,420	5,623
Total other liabilities (current and non-current)	5,623	5,826		

The "Other" total liabilities relates to the inclusion of the Lister Hospital multi storey car park in the assets of the Trust. The car park has been funded through a private/public partnership arrangement. The liabilities relating to the car park asset will be amortised over a 30 year period at the end of which ownership will transfer to the Trust. The liability relating to the car park is split between other financial liabilities (Note 31) and deferred income (Note 32).

30 Borrowings

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - commercial banks	0	0		
Loans from Department of Health	2,509	1,561	54,351	34,271
Loans from other entities	0	0	0	0
PFI liabilities:				
Main liability	275	241	7,711	7,875
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	0	0	0	0
Other (describe)	0	0	0	0
Total	2,784	1,802	62,062	42,146
Total other liabilities (current and non-current)	64,846	43,948		

Loans - repayment of principal falling due in:

	31 March 2014		Total £000s
	DH £000s	Other £000s	
0-1 Years	2,509	275	2,784
1 - 2 Years	2,509	307	2,816
2 - 5 Years	7,528	952	8,480
Over 5 Years	44,314	6,452	50,766
TOTAL	56,860	7,986	64,846

31 Other financial liabilities

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Embedded Derivatives at Fair Value through SoCI	0	0	0	0
Financial liabilities carried at fair value through profit and loss	140	135	2891	3030
Amortised Cost	0	0	0	0
Total	140	135	2,891	3,030
Total other financial liabilities (current and non-current)	3,031	3,165		

32 Deferred revenue

	Current		Non-current	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Opening balance at 1 April 2013	2,904	203	5,623	5,826
Deferred revenue addition	2,449	2,701	0	0
Transfer of deferred revenue	0	0	-203	(203)
Current deferred income at 31 March 2014	5,353	2,904	5,420	5,623
Total deferred income (current and non-current)	10,773	8,527		

33 Finance lease obligations as lessee

[General description of significant leasing arrangements, including:

- the basis on which contingent rent is determined
- the terms of renewal or purchase options and escalation clauses, and
- restrictions imposed by lease arrangements
- narrative disclosure to reconcile the total future minimum lease payments at the end of the reporting period and their present value]

Amounts payable under finance leases (Buildings)

	Minimum lease payments		Present value of minimum	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Minimum Lease Payments / Present value of minimum lease payments	0	0	0	0
Included in:				
Current borrowings			0	0
Non-current borrowings			0	0
			0	0

Amounts payable under finance leases (Land)

	Minimum lease payments		Present value of minimum	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Minimum Lease Payments / Present value of minimum lease payments	0	0	0	0
Included in:				
Current borrowings			0	0
Non-current borrowings			0	0
Total	0	0	0	0

Amounts payable under finance leases (Other)

	Minimum lease payments		Present value of minimum	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Minimum Lease Payments / Present value of minimum lease payments	0	0	0	0
Included in:				
Current borrowings			0	0
Non-current borrowings			0	0
			0	0

	31 March 2014 £000s	31 March 2013 £000s
Future Sublease Payments Expected to be received	0	0
Contingent Rents Recognised as an Expense	0	0

Finance leases as lessee

Future Sublease Payments Expected to be received
Contingent Rents Recognised as an Expense

34 Finance lease receivables as lessor

[General description of significant leasing arrangements]

Amounts receivable under finance leases (buildings)

Of minimum lease payments

	Gross investments in leases		Present value of minimum	
	31 March 2014 £000s	31 March 2013 £000s	31 March 2014 £000s	31 March 2013 £000s
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

Amounts receivable under finance leases (land)

Of minimum lease payments

	31 March 2014 £000		31 March 2013 £000	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

Amounts receivable under finance leases (Other)

Of minimum lease payments

	31 March 2014 £000		31 March 2013 £000	
	31 March 2014 £000	31 March 2013 £000	31 March 2014 £000	31 March 2013 £000
Within one year	0	0	0	0
Between one and five years	0	0	0	0
After five years	0	0	0	0
Less future finance charges	0	0		
Gross Investment in Leases / Present Value of Minimum Lease Payments	0	0	0	0
Less allowance for uncollectible lease payments:	0	0	0	0
Total finance lease receivable recognised in the statement of financial position	0	0	0	0
Included in:				
Current finance lease receivables			0	0
Non-current finance lease receivables			0	0
			0	0

	31 March 2014 £000	31 March 2013 £000
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The unguaranteed residual value accruing to the [organisation]	0	0
Accumulated allowance for uncollectible minimum lease payments receivable	0	0

Rental revenue

	31 March 2014	31 March 2013
Contingent rent	0	0
Other	0	0
Total rental revenue	0	0

Finance lease commitments	0	0
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35 Provisions

Comprising:

	Total	Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change)	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	1,155	1,062	93	0	0	0	0	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0
Arising During the Year	312	132	0	0	0	0	180	0
Utilised During the Year	(224)	(210)	(14)	0	0	0	0	0
Reversed Unused	0	0	0	0	0	0	0	0
Unwinding of Discount	19	19	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0
Balance at 31 March 2014	1,262	1,003	79	0	0	0	180	0

Expected Timing of Cash Flows:

No Later than One Year	363	104	79	0	0	0	180	0
Later than One Year and not later than Five Years	405	405	0	0	0	0	0	0
Later than Five Years	494	494	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2014	74,461
As at 31 March 2013	75,437

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 payments made on behalf of the trust by the Pension agency, this cost is charged to the provision.

The Treasury discount rate of 2.35% was used to calculate the amount of unwinding of the provision for pensions relating to staff that have retired early. In the previous year the Treasury rate had been 2.8%.

36 Contingencies

	31 March 2014 £000s	31 March 2013 £000s
Contingent liabilities		
Equal Pay	0	0
Other	(57)	(70)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(57)	(70)
Contingent Assets		
Contingent Assets	0	0
Net Value of Contingent Assets	0	0

The net contingent liability relates 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.

37 PFI and LIFT - additional information

The Trust has one PFI scheme which 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 on 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 of the charge at 31st March 2013 are as follows:

	£000
Capital	7,986
Lifecycle replacement cost	4,158
Interest	6,993
Contingent rental	9,550
Service	2,361

The Lessor is obligated to maintain Hertford County Hospital for the period of the contract. Lifecycle capital replacement costs are incurred by the Lessor as part of required routine maintenance; these costs are part of the annual unitary charge which is charged in monthly instalments. This element is subsequently capitalised as a capital enhancement of the asset in the year the costs are incurred.

The contingent rental costs relate to the effect of inflation on the finance charge over the period of the contract. The cost is charged annually to the Statement of Comprehensive Net Income under finance costs.

The Trust is 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 asset will be reviewed annually to ensure carrying values are appropriately recorded.

The information below is required by the Department of Health for inclusion in national statutory accounts

	2013-14	2012-13
	£000s	£000s
Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI		
Total charge to operating expenses in year - OFF SOFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	101	93
Total	101	93
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	98	95
Later than One Year, No Later than Five Years	416	406
Later than Five Years	1,847	1,955
Total	2,361	2,456

The estimated annual payments in future years are expected to be materially different from those which the [organisation] is committed to make materially different from those which the [organisation] is committed to make during the next year. The likely financial effect of this is:

Estimated Capital Value of Project - off SOFP PFI	0	0
Value of Deferred Assets - off SOFP PFI	0	0
Value of Reversionary Interest - off SOFP PFI	0	1,000

	2013-14	2012-13
	£000s	£000s
Imputed "finance lease" obligations for on SOFP PFI contracts due		
No Later than One Year	866	842
Later than One Year, No Later than Five Years	3,397	3,457
Later than Five Years	10,717	11,523
Subtotal	14,980	15,822
Less: Interest Element	(6,994)	(7,706)
Total	7,986	8,116

	2013-14	2012-13
	£000s	£000s
Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due		
Analysed by when PFI payments are due		
No Later than One Year	0	
Later than One Year, No Later than Five Years	0	

Later than Five Years	0	0
Total	<u>0</u>	<u>0</u>
Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	0	
Number of on PFI contracts which individually have a total commitments value in excess of £500m	0	
Present Value Imputed "finance lease" obligations for off SOFP PFI contracts due		
Analysed by when PFI payments are due	2013-14	2012-13
	£000s	£000s
No Later than One Year	0	
Later than One Year, No Later than Five Years	0	
Later than Five Years	0	
Total	<u>0</u>	<u>0</u>
Number of on SOFP PFI Contracts		
Total Number of off PFI contracts	0	
Number of off PFI contracts which individually have a total commitments value in excess of £500m	0	
Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT		
	2013-14	2012-13
	£000s	£000s
Total Charge to Operating Expenses in year - OFF SOFP LIFT	0	0
Service element of on SOFP LIFT charged to operating expenses in year	0	0
Total	<u>0</u>	<u>0</u>
Payments committed to in respect of off SOFP LIFT and the service element of on SOFP LIFT.		
	2013-14	2012-13
	£000s	£000s
LIFT Scheme Expiry Date:		
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Total	<u>0</u>	<u>0</u>
	2013-14	2012-13
	£000s	£000s
The estimated annual payments in future years are expected to be materially different from those which the NHS [organisation] is committed to make during the next year. The likely financial effect of this is:		
Estimated capital value of project - off SOFP LIFT	0	0
Value of Deferred Assets - off SOFP LIFT	0	0
Value of Residual Interest - off SOFP LIFT	0	0
Imputed "finance lease" obligations for on SOFP LIFT Contracts due		
	2013-14	2012-13
	£000s	£000s
No Later than One Year	0	0
Later than One Year, No Later than Five Years	0	0
Later than Five Years	0	0
Subtotal	<u>0</u>	<u>0</u>
Less: Interest Element	0	0
Total	<u>0</u>	<u>0</u>
Present Value Imputed "finance lease" obligations for on SOFP LIFT contracts due		
Analysed by when LIFT payments are due	2013-14	2012-13
	£000s	£000s
No Later than One Year	0	
Later than One Year, No Later than Five Years	0	
Later than Five Years	0	
Total	<u>0</u>	<u>0</u>
Number of on SOFP LIFT Contracts		
Total Number of LIFT contracts	0	
Number of LIFT contracts which individually have a total commitments value in excess of £500m	0	

Present Value Imputed "finance lease" obligations for off SOFP LIFT contracts due Analysed by when LIFT payments are due	2013-14 £000s	2012-13 £000s
No Later than One Year	0	
Later than One Year, No Later than Five Years	0	
Later than Five Years	0	
Total	0	0

Number of off SOFP LIFT Contracts	
Total Number of LIFT contracts	0
Number of LIFT contracts which individually have a total commitments value in excess of £500m	0

38 Impact of IFRS treatment - current year

	2013-14 £000s	2012-13 £000s
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The information below is required by the Department of Health for budget reconciliation purposes

Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)

Depreciation charges	0	0
Interest Expense	0	0
Impairment charge - AME	0	0
Impairment charge - DEL	0	0
Other Expenditure	0	0
Revenue Receivable from subleasing	0	0
Impact on PDC dividend payable	0	0
Total IFRS Expenditure (IFRIC12)	0	0
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	0	0
Net IFRS change (IFRIC12)	0	0

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12

Capital expenditure 2013-14	0	0
UK GAAP capital expenditure 2013-14 (Reversionary Interest)	0	0

39 Financial Instruments

39.1 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 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

39.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0			0
Receivables - NHS		26,320		26,320
Receivables - non-NHS		4,055		4,055
Cash at bank and in hand		4,289		4,289
Other financial assets	0	0	0	0
Total at 31 March 2014	0	34,664	0	34,664
Embedded derivatives	0			0
Receivables - NHS		8,713		8,713
Receivables - non-NHS		12,060		12,060
Cash at bank and in hand		10,099		10,099
Other financial assets	0	0	0	0
Total at 31 March 2013	0	30,872	0	30,872

39.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		0
NHS payables		7,883	7,883
Non-NHS payables		29,445	29,445
Other borrowings		56,860	56,860
PFI & finance lease obligations		7,986	7,986
Other financial liabilities	0	8,654	8,654
Total at 31 March 2014	0	110,828	110,828
Embedded derivatives	0		0
NHS payables		6,021	6,021
Non-NHS payables		26,355	26,355
Other borrowings		35,832	35,832
PFI & finance lease obligations		8,116	8,116
Other financial liabilities	0	8,991	8,991
Total at 31 March 2013	0	85,315	85,315

40 Events after the end of the reporting period

£000

0

There are no non-adjusting events after that the reporting period that require disclosure

41 Related party transactions

During the year none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the East and North Hertfordshire NHS Trust.

