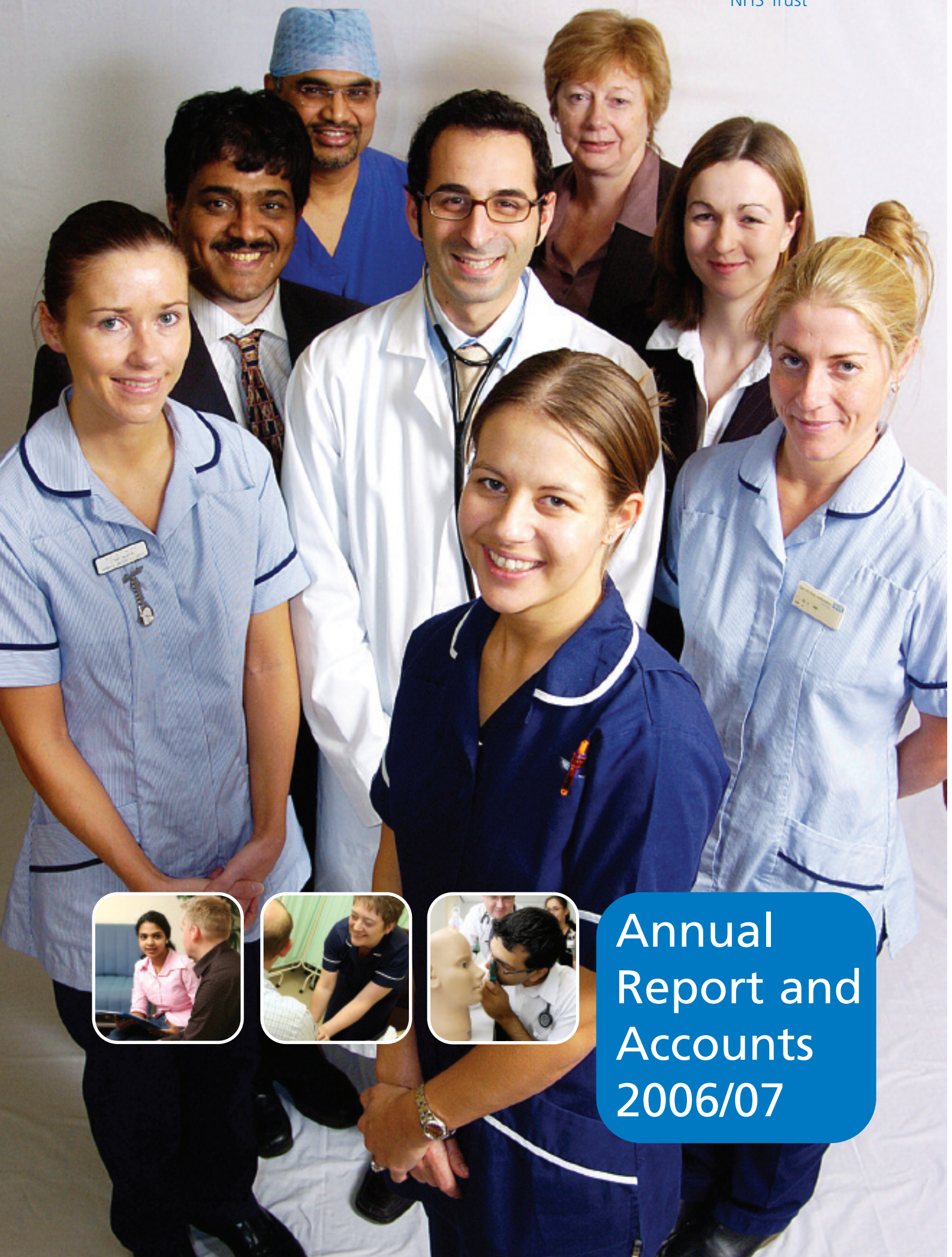
East and North Hertfordshire NHS
NHS Trust



Annual Report and Accounts 2006/07

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Chairman's statement

2006/07 was a year of considerable change, much of it difficult. However, clarity of strategic vision, strong values and extraordinary commitment and professionalism by the Trust's some 5,500 staff and volunteers enabled the Trust to make significant progress and end the year in good order.

The Trust has two strategic issues with which it has to deal. The first is to reconfigure its facilities so that it can capture developments that are occurring in medical science and technology, and thus enable it to provide its patients with 21st century standards of care. The second is to respond to changes that are occurring in the NHS, and in particular to prepare for foundation trust status.

The scheme to consolidate services from the QEII, Lister and Mount Vernon Cancer Centre in a new hospital to be built at Hatfield was the ideal solution to the Trust's need to reconfigure its facilities. Changes made by the Government in the guidance governing how such schemes are funded through the private financial initiative (PFI) route meant that the Hatfield project became unaffordable, which was a considerable disappointment to the Trust and the community.

However, the need to reconfigure the Trust's facilities remains. Its senior clinicians – doctors and nurses – are calling for change. They are of the view that acute hospital services in east and north Hertfordshire are spread too thinly across ageing and inadequate facilities. They believe that without significant change and investment, they will not be able to capture advances in medicine for the benefit of patients, who will increasingly feel the need to go to London or other medical centres for the latest forms of treatment. Clearly such a scenario is not acceptable, either to the Trust or to the communities it serves.

Thus with the status quo not an option, the Trust has been working with the PCTs and the East of England strategic health authority (SHA) to develop an alternative proposal to the



Hatfield scheme. In essence, this is likely to involve relocating some services the Trust has provided traditionally in its two main acute hospitals – the Lister and QEII – to new facilities run by the PCTs, which are more convenient for patients; and the consolidation of major acute services onto one hospital site – either the Lister or QEII. Such a scheme would require significant and welcome investment in Hertfordshire's health services, and would of course be the subject of detailed consultation with the community before any decisions are made.

The need for the Trust to respond to changes that are occurring in the NHS, and in particular to prepare for foundation trust status, has resulted in significant change in the way in which the Trust operates. Change is never easy, and the extent of the change has been difficult for the Trust's staff, who have responded in a very professional way.

However, while the focus quite understandably has been on reducing costs and becoming more efficient so that the Trust can live within its new level of income, a number of the changes have involved introducing best practice from other parts of the NHS in the treatment of patients that not only has reduced costs but also improved the quality of care provided. As is the case in every other part of life, developments in science, technology and society will continue to drive change. It is important the Trust understands this and readies itself for a process of constant change.

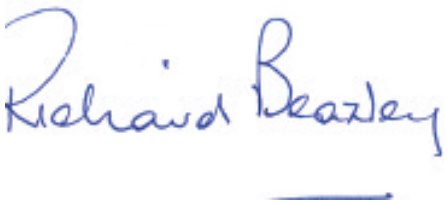
The Trust has always been clear in its vision to be trusted by the community. It is part of the community and it serves the community. This involvement will be enhanced as the Trust prepares to become an NHS foundation trust – a status that will involve representatives from the community having a strong governance role in the Trust on its board of governors, as well as hundreds, hopefully thousands, from the community choosing to become members of the Trust.

This year saw the departure of Lance Stanbury, Nick Gerrard and Jane McCue from the Trust Board. Lance's experience as a businessman and a former leader of Welwyn Hatfield district council enabled him to make a lively and very valuable contribution to the Board as a non-executive director. Sadly his burgeoning business is requiring him to spend ever more time abroad.

Nick Gerard left to pursue interests elsewhere after four very successful years as the Trust's finance director. Jane McCue's three-year term as the Trust's medical director ended in January 2007. Recognised through national awards for her excellence as an outstanding surgeon and highly respected both within the Trust and the wider community, Jane made a very significant contribution to the Trust as its medical director; the Trust will continue to benefit from the work she did for many years.

While 2006/07 was another challenging year, it is important to recognise the progress the Trust has made. It looks after increasing numbers of patients to high standards of care. The Trust meets Government performance targets routinely and has begun to turn the corner in managing the new financial environment. It has reduced its financial deficit to manageable proportions, and is making good progress in finding solutions to its strategic challenges. All this is due to the Trust's very professional and dedicated staff and volunteers who care for patients 24 hours of the day, 365 days in the year; and of whom all of us living in the community can feel proud.

Richard Beazley



Chairman

Chief executive's statement

A year of achievement

The past 12 months have been challenging for the Trust. During that time we have taken difficult decisions about how best to provide services for local people.

We introduced new services – like the new Trust-wide stroke facility at the QEII and the Trust's first ever 23-hour ward at the Lister. These important new initiatives meant that we needed fewer beds overall and in their implementation, we retained our highly qualified staff through redeploying them into vacancies elsewhere in the Trust.

Last year saw the Trust open important new facilities, including the Vicki Adkins Breast Unit at the QEII and a new brachytherapy suite for the treatment of prostate and other cancers at the Mount Vernon Cancer Centre, which was made possible through a £2.25 million private donation.

None of the Trust's considerable achievements set out in this report would have been possible, however, without the professionalism and dedication of our staff. I would like to thank them publicly for their individual and collective contribution to our continued success.

Involving the local community

The Trust has strived always to be honest and transparent with local communities. We have worked hard to build relationships with a wide range of individuals and groups served by the Trust.

While of course more work remains to be done, the progress made in the last year in involving people – from our staff through to members of the public – in how we would like to develop our clinical services bodes well for our desire to become an NHS foundation trust.

The year's highlights

Emergency care

The A&E teams at the Lister and QEII hospitals provide local people with an excellent service. They have struggled at times, however, to maintain the national standard that 98% of those attending should be treated, discharged or admitted within four hours. Between them our two A&E teams cared for 133,000 attendances in 2006/07 – slightly more than planned. The department's senior clinicians know that without consolidating the service on to a single site, they will always struggle to meet this most challenging of national standards.

Waiting times

At the end of March 2007, the total size of the Trust's waiting list at 6,204 people was just under half that of its peak in July 2003, when it stood at around 12,500. Today no one waits more than 13 weeks for a first outpatient appointment and the 26-weeks for inpatient or day case treatment.

Real progress has also been made towards meeting the new total 18-week standard – from referral through to treatment – that must be met by the end of December 2008.

Infection control

Combating healthcare associated infections remains a top priority for the Trust. Although the data for the last quarter of 2006/07 has yet to be validated by the Health Protection Agency, it is clear that the Trust will not have achieved its target for reducing MRSA blood infections. There is every belief, however, that the level of infections due to Clostridium difficile will have reduced year-on-year, which is welcome news.

The Trust's staff, guided by its infection control team, have put a great deal of effort into combating such infections. Their work is all the harder given that evidence now exists showing that up to half of all MRSA were actually acquired within the community.

Hospital facilities and equipment

Major projects in last 12 months have been the building of the new Vicki Adkins Breast Unit at the QEII, as well as the redevelopment of the staff accommodation block at the hospital – now renamed Birch Court – undertaken by the Origin Housing Group.

Last August we opened the Trust's first ever 23-hour ward for surgical patients who are not suitable for day case surgery, yet need not be admitted as a full inpatient. This new ward, which covers the whole Trust and is open Monday to Friday, has been a great success and represents a new way of working for many of our surgical colleagues.

In October 2006, the first Trust-wide stroke service was opened at the QEII. Formerly there had been a good, but limited, service at the Lister only. The new service means that suitable patients across the Trust now benefit from intensive rehabilitative support.

Finally, important improvements have taken place at the Mount Vernon Cancer Centre. Working with Hillingdon Hospital NHS Trust, which is the cancer centre's landlord, we have tackled many long-standing health and safety issues on the site. Following a £2.25 million private donation secured in 2005, the Trust developed a state-of-the-art brachytherapy facility for the treatment of prostate and other cancers. During March 2007, the first patients were treated in the cancer centre's new £21 million linear accelerator radiotherapy facility, which is due for completion later in 2007.

Finances

For the first time in three years, the Trust met the financial target lain down for it by the strategic health authority (SHA). This was set at the start of the year as the achievement of a deficit of no worse than £8 million, which was revised subsequently to an even more challenging position of £7.5 million. By driving through clinical efficiencies and reducing our costs, we have managed to more than meet our financial targets this year whilst at the same time maintaining a good standard of patient care.

Our plan for 2007/08 sees the Trust aiming to go in to surplus, which will go help pay off the historical debt by 2008/09. While still very challenging, the Trust's financial position is now more stable than it has been for some time.

Looking to the future

Much of what I have covered talks about the year just gone by and the immediate challenges that lie ahead. I would like to join the Trust's chairman, Richard Beazley, in emphasising the need for continued improvement in the longer-term.

While we are set to achieve financial balance in 2007/08, without further change this will prove to be a temporary reprieve in our fortunes. We now face a range of pressures, including the full impact of the national Payment by Results financial system and the next phase of the European Working Time Directive. Without consolidating our acute hospital services on to a single site – even if we become the most efficient organisation in the NHS – the Trust faces a poor prognosis.

Services will begin to deteriorate as we struggle to cover them with compliant staff rotas – especially doctors. Just keeping our old buildings maintained to a reasonable standard will soak up any available investment – despite the fact that most of them are no longer really fit for modern clinical practice. That is a scenario – one of a failing service – that the Trust's staff are anxious to avoid. It is my job and that of my fellow executive directors to make sure that the opposite happens. And the only way that will be achieved is through the consolidation of acute clinical services on to a single site.

Nick Carver

Chief Executive

Background and summary information

Provided on the next eight pages are notes on a range of issues that between them provide background to information found later in this annual report.

Background

The East and North Hertfordshire NHS Trust is recognised increasingly as an organisation that performs well across many of the national standards set for the NHS by the Government.

Annual health check (2005/06)

In October 2006, the Healthcare Commission published the first results from its new national rating system for the national health service in England – the Annual health check. The Commission's assessment for 2005/06 looked at the quality of clinical services that the Trust provided for its patients, as well as the state of its finances.

On the issue of quality, the Commission highlighted many areas where the Trust did well. This included meeting national inpatient and outpatient waiting time targets. Another success was how well the Trust performed in diagnosing and treating patients with cancer.

Areas of the Trust's work that stood out in the report included the rating of its inpatient children's services as being good. A second was the achievement of 100% compliance in providing the right level of information to enable patients to use the new NHS Choose and Book system for making outpatient appointments.

In its report, the Commission also showed where more improvement was needed. The majority of these issues related to wider public health targets, with examples including smoking cessation and reducing obesity levels.

The latter are areas not within the Trust's sole control, so greater joint working with primary care trusts will be required.

Overall, the Commission rated the Trust's clinical services as being fair.

On the state of its finances, 2005/06 saw the Trust commence what has turned out to be the first of a three-year recovery plan that aims to return it to financial balance by 2007/08. Under the rules of the Annual health check system, a weak rating had to be expected since the Trust ended 2005/06 with a deficit of £22.379 million – £3.509 million greater than the control total set for it by the local strategic health authority.

It is anticipated that the Healthcare Commission will issue its annual health check rating for 2006/07 during July 2007.

Education and training

The Trust has always placed considerable importance on training and education, but like many NHS organisations in the East of England, 2006/07 proved to be a challenging year. Previously received NHS workforce development funding to support training and education was cut significantly during the year, limiting the amount of externally provided education available to all staff groups.

The Trust was still able to deliver a comprehensive range of internal training in a range of subjects including:

- mandatory topics – e.g. health and safety, fire safety and infection control
- clinical subjects – e.g. diabetes care, palliative care and wound management
- developmental courses – e.g. leadership and management, assertiveness skills, stress management and IT skills and systems

The Trust continued to rollout its programme of conflict resolution training. The aim is that by 2008, all staff will be trained in how to deal more effectively with violence and aggression in the workplace. In 2006/07, over 1,260 staff underwent this training.

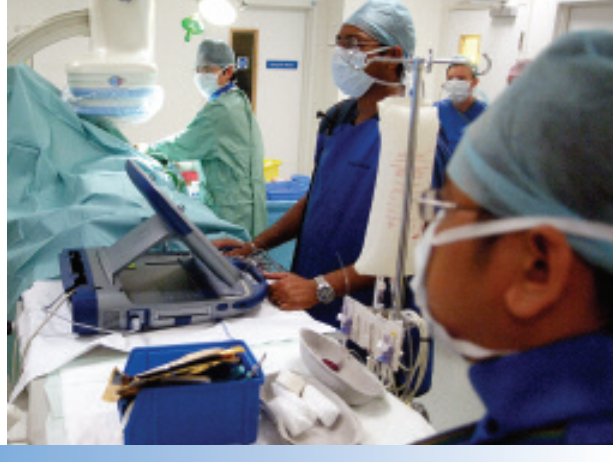
A number of e-learning packages were introduced to support some elements of regular update training. This enabled the Trust to create blended learning options for staff to undertake a mix of electronic and classroom-based training.

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

Population served

The Trust provides an extensive range of acute services through its two district general hospitals – the Lister in Stevenage and the Queen Elizabeth II (QEII) in Welwyn Garden City. In addition, the Trust's Hertford County Hospital in Hertford offers local people outpatient, diagnostic and minor treatment services. The Trust also manages several important regional services, including renal medicine and plastic surgery (both based from the Lister). Finally the Trust runs the Mount Vernon Cancer Centre, which provides radiotherapy and complex chemotherapy services regionally.

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



Budget and patient activity

Since it was formed in April 2000, the Trust has invested more than £69 million in modernising and expanding its hospital facilities, including new medical equipment and upgrading its IT services. With a budget of some £269 million in 2006/07, the Trust treated more than 73,000 inpatients and day cases, provided just over 93,000 first outpatient consultations, attended to 133,000 A&E patients and saw 5,400 babies born through its two maternity units.

Developments in the past year

During 2005/06, the Trust completed a number of major developments, including:

- Opening of the new £1.36 million education centre at the Lister in August 2006, which replaces the old postgraduate unit and provides modern education and training facilities for clinical staff from across the Trust.
- Creation of a 23-hour surgical ward at the Lister hospital in August 2006 has proved a considerable success, enabling the Trust to offer an alternative service to patients for whom day case surgery is not suitable but whose treatment does not require them to be admitted as a full inpatient.
- The Lister's cardiac laboratory opened in September 2004 with the aim of reducing waiting times for angiography, a routine coronary diagnostic procedure. In June 2005, the laboratory's service was extended to cover the implantation of pacemakers, with over 350 patients now benefiting from a service that up until now would involve travelling to centres outside Hertfordshire. Last year, the laboratory also developed an angioplasty service, which is an interventional technique that treats coronary blockages.
- Centralisation of the Trust's neonatal intensive care service was completed in December 2006, following a £660,000 project bringing intensive care, high dependency and some special care services provided previously from the QEII to the Lister; both hospitals continue to provide a special care baby unit service.
- Following securing a £2.25 million donation from a private individual, a new brachytherapy unit – which provides specialist radiotherapy for diseases such as prostate cancer – opened at the Mount Vernon Cancer Centre in September 2006.
- March 2007 saw the Trust treat its first patients in the Mount Vernon Cancer Centre's new £21.82 million linear accelerator facility, which provides the complex radiotherapy needed by many patients with cancer. The new unit is expected to be completely by early 2008.
- Development of the Trust's first breast cancer diagnostic unit, which opened to patients in August 2006. The £2.4 million unit, which was funded in part through the Hertfordshire Breast Unit Appeal, now sees patients with suspected breast cancer from across east and north Hertfordshire.
- October 2006 saw the creation of the first Trust-wide dedicated stroke service, which is based at the QEII hospital. The new unit built on the success of the relatively limited stroke rehabilitation service that had been based at the Lister.
- During 2006, the Trust invested £118,000 in two new pharmacy robots – one each at the Lister and QEII hospitals. The new robots speed up the dispensing of medication, enable stock levels to be managed more effectively and release pharmacist to spend more time on wards advising their clinical colleagues on prescribing issues.

Future developments

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

- Subject to satisfactory completion of a new national review process for proposed recon figuration plans for hospital services, which was launched by the Department of Health in February 2007 and which will be run the East of England Strategic Health Authority, the NHS in Hertfordshire expects to launch full public consultation on the future of health services during 2007/08. From the Trust's perspective the major issue will be the long-term site on to which acute hospital services should be concentrated in future – either the Lister of the QEII.
- Also during 2007/08, the Trust expects the Hertfordshire primary care trusts to announce how it intends to review the future of the Mount Vernon Cancer Centre, which has been managed by the Trust since April 2005.

- Work towards achieving the national 18-week waiting time standard, which will mean that by 31 December 2008 no patient will wait for longer than 18 weeks between being referred to one of the Trust's consultants by their GP to being treated and/or admitted. While the new standard does not cover every medical and surgical service, e.g. those attending A&E and emergency admissions, the vast majority of patients will see all aspects of their care take place much more quickly than has been the case previously in the NHS – including diagnostic services.
- From spring 2007, the Trust expects to complete changes that will see the Lister develop a specialist cardiac inpatient service providing care for patients from across east and north Hertfordshire. The new service will complement advances in care offered through the Trust's cardiac laboratory, which is also based at the Lister. The QEII and Lister will continue to treat A&E patients with suspected cardiac problems, with both retaining dedicated coronary care units.
- Work on the second phase of creating a new centralised medical records library for the Trust at the Lister hospital began in April 2007. Following £250,000 capital investment, the new records library will result in patients' notes being tracked far more easily, with fewer sets of duplicate and/or temporary notes being created. The overall impact will be less disruption to outpatient clinics due to patients' notes being missing or incomplete, thus improving the service to patients and estimated revenue saving of £200,000 in 2006/07.

The environment in which the Trust operates during 2007/08 will continue to change. The Hertfordshire primary care trusts, in line with the local Investing in your Health strategy approved in 2003, will continue to provide greater levels of care for patients closer to where they live, typically through community hospitals, health centres and GP surgeries.

This means that during the coming year, fewer patients will be referred to the Trust's hospitals than previously – in 2006/07, the Trust saw a drop of 8% in the number of referrals made by GPs – some 6,300 referrals. Based on the primary care trusts' commissioning intentions, the Trust is not expecting referral rates for 2007/08 to fall again significantly. At the same time, the national Payment by Results financial system will continue to be rolled out and the Trust will need to plan for the implementation of the next phase of the European Working Time Directive, which comes into force from August 2009 and will reduce the number of hours that doctors can work to 48 per week.

All of these issues mean that the Trust's finances will continue to face significant pressures, especially at a time when the Patient Choice and Practice-based commissioning initiatives also being to play an increasing part in the number of patients referred to the Trust's hospitals. This must be seen in the context of a year in which the East of England Strategic Health Authority expects the Trust to breakeven financially and preferably make a surplus to help begin paying back deficits recorded from previous years.

Significant activities in research and development

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

During 2006/07, the Trust had 257 active studies, of which 218 were funded externally. During 2005, the last year for which complete figures are available currently, researchers at the Trust produced over 180 publications in peer-reviewed journals. Feedback from the Department of Health for its 2006 annual report stated that: "This is a good report overall and clearly there is much high quality research being supported."

Systems are in place to ensure that the principles and requirements of the national Research governance framework are applied consistently. The management and administrative arrangements for research activity are governed by a full set of policies and standard operating procedures that are ratified by the Trust. A record of all research being conducted is maintained by the Trust, with regular submissions made to the national research register.

The Trust's R&D committee reviews all projects, which is a multidisciplinary group that includes lay representation. Each research proposal requires the approval of the Trust's ethics and R&D committees before they can commence. All studies involving other third party organisations have agreements in place ensuring that responsibilities are allocated clearly.

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Staff and staff-related issues

Pensions

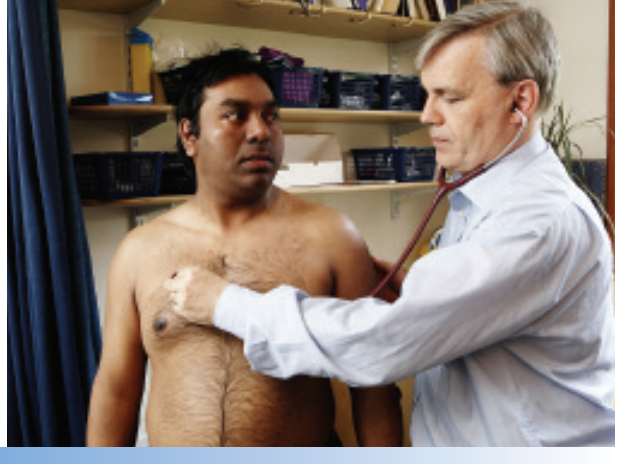
The Trust participates in the NHS Pension scheme. Details of the accounting policy for pension schemes are set out in note 1.12 to the annual accounts.

Employment policies relating to people with disabilities

In December 2006, the Trust Board's executive committee approved a new disability equality scheme to take account of the Disability Discrimination Act (DDA) 2005, as well as other recent changes in legislation and national policy – such as the Race Relations Amendment Act and the European Equality Directive.

The Trust is committed to equality of opportunity for all staff, which is reinforced in its policies and procedures aimed at the prevention of discrimination – whether on grounds of age, disability, gender, marital status, membership or non-membership of a trade union, race, religion, domestic circumstances, sexual orientation, ethnic or national origin, social and employment status, HIV status, or gender re-assignment – in line with employment legislation and good employment practice.

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



Information on Board members

Details of the remuneration received by the Trust's senior employees during 2006/07 are set out in the remuneration section of this annual report.

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

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

External auditor

Due to the special accountabilities attached to public money and the conduct of public business, the Audit Commission independently of the Trust appoints external auditors. The Audit Commission Act 1998 sets out the role of the Audit Commission in the appointment of external auditors for NHS bodies. The Commission appoints auditors from its own staff and from private firms of auditors. For 2006/07, the Audit Commission reappointed its own staff to carry out their statutory and other responsibilities and exercise their professional judgement independently of the Commission.

Private finance initiative (PFI) schemes

Currently the Trust is involved in one PFI scheme: the new Hertford County Hospital, which opened to patients in November 2004. The hospital, which was an £8.5million PFI scheme, was built and is operated by Ryhurst Ltd. It involves an annual unitary payment of approximately £1 million. This fee is payable every year until 2034, when the hospital reverts to ownership by the NHS. Further financial information is provided in note 25.1 of the accounts.

It is not clear yet whether or not the capital investment associated with Trust's plans to reconfigure its acute hospital services on to a single site, subject to the outcome of public consultation expected to be held during 2007/08, will be funded by the Treasury or be required to become a PFI scheme. This will be explored further and determined as part of the subsequent business case process.

Fixed assets

As stated in note 1 to the 2006/07 accounts, fixed assets are stated at the lower of replacement cost and recoverable amount. A review is carried out annually for any potential impairments and a formal revaluation of building value was carried out as at 1st April 2006.

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 2006/07 accounts.

Political and charitable donations

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

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

A summary of the transactions and balances within enhance herts are provided in note 24 to the 2006/07 accounts on related parties, with the total of additions donated received shown in note 11 on tangible fixed assets to the accounts.

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

- Hertfordshire Breast Unit Appeal, which donated more than £850,000 towards equipping the new £2.4 million Vicki Adkins Breast Unit at the QEII hospital, which opened in January 2007.
- Lister and QEII Hospital Leagues of Friends, who donated equipment valued at more than £40,000 during 2006/07.
- At Mount Vernon, the Trust is grateful to the Comforts Fund and the Friends of the Mount Vernon Cancer Centre for donations and gifts-in-kind amounting to more than £20,000.
- Friends of Michael Sobell House, who part-fund the NHS hospice at Mount Vernon, provided funding amounting to more than £850,000 during 2006/07.
- Of especial note were the fundraising efforts of the Lister Hospital Appeal, which completed its fundraising programme for the Trust during 2006/07. During its 25 years, the Appeal has raised in excess of £1 million, which was used to support a wide range of initiatives, mainly to do with the purchase of medical equipment.

During 2006/07, enhance herts was able to support the NHS Trust with two specific projects funded through significant donations:

- £2.25 million was donated by an anonymous benefactor for the development of a state-of-the-art brachytherapy facility at the Mount Vernon Cancer Centre for the treatment of diseases such as prostate cancer. The donation, which was made during the 2005/06 financial year, led to the new unit opening to patients in September 2006.
- Following an application for a grant from the Wolfson Foundation, £200,000 was given towards the development of the Lister education centre, which opened in August 2006.

In 2006/07, the Trust's fundraising team developed several new initiatives, including:

- The CTRT Appeal to raise £1 million to improve the delivery of chemotherapy research trials at the Mount Vernon Cancer Centre
- The Building Blocks campaign as a focus for fundraising initiatives around enhancing children and babies' services within the Trust, with particular support from Woolworths, Hitchin and Notcutts in St Albans
- Nightingale Funds, including the Lee Haynes Nightingale Fund that is raising money towards a new Renal research institute at the Lister.

Operating and financial review

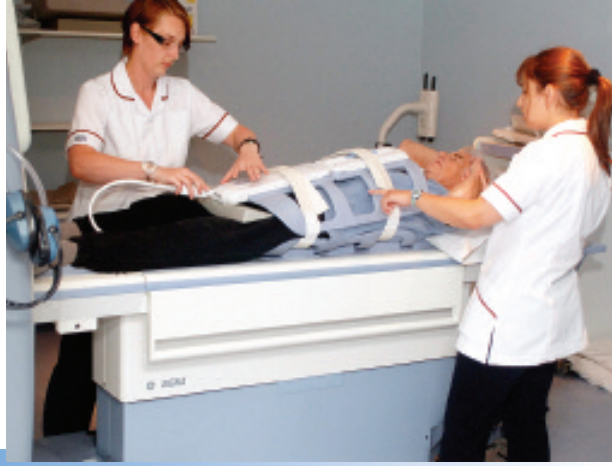
This section is the main body of the Trust's annual report. It explains what the Trust does, how it has worked to develop and improve services over the past year and sets out the performance against key national standards and targets – which are all to do with providing good health care.

The Trust's vision is to be: Trusted by our community to deliver first class healthcare services. In this context first class is defined as being clinically excellent, patient-centred, seamless, modern, cost-effective and provided by a workforce that views learning as being a constant process.

Underpinning its vision, the Trust has adopted six core values:

- One NHS – upholding the principles and values of the NHS. Supporting the wider NHS and expecting support from the wider NHS.
- Integrity and honesty – ensuring that decision-making is intellectually robust, patient-centred, shared openly and based upon sound financial principles.
- Proactivity and innovation – taking responsibility and doing things differently.
- Inclusivity – involving staff and stakeholders in decision-making, thus enabling staff to be successful and celebrating that success.
- Accountability – being accountable to stakeholders and prepared to make life more difficult for our selves.
- High standards of personal conduct - demonstrating respect at all times to all individuals.





Highlights of the year

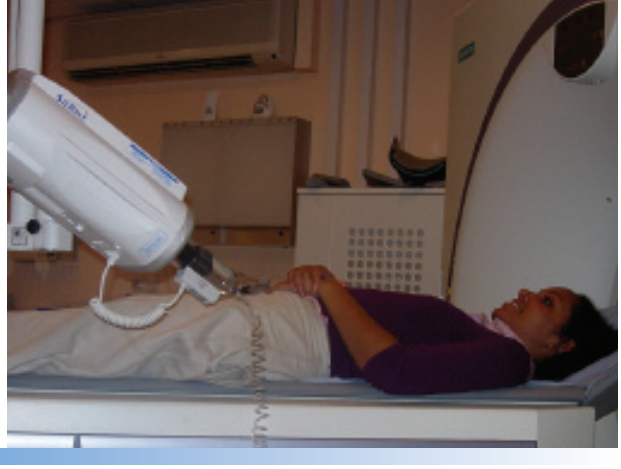
- In the first year of the Healthcare Commission's new performance rating system for the NHS, the Trust passed its first Annual health check. In October 2006 the Commission rated the Trust as being fair for its clinical services and weak on its use of resources for 2005/06.
- In 2006/07, the Trust met the financial target set for it by the local strategic health authority for the first time in three years, achieving a year-end deficit of £1.5 million as part of a three-year financial recovery plan that should see the Trust returning a surplus in 2007/08.
- By the end of 2006/07, no patients waited more than 13 weeks for their first outpatient appointment, with just six people waiting more than 11 weeks.
- Also by the end of the year, no patients waited more than 26 weeks for day case or inpatient care, with only 121 waiting more than 20 weeks.
- The total number of people on the Trust's waiting lists at the end of March 2007 stood at 6,204, which is the lowest ever recorded by the Trust and less than half of the some 12,500 people who were waiting at the list's peak in July 2003.
- The Trust met national cancer treatment standards routinely throughout the year, with waiting times for this important group of patients being amongst the best in the country.
- The Trust's total budget for treating patients was £269 million. This was used to treat 72,781 people as inpatients or on day case basis – of which nearly 32,000 were elective cases – i.e. their admission to hospital was planned. The Trust also cared for around 93,000 patients through a first outpatient appointment and provided some 283,000 outpatient appointments overall. There were 133,000 attendances at the Trust's two A&E departments.
- Of the Trust's £269 million budget last year:
  - £126.4 million (47.0%) was spent on the salaries of clinical staff
  - £21.3 million (8.0%) on drugs
  - £19.1 million (7.1%) on clinical services and supplies
  - £3.7 million (1.4%%) on cleaning
  - £2.5 million (0.9%) on fuel, light and power
  - £1.2 million (0.4%) on building and engineering.
- In 2006/07, the total capital investment made by the Trust to provide improved patient services and facilities was £13.3 million (excludes donations).
- In March 2007, the first patients underwent radiotherapy treatment in the new £21.82 million linear accelerator facility at the Mount Vernon Cancer Centre – the largest investment in the centre's facilities in many years, which has enabled vital ageing equipment to be replaced.
- The QEII now has its own NHS MRI suite, which is housed in an extension to the hospital that also houses the Trust's £2.4 million breast unit, which opened to patients in August 2006.

Operational report

Principal activities

The Trust provides a wide range of acute clinical services for people who live and/or work in east and north Hertfordshire. These services, which form the major part of the Trust's principal activities, are organised into 10 clinical directorates. Each is led by a clinical director and general manager, supported by a modern matron/lead nurse.

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



The clinical directors and general managers meet monthly with the Trust's executive directors at the clinical directors board, where major clinical, operational and financial issues affecting the organisation are discussed and decisions made and/or confirmed. The general managers, along with their team, from each clinical directorate meet weekly with members of the executive team to review their performance, principally around finance.

In addition, each of the clinical directors meets monthly with the Trust's medical director and deputy chief executive (strategy) to review clinical efficiency projects. The Trust's modern matrons/lead nurses attend the monthly nursing executive committee with the Trust's director of nursing.

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

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

Activity plans

The number of patients using the Trust's services is influenced by three main factors: the commissioning plans of primary care trusts (PCTs); the choices made by patients through the national Patient Choice initiative; and , increasingly, the impact of decisions made by GPs through practice-based commissioning. Although the Trust is working towards developing medium-term activity plans, currently this is limited to the year ahead (i.e. 2007/08). This information is provided in the table below.

Activity	2005/06 actual	2006/07 actual	2007/08 plan
A&E attendances	132,900	133,000	-
Outpatients – first appointments	85,087	93,133	85,543
Outpatients – follow-up appointments	208,975	190,060	141,363
Elective inpatients (planned admissions)	9,747	10,343	11,320
Elective day cases	22,195	21,545	23,389
Average length of stay for elective patients (days)	3.70	3.32	-
Non-elective (unplanned or emergency admissions)	41,257	40,893	40,828
Average length of stay for non-elective patients (days)	5.3	5.08	-
Average bed occupancy rates (the proportion of beds occupied at any point in time)	92%	90.8%	-

Service moves

During 2006/07, the Trust made a number of changes in how some of its clinical services used directly by patients were organised. These are set out below:

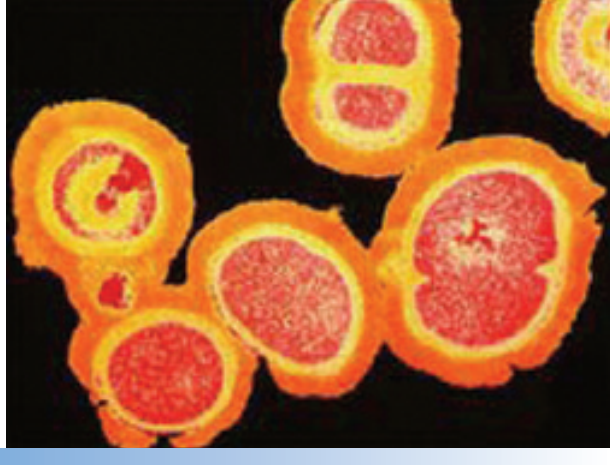
- In August 2006, the Trust created its first 23-hour surgical ward at the Lister hospital, which serves patients from across east and north Hertfordshire. The new ward, which has proved a real success, means that an efficient alternative now exists for patients who are not suitable for day case surgery but also should not be admitted as a full inpatient.
- October 2006 saw the creation of the Trust's first ever full stroke service on a ward at the QEII. Previously there had been a limited, although very innovative stroke rehabilitative service at the Lister, with no dedicated facilities at the QEII.
- In December 2006, the Trust centralised its neonatal intensive care service at an expanded unit at the Lister hospital. This service change implemented one of the key recommendations from the 2005 Better care for sick children public consultation. Both the Lister and QEII hospitals continue to provide a special care baby unit service.
- From March 2007, following the outcome of the Fit for the future public consultation run by the former North Hertfordshire and Stevenage primary care trust in 2005/06, people from north Hertfordshire began to be seen at the new Vicki Adkins Breast Unit at the QEII hospital, which opened to patients in August 2006.

Performance

The Trust's performance against key national patient access and infection control standards during 2006/07 are listed below:

National standard	2006/07 performance
Outpatients - 13 week maximum waiting time	No breaches
Inpatients – 26-week maximum waiting time	10 breaches
A&E – 98% seen, treated, transferred/discharged within four hours	97.5%
Cancer – 100% GP referrals seen within two weeks	100%
Cancer – 98% waited less than 31 days to diagnosis	99%
Cancer – 95% waited less than 62 days to treatment	96%
Rapid access chest pain clinic - within two weeks	51 breeches

*Subject to validation by the Health Protection Agency



In 2006/07, the Trust was set target by the Government to reduce to number of bacteraemias (i.e. blood infections) caused by methicillin-resistant Staphylococcus aureus (MRSA) bacteria to 31 cases by the end of March 2006. Although the final figure has yet to be confirmed by the Health Protection Agency (HPA), the Trust's data suggests that 53 MRSA bacteraemias were confirmed in its hospitals during 2006/07.

While this is performance is lower than the 56 confirmed cases reported the previous year and the 86 cases reported back in 2002/03, clearly the level of reduction – while very welcome – has been insufficient to meet the Trust's target in 2006/07. Infection control, therefore, remains a top priority for 2007/08 and beyond.

It is important to note, however, that information from the HPA shows that of the 53 cases recorded by the Trust in 2006/07, 41% were diagnosed within 48 hours of the patients being admitted. According to experts, the vast majority of these individuals will have acquired their infections before they came into hospital, although they still count towards the Trust's figures.

Another area of the Trust's performance that continues to cause concern is the number of delayed discharges in care. Although internal procedures have improved considerably, with far greater planning of patients' journeys through the Trust's hospitals, a significant number wait longer than necessary to be transferred to other facilities.

At any one time, the equivalent of a ward full of patients who no longer need to be in acute hospital are waiting to be discharged. The major blockage is the availability of suitable places in the community, which the Trust continues to address with primary care trusts and social services to limited effect.

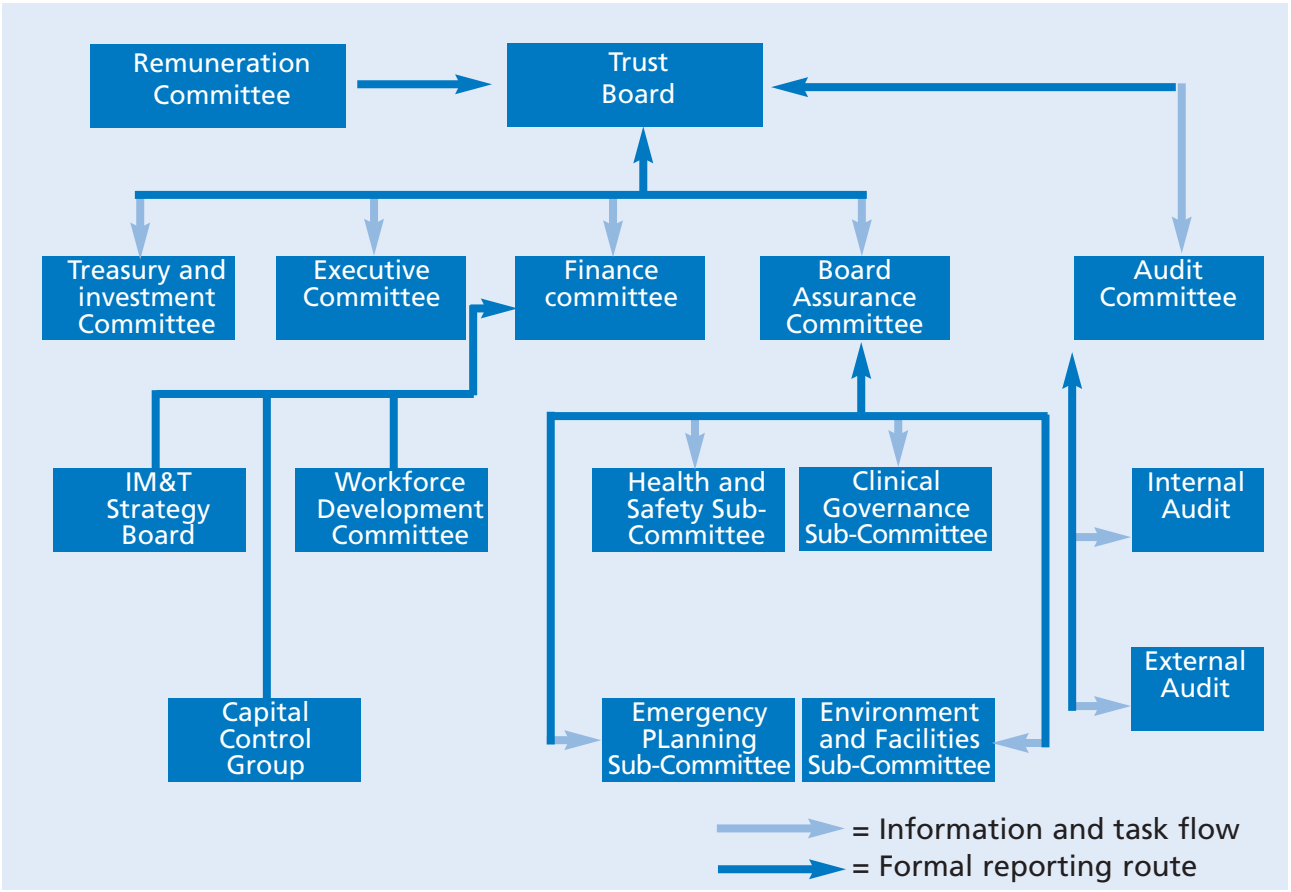
Finally, in February 2006 the Trust created a single sterile services department from the two old units based at the Lister and QEII hospitals. The new service, which is housed in a considerably expanded unit at the Lister, experienced initial problems that led to a rise in the numbers of patients having their surgery cancelled at the last minute.

Typically the level of all such cancellations is around 50 per month, i.e. including those caused by other reasons such as bed availability and problems with theatre lists. Following the new service going live, the level of overall last-minute cancellations more than doubled initially, although as the problems began to be tackled, this fell back to more acceptable levels within a few months. The service is now running far more effectively and is on track to meet all the national and European standards that have been set for sterile services departments.

Performance management

Service and financial performance issues are considered at the weekly meetings of the Trust's executive committee. Each directorate also meets weekly with some executive directors to review their financial performance and there are monthly meetings to consider operational performance against national standards, including infection control. At its monthly meetings held in public session, the Trust Board reviews service and financial performance.

This process for monitoring the Trust's service and financial performance will be altered during 2007/08 to meet the changing governance needs of the organisation. The executive committee fits into a governance structure for the Trust that was revised and agreed by the Trust Board in November 2006 – see chart on the next page.



Results for key operational performance indicators for 2006/07 compared to those forecasted by the Trust for the year are as follows:

	2006/07 planned	2006/07 planned	Variance (%)
A&E activity (attendances)	130,300	133,000	2.3%
Outpatient activity (first attendances)	79,566	93,133	14%
Elective activity30,446 (number of planned episodes of surgery/treatment)	31,888	5%	
Non-elective activity (number of emergency admissions)	39,967	40,893	2%
Average length-of-stay for planned surgery/treatment	-	3.0 days	-
Average length-of-stay following emergency admission	-	5.1 days	-
Average bed occupancy (the proportion of beds occupied at any one time)	-	89%	-

Service performance objectives for 2007/08

The Trust's principal service aims and objectives for 2007/08 are:

- To reduce the maximum waiting from GP referral to treatment to a maximum of 18 weeks by 31 December 2008.
- To achieve continuous compliance with the existing national 98% A&E waiting time standard.
- To reduce the number of MRSA bacteraemias to the Trust's target for 2007/08 – 26 cases.

Achieving the Trust's service performance objectives

- **Achieving the 18-week GP referral to treatment waiting standard:** as the Trust works to meet the new 18-week waiting standard from GP referral to treatment, which must be met by 31 December 2008, progress in reducing waiting times continued to be made during 2006/07. During the year, the Trust achieved the following by 31 March 2007:
  - All but six patients waiting for their first outpatient appointed were seen within 11 weeks
  - Just 121 people waited more 20 weeks for their day case or inpatient treatment
  - At the same time, progress was made towards reducing waiting times for many of the diagnostic services provided by the Trust, e.g. audiology, endoscopy, pathology and radiology

  The work being undertaken by the Trust moving towards achieving the 18-week standard – which comes into effect initially from April 2008 and must be met in full by 31 December 2008 – will now focus on improving flows through the Trust's hospitals and eliminating bottle necks, as well as improving a number of clinical efficiency indicators – especially achieving lengths-of-stay that are comparable with the best performing NHS trusts nationally.
- **Achieving continuous compliance with the A&E waiting time standard:** although throughout 2006/07 the Trust did achieve the national A&E waiting time standard in some months – i.e. that 98% of A&E patients should wait no more than four hours to be seen and treated or be transferred, admitted or discharged – this was not the case throughout the year, especially in the six months to March 2007. Much work has been undertaken during 2006/07 to support the Trust's two A&E departments, with the aim of achieving the national standard during 2007/08.
- **Reducing the number of MRSA bacteraemias:** during 2006/07, the Trust invited a specialist team from the Department of Health to review its infection control procedures and to recommend additional actions that should be taken. This review took place in October 2006 and resulted in a new action plan that is still being implemented. Key elements of that plan is greater use of root cause analysis to understand how individual infections happen and thus additional measures that may need to be made to prevent reoccurrence elsewhere in the Trust.

  Hand hygiene and hand washing compliance remain a crucial element of the Trust's infection control procedures, with every ward and clinical area being monitored routinely. Infection control will remain a key element of the regular performance review meetings held monthly with individual directorates.

The Health Protection Agency have suggested that up to half of all MRSA bacteraemias and a quarter of patients with Clostridium difficile infections diagnosed while in hospital may have actually acquired these where they live, which may have been a nursing home or community hospital. This is why the Trust is now seeking to work with its colleagues in primary care, the independent sector and social services to ensure that the lessons learnt on infection control are extended out in to the community as well.

Given the starting point, however, the target to reduce the number of MRSA bacteraemias in 2007/08 to 26 cases – which represents a reduction of over half the level in 2006/07– will prove very challenging indeed.

Stakeholder relations

During 2006/07, primary care trusts (PCTs) across England were merged as part of the Government's Commissioning a patient-led NHS initiative to help the delivery of the implementation of the NHS Plan. From October 2006, the four PCTs in east and north Hertfordshire were merged to form the new East and North Hertfordshire Primary Care Trust; the West Hertfordshire Primary Care Trust was established to replace the four PCTs that had been in existence in that part of the county.

This made maintaining relationships with the old PCTs that commissioned services from the Trust, as well as developing them with their successor organisation, a highly challenging experience. Despite this, positive working relationships were maintained throughout 2006/07 and any contractual disputes were resolved locally.

The Trust has Board-level and, where relevant, senior management representation on the local strategic partnerships that exist in Stevenage, Welwyn Garden City and Hatfield. Strong working relationships have been established with several of the district and borough councils within east and north Hertfordshire, with the Trust often attending community-based meetings organised by the council.

The Trust has continued to enjoy very positive experiences working with Hertfordshire County Council's health scrutiny committee and has strong links in place with the University of Hertfordshire – in particular its schools of:

- Health and emergency professions
- Pharmacy
- Postgraduate medicine
- Nursing and midwifery

Social, environmental and community policies

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

- **Estates strategy:** The Trust recognises the importance of an estate strategy in order to ensure its property asset base supports clinical services fully. The strategy is also critical for focussing capital investment most effectively. The outcome of the acute services review announced in November 2006 by the Hertfordshire primary care trusts, along with the work leading up the resulting public consultation and development of a business case, will allow the Trust's new estates strategy to be finalised.

  Work during 2006/07 concentrated on developing well-considered options for future acute service configurations within the Trust. A comprehensive property survey of the Trust's estate was completed during the year and backlog maintenance assessments are being revised in line with this information.

- **Green travel plan:** This plan has been developed by the Trust in order to promote and demonstrate its commitment to sustainable solutions to current transport issues. The plan's main aim is to reduce adverse environmental impacts of transport to and from the Trust's hospital sites.

  Over the last year there has been increased interest from staff in alternative forms of transport, particularly cycling. The waiting list for staff parking permits has increased, but this is a key initiative in managing traffic congestion on hospital sites and encouraging greener forms of travel. Plans are currently being developed for a staff travel survey and for new schemes for cycle purchase and borrowing.

- **Energy strategy:** The Trust's current energy strategy was introduced in 2005 and was updated last year. Its aim is to manage energy usage to reduce revenue costs, as well as minimise the impact the Trust has on the global environment. With an annual energy bill now around £2.5 million, this work now has even greater relevance to the Trust's performance.

  The strategy includes short and longer-term targets, which incorporate Government and Department of Health targets – including the requirement to reduce CO_2 emissions by 15% by 2010. Over the last two years, the Trust's:

  - energy costs have increased by 12.5%
  - energy efficiency has increased by 8.9%
  - emission of CO_2 has decreased by 7.2%
  - consumption of fossil fuels has decreased by 8.9%
  - consumption of renewable energy has increased by 10%

  With new energy efficiency measures, such as only installing low energy lamps, and an energy awareness campaign started recently, the Trust is confident that the targets set for it nationally will be met.

  Over recent years, the Trust's estates team has taken the use of utilities very seriously. The cost last year was some £2.1 million. As a result, the Trust has sought ways to reduce the amount of water, gas and electricity consumed as much as possible.

- **Sustainability and environmental report:** The Trust is committed to full disclosure and accountability on these issues. Through its committee structure, the Board receives reports – on roughly an annual basis – about the Trust's achievements against the key performance indicators covering energy and water consumption, waste production and disposal, CO_2 emissions and progress towards mandatory environmental targets.

Improving patient care

Highlights of the year

Elsewhere in this report on 2006/07, major developments affecting patient care – such as the new MRI and breast units at the QEII, new 23-hour ward at the Lister and the improved cancer treatment facilities at the Mount Vernon Cancer Care – are listed in some detail.

In this section, the Trust would like to highlight some of the smaller, yet in many ways equally important, projects that took place during the year. All led to improvements in the care that very specific groups of patients and their carers/families received from the Trust's staff.

- For the first time since 2001, the Lister's tower block was revealed as the final pieces of scaffolding and netting that have been in place for the last five years were removed in May 2006. This followed a £2.5 million scheme that had seen the exterior tiling façade clad in special white metal sheets to prevent tiles – which had begun to loosen – from falling off and injuring people below. During the works, all windows and blinds – except those facing the fire escape balconies – were replaced. Apart from improving the view, the new windows and blinds made the patient areas a much more pleasant environment.
- May was also the month that the Trust received the results of a satisfaction survey carried out with cancer patients. It made very good reading, with 98% saying they felt their privacy was respected at all times and three quarters stating they were very involved in care and treatment decisions. Over 90% said that they felt able to discuss issues with a specialist nurse.
- According to data produced through the Royal College of Physicians' annual MINAP study in June 2006, showed that people brought to the Lister and QEII hospitals with heart attacks continued to receive better care than the standard expected of hospitals in England. According to the national service framework (NSF) for coronary heart disease, 75% of people having a heart attack are expected to receive clot-busting drugs within 30 minutes of arriving at A&E – the so-called door to needle time target. Both the Lister and QEII exceeded not only the national target, but also the average performance of hospitals across the country.
- From the Autumn of 2006, the Trust began rolling out the introduction of a remote medical transcription service across the Trust's directorates. Using encrypted digital technology, the service uses dedicated dictation equipment and software to allow the Trust's senior doctors to dictate routine patient letters for GPs following an outpatients clinic. These are then transmitted electronically, with full encryption security having had all patient identifying details removed first, to a remote transcription service that returns the typed letters for checking within 48 hours. While still in its implementation phase, this will be the first time that the Trust has a common checking process in place for all such letters, with the aim of improving the time within which GPs receive letters from the Trust, thus speeding up treatment decisions for their patients.

- In a report published by the Healthcare Commission on the management of patients' admissions to hospitals across England in October 2006, the Trust was awarded an overall satisfactory score. The report showed that the Trust continues to improve as it strives to become more efficient and responsive to patients' needs. As a result, very few people wait for more than four hours in the Trust's A&E departments, with the average waiting time – especially for minor injuries – being far less. By the end of 2006, fewer medical patients found themselves admitted to beds on surgical wards because the Trust's medical wards were full.
- Also in October 2006, the Lister and Queen Elizabeth II (QEII) hospitals were awarded a certificate of commitment in their first step towards gaining international recognition from UNICEF's Baby friendly initiative. (United Nation's Children's Fund). The aim of the work is to increase breastfeeding rates and to improve care for all mothers looking after their babies at the Lister and QEII.
- Part of implementing the national service framework (NSF) for older people, a Trust-wide project aimed at improving care for this group of patients was completed in October 2006. The staff team involved delivered eight dementia care champions programmes over the past year. Altogether 40 staff attended from across the Lister and QEII. The courses focused on developing staff skills and awareness of dementia care. This has led to better understanding of the needs of patients with dementia who require acute hospital care, as well as the practical solutions required for the management of this specialist group of patients.
- Autumn 2006 saw a £1,000 makeover of a courtyard area used regularly by patients and staff at the Mount Vernon Cancer Centre. A team from the Prince's Trust spent two weeks clearing rubbish, painting walls, chairs and tables, provided new garden furniture and plants outside. They also managed to stretch the funds to buy a TV and DVD player, plants and paintings to update the centre's day room – real benefit to patients.
- In November 2006, following the opening of the dedicated stroke unit at the QEII that now supports the whole of east and north Hertfordshire, the Health Shuttle piloted a new transport service for stroke patients' relatives between the two hospitals. People who suffer strokes are often older, with many spending several weeks in hospital undergoing rehabilitation. The new transport link was put in place to support patients' relatives from north Hertfordshire who wished to travel to the QEII, but had difficulty getting there on their own.
- At the start of 2007, a project to promote healthy eating and aid recovery proved popular with patients on the children's ward at the Lister. The team wanted to find a way of developing a more homely environment that would encourage children to eat and parents to feel more engaged with their care. Making sure that children were not interrupted by staff while eating, using calming music and laying out the tables with bright table cloths signalled one thing – a time dedicated to food, as well as a social occasion for all of the patients and parents on the ward.

Developing new services

2006/07 was the second of the Trust's three-year financial recovery plan, which meant less scope existed in investing in new services. During the year, however, the following new services were introduced:

- The Trust introduced a 23-hour surgical ward at the Lister, which opened to patients in August 2006. This innovation for the Trust meant that specific groups patients whose surgery was not suitable to be carried out on a day case basis were no longer admitted as full inpatients when their operation required them to be in hospital for up to 23 hours, including an overnight stay if needed. The ward has been a real success and contributed significantly to improving surgical efficiency across the Trust.
- For the majority of dialysis patients, kidney transplantation improves their quality of life greatly, allowing freedom from regular dialysis treatments and dietary restrictions. An investment in live kidney donor co-ordination in 2004 has resulted in a gradual increase in dialysis patients receiving a live donation from a family member. 2006/7 was the best year so far, with 16 patients receiving a live donation, with a further 32 having received a cadaver kidney transplant. This service will continue to be developed in 2007/08, given the rising numbers of patients requiring renal dialysis.

Improving existing services

Throughout 2006/07, the Trust continued to ensure its services were improved, by concentrating on four key areas:

- Ensuring that patients had improved quality of information during their time in hospital;
- Making it clear how patients and their carers can raise issues of concern;
- Raising levels of hygiene and cleanliness, especially around hand washing, to combat healthcare-associated infections
- Encouraging staff to report errors, even those that were caught before they happened (i.e. so called near misses)

Improved communications: During 2006/07, the Trust introduced a comprehensive patient handbook, which covered all aspects of a patient's stay while in hospital. The range and quality of patient information leaflets has been improved through the involvement of the Trust's patient information group.

Following the results of previous inpatient surveys, the Trust's staff have also worked hard to ensure that patients felt more involved in decisions taken about their care and were given the information that they needed – especially when being discharged.

Early complaints management: Using a combination of the Trust's patient advice and liaison service (PALS), the Essence of care initiative and modern matrons, it has been possible to make sure that more patients and their carers/families had a greater variety and more immediate opportunities to voice concerns and raise issues, rather than feel that they need to make a formal written complaint to the Trust. By resolving issues early on, this often leads to improved patient care.

One of the more important initiatives undertaken by the Trust to help with patients and/or their carers in recent years has been PALS. Delivered principally through trained volunteers and led by Trust staff, in 2006/07 PALS dealt with some 1,000 enquiries. The vast majority of these were resolved quickly, involving relevant clinical staff – especially modern matrons and ward sisters – with relatively few needing to be passed on to the Trust's formal complaints process.

Since the introduction of ALS at the Trust's hospitals in 2003 – initially at Hertford County, Lister and QEII, followed by the extension of a satellite service to the Mount Vernon Cancer Centre in 2005, an analysis of issues raised by patients and the public carried out in 2006 showed that key concerns are:

- Communication between staff and patients, as well as their carers/families
- Operations cancelled at short notice, with patients having experiencing prolonged periods of Nil by mouth, i.e. when they are not allowed to eat or drink anything
- Clinics cancelled at short notice
- Access to suitable transport

As a result of comments received through PALS, many small changes were made by wards and departments to improve patients' experience. Set out below are two such examples.

Following braking her arm, a woman was given a date for the removal of the plaster and her arm to be checked. When she arrived, she was told that the clinic had been cancelled and to come back in three weeks. The woman was seen that day after she refused to leave the clinic. She approached PALS subsequently and through working with the clinic, staff now have codes on their screen stating clearly that a plaster needs to be removed and these patients, therefore, cannot be cancelled in future.

Another good example of PALS working with its staff colleagues to bring about change for the patient was when a profoundly deaf man needed to change appointments, which involved several clinical departments. With the involvement of PALS, the Trust's outpatients manager liaised with the relevant departments on his behalf. Now this gentleman uses e-mail regularly as a successful form of communication with the Trust.

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

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

Formal complaints and complements:
During 2006/07, the Trust received 732 formal written and oral complaints. Of these, 78% received a full response letter within 20 working days – the national standard expected of NHS trusts is at least 80%. As and from 1 September 2006, the national NHS complaints system was changed and NHS trusts were required thereafter to respond to all formal complaints within 25 working days. The position over the last three years is set out in the table below.

- One complaint was returned to the Commission as the recommendations made were disputed by the Trust. Upon further investigation, its recommendations concerning a specialist service (oncology) were made by a nurse and not by a specialist doctor, as would be expected. The Commission has agreed to review the complaint again.

Towards the end of 2006/07, the Trust made efforts to promote how patients and/or their families and carers can make a complaint, should they wish to do so.

Year	2003/04	2004/05	2005/06	2006/07
Total formal complaints	705	702	722	732
% response within 20 working days*	86%	80%	84%	78%

**From 1 September 2006, the Healthcare Commission amended this standard to response rate within 25 working days*

In the 12 months to the end of March 2007, the Trust had: 15 patients ask for their complaint to be referred to the Healthcare Commission; a further 12 had their referrals dealt with by the Commission, although it was made originally in 2005/06. Of all of these cases, the outcomes were as follows:

- Where the Commission made recommendations, the Trust either produced and implemented action plans or further explanations were given to the complainant. To date, the Trust is not aware that any individuals have taken their complaint to the Health Ombudsman.

In addition to the formal complaints that the Trust received, during 2006/07 it also received over 130 letters complementing the care provided by the Trust's staff. This in addition to the many conversations, cards, notes and small gifts given to ward staff directly. Anecdotally, it remains the case that complements outstrip complaints by a ratio of approximately four to one.

Combating healthcare-associated infections: Healthcare associated infections are one of the issues of greatest concern to patients and their carers. Apart from the fear they engender, they are a major reason why some patients spend longer in hospital then they should and if someone is already very ill, then an infection may even be a contributory factor to their death.

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

During 2006/07, the Trust began implementing the Department of Health's Saving lives initiative to improve infection control through making high impact changes that are derived from best practice from across the NHS. This includes:

- the most appropriate patients being nursed in the Trust's limited number of side rooms;
- patients with accepted high risk factors for infections are screened;
- cross isolation audits are completed

Every clinical area is now audited for hand washing compliance, both in terms of its quality and frequency. In December 2006, the Trust also enforced a strict dress code: staff wearing theatre scrubs are no longer able to be served in the Trust's catering outlets and clinical staff in patient areas rolling up sleeves and ensuring that ties are tucked in to shirts. The Trust also began to take part in a multi-centre clinical trial, co-ordinated by a major London teaching hospital, looking into the potential for silver containing pyjamas and bed linen in combating infections caused by bacteria such as MRSA.

Towards the end of 2006/07, the Trust was also successful in bidding for £300,000 of additional funding from the East of England strategic health authority for capital works that will help infection control. The Trust has used these funds to upgrade hand washing and bathroom facilities on many wards.

Finally the Trust, working in partnership with members of its patient and public involvement forum and patient panel, carried out PEAT inspections at each of its hospital sites. In 2006/07, these showed that the ratings for both Lister and QE2 in relation to cleanliness were deemed as acceptable. In respect of the food scores, both sites were rated as good.

Key points to emerge from the 2006/07 PEAT inspections were:

- Improvements had been made to the cleanliness of the Trust's two acute hospitals, the Lister and QEII – notably bathroom and toilet cleanliness had improved from the previous year.
- Storage of equipment in wards and departments had also improved following investment in bathroom and shower rooms from the Trust's environment budget.
- The food scores for the Lister and QEII continued to result in a good rating due to the choice, quality and presentation of the meals provided by the Trust.

There were additional sections within the PEAT inspections relating to infection control, which looked at hand decontamination, hand washbasins, uniform laundering and staff changing facilities. These did not influence the scores, as they were only yes/no responses, but identified the shortfalls in relation to changing facilities and Trust laundering of staff uniforms.

The Trust recognises that there is still room for improvement in a number of areas, but it was pleasing to see that efforts to improve its hospital environment for patients had resulted in an improved cleanliness score in particular.

Reporting errors: The Trust is taking part in the National Patient Safety Agency's (NPSA) national reporting and learning and system (NRLS). In September 2006, the Trust published the NPSA's first report, which covered the period from January to March 2006 and bench-marked performance against a group of similar NHS trusts from across the country. The report characterised the Trust as having a very high level of incident reporting. The vast majority – some 98% - involved no or little harm to patients. This profile is typical of an organisation that has a positive and open approach, encouraging staff to report incidents and ensure that lessons are learnt and actions taken. Such organisations also tend to have low levels of incidents were patient harm is more serious.

Improving patient care – the role of clinical governance and audit

Clinical governance: The Trust's clinical governance support centre works closely with clinical directorates to manage incidents, claims, audit, clinical effectiveness and complaints processes. Throughout 2006/07, trends relating to incidents and claims have remained stable and following their analysis, safer systems have been put in place. A study into the impact of reconfiguration on patient safety has demonstrated encouraging results.

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

Clinical audit: During 2006/07, all clinical specialties across the Trust responded well to the new forward planning process, which resulted in a comprehensive clinical audit forward plan being produced; the latter reflected all of the Trust's key priority topics. The Trust also participated in a number of important national audits, in particular the national sentinel stroke and continence audits, as well as the national paediatric diabetic audit – all of which were supported by the Trust's clinical audit team.

Good progress was made with the Trust's clinical audit database, which will be used to produce reports, by specialty, on all audit activity. From information received by the clinical audit team, a large number of audits took place within the year, many of which resulted in changes in practice. Examples of the latter include the:

- Production of new clinical guidelines;
- Revision of processes and training;
- Provision of diaries to cancer patients.

In addition to providing support for a variety of audits that took place within the Trust during 2006/07, the clinical audit team was also involved heavily in the production of generic audit tools for key mandatory audits and the development of new care bundles. Two of the latter – for the insertion and maintenance of urethral catheters and central lines – were launched in 2006/07, with four more in the pipeline currently.

Standards for better health declaration: The Trust has a devolved system for managing the annual Standards for better health declaration process, with staff overseeing local standards. Such ownership at a local level ensures national standards become part of everyday business. The Trust's board assurance committee monitors their implementation.

For 2006/07, the Trust has declared itself compliant with all core standards with the exception of decontamination. Although decontamination services are considered to be safe a declaration of insufficient assurance has been given until formal accreditation is sought in the autumn.

For the declaration submitted in May 2006 for the 2005/06 NHS year, the Trust declared not met for decontamination and limited assurance on child protection and safety alerts; all other care standards were met. This shows that between the two years, significant progress has been achieved.

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

Over the past year, the Trust has continued to develop close working relationships with its patient and public involvement forum. The forum's chair now sits with the Trust Board at its monthly meetings in public session. At the same time, the Trust has sought to involve its Patients panel in work being undertaken in a variety of areas across its hospitals.

The advice and input of both bodies have proved invaluable, while the Trust has sought to make changes to the way in the services it offers to local communities or in ensuring that existing ones continue to be delivered to a high standard. Examples of these close working relationships include:

- In 2006/07, the Trust carried out the annual patient environment action team (PEAT) assessment survey of its hospitals, with forum and patient panel members joining Trust staff, including executive directors, infection control nurses, modern matrons and facilities staff.
- The Trust has worked closely with its patient and public involvement forum and patients panel to engage members of the public in a range of service planning and improvement issues, including reconfiguration of acute services, the development of a consolidated acute stroke unit at the QEII hospital and non-emergency patient transport. The patients panel has also assisted the University of Hertfordshire by contributing to a periodic review of undergraduate medical programmes, which look at service users' experience of health care professionals.
- Throughout the year, the Trust continued its work with staff, the community and stake holders in shaping proposals for a single acute hospital and pathways of care in east and north Hertfordshire. Events included the Getting health right for the future - shaping the hospital workshop, which was designed specifically for members of the public. Another meeting – the Models of care - workforce challenge and confirm conference – was developed to engage NHS staff in identifying future workforce needs arising from new pathways of care.
- As part of its audit work on partnerships, in 2006 the Trust's internal auditors looked at the consultation processes for four services: women and children's, breast, chemotherapy and non-emergency patient transport. The report, which is still in draft form, has indicated substantial assurance on the effectiveness of the Trust's partnership arrangements relating to these processes.

Responding to national patient surveys

Every year, the Healthcare Commission carries out a national patient survey, with information provided for every NHS trust in the country. The 2006 survey was published in April, which showed that patients' experiences of their admission to the Trust's hospitals and in levels of cleanliness had improved markedly. The latter is an area in which considerable investment had been made over the previous 12 months. The results are summarised in the table below.

A total of 850 patients selected randomly from the Trust were sent a questionnaire through Picker Institute Europe – one of several research companies working to the Healthcare Commission. Of these, 467 returned a completed questionnaire – a response rate of 55.4% (against a national average of 56.1%).

A total of 61 questions were used in both the 2004 and 2005 surveys, the responses to which are set out in the tables below. In terms of changes recorded between the two years, these are set out in the tables below with the results grouped as follows:

- Better/worse – a change of greater than five percentage points
- Slightly better/worse – a change of less than five percentage points
- No change – no move in the percentage points recorded

Overall	2004	2005	Change
Would not recommend this hospital to family/friends	10%	8%	Slightly better
Not treated with respect or dignity	24%	24%	No change
Doctors and nurses working together poor or fair	9%	9%	No change
Rating of care poor or fair	10%	12%	Slightly worse
Did not know how to complain	26%	38%	Worse

Admission to hospital	2004	2005	Change
Should have been admitted sooner	40%	29%	Better
Admission date changed by hospital	23%	18%	Better
Not given printed information about hospital	41%	28%	Better
Not given printed information about condition or treatment	34%	27%	Better
Had to wait long time to get to room/ward/bed	39%	34%	Better
Admission process not at all/fairly organised	48%	44%	Slightly better
Not given enough notice of admission	2%	2%	No change
Not given choice of admission date	67%	68%	Slightly worse
No explanation for wait in getting to room/ward/bed	32%	44%	Worse

The hospital and ward	2004	2005	Change
Room or ward not very or not at all clean	14%	9%	Better
Toilets not very or not at all clean	23%	16%	Better
Patient found it upsetting to move wards	34%	33%	Slightly better
Bothered by noise at night from other patients	43%	42%	Slightly better
Patient in mixed sex ward	22%	22%	No change
Bothered by noise at night from staff	19%	19%	No change
In two or more wards during stay	33%	34%	Slightly worse
Upset by being on a mixed sex ward	32%	34%	Slightly worse
Food was fair or poor	50%	53%	Slightly worse

Doctors	2004	2005	Change
Didn't always get clear answers to questions	35%	34%	Slightly better
Talk in front of you as if you're not there	33%	33%	No change
Didn't always have confidence and trust	24%	26%	Slightly worse
Didn't always get chance to talk to when needed	39%	42%	Slightly worse
Some/none knew enough about condition/treatment	12%	15%	Slightly worse

Nurses	2004	2005	Change
Sometimes, rarely or never enough on duty	50%	46%	Slightly better
Didn't always get chance to talk to when needed	41%	40%	Slightly better
Didn't always have confidence and trust	31%	31%	No change
Some/none knew enough about condition/treatment	23%	24%	Slightly worse
Didn't always get clear answers to questions	30%	40%	Worse
Talk in front of you as if you're not there	19%	25%	Worse

Your care and treatment	2004	2005	Change
Didn't always get help in getting to the bathroom when needed	21%	20%	Slightly better
Didn't always get enough help from staff to eat meals	10%	9%	Slightly better
Wanted to be more involved in decisions	53%	54%	Slightly worse
Not enough (or too much) information given on condition/treatment	23%	25%	Slightly worse
Couldn't always find staff members to discuss concerns with	39%	40%	Slightly worse
Not always enough privacy when being examined or treated	13%	14%	Slightly worse
More than five minutes to answer call button	10%	12%	Slightly worse
Results not explained well/not explained at all	49%	53%	Slightly worse
Staff contradict each other	33%	38%	Worse
Not always enough privacy when discussing condition/treatment	30%	35%	Worse
Not enough chance for family to talk to doctors	39%	48%	Worse

Pain	2004	2005	Change
More than 15 minutes to get medicine	12%	14%	Slightly worse
Staff didn't do everything to help control	27%	35%	Worse

Operations and procedures	2004	2005	Change
Risks and benefits not explained fully	22%	19%	Slightly better
What would be done during operation not explained fully	24%	26%	Slightly worse
Questions not answered fully	23%	26%	Slightly worse
Results not explained in a clear way	37%	40%	Slightly worse

Leaving hospital	2004	2005	Change
Not given written or printed information	44%	43%	Slightly better
Not told fully purpose of medications	21%	19%	Slightly better
Discharge too early or too late	18%	15%	Slightly better
Discharge delayed by one hour or more	83%	85%	Slightly worse
Not told fully side-effects of medications	45%	49%	Slightly worse
Family not given enough information to help	40%	42%	Slightly worse
Not told who to contact if worried	25%	26%	Slightly worse
Discharge was delayed	39%	44%	Worse
Not enough time spent discussing recovery	31%	36%	Worse
Not told fully of danger signals to look for	45%	51%	Worse

In addition to where the Trust improved compared to its performance in 2004, the survey also showed a fairly consistent theme of the Trust's staff being perceived as not being as good as they could be in spending time explaining what is happening to patients, especially in relation to treatment and discharge arrangements.

Nine out of 10 patients continue to feel that the Trust's nurses and doctors worked well together and that only about one in 10 felt that their care had not been up to their expectations. The number of patients who would not recommend one of the Trust's hospitals to family or friends dropped to below 10 per cent.

On reviewing the survey data, the Trust Board was concerned that there was a significant rise in patients not knowing how to go about making a complaint – this is an area in which considerable efforts were made during the following 12 months. With regard to quality of communications between staff, patients and their carers, this was also an issue on which the Trust placed considerable emphasis during 2006/07.

Ensuring the Trust has the best staff

Highlights of the year

- Over 150 staff and their guests attended the Trust's annual staff awards, which were held at Knebworth Barns in March 2006. Awards were presented for the best team, team leader and innovation within the Trust, as well as three separate chief executive awards to staff who had made a special contribution to the organisation.
- In May, the Trust's nursing staff went back to school for a series of interactive sessions with children to promote the work they do, ahead of International Nurses' Day on 12 May 2006. These are amongst some of the most fulfilling and popular events organised as part of the annual celebrations every year. From dressing up, to hand-washing, x-rays, plaster-making, observation and bandaging, the youngsters had a chance to try them all.
- In November 2006, the team that runs the Trust's endoscopy and inflammatory bowel disease service made it to the finals in last's year's national Hospital Doctor Awards. In the end, they were judged runner up in the Best in GI medicine category.
- Some 42 staff received long service awards in May 2006 at a special event held by the Trust at Tewin Bury Farm. To qualify, they had to have over 25 years of continuous service at any of the Trust's four hospitals sites.
- In June 2006, once again the Trust organised its annual volunteer awards lunch to say thanks to the more than 350 volunteers that it manages across its four hospitals. Between them, these volunteers give up 5,000 hours every month to support staff, patients and their carers/families.
- Good progress was made in 2006/07 in moving virtually all relevant staff onto the new national Agenda for Change pay and conditions scheme and implementing the related knowledge and skills framework (KSF).
- By March 2007, the Trust's vacancy rate stood at 10.68%, which compared to 4.23% in March 2006. This reflects the strict controls placed on the recruitment to vacant posts while the Trust reviews the skill mix of the workforce needed to deliver the treatment and care of patients expected through the commissioning intentions of primary care trusts.
- The turnover rate of staff during 2006/07 was 10.56%, which is only slightly higher than the 9.81% recorded in the previous year.

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

More than any other year, this has been true for 2006/07 during which the Trust changed some of its services, including reducing the number of beds in its hospitals. This resulted in posts being removed from the Trust's establishment, but every effort was made to ensure that its highly skilled staff – especially nurses – were redeployed into vacant positions elsewhere within the organisation.

As a result of these changes, during the year no staff were made redundant compulsorily; 12 medical secretaries took voluntary redundancy through the implementation of the remote medical transcription service project towards the end of the year.

Recruiting and retaining staff

The Trust enjoys a general good reputation as being a good employer. Thanks to its growing national profile and developments such as the Trust's new cardiac laboratory, high calibre staff continue to be attracted to come and work at its hospitals.

Nursing and midwifery strategy

The Trust's nursing and midwifery strategy, which was produced in 2003 and is due for review in 2007, focuses on improving the patient experience and quality of care, with modern matron/lead nurses having a particular role to play in this aspect of the Trust's work.

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

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

Modernising pay and conditions

This section of the Trust's 2006/07 annual report looks at:

- Junior doctors' hours
- Non-consultant career grade doctors
- Consultants
- Agenda for Change

Junior doctors hours: During 2006/07, the Trust was compliant with the European Working Time Directive, which limits the number of hours a junior doctor can work to 56 per week. Implementing the Directive's next phase, where by 2009 no junior doctor must work more than 48 hours per week, will be equally challenging. This is particularly so for an organisation like the Trust that runs services across split sites, where each hospital is still required to run compliant rotas for junior doctors.

Previously the Trust has established a successful Hospital at night system of working. This involves taking a team-based approach to delivering essential services at night and over weekends. The effectiveness of this system is monitored regularly to ensure that the Trust understands its impact on working patterns and patient care.

Non-consultant career grade (NCCGs) doctors: Negotiations nationally on terms and conditions for NCCG staff continue and have taken longer than anticipated. A ballot of all doctors affected by the change is still expected to be conducted during 2007/08.

Consultants: Annual appraisals and job planning has been established for all of the Trust's consultants, which has enabled closer linking to service planning and actual changes that may be made during any given year. The latter is essential as the Trust needs to be able to respond to increases or decreases in demand for its various clinical services.

In July 2006, the Trust announced changes for the 165 of its 190 consultants on the new national contracts introduced across the NHS in 2003/04. This contract divides the work that consultants undertake within the NHS into blocks of time – usually four hours each – called programmed activities (or PAs for short). Every consultant on the new contract must work a minimum of 10 PAs on NHS duties every month, covering everything from outpatient clinics through to caring for patients on wards and operating theatres. On average within the Trust, most consultants work a weekly minimum of 11 to 12 PAs.

Within their overall earnings, consultants are also paid to carry out a range of activities that involve much less direct contact with patients – for example auditing their clinical practice, keeping abreast of developments within their specialism and teaching and research activities. These are called supporting professional activities (SPAs), which underpin clinical activities undertaken by consultants. With effect from October 2006, as a cost reduction measure the Trust reduced the maximum number of additional SPAs for which most of its consultants are paid from 2.5 to 2. The Trust will seek to reallocate 20% of these sessions back to identified consultants who undertake extensive commitments.

Agenda for Change: During 2006/07, the Trust completed the introduction of the new national pay and conditions, which covers all employees except doctors and very senior managers, both of whom have separate contract arrangements. The year also saw the Trust's Agenda for Change teams – which are made up of trained managers and staff side representatives – started reviewing all claims for bandings to be reconsidered.

The year also saw the Trust rollout the national knowledge and skills framework (KSF), which governs how staff move between Agenda for Change pay points and bands through their related personal and professional development plans produced following the annual appraisal process. All of this is key in helping the Trust ensure that it has a well-trained workforce.

Improving Working Lives

Set by the Department of Health, Improving Working Lives (IWL) is a national standard to encourage the NHS to become an employer of choice. It recognises that staff work best for patients when they can strike a healthy balance between their work and other aspects of their lives. IWL was launched in October 2000 and forms part of the Government's NHS Plan.

There are three stages of development within IWL that each Trust in the country has to meet. They are:

- **Pledge stage** – where the Trust begins to put into place the people, policies and planning to achieve accreditation.
- **Practice stage** – where external assessors come into the Trust and assess the evidence presented to achieve the required standards.
- **Practice Plus stage** – where the Trust has to demonstrate that each of the seven standards is being met in full.

As of October 2005, the Trust achieved Practice Plus stage. To achieve this, the Trust had to present a thorough and detailed self-assessment report, along with a portfolio of supporting evidence. These were then reviewed during site visits by a team of trained validators from other NHS Trusts, who also held discussions and interviews with members of staff. This all took place in September 2005.

Accreditation is only awarded if the Trust reaches the required standards set out in the validation process for IWL Practice Plus. Achievement of this important NHS standard had a beneficial impact on the Trust's national performance assessment for 2005/6 and beyond.

A highly skilled workforce

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

In 2006/07, the Trust supported undergraduate medical training by developing more clinical placements and expanding its research base. Last year also saw the introduction nationally of Modernising medical careers – the new national curriculum for the foundation years in postgraduate training and education.

The Agenda for Change knowledge and skills framework now underpins all of the Trust's education and training provision. Set out below is a summary of the training achievements from 2006/07:

- 17 clinical leaders took part in the national clinical leadership programme
- 96 staff began national vocational qualifications (NVQs) through local institutes of higher education
- To date, six staff have gained the full European Computer Driving Licence (ECDL) and British Computer Society (BCS) level 1; a further three achieved BCS level 1
- There were 826 attendances on IT skills or IT systems related training courses
- There were 559 attendances on in-house management development courses
- There were 315 attendances on in-house personal skills development courses

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

Informing and consulting staff

The Trust aims to ensure that its staff are fully aware 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:

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

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

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

- Intranet: overseen by an editorial board, the Intranet has grown to become one of the single biggest sources of general information within the Trust
- Trust Bulletin: weekly electronic newssheet, issued by all staff e-mail, which carries a wide range of operational articles

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

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

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

Once a quarter, the Trust's chief executive, finance director and other executive directors meet with staff side representatives to brief them personally on strategic issues, as well as on the organisation's clinical, operational and financial performance.

Equal opportunities

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

The Trust accepts that not only do such differences between individuals exist, but that it values the benefits that diversity brings to the organisation, its patients and the people served in the local community. Sessions on diversity training have been held during 2006/07, which have proved popular.

Disability policy

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

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

Occupational health policy

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

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

Health and safety

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

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

The Trust has an accredited local security management specialist and it is a partner in local crime and disorder partnerships. The Trust is also committed to conflict resolution training, with all staff being required to attend this training, which is delivered to a nationally agreed syllabus. A total of 1,759 staff have been trained since the training programme commenced in November 2005.

Whistleblowing policy and procedure

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

Emergency preparedness – major incident plan

The Trust has a comprehensive major incident plan, which covers its two hospitals with accident and emergency departments – the Lister in Stevenage and the QEII in Welwyn Garden City; it complies with Department of Health guidelines. During 2006/07, the plan did not need to be activated by the Trust.

The plan is updated on an ongoing basis, and Beyond a major incident action cards were added during 2006/07 to ensure compliance with the latest national guidance. The Trust tests the plan on a regular basis to ensure that key staff are familiar with their roles.

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

Victoria Fisher, Secretary to the Trust Board

Tel: 01438 781594 (direct line)

E-mail: victoria.fisher@nhs.net

Financial review

2006/07 was, in so many different ways, one of the most challenging for the Trust's finances. While it was in the second year of its financial recovery plan, local primary care trusts (PCTs) also were experiencing significant pressures too. Part of their financial recovery plan was to reduce the number of referrals made to NHS trusts, thus impacting the Trust's potential income for the year.

In May 2006, the Trust's finance director, Nick Gerrard left after four and a half successful years. His replacement, Wendy Hull, took up post in December 2006. At the same time, the Trust was subjected to very close scrutiny through the East of England strategic health authority's (SHA's) turnaround specialists, who in turn worked closely with the Department of Health.

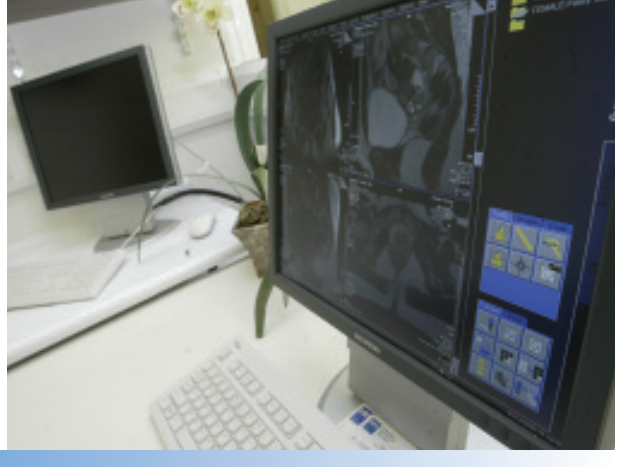
At the start of the year, the SHA set the Trust a control total, as part of its financial recovery programme, to achieve a planned deficit of no greater than £8.0 million. In October 2006, that changed when the SHA advised all NHS organisations in the region that their control totals were being tightened. In the case of the Trust, its new control total was set at no more than a £7.5 million deficit by year-end. The Trust also learnt during November 2006 that the central funding made available for education and training was being reduced retrospectively – with the estimated reduction being £1.0 million.

Given these highly challenging circumstances, it is a real tribute to everyone working for the Trust that final year-end position achieved for 2006/07 was a deficit of £1.5 million out of a total income of £270 million. While this was achieved partly through the use of some non-recurrent measures, the Trust's underlying financial management performance was very good. This has given the sufficient confidence to forecast that for 2007/08, the Trust's finances will return to balance.

The PCTs planned for GPs to make many fewer referrals to the Trust in 2006/07, during which 94,496 people came for a first outpatient appointment – some 4% less than the plan set for the year. Compared to 2005/06, the Trust treated 304 more elective inpatient admissions, but 2,545 fewer day case procedures. This gap was offset by the number of emergency admissions finishing up 2.3% ahead of plan by the end of the year.

Throughout the year, the Trust's staff and managers handled a range of financial pressures successfully. This included delivering £13.8 million of cost reductions and efficiency savings – clinical and non-clinical – to meet cost improvement targets set by the Trust at the start of the year. The latter took into account not just the need for continued financial recovery, but also the affect on the Trust's finances of the impact of such issues as Payment by Results, Agenda for Change and substantial increases in the Trust's energy costs.

Given the Trust's historical deficit, its cash position has been a significant issue throughout 2006/07. Towards the end of the year, the Trust was successful in agreeing a £7.8 million loan with the Department of Health – which helped to improve the cash position towards the end of 2006/07. During 2006/07, the Trust paid 65% of all non-disputed, non-NHS invoices within 30 days, with the figure for NHS invoices standing at 31% for the year.



In 2006/07, despite its financial challenges, the Trust embarked upon or completed a number of major capital investments projects across its hospitals, including:

- £0.66 million on consolidating the Trust's neonatal intensive care service at the Lister
- £2.4 million new breast unit at the QEII (although part of these funds came from the Hertfordshire Breast Unit Appeal)
- Continued development of the £21.82 million new linear accelerator radiotherapy facility at the Mount Vernon Cancer Centre

In addition, the Trust was able to make further investments following successful fundraising donations received in 2006/07, including:

- £2.25 million brachytherapy unit at the Mount Vernon Cancer Centre (the original donation was received in the 2005/06 financial year, although the majority of the investment took place in 2006/07)
- £0.2 million on the new Lister education centre

2006/07 also the Trust continue to develop its planning to deliver a successful application to become an NHS foundation trust by the end of 2008, in line with Government requirements. This is a highly challenging and rigorous process, but one that is being tackled with enthusiasm by the Trust. Its good financial performance achieved during the year, along with that forecast for 2007/08, put it in a much better position in terms of achieving foundation trust status.

With 2007/08 and beyond in mind, the Trust expects the financial environment to be equally challenging. PCTs will continue to shift more patient care closer to where people live. The annual uplift in the NHS budget has now slowed considerably compared to growth received over the last few years. The health service is expected to meeting new tough national performance standards from within existing resources. If it is to be successful, therefore, sound financial management continues to be required to ensure that the Trust's resources are used very efficiently indeed.

Financial notes

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

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

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

	2005/06		2006/07	
	Number	Value (£000)	Number	Value (£000)
Total bills paid	67,421	31,141	65,283	76,352
Total paid within 30 days	41,258	15,421	42,333	41,197
Percentage within target	61.19%	49.5%	64.85%	53.96%

Governance and the Trust Board

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

The Trust Board

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

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

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



The role of the Trust Board

Collective responsibility for adding value to the organisation

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

Leadership and control

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

Looking ahead

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

Setting and maintaining values

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

The role of the Trust's chairman

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

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

The role of non-executive directors

Non-executive directors are appointed to:

- Contribute to the development of strategy
- Scrutinise the performance of the Trust's management in meeting agreed goals and objectives, both clinical and non-clinical, as well as monitor the reporting of this performance
- Satisfy themselves that financial information is accurate and that financial controls and risk management systems are robust and defensible
- Be responsible for determining appropriate levels of remuneration for executive directors and having a prime role in appointing – and, if necessary, removing – the Trust's chief executive, and in succession planning

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

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

Key to principal committee membership

BAC – board assurance committee

AC – audit committee

FC – finance committee

RC – remuneration committee

TIC – treasury and investment committee

EC – executive committee

The Trust Board 2006/07

Richard Beazley, chairman

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

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

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

Committee membership: FC, RC, TIC

Nick Carver, chief executive

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

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

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

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

Committee membership: EC, FC, TIC

Alison Murray, non-executive director and deputy chair

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

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

Her term of office runs from 1 December 2003 to 30 November 2007. Alison lives in Ashwell, near Baldock.

Committee membership: BAC, FC, RC

Stephen Brooker, non-executive director

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

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

Committee membership: AC, FC, RC, TIC

Iain Morfett, non-executive director

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

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

Iain took up his role of non-executive director with the Trust on 1 August 2005, with the end of term date being 31 July 2009. He lives in Letchworth.

Committee membership: BAC, FC, RC

Roger Bailey, non-executive director

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

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

Roger was re-appointed as a non-executive director in 2006; his current term of office runs from 1 January 2007 to 31 December 2011. He lives in Sawbridgeworth.

Committee membership: AC, BAC, FC, RC

Lance Stanbury, non-executive director (to 31 May 2006)

A non-executive director since April 2004, due to overseas business commitments Lance stepped down from his role as a non-executive director on 31 May 2007. He was a former conservative councillor on Welwyn Hatfield District Council, including serving a period as its leader.

Committee membership: AC, RC, TIC

Rory Landman, non-executive director (to 31 December 2006)

Rory was co-opted, following discussion with the Appointments Commission, to the Trust Board as a non-executive director without voting rights from 1 September 2005. He stepped down from this role on 31 December 2006.

Committee membership: AC, FC, RC

Jane McCue, medical director

Jane, who took up her post as the Trust's medical director on 1 April 2003, is a consultant general surgeon with a special interest in colorectal surgery. She trained as a doctor at St Bartholomew's Hospital in the City of London, since when she has held a wide range of surgical posts within the NHS, predominantly in London teaching hospitals.

In her role as medical director, Jane is responsible for leading on strategic planning and the maintenance and improvement of medical standards across the Trust's three hospitals, as well as the Mount Vernon Cancer Centre. She stepped down from her role in January 2007, following completion of her three-year term as the Trust's medical director.

Committee membership: BAC, EC

Noel Scanlon, director of nursing

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

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

Committee membership: BAC, EC, FC (from February 2007)

Nick Gerrard, finance director (to 31 May 2006)

With five years previous experience as an NHS finance director, Nick joined the Trust in November 2001. Prior to his appointment, he worked as the acting regional director of finance at the former South East regional office of the NHS Executive. He has also worked for several other NHS Trusts, including Barts and the London. Nick left the Trust in May 2006.

Committee membership: EC, FC, TIC

Wendy Hull, finance director (from December 2006)

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

She has specific expertise in financial turnaround and relishes the challenges faced by the NHS in Hertfordshire. Wendy is now building a strong finance team at the Trust and strengthening financial governance across the organisation.

Committee membership: EC, FC, TIC

Julie Lowe, deputy chief executive (operations)

Having joined the Trust in May 2002, Julie manages a group of general managers who work with the Trust's 10 clinical directorates. Her main role, therefore, is to ensure that the Trust delivers its performance targets.

Julie began working in the NHS in 1992, following her graduation from university. Her first job was as national management trainee, based initially at Addenbrooke's hospital in Cambridge. In 1993, Julie joined Chase farm Hospitals NHS Trust, staying there for four years before taking up a post at Greenwich hospital in south east London. She then became the executive director/general manager of acute services for the North East Yorkshire Healthcare NHS Trust. Julie became one of the Trust's two deputy chief executives from 1 November 2006.

Committee membership: BAC, EC, FC

Sarah Crowther, deputy chief executive (strategy)

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

Sarah is responsible for leading the Trust's work on strategic planning and modernisation, working internally with clinical directorates and externally with primary care trusts and the local strategic health authority. She became one of the Trust's two deputy chief executives from 1 November 2006.

Committee membership: EC, FC, TIC

John Webster, director of performance and information

In July 2003, John took up the newly created post of director of performance and information with the Trust. Prior to this appointment, he held roles as the performance lead within the former Midlands and Eastern Directorate of Health and Social Care and head of performance for Essex strategic health authority, as well as five years spent working in acute NHS Trusts.

John takes the lead on improving information management within the Trust, working closely with clinical directors and general managers to develop improved performance management processes.

Committee membership: EC, FC

Danny Mortimer, director of human resources and organisational development

Danny's first experience of working in the NHS was as a hospital porter during university holidays. After his graduation, he worked as a CSV volunteer with learning disabilities clients.

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

Committee membership: BAC, EC

Remuneration and interests

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

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

Victoria Fisher, Secretary to the Trust Board

Tel: 01438 781594 (direct line)
E-mail: victoria.fisher@nhs.net

Trust Board, 2006/07

	Title	Appointment date	Term of office (years)	End of term of office
Mr Richard Beazley	Chairman	1 April 2006	Four	31 March 2010
Mr Nick Carver	Chief executive	18 November 2002	-	-
Ms Alison Murray	Non-executive director	1 December 2003	Four	30 November 2007
Mr Stephen Brooker	Non-executive director	1 January 2007	Four	31 December 2011
Mr Iain Morfett	Non-executive director	1 August 2005	Four	31 July 2009
Mr Roger Bailey	Non-executive director	1 January 2007	Four	31 December 2011
Mr Lance Stanbury	Non-executive director	1 April 2004	Four	Left the Trust on 31 May 2006
Mr Rory Landman*	Non-executive director	1 September 2005	Four	Left the Trust from 31 December 2006
Ms Jane McCue	Medical director	1 April 2007	-	Stepped down from 5 January 2007
Mr Noel Scanlon	Nursing director	6 May 2002	-	-
Mr Nick Gerrard	Finance director	1 November 2001	-	Left the Trust on 31 May 2006
Mr John Sloan	Acting finance director	1 June 2006		2 December 2006
Ms Wendy Hull	Finance director	3 December 2006	-	-
Ms Julie Lowe	Deputy chief executive (operations)	13 May 2002	-	-
Dr Sarah Crowther*	Deputy chief executive (strategy)	4 October 2004	-	-
Mr John Webster*	Director of performance and information	20 July 2003	-	-
Mr Danny Mortimer*	Director of human resources and organisational development	22 April 2003	-	-

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

The executive committee

The Trust's executive committee, which meets weekly, comprises the Trust's chief executive and eight executive directors. Also in attendance are the director for strategic estates, head of public affairs, deputy medical director (as clinical duties allow) and the secretary to the Trust Board.

Once a month, the executive committee meets with the Trust's clinical directors and general managers at the board of clinical directors to ensure wider clinical input into the decision-making process. The clinical directors are all senior consultants who take on management responsibilities in addition to their clinical duties.

For 2006/07, the management of the Trust's 10 clinical directorates was

Cancer services, oncology and haematology

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

Emergency care (A&E, emergency medicine and elderly care)

- Simon Greenfield, clinical director
- Clare Steward, associate director

General surgery and urology

- Sadisavam Selvakumar, clinical director
- Neil Dardis, general manager

Radiology and pathology

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

Renal medicine

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

Specialist medicine (cardiology, diabetes, rheumatology, dermatology and respiratory medicine)

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

Surgical specialties (audiology, ear, nose and throat, plastic surgery, ophthalmology, oral maxillofacial surgery and gastroenterology)

- James Quinn, clinical director
- Neil Dardis, general manager

Theatres, anaesthetics and critical care

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

Trauma and orthopaedics

- Andrew Waterfield, clinical director
- Neil Scotchmer, general manager

Women's and children's services

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

Remuneration Report

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

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

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

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

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

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

Nick Carver

Chief Executive

Salary and pension entitlements of Senior Managers

Details of director remuneration and their pension entitlement are shown in the tables that follow.

Name and title	Salary (bands of £5000)	Other remuneration (bands of £5000)	Benefits in kind rounded to the nearest £100	Salary (bands of £5000)	Other remuneration (bands of £5000)	Benefits in kind rounded to the nearest £100
	£000	£000	£000	£000	£000	£000
Nick Carver, chief executive	145-150	0	8	135-140	0	8
Nick Gerrard to 31/5/06, director of finance	20-25	55-60	1	105-110	0	8
John Sloan 24/5/06 to 4/12/06, director finance	45-50	0	4		not in post	
Wendy Hull from 4/12/06, director finance	40-45	0	0		not in post	
Jane McCue, medical director	115-120	0	0		details withheld	
Julie Lowe, director of operations	85-90	0	8	85-90	0	8
Noel Scanlon, director of nursing	85-90	0	0	80-85	0	15
Danny Mortimer, director of human resources	85-90	0	8	85-90	0	8
John Webster, director of performance & information	85-90	0	8	85-90	0	8
Sarah Crowther, director of strategic development	91-95	0	76	85-90	0	4
Non-Executive Directors						
Richard Beazley, chairman	20-25	0	0	20-25	0	0
Roger Bailey	5-10	0	0	5-10	0	0
Stephen Brooker	5-10	0	0	5-10	0	0
Alison Murray	5-10	0	0	5-10	0	0
Lance Stanbury (to 31 May 2007)	0-5	0	0	5-10	0	0
Ian Morfett	5-10	0	0	0-5	0	0
Rory Landman (to 31 December 2006)	0-5	0	0	0-5	0	0

Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of travel expenses, lease cars and removal expenses for new starters

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 07 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31st March 07 (bands of £5,000)	Cash equivalent transfer value at 31 March 07	Cash equivalent transfer value at 31 March 06	Real increase in cash equivalent transfer value
	£000	£000	£000	£000	£000	£000	£000
Nick Carver, chief executive	2.5-5	7.5-10	35-40	105-110	486	417	58
Nick Gerrard to 31/5/06, director of finance	0-2.5	0-2.5	25-30	80-85	396	381	5
John Sloan 24/5/06 to 4/12/06, director finance	0-2.5	2.5-5	20-25	65-70	268	244	17
Wendy Hull from 4/12/06, director finance	0-2.5	2.5-5	30-35	95-100	549	520	16
Jane McCue, medical director	5-7.5	20-22.5	35-40	115-120	568	442	115
Julie Lowe, director of operations	0-2.5	2.5-5	15-20	45-50	167	147	15
Neil Scanlon, director of nursing	2.5-5	7.5-10	25-30	85-90	389	334	46
Danny Mortimer, director of human resources	0-2.5	2.5-5	10-15	40-45	143	125	15
John Webster, director of performance & information	0-2.5	2.5-5	5-10	20-30	121	104	15
Sarah Crowther, director of strategic development	0-2.5	2.5-5	5-10	20-25	77	60	16

As non-executive members do not receive pensionable remuneration there will be no entries in respect of pensions for non-executive members.

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 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 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 membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchase pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Accounts

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

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

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

21st June 2007 Date.....Chief Executive

Statement of Directors' Responsibilities in Respect of the Accounts

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

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

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

By order of the Board

21st June 2007 Date.....Chief Executive

21st June 2007 Date.....Finance Director

Statement on Internal Control

1.Scope of responsibility

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

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

Responsibility for ensuring that there is a comprehensive risk management system in place is delegated to the Director of Nursing, for the co-ordination of the management for all clinical risks, supported by the Medical Director for clinical governance, the Director for Finance for financial and non clinical risks, the Director of Operations for Emergency Planning, the Director of Human Resources for Health & Safety, and the Director of Strategic Development for Information Technology and the development of the Trust.

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

2.The purpose of the system of internal control

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

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

The system of internal control has been in place in East & North Hertfordshire NHS Trust for the year ended 31 March 2007 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

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

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

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

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

4.The risk and control framework

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

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

- To ensure that the organisational structure and management arrangements clearly articulate and support the key elements for risk management
- To provide a process for the effective and efficient management of risk throughout the Trust
- To ensure that the essential complex interrelating systems and services that underpin the management of risk are robust
- To review risk management performance against national standards and key indicators

- To ensure that there is a holistic approach towards risk management, throughout the Trust, which protects all staff, patients and visitors from harm
- To ensure the protection and development of a highly skilled and well educated work force in a high risk industry.
- To ensure that all new developments, new services and service progression, including new medical procedures, are assessed for their potential risks at the planning stage before they are commissioned.

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

- Assess the risk by a logical and systematic method of identifying, quantifying, analysing and evaluating potential risks, followed by a decision to accept, reduce or eliminate those risks.
- Log the risks onto a register
- Communicate the risks to stakeholders and inform the business planning and governance of the Trust
- Take action to control (or treat) the risks via prioritised action plans
- Review the risk management performance via indicators and via compliance with validated standards.

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

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

The Board Assurance Committee is supported by:

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

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

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

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

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

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

5.Review of effectiveness

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

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

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

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

The Head of Internal Audit through the Internal Audit annual report advises me that, based on the work undertaken during the year, significant assurance can be given that there is a generally sound system of internal control, designed to meet our objectives, and that controls are generally being applied consistently. However, weakness in the design and inconsistent application of controls put achievement of certain objectives at risk. I am pleased to report that recent audit testing has demonstrated significant progress in addressing the following areas: child protection, operational aspects of services at Mount Vernon, controls over the use of bank and agency staff, risk management, staff sickness management and the consultant contract. Further work will be undertaken to safeguard the Trust's objectives in other very important areas where the Trust expects a high level of performance:

- To deliver required access and waiting targets and ensure that patients receive treatment in accordance with clinical need in line with these targets.
- To improve the patient experience
- To ensure compliance with the statutory requirement for quality and the delivery of safe, high quality patient care within a reporting and learning culture

The Trust has conducted a self-assessment of its assurance framework during 2006/07. This highlighted the following issues of significance:

- The Trust received formal confirmation from the SHA of an extension to its statutory break-even duty to five years, ending March 2008. The Trust, which now has a robust financial plan in place, agreed with the SHA to achieve this duty.
- In relation to the Healthcare Commission's self-assessment the Trust is reporting 'insufficient assurance' for its decontamination requirements. An inspection visit is due and will confirm compliance status.
- The level of MRSA and other hospital acquired infections remains above target. In response the Trust has a proactive action plan in place, led by the Director of Nursing.
- The Trust acknowledges issues raised by the Environment Agency at Mount Vernon Cancer Centre and the necessary corrective action has now been undertaken.
- The Head of Internal Audit has identified some control weaknesses identified in Internal Audit reports in 2006/7 but expresses confidence that these are now being addressed positively, particularly at Mount Vernon Cancer Centre.

21st June 2007.....Date.....Chief Executive

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

Opinion on the financial statements

I have audited the financial statements of East & North Hertfordshire Hospitals NHS Trust for the year ended 31 March 2007 under the Audit Commission Act 1998. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement, the Statement of Total Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies relevant to the National Health Service set out within them.

This report is made solely to the Board of East & North Hertfordshire Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 36 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of Directors and auditor

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

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

I report to you my our opinion as to whether the financial statements give a true and fair view and whether the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

I review whether the directors' statement on internal control reflects compliance with the Department of Health's requirements ('The Statement of Internal Control 2003/04' issued on 15 September 2003 and further guidance on 7 April 2006 and 2 April 2007).

I report if it does not meet the requirements specified by the Department of Health or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the directors' statement on internal control covers all risks and controls. I am are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures

I read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises only the Foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the Operating and Financial Review. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement, whether caused by fraud or other irregularity or error. In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England, of the state of the Trust's affairs as at 31 March 2007 and of its income and expenditure for the year then ended; and

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State as being relevant to the National Health Service in England.

ROB MURRAY –
ENGAGEMENT LEAD

Date: 21 June 2007

(Officer of the Audit Commission), Sheffield House, Lytton Way, Stevenage, Hertfordshire, SG1 3HB

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

Directors' Responsibilities

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

Auditor's Responsibilities

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

Conclusion

- I have undertaken my audit in accordance with the Code of Audit Practice and having regard to the criteria for NHS bodies specified by the Audit Commission and published in December 2006, I am satisfied that, in all significant respects, East & North Hertfordshire Hospitals NHS Trust made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2007.

Certificate

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

ROB MURRAY – ENGAGEMENT LEAD

Date: 21 June 2007

(Officer of the Audit Commission), Sheffield House, Lytton Way, Stevenage, Hertfordshire, SG1 3HB

Income and Expenditure Account for the year ended 31 March 2007

	NOTE	2006/07 £000	2005/06 £000
Income from activities	3	238,722	209,191
Other operating income	4	31,535	37,116
Operating expenses	5	(265,318)	(261,870)
OPERATING SURPLUS/(DEFICIT)		4,939	(15,563)
Cost of fundamental reorganisation/restructuring		0	0
Profit/(loss) on disposal of fixed assets	8	0	244
SURPLUS/(DEFICIT) BEFORE INTEREST		4,939	(15,319)
Interest receivable		262	285
Interest payable	9	0	0
Other finance costs - unwinding of discount	16	(17)	(15)
Other finance costs - change in discount rate on provisions		0	(88)
SURPLUS/(DEFICIT) FOR THE FINANCIAL YEAR		5,184	(15,137)
Public Dividend Capital dividends payable		(6,711)	(7,242)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR		(1,527)	(22,379)

The notes on pages 6 to 29 form part of these accounts.
All income and expenditure is derived from continuing operations.

Note to the Income and Expenditure Account for the Year Ended 31 March 2007

	31 March 2007 £000	31 March 2006 £000
Retained surplus/(deficit) for the year	**(1,527)**	(22,379)
Financial support included in retained surplus/(deficit) for the year - NHS Bank	**0**	0
Financial support included in retained surplus/(deficit) for the year - Internally Generated	**0**	0
Retained surplus/(deficit) for the year excluding financial support	**(1,527)**	(22,379)

The retained deficit for the year ended 31st March 2006 of £22,379k is after a one off reduction of income of £8,000k caused by the deficit for the year ended 31st March 2005.

Financial support is income provided wholly to assist in managing the NHS Trust's financial position. Internally generated financial support is financial support received from within the local health economy, consisting of the area of responsibility of East of England Strategic Health Authority.

In 2006/07 the provision of financial support has been replaced by a regime of loans and deposits with the Department of Health. Details of the loan received from the Department of Health can be found in note 15.2 to the accounts.

Balance Sheet as at 31 March 2007

	NOTE	31 March 2007 £000	31 March 2006 restated £000
FIXED ASSETS			
Intangible assets	10	**0**	0
Tangible assets	11	**218,936**	192,775
Investments	14	**0**	0
		218,936	192,775
CURRENT ASSETS			
Stocks and work in progress	12	**3,896**	3,349
Debtors	13	**17,695**	23,892
Investments	14	**0**	0
Cash at bank and in hand	18.3	**789**	2,854
		22,380	30,095
CREDITORS: Amounts falling due within one year	15	**(20,652)**	(35,114)
NET CURRENT ASSETS/(LIABILITIES)		**1,728**	(5,019)
TOTAL ASSETS LESS CURRENT LIABILITIES		**220,664**	187,756
CREDITORS: Amounts falling due after more than one year	15	**(6,240)**	0
PROVISIONS FOR LIABILITIES AND CHARGES	16	**(1,510)**	(1,176)
TOTAL ASSETS EMPLOYED		**212,914**	186,580
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital	22	**143,930**	134,675
Revaluation reserve	17	**91,126**	74,688
Donated asset reserve	17	**4,214**	2,727
Government grant reserve	17	**22**	30
Other reserves	17	**0**	(458)
Income and expenditure reserve	17	**(26,378)**	(25,082)
TOTAL TAXPAYERS' EQUITY		**212,914**	186,580

The financial statements on pages 1 to 29 were approved by the Board on 21 June 2007 and signed on its behalf by:

Signed: .....(Chief Executive)

Date: 21st June 2007

Statement of Total Recognised Gains and Losses for the Year ended 31 March 2007

	2006/07 £000	2005/06 £000
Surplus/(deficit) for the financial year before dividend payments	**5,184**	(15,137)
Fixed asset impairment losses	**(1,814)**	0
Unrealised surplus/(deficit) on fixed asset revaluations/indexation	**18,886**	6,070
Increases in the donated asset and government grant reserves due to receipt of donated and government grant financed asset	**1,897**	1,155
Defined benefit scheme actuarial gains/(losses)	**0**	0
Additions/(reductions) in "other reserves"	**0**	0
Total recognised gains and losses for the financial year	**24,153**	(7,912)
Prior period adjustment	**0**	0
Total gains and losses recognised in the financial year	**24,153**	(7,912)

Cash Flow Statement for the Year ended 31 March 2007

	NOTE	2006/07 £000	2005/06 £000
OPERATING ACTIVITIES			
Net cash inflow/(outflow) from operating activities	18.1	2,317	(7,159)
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		262	285
Interest paid		0	0
Interest element of finance leases		0	0
Net cash inflow/(outflow) from returns on investments and servicing of finance		262	285
CAPITAL EXPENDITURE			
(Payments) to acquire tangible fixed asset		(12,826)	(14,980)
Receipts from sale of tangible fixed assets		0	2,479
(Payments) to acquire intangible assets		0	0
Receipts from sale of intangible assets		0	0
(Payments to acquire)/receipts from sale of fixed asset investments		0	0
Net cash inflow/(outflow) from capital expenditure		(12,826)	(12,501)
DIVIDENDS PAID		(6,711)	(7,242)
Net cash inflow/(outflow) before management of liquid resources and financing		(16,958)	(26,617)
MANAGEMENT OF LIQUID RESOURCES			
(Purchase) of investments with DH		0	0
(Purchase) of other current asset investments		0	0
Sale of investments with DH		0	0
Sale of other current asset investments		0	0
Net cash inflow/(outflow) from management of liquid resources		0	0
Net cash inflow/(outflow) before financing		(16,958)	(26,617)
FINANCING			
Public dividend capital received		24,408	26,778
Public dividend capital repaid (not previously accrued)		(15,153)	0
Public dividend capital repaid (accrued in prior period)		0	0
Loans received from DH		7,800	0
Other loans received		0	0
Loans repaid to DH		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital element of finance lease rental payments		0	0
Net cash inflow/(outflow) from financing		17,055	26,778
Increase/(decrease) in cash		97	161

1 ACCOUNTING POLICIES

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

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is from commissioners in respect of healthcare services provided under local agreements. Income is recognised in the period in which services are provided, where these services are partly completed during the year an appropriate proportion of total income due for that service is accrued. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. The accrual of income for partially completed spells is a change in accounting policy with the revised policy being in compliance with FRS5 (Reporting substance of transactions).

1.4 Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a Trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are depreciated over the estimated life of the asset on a straight line basis, except capitalised Research and Development which is revalued using an appropriate index figure. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

1.5 Tangible fixed assets

Capitalisation

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

- individually have a cost of at least £5,000; or

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

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

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

Expenditure on digital hearing aids in the year ended 31 March 2004 (but not in earlier years) was treated as capital expenditure, in accordance with the amendment to the Capital Accounting Manual issued in July 2003, giving rise to an increase in fixed assets regardless of the cost of the individual hearing aids. Subsequent purchases of digital hearing aids are capitalised only when the collective total value is greater than £5,000. Where small numbers of appliances are purchased the costs are expensed as incurred.

Valuation

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

All land and buildings are restated to current value using professional valuations in accordance with FRS15 every five years and in the intervening years by the use of indices. The buildings index is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. The District Valuer undertook valuations as at 1st April 2006 to include significant recent capital developments.

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

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

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

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

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

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

Depreciation, amortisation and impairments

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

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

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

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

1.6 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Income and Expenditure account. Similarly, any impairment on donated assets charged to the Income and Expenditure Account is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the Income and Expenditure Reserve.

1.7 Government Grants

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

1.8 Private Finance Initiative (PFI) transactions

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

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

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

1.9 Stocks and work-in-progress

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

1.10 Research and development

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

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

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

research and development expenditure charged in the income and expenditure account because some research and development activity cannot be separated from patient care activity.

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

1.11 Provisions

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

Clinical negligence costs

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

Since financial responsibility for clinical negligence cases transferred to the NHSLA at 1 April 2002, the only charge to operating expenditure in relation to clinical negligence in 2006/07 relates to the Trust's contribution to the Clinical Negligence Scheme for Trusts.

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 adjustment to the provision for 'excesses' payable in respect of particular claims are charged to operating expenses as and when they become due.

1.12 Pension 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. As a consequence it is not possible for the NHS Trust to identify its share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full valuation for FRS 17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers contribution rates, this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions are based covered the period 1 April 1994 to 31 March 1999. Between valuations, the Government Actuary provides an update of the scheme liabilities. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14% of pensionable pay from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

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

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

Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Income and Expenditure account at the time the NHS Trust commits itself to the retirement, regardless of the method of payment.

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

1.13 Liquid resources

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

1.14 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.

1.15 Foreign Exchange

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

1.16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 28 to the accounts.

1.17 Leases

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

1.18 Public Dividend Capital (PDC) and PDC Dividend

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

A charge, reflecting the forecast cost of capital utilised by the NHS Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average carrying amount of all assets less liabilities, except for donated assets and cash with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. A note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year.

1.19 Losses and Special Payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared

with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). Note 30 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.20 EU Emmissions Trading Scheme

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

2 SEGMENTAL ANALYSIS

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

3. Income from Activities

	2006/07	2005/06
	£000	£000
Strategic Health Authorities	0	0
NHS Trusts	14	13
Primary Care Trusts	209,363	199,864
Foundation Trusts	0	3
Local Authorities	644	0
Department of Health	23,355	4,024
NHS Other	0	0
Non NHS:		
- Private patients	4,140	4,122
- Overseas patients (non-reciprocal)	125	143
- Road Traffic Act*	789	766
- Injury cost recovery	0	0
- Other	292	256
	238,722	209,191

* Road Traffic Act income is subject to a provision for doubtful debts of 7.7% to reflect expected rates of collection

4. Other Operating Income

	2006/07	2005/06
	£000	£000
Patient transport services	0	0
Education, training and research	13,309	13,736
Charitable and other contributions to expenditure	0	0
Transfers from donated asset reserve	355	234
Transfers from government grant reserve	8	8
Non-patient care services to other bodies	9,785	10,899
Income Generation	0	6,118
Other income	8,078	6,121
	31,535	37,116

5. Operating Expenses

5.1 Operating expenses comprise:

	2006/07	2005/06
	£000	£000
Services from other NHS Trusts	4,836	1,342
Services from other NHS bodies	3,998	3,233
Services from Foundation Trusts	0	0
Purchase of healthcare from non NHS bodies	1,910	1,711
Directors' costs	1,002	857
Staff costs	172,835	166,863
Supplies and services - clinical	41,573	42,328
Supplies and services - general	6,876	7,953
Establishment	7,123	6,949
Transport	807	626
Premises	8,179	8,906
Bad debts	229	13
Depreciation	6,170	7,269
Amortisation	0	0
Fixed asset impairments and reversals	0	0
Audit fees	217	226
Other auditor's remuneration	0	0
Clinical negligence	3,831	3,817
Redundancy costs	297	0
Other	5,435	9,777
	265,318	261,870

5.2 Operating leases

5.2/1 Operating expenses include:

	2006/07	2005/06
	£000	£000
Hire of plant and machinery	553	486
Other operating lease rentals	2,472	1,789
	3,025	2,275

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

	Land and buildings		Other leases	
	2006/07	2005/06	2006/07	2005/06
	£000	£000	£000	£000
Operating leases which expire:				
Within 1 year	0	0	65	56
Between 1 and 5 years	0	0	2,539	706
After 5 years	0	0	592	1,446
	0	0	3,196	2,208

6. Staff costs and numbers

6.1 Staff costs

	2006/07			2005/06
	Total	Permanently Employed	Other	
	£000	£000	£000	£000
Salaries and wages	146,917	144,091	2,826	141,600
Social Security Costs	11,955	11,955	0	12,056
Employer contributions to NHS Pension Scheme	14,912	14,912	0	14,008
Other pension costs	0	0	0	0
Total	173,784	170,958	2,826	167,664

6.2 Average number of persons employed

	2006/07			2005/06
	Total	Permanently Employed	Other	
	Number	Number	Number	Number
Medical and dental	584	574	10	580
Ambulance staff	0	0	0	0
Administration and estates	912	894	18	986
Healthcare assistants and other support staff	769	769	0	229
Nursing, midwifery and health visiting staff	1,464	1,452	12	1,982
Nursing, midwifery and health visiting learners	8	8	0	0
Scientific, therapeutic and technical staff	673	643	30	655
Social care staff	0	0	0	0
Other	8	0	8	0
Total	4,418	4,340	78	4,432

6.3 Employee Benefits

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

6.4 Management costs

	2006/07	2005/06
	£000	£000
Management costs	11,550	10,912
Income	270,257	254,307

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

6.5 Retirements due to ill-health

During 2006/07 there were 7 early retirements from the NHS Trust on the grounds of ill-health and there were 2 in 2005/06. The estimated additional pension liabilities of ill-health retirements are £191k (2005/06 - £136k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

7. Better Payment Practice Code

7.1 Better Payment Practice Code - measure of compliance

	2006/07 Number	£000
Total Non-NHS trade invoices paid in the year	65,283	76,352
Total Non NHS trade invoices paid within target	42,333	41,197
Percentage of Non-NHS trade invoices paid within target	65%	54%
Total NHS trade invoices paid in the year	3,574	36,598
Total NHS trade invoices paid within target	1,124	5,521
Percentage of NHS trade invoices paid within target	31%	15%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

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

There was no interest payable under this legislation in 2006-07 or 2005-06.

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

Profit/(loss) on the disposal of fixed assets is made up as follows:

	2006/07 £000	2005/06 £000
Profit on disposal of land and buildings	0	229
(Loss) on disposal of land and buildings	0	0
Profits on disposal of plant and equipment	0	15
(Loss) on disposal of plant and equipment	0	0
Total	0	244

9. Interest Payable

There was no interest payable during 2006-07or 2005-06.

10. Intangible Fixed Assets

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

11. Tangible Fixed Assets

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

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2006	92,391	72,310	0	8,602	34,000	105	11,554	1,786	220,748
Additions purchased	0	10,118	0	0	2,081	0	946	217	13,362
Additions donated	0	1,199	0	78	575	0	6	39	1,897
Additions government granted	0	0	0	0	0	0	0	0	0
Impairments	0	(1,814)	0	0	0	0	0	0	(1,814)
Reclassifications	0	6,166	0	(6,381)	101	0	114	0	0
Indexation	5,276	6,048	0	0	869	3	0	49	12,245
Other in year revaluation	0	7,149	0	0	0	0	0	0	7,149
Disposals	0	0	0	0	(2,303)	0	(414)	0	(2,717)
Cost or Valuation at 31 March 2007	97,667	101,176	0	2,299	35,323	108	12,206	2,091	250,870
Depreciation at 1 April 2006	0	0	0	0	19,736	91	7,231	91	27,973
Charged during the year	0	2,261	0	0	2,572	3	1,148	186	6,170
Impairments	0	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Indexation	0	0	0	0	481	2	0	25	508
Other in year revaluation	0	0	0	0		0	0	0	0
Disposals	0	0	0	0	(2,303)	0	(414)	0	(2,717)
Depreciation at 31 March 2007	0	2,261	0	0	20,486	96	7,965	1,126	31,934
Net book value									
- Purchased at 1 April 2006	92,391	71,672	0	8,602	12,214	14	4,267	858	190,018
- Donated at 1 April 2006	0	638	0	0	2,050	0	26	13	2,727
- Government granted at 1 April 2006	0	0	0	0	0	0	30	0	30
- Total at 1 April 2006	92,391	72,310	0	8,602	14,264	14	4,323	871	192,775
- Purchased at 31 March 2007	97,667	97,139	0	2,299	12,483	12	4,203	897	214,700
- Donated at 31 March 2007	0	1,776	0	0	2,354	0	16	68	4,214
- Government granted at 31 March 2007	0	0	0	0	0	0	22	0	22
- Total at 31 March 2007	97,667	98,915	0	2,299	14,837	12	4,241	965	218,936

Of the totals at 31 March 2007 none of the land, buildings or dwellings are valued at open market value.

The Trust does not hold any finance leases.

11.2 The net book value of land, buildings and dwellings at 31 March 2007 comprises:

	31 March 2007 £000	31 March 2006 £000
Freehold	196,582	164,701

12. Stocks and Work in Progress

	31 March 2007 £000	31 March 2006 £000
Raw materials and consumables	3,896	3,349

13. Debtors

	31 March 2007 £000	31 March 2006 £000
Amounts falling due within one year:		
NHS debtors	10,040	13,569
Other debtors	5,318	5,208
Provision for irrecoverable debts	(540)	(429)
Other prepayments and accrued income	1,572	4,407
Sub Total	16,390	22,755
Amounts falling due after more than one year:		
Other debtors	1,305	1,137
TOTAL	17,695	23,892

Other Debtors does not include any prepaid pension contributions at 31 March 2007 or at 31 March 2006

14. Investments

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

15. Creditors

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

	31 March 2007 £000	31 March 2006 £000
Amounts falling due within one year:		
Bank overdrafts	0	2,162
Current instalments due on loans	1,560	0
Interest payable	0	0
Payments received on account	0	0
NHS creditors	4,374	10,793
Non - NHS trade creditors - revenue	3,529	4,153
Non - NHS trade creditors - capital	1,547	1,011
Tax	610	3,944
Social security costs	612	1,611
Obligations under finance leases and hire purchase contracts	0	0
Other creditors	3,487	2,573
Accruals and deferred income	4,933	8,867
Sub Total	20,652	35,114
Amounts falling due after more than one year:		
Long - term loans	6,240	0
TOTAL	26,892	35,114

Other creditors include;

-£1,814k outstanding pensions contributions at 31 March 2007 (31 March 2006 £1,778k).

15.2 Loans

	31 March 2007 £000	31 March 2006 £000
Amounts falling due:		
In one year or less	1,560	0
Between one and two years	1,560	0
Between two and five years	4,680	0
Over 5 years	0	0
TOTAL	7,800	0

	31 March 2007 £000	31 March 2006 £000
Wholly repayable within five years	7,800	0

The Loan detailed above is from the Department of Health

15.3 Finance Lease obligations

There are no finance lease obligations

16. Provisions for liabilities and charges

	Pensions relating to former directors	Pensions relating to other staff	Legal claims	Restruct-uring	Other	**Total**
	£000	£000	£000	£000	£000	**£000**
At 1 April 2006	0	828	348	0	0	**1,176**
Restated	0	0	(199)	0	0	**(199)**
Arising during the year	0	662	66	0	0	**728**
Utilised during the year	0	(73)	(46)	0	0	**(119)**
Reversed unused	0	(76)	(17)	0	0	**(93)**
Unwinding of discount	0	17	0	0	0	**17**
At 31 March 2007	**0**	**1,358**	**152**	**0**	**0**	**1,510**
Expected timing of cashflows:						
Within one year	0	73	62	0	0	**135**
Between one and five years	0	291	90	0	0	**381**
After five years	0	994	0	0	0	**994**

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

Legal Claims: The constructive obligation for payments under the Litigation to Third Parties Scheme (LTPS). The balance as at 1st April 2006 has been restated to reflect the Trust's liability for excess under the scheme. The balance as at 31st March 2007 is on the same basis and is as advised by the Litigation Authority taking into consideration the probability as to the outcome of each claim.

£17,362k is included in the provisions of the NHS Litigation Authority at 31 March 2007 in respect of clinical negligence liabilities of the NHS Trust (31 March 2006 £15,752k).

17. Movements on Reserves

Movements on reserves in the year comprised the following:

	Revaluation Reserve £000	Donated Asset Reserve £000	Government Grant Reserve £000	Other Reserves £000	Income & Expenditure Reserve £000	**Total £000**
At 1 April 2006 as previously stated	77,235	2,727	30	(458)	(27,629)	**51,905**
Prior Period Adjustments (see note 1 below)	(2,547)	0	0	0	2,547	**0**
At 1 April 2006 as restated	74,688	2,727	30	(458)	(25,082)	**51,905**
Transfer from the income and expenditure account	0	0	0	0	(1,527)	**(1,527)**
Fixed asset impairments	(1,814)	0	0	0	0	**(1,814)**
Surplus/(deficit) on other revaluations/indexation of fixed/current assets	18,863	23	0	0	0	**18,886**
Transfer of realised profits/ (losses) to the income and expenditure reserve	0	0	0	0	0	**0**
Receipt of donated/ government granted assets	0	1,897	0	0	0	**1,897**
Transfers to the income and expenditure account for depreciation, impairment, and disposal of donated/ government granted assets	0	(355)	(8)	0	0	**(363)**
Other transfers between reserves	(611)	(78)	0	458	231	**0**
At 31 March 2007	**91,126**	**4,214**	**22**	**0**	**(26,378)**	**68,984**

Note 1
Prior period adjustment relates to the difference in depreciation calculated on a current cost basis compared with the historical cost basis

18. Notes to the cash flow Statement

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

	2006/07 £000	2005/06 £000
Total operating surplus/(deficit)	4,939	(15,563)
Depreciation and amortisation charge	6,170	7,269
Fixed asset impairments and reversals	0	0
Transfer from donated asset reserve	(355)	(234)
Transfer from the government grant reserve	(8)	(8)
(Increase)/decrease in stocks	(547)	(460)
(Increase)/decrease in debtors	6,197	(9,340)
Increase/(decrease) in creditors	(14,396)	11,692
Increase/(decrease) in provisions	317	(515)
Net cash inflow/(outflow) from operating activities before restructuring costs	2,317	(7,159)
Payments in respect of fundamental reorganisation/restructuring	0	0
Net cash inflow from operating activities	2,317	(7,159)

18.2 Reconciliation of net cash flow to movement in net debt

	2006/07 £000	2005/06 £000
Increase/(decrease) in cash in the period	97	161
Cash (inflow) from new debt	(7,800)	0
Cash outflow from debt repaid and finance lease capital payments	0	0
Cash (inflow)/outflow from (decrease)/increase in liquid resources	0	0
Change in net debt resulting from cash flows	(7,703)	161
Non - cash changes in debt	0	0
Net debt at 1 April 2006	692	531
Net debt at 31 March 2007	(7,011)	692

18.3 Analysis of changes in net debt

	At 1 April 2006	Cash Transferred (to)/from other	Other cash changes in year	Non-cash changes in year	**At 31March 2007**
	£000	£000	£000	£000	**£000**
OPG cash at bank	2,806	0	(2,250)	0	**556**
Commercial cash at bank and in hand	48	0	185	0	**233**
Bank overdraft	(2,162)	0	2,162	0	**0**
Loan from DH due within one year	0	0	(1,560)	0	**(1,560)**
Other debt due within one year	0	0	0	0	**0**
Loan from DH due after one year	0	0	(6,240)	0	**(6,240)**
Other debt due after one year	0	0	0	0	**0**
Finance leases	0	0	0	0	**0**
Current asset investments	0	0	0	0	**0**
	692	0	(7,703)	0	**(7,011)**

19. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2007 were £429,000 (31 March 2006- £5,561,000)

20. Post Balance Sheet Events

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

21. Contingencies

	2006/07	2005/06
	£000	£000
Contingent liabilities	**(59)**	(197)
Amounts recoverable against contingent liabilities	**0**	131
Net value of contingent liabilities	**(59)**	(66)

Net Contingent Liabilities are: - Liabilities to Third Parties Scheme £59k (2006 - £66k)

22. Movement in Public Dividend Capital

	2006/07	2005/06
	£000	£000
Public Dividend Capital as at 1 April 2006	**134,675**	107,897
New Public Dividend Capital received Trusts) (including transfers from dissolved NHS	**24,408**	26,778
Public Dividend Capital repaid in year	**(15,153)**	0
Public Dividend Capital as at 31 March 2007	**143,930**	**134,675**

23. Financial Performance Targets

23.1 Breakeven Performance

The trust's breakeven performance for 2006/07 is as follows:

	2000/01 £000	2001/02 £000	2002/03 £000	2003/04 £000	2004/05 £000	2005/06 £000	2006/07 £000
Turnover	195,153	163,019	179,917	191,938	207,374	246,307	270,257
Retained surplus/ (deficit) for the year	(3,297)	62	2,495	19	(8,557)	(22,379)	(1,527)
Adjustment for: - Other agreed adjustments	0	0	0	0	0	8,557	22,379
Break-even in-year position	(3,297)	62	2,495	19	(8,557)	(13,822)	20,852
Break-even cumulative position	(3,297)	(3,235)	(740)	(721)	(9,278)	(23,100)	(2,248)
- Break-even in-year position as a percentage of turnover	(1.69%)	0.04%	1.39%	0.01%	(4.13%)	(5.61%)	7.72%
- Break-even cumulative	(1.69%)	(1.98%)	(0.41%)	(0.38%)	(4.47%)	(9.38%)	(0.83%)

Narrative Note:

The Trust's recovery plan, approved by the SHA aims to achieve break-even by the end of 2007/08.

The East of England SHA has formally agreed that the deficits incurred within each of 2004/05 and 2005/06 were repaid in the following financial year through reduced PCT purchasing power, an option to recalibrate has been implemented

The Trust's duty to break even over a rolling 3 year period therefore commences from the 2006/07 financial year, in which the deficit of £1.527m was incurred.

Financial Recovery Plans, as agreed with the EoE SHA show that this amount will be recovered in 2007/08, with sufficient headroom to allow re-payment of the loan shown in note 15.2.

The 2006/07 Income & Expenditure deficit of £1.527m is as shown on Page 2 of these accounts. The cumulative position for the purpose of measuring breakeven duty has been recalibrated as explained above.

23.2 Capital cost absorption rate

The Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital, totalling £6,711,000, bears to the average relevant net assets of £194,596,000, that is 3.45%.

This variation from 3.5% of 0.05% is not considered material

23.3 External financing

The Trust is given an external financing limit which it is not permitted to overshoot.

	£000	**2006/07 £000**	2005/06 £000
External financing limit		**16,958**	26,778
Cash flow financing	16,958		26,617
Finance leases taken out in the year	0		0
Other capital receipts	0		0
External financing requirement		**16,958**	26,617
Undershoot/(overshoot)		**0**	161

23.4 Capital Resource Limit

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

	2006/07 £000	2005/06 £000
Gross capital expenditure	**15,259**	16,555
Less: book value of assets disposed of	**0**	(2,298)
Plus: loss on disposal of donated assets	**0**	4
Less: capital grants	**0**	0
Less: donations towards the acquisition of fixed assets	**(1,897)**	(1,155)
Charge against the capital resource limit	**13,362**	13,106
Capital resource limit	**13,368**	21,387
(Over)/Underspend against the capital resource limit	**6**	8,281

24. Related Party Transactions

East and North Hertfordshire NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with East and North Hertfordshire NHS Trust.

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

Strategic Health Authority

East of England Strategic Health Authority

Primary Care Trust

East and North Hertfordshire PCT
Bedfordshire PCT
West Hertfordshire PCT
Hillingdon PCT
Harrow PCT
Barnet PCT
Buckinghamshire PCT
Berkshire East PCT
Brent Teaching PCT

NHS Trust

East of England Ambulance Service NHS Trust
Hertfordshire Partnership Trust
West Hertfordshire Hospitals Trust

Foundation Trust

Luton & Dunstable NHS Foundation Trust

NHS Litigation Authority

NHS Blood & Transplant

The Trust has also received donations from enhance herts charitable funds (£1.8m) the bulk of which was an anonymous donation transferred from the charity over the two years 2005/06 and 2006/07. Certain of the Trustees for the charity are also members of the NHS Trust.

25. Private Finance Transactions

PFI schemes deemed to be off-balance sheet

	2006/07	2005/06
	£000	£000
Amounts included within operating expenses in respect of PFI transactions deemed to be off-balance sheet - gross	1,046	1,022
Amortisation of PFI deferred asset	(131)	(113)
Net charge to operating expenses	915	909

The NHS Trust is committed to make the following payments during the next years

PFI scheme which expires; 26th to 30th years (inclusive)	1,046	1,022

Description of the scheme:- Hertford County Hospital

	£000	£000
Estimated capital value of the PFI scheme	6,336	6,321

Contract Start date: October 2004
Contract End date: September 2034

26. Pooled Budgets

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

27. Financial Instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than the currency profile. Provisions are shown gross. Any amount expected in reimbursement against a provision (and included in debtors) is separately disclosed.

Liquidity risk

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

Interest-Rate Risk

100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. East and North Hertfordshire NHS Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

27.1 Financial Assets

Currency	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000	Weighted average interest %	Weighted average period for which fixed Years	Weighted average term Years
At 31 March 2007							
Sterling	789	789	0	0	0.00%	0	0
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**789**	**789**	**0**	**0**			
At 31 March 2006							
Sterling	2,854	2,854	0	0	0.00%	1	0
Other	0	0	0	0	0.00%	0	0
Gross financial assets	**2,854**	**2,854**	**0**	**0**			

27.2 Financial Liabilities

	Total £000	Floating rate £000	Fixed rate £000	Non-interest bearing £000	Weighted average interest %	Weighted average period for which fixed Years	Weighted average term Years
At 31 March 2007							
Sterling	151,730	0	7,800	143,930	5.45%	5	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**151,730**	**0**	**7,800**	**143,930**			
At 31 March 2006							
Sterling	136,837	2,162	0	134,675	0.00%	1	0
Other	0	0	0	0	0.00%	0	0
Gross financial liabilities	**136,837**	**2,162**	**0**	**134,675**			

Note: The public dividend capital is of unlimited term.

Foreign Currency Risk

The Trust has no foreign currency income or expenditure.

27.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the NHS Trust's financial assets and liabilities as at 31 March 2007.

	Book Value £000	Fair Value £000
Financial assets		
Cash	789	789
Financial liabilities		
Provisions under contract	(1,510)	(1,510)
Loans	(7,800)	(7,800)
Public dividend capital*	(143,930)	(143,930)
Total	(153,240)	(153,240)

Notes

The fair value of the assets and liabilities tabled above is not expected to be significantly different from the book value.

Provisions under contract in calculation of book value the expected cash flows have been discounted by the Treasury discount rate at 3.5% in real terms

*This figure includes £2,800,000 which relates to short-term repayable (within a set period) PDC held by the Trust.

28 Third Party Assets

The Trust held £7k cash at bank and in hand at (£5k 2005/06) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from cash at bank and in hand figure reported in the accounts.

29 Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	9,120	880	7,228	6,240
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,493	0	1,530	0
Balances with Public Corporations and Trading Funds	0	0	212	0
Balances with bodies external to government	5,777	425	11,682	0
At 31 March 2007	**16,390**	**1,305**	**20,652**	**6,240**
Balances with other Central Government Bodies	9,489	642	8,872	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	4,050	0	6,391	0
Balances with Public Corporations and Trading Funds	29	0	1,085	0
Balances with bodies external to government	9,187	495	18,766	0
At 31 March 2006	22,755	1,137	35,114	0

30 Losses and Special Payments

There were 8,247 cases of losses and special payments (2005-06: 1,932 cases) totalling £14,796 (2005-06: £132k) paid during 2006-07.

The majority of these cases relate to small charges levied for drugs supplied to individuals by the hospital not paid and over one year old.

The total costs included in this note are on a cash basis and will not necessarily reconcile to the amounts in the notes to the accounts which are prepared on an accruals basis.

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

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