East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2010/11 annual report and accounts

29 June 2011

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Chapter 1: about the Trust

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

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

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

The Trust's main catchment is a mixture of urban and rural areas in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in Stevenage, Hatfield, Welwyn Garden City and Cheshunt. Over the past ten years, rates of death from all causes, early deaths from cancer and early deaths from heart disease and stroke have all improved and are generally similar to, or better than, the England average. The birth rate is close to the England average, with the Trust's core catchment population forecast to rise by 10.5% over the next ten years, with the most significant growth expected in people aged 45 to 74 years. Black and minority ethnic groups make up approximately 5% of the population in east and north Hertfordshire.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including A&E, maternity care and an urgent care centre – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,500 staff are employed by the Trust, which represents around 4,700 whole time equivalents.

The Trust's annual budget is approximately £340 million. The majority of Trust clinical income comes from two PCTs – NHS Hertfordshire and NHS Bedfordshire, with the former providing 78% of the Trust's income.

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

Chapter 2: chairman and chief executive's reports

Chairman's report

The Trust continues to work its way through a period of great strategic change that will make it one of the best hospital trusts of its kind. As has been the case in previous years, those parts of the overall strategic change programme that fall within the control of the Trust and its staff, along with the local community and its leaders, have been challenging, but successful.

With everyone working together, a remarkable amount has been achieved (which Nick Carver talks about in his chief executive's report), and patients are already deriving the benefits of this cooperation. However, there continue to be significant delays in obtaining approval of those parts of the programme that are not controlled locally, and this has created difficulties. With very helpful support from the community's leaders, we are hopeful these delays will be resolved this year and that we will all be able to work together over the next three years to complete the programme.

If this leaves the impression that the Trust views itself as being very much a part of the community, working closely with the community and its leaders, then that impression is correct. This is one of the main reasons why the Trust wants to become a NHS foundation trust. While appropriately subject to national standards of financial control and quality, foundation trusts are *owned* by those members of the community who are interested in them, with their views being represented by members of the Council of Governors (a majority of which are elected by the *members*).

To date about 15,000 *members* of the community and the Trust's staff have signed up as *members* of our proposed foundation trust. This is very encouraging, and we hope that over time ever more from the community will sign up as *members* and take an interest in the Trust. In addition, ten governors have been appointed on a *shadow* basis by local organisations with the right to do so, and the Trust has started to work with them. This has proved to be very constructive, and we look forward to the remaining governors being elected by the *members* as soon as we are allowed to arrange the necessary elections process.

Becoming a NHS foundation trust is an important step in the Trust's continued development, and we support fully the Government's policy for hospital trusts to become ever closer and more responsive to their patients and the communities they serve.

Throughout 2010/11, which has been a period of some uncertainty for the future of the Trust, we have continued to ensure that patients have received high quality care at the right time and in the right setting. Once again, the Trust recorded its best ever performance across a broad range of clinical, operational and financial standards; a number of important new services were also introduced, which are described elsewhere in this report.

All of these achievements, however, were only made possible by our very professional, dedicated and hard working staff and volunteers, who above all else seek to provide the best possible care to patients, and who are delightful with whom to work. The challenges that have arisen during 2010/11 have been significant, but the Trust's staff and volunteers, have risen to them all.

Richard Beazley
Chairman

Chief executive's report

In his report, chairman Richard Beazley, set out clearly the wider strategic challenges faced by the Trust as it continues to deliver its longer-term plans for the future. We now perform well against virtually every clinical, operational and financial standard set for the NHS – the days of being a poorly performing organisation are now well and truly behind us.

The challenge facing the Trust is to move from being a better performing organisation to one that is *amongst the best* in the health service. We now have a clear process in place that will help us achieve this ambition, but before setting this out it is important to reflect on some of the more notable achievements made by our staff and volunteers over the last 12 months.

In many ways, the most significant was the opening of the new £16.4 million maternity unit at the Lister in December 2010. With the project having been designed, managed and implemented with close input from the Trust's maternity team, it was delivered on time and to budget. Although initially housing the Lister's existing maternity service while the hospital's former unit is refurbished, by October 2011 the new combined unit will ready.

This is when inpatient maternity care at the QEII will move to the Lister and the Trust's new service is launched – co-located midwife and consultant-led units, a day assessment unit and improved neonatal care. When it is up and running, our new maternity service will compare with the best anywhere in the East of England.

The £47 million Lister Surgicentre was due to have started treating its first patients from 18 April 2011. Despite the best efforts of all involved, including that of the many Trust staff involved in this important project, during February 2011 NHS Hertfordshire confirmed that Clinicenta – the health service's independent sector partner who has built and will run the Surgicentre – was not yet ready to start treating patients; the latest position is that these services will not start before July 2011 at the earliest.

Although disappointing to everyone associated with this important project, the Surgicentre is an impressive facility and when it opens, some 12,000 adult patients will be treated in the unit for a wide range of routine day surgery procedures, as well as short story orthopaedic joint replacement cases.

Our new £7.9 million multi-storey car park at the Lister continues to take shape and is expected to be open by the end of summer 2011. Since September 2010, when work on the project started, the Lister site has experienced significant parking disruption, which has been alleviated by a range of measures – including the use of a staff park-and-ride scheme. While largely successful in containing the problems faced by our staff, patients and their visitors, I would still like to thank them for their perseverance and support of the work involved.

Our colleagues in NHS Hertfordshire have advanced their plans for the new QEII hospital that will be built by early 2014. Following a review of the clinical and financial viability of a midwife-led birthing unit, it has been decided that such a facility is not viable. The plans for the new hospital, however, do include a wide range of ante/post natal, outpatient and diagnostic services; it will also have a 24/7 local A&E service. The outline business case has been approved and planning applications have been submitted to the local authority for consideration.