The Department of Health is regarded as a related party. During the year the 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:

Related party organisation	Income £000's	Expenditure £000's	Debtors £000's	Creditors £000's
Clinical Commissioning Groups				
Barnet CCG	521	0	42	90
Bedfordshire CCG	20,307	0	3,998	0
Brent CCG	262	0	6	0
Cambridgeshire and Peterborough CCG	1,646	0	5	200
Chiltern CCG	297	0	9	121
East and North Hertfordshire CCG	197,279	0	7,750	20
Enfield CCG	222	0	122	0
Harrow CCG	997	0	123	0
Herts Valleys CCG	14,616	48	287	0
Hillingdon CCG	2,089	0	406	0
Luton CCG	2,812	2	118	0
West Essex CCG	471	0	215	0
NHS trusts				
Hertfordshire Community NHS Trust	2,060	4,030	384	135
West Hertfordshire Hospitals NHS Trust	538	1,412	251	259
The Princess Alexandra Hospital NHS	138	0	123	1,225
NHS foundation trusts				
Hertfordshire Partnership NHS Foundation Trust	2,131	52	81	4
Luton and Dunstable University Hospital NHS Foundation Trust	280	580	528	480
The Hillingdon Hospital NHS Foundation Trust	337	1,705	871	9,985
Other Health Bodies				
NHS Blood and Transplant	1	1,739	13	0
NHS Business Services Authority	0	2,687	0	636
NHS Litigation Authority	0	8,125	0	0
Health Education England	13,803	3	585	0
Department of Health (incl. core trading and NHS Supply Chain)				
Maidstone, not incl. Parliamentary funding or grant-in-aid)	254	11,441	0	1,145
Public Health England	272	0	0	0
Other non-NHS organisations				
Clinicenta Ltd	5,784	0	59	0

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. The Pensions Agency is the largest other central government body the Trust has had transactions with, and this entirely involves the payment of employees and employers pension contributions. Transactions with local authorities although not material in the context of the above disclosures, relate in the main to the payment of business rates.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the Trust board. [The audited accounts/the summary financial statements of the Funds Held on Trust are included/consolidated in this annual report and accounts.]

42 Losses and special payments

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	103,837	174
Special payments	10,413	42
Total losses and special payments	114,250	216

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	53,457	208
Special payments	1,307,460	21
Total losses and special payments	1,360,917	229

43. 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.

43.1 Breakeven performance

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s
Turnover	246,307	270,257	286,332	309,074	331,312	340,309	346,402	350,543	365,313
Retained surplus/(deficit) for the year	(22,379)	(1,527)	2,003	2,070	(19,220)	1,459	3,193	(12,416)	22,153
Adjustment for:									
Timing/non-cash impacting distortions:									
Pre FDL(97)24 Agreements	0	0	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0								
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0							
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0						
Adjustments for Impairments				0	21,758	1,906	88	12,658	781
Adjustments for impact of policy change re donated/government grants assets							287	290	(414)
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					(38)	(37)	0	0	0
Adsorption Accounting Adjustment								0	(22,411)
Other agreed adjustments	8,557	22,379	0	0	0	0	0	0	0
Break-even in-year position	(13,822)	20,852	2,003	2,070	2,500	3,328	3,568	532	109
Break-even cumulative position	(23,100)	(2,248)	(245)	1,825	4,325	7,653	11,221	11,753	11,862

* 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. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2012-13 %
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	0.98	1.03	0.15	0.03
Break-even cumulative position as a percentage of turnover	-9.38	-0.83	-0.09	0.59	1.31	2.25	3.24	3.35	3.25

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

43.2 Capital cost absorption rate

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%.

43.3 External financing

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

	2013-14 £000s	2012-13 £000s
External financing limit (EFL)	37,974	11,961
Cash flow financing	37,678	11,003
Unwinding of Discount Adjustment	19	0
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	<u>37,697</u>	<u>11,003</u>
Under/(Over) Spend against EFL	<u>277</u>	<u>958</u>

The Trust undershot the external financing limit.

43.4 Capital resource limit

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

	2013-14 £000s	2012-13 £000s
Gross capital expenditure	39,025	18,410
Less: book value of assets disposed of	0	(3,094)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	<u>(967)</u>	<u>(269)</u>
Charge against the capital resource limit	<u>38,058</u>	<u>15,047</u>
Capital resource limit	<u>40,132</u>	<u>24,675</u>
(Over)/underspend against the capital resource limit	<u>2,074</u>	<u>9,628</u>

The Trust undershot on the capital resource limit, thereby not breaching an administrative duty.

44 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2014	31 March 2013
	<u>£000s</u>	<u>£000s</u>
Patients monies	<u>4</u>	<u>1</u>

Sustainability Report

Introduction

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, RWH has the following sustainability mission statement located in our sustainable development management plan (SDMP):

" No. "

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The board approved our SDMP in the last 12 months so our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self assessment was in 26/03/2014, scoring 0.5.

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

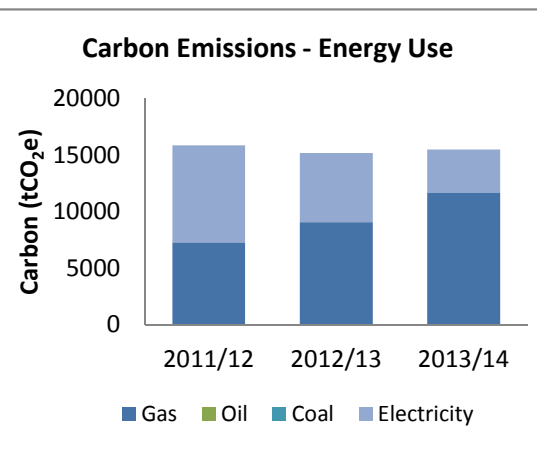
Context info	2007/08	2011/12	2012/13	2013/14
Floor Space (m ²)	107025	122827	118003	128240
Number of Staff	4256	4716	4732	4802

As a part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. It is our aim to supercede this target by reducing our carbon emissions 0.1% by 2015 using 2007/08 as the baseline year. Here's how we have done:

Energy

RWH has spent £2776613 on energy in 2013/14, which is a 0.3% increase on energy spend from last year.

Resource		2011/12	2012/13	2013/14
Gas	Use (kWh)	35683907	44443522	55229788
	tCO ₂ e	7292.006395	9082.033721	11716.44723
Oil	Use (kWh)	0	0	0
	tCO ₂ e	0	0	0
Coal	Use (kWh)	0	0	0
	tCO ₂ e	0	0	0
Electricity	Use (kWh)	15318608	15271169	17555348
	tCO ₂ e	8584.547923	6106.580749	3784.650055
Total Energy CO ₂ e		15876.55432	15188.61447	15501.09728
Total Energy Spend		£ 2,569,198.00	£ 2,768,225.00	£ 2,776,613.00



Performance

Please insert a commentary on your performance in this area.

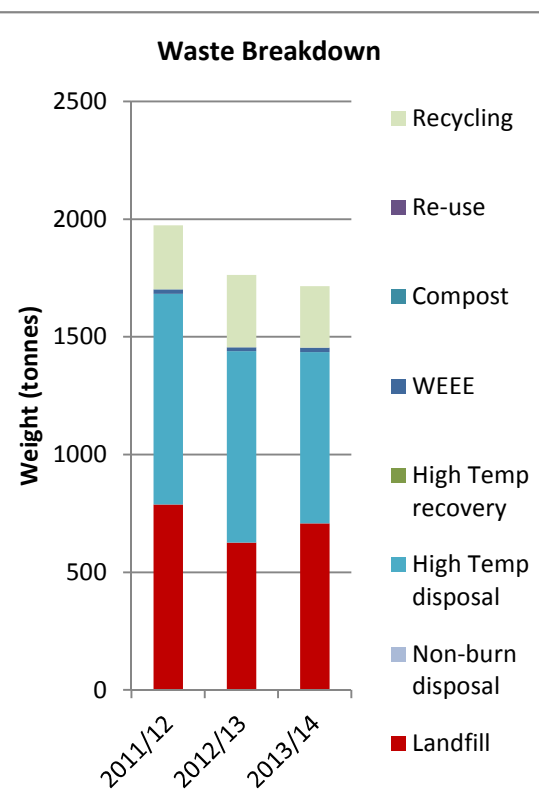
0% of our electricity use comes from renewable sources.

Commentary

Please insert a commentary on contextual information e.g. projects, initiatives etc. related to energy use here

Waste

Waste		2011/12	2012/13	2013/14
Recycling	(tonnes)	272	307	261
	tCO ₂ e	5.712	6.447	5.481
Re-use	(tonnes)	0	0	0
	tCO ₂ e	0	0	0
Compost	(tonnes)	0	0	0
	tCO ₂ e	0	0	0
WEEE	(tonnes)	19	17	20
	tCO ₂ e	0.399	0.357	0.42
High Temp recovery	(tonnes)	0	0	0
	tCO ₂ e	0	0	0
High Temp disposal	(tonnes)	895	813	727
	tCO ₂ e	18.795	17.073	15.267
Non-burn disposal	(tonnes)	0	0	0
	tCO ₂ e	0	0	0
Landfill	(tonnes)	788	626	708
	tCO ₂ e	192.6011924	153.0055158	173.0477718
Total Waste (tonnes)		1974	1763	1716
% Recycled or Re-used		0.002893617	0.003656835	0.003194056
Total Waste tCO ₂ e		217.5071924	176.8825158	194.2157718



Performance

Please insert a commentary on your performance in this area.

Commentary

Please insert a commentary on contextual information e.g. projects, initiatives etc. related to waste here

Water

Water		2011/12	2012/13	2013/14
Mains	m ³	204269	191594	196511
	tCO ₂ e	186	175	179
Water & Sewage Spend		£ 368,694	£ 328,494	£ 356,547

Performance

Please insert a commentary on your performance in this area.

Commentary

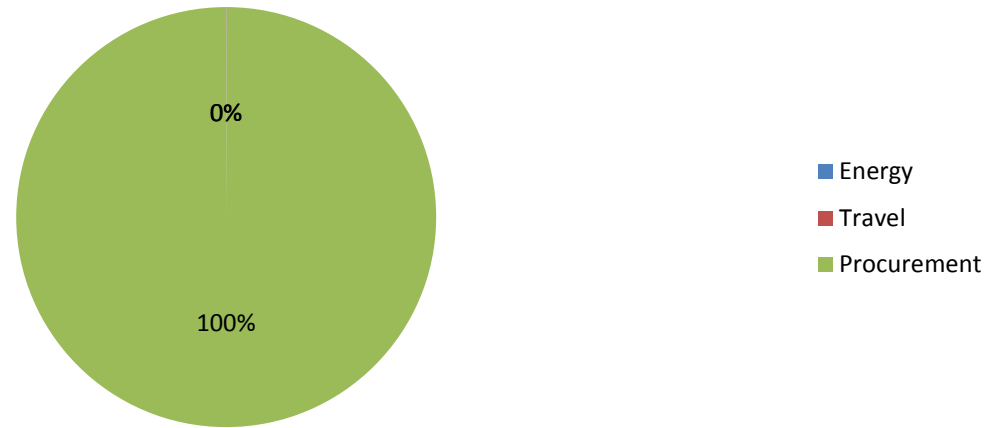
Please insert a commentary on contextual information e.g. projects, initiatives etc. related to water here

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the NHS Sustainable Development Unit (SDU) in 2009/10.

Resulting in an estimated total carbon footprint of 57615767 tonnes of equivalent carbon emissions.

Proportions of Carbon Footprint



Organisation Carbon Emissions Profile