2010/11 also saw significant developments take place at the Mount Vernon Cancer Centre, which now has a new chemotherapy unit as well as the first CyberKnife in the NHS – a form of stereotactic radiotherapy that can be used to treat some patients whose tumours are inoperable or too small and/or located in parts of the body unsuitable for traditional forms of radiotherapy unit. Both of these important developments at the cancer centre have been made possible through the generosity of benefactors.

Discussions are also underway with Hillingdon Hospitals NHS Foundation Trust, the owners of the Mount Vernon site, on a longer term solution to some of the remaining estates challenges on the site – most notably the pressing need to build a new ward block to replace the cancer centres existing wards, which are now very old.

In March 2011, NHS Hertfordshire decided that its pilot of two urgent care centres at the Hertford County and Cheshunt Community hospitals, the running of which involved Trust staff, should not be continued. The plan currently is for both of these services to stop from October 2011. NHS Hertfordshire has since brought forward plans for a minor injuries service to be created in Cheshunt.

During 2010/11, several of the Trust's clinical services were noted to be amongst the better performing within the NHS. Guidelines developed by one of our diabetes specialist nurses for treating diabetes patients in hospital have been rolled out across the NHS. The Trust's cardiology team was revealed as one of the best in the UK for implanting pacemakers, as well as providing a high performing heart attack service. The continuing success of the Trust's renal dialysis teams was underlined by a national report that showed this service to be in the top six in the country when it comes to annual survival rates.

Indeed a look at any clinical, operational or financial standard that the Trust is expected to achieve showed good performance in virtually every case. Our stated aim is now to move from being good to *amongst the best*. Key to achieving this ambition will be the delivery of two important strands of work – organisational development and a focus on improving patient experience.

The first of these two initiatives, which has been called the ARC (*Accelerate*, *refocus* and *consolidate*) programme and was launched in May 2011, seeks to support its staff in turning the Trust in to a high performing organisation. The programme aims to embed the Trust's values and behaviours in everything that we do, whilst at the same time focusing on developing leadership at every level of the organisation that seeks out high levels of performance for every function across the Trust.

Improving the patient experience – something on which the Trust has been focussed for the last year – goes hand-in-hand with becoming a high performing organisation. A strong link exists between these two objectives and positive patient feedback will be one of the measures used to indicate whether or not our organisational development work is successful.

I look forward to reporting on the progress we make in next year's annual report.

Finally, I would like to pay tribute to of the Trust's staff and volunteers for their dedication and hard work throughout 2010/11. The change agenda facing us is amongst the most challenging to be found anywhere in the NHS today. Across our hospitals, our clinical and non-clinical staff have engaged in a wide range of projects that between them aim to transform the services provided by the Trust. At no point, however, have they lost sight of their main purpose – making sure that patients get consistently high quality and safe care.

Nick Carver
Chief Executive

Chapter 3: future trends and projections

Strategic change underway

Since April 2000, the Trust has provided emergency and planned acute services from its two district general hospitals in Hertfordshire – the Lister and QEII – with limited scope for economies of scale and without the critical mass required to introduce key service improvements. Whilst some consolidation has been achieved, for fully efficient, modern and high quality services to be developed, all of the Trust's acute services will be brought together on to one site, the Lister, with outpatient and diagnostic services provided in other hospitals – including Hertford County and the new QEII hospital being planned currently by NHS Hertfordshire.

The NHS in Hertfordshire approved the *Delivering quality health care for Hertfordshire* strategy in December 2007, following extensive public consultation. Since then, the Trust has been implementing a detailed phased programme of developments. This has been managed through the Trust's *Our changing hospitals* programme, which is addressing the following clinical quality and efficiency challenges:

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

The *Our changing hospitals* programme being delivered at the Lister currently takes a phased approach to change, testing deliverability and flexibility at each stage. The following progress was made by the end of March 2011:

- Phase one – the Lister Surgicentre: financial close on this important development was reached between the NHS and its independent sector partner Clinicenta in 2009 and construction of the new £47 million facility was completed in Spring 2011. We expect that the service will become operational during 2011 and the mobilisation work needed for this to happen is progressing well.

- Phase two – maternity expansion: full business case approval for this £16.5 million NHS-funded scheme was achieved in August 2009, with construction completed in December 2010. The new maternity service is scheduled to start in October 2011, which is when inpatient maternity and gynaecology services at the QEII will transfer to the Lister. In the meantime, the former maternity unit at the Stevenage site is being refurbished to accommodate the Trust's new service, which will feature co-located midwife and consultant-led units, as well as day assessment and level two neonatal units. Ante and post natal services are not affected by this service change.

- Phase three – multi storey car park: financial close was reached with the Trust's preferred bidder, Vinci Park, in June 2010. Work on building the new facility commenced in September 2010 and it will open for use by late summer 2011. The additional parking spaces, which include much improved provision for blue badge holders, will help support the transfer of inpatient and emergency services from the QEII to the Lister over the next few years.

- Phase four – full consolidation of all remaining emergency and planned acute hospital services: in 2010 the Trust refined the outline business case to reflect NHS Hertfordshire's refreshed commissioning strategy. Having been approved by the respective boards of the Trust, NHS Hertfordshire and NHS East of England in September 2010, currently the outline business is awaiting Department of Health and HM Treasury approval. It is anticipated that the full consolidation will be achieved in early 2014.

This strategic framework provides an opportunity for the Trust to extend some services, on cost-effectiveness and quality grounds, into community settings. Examples include working with NHS Hertfordshire on its plans for the new QEII hospital.

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

The Mount Vernon Cancer Centre has been a key component of the Trust since 2005, following which £28.2 million of combined NHS and charitable investment has been made in developing its services. Whilst many of the centre's facilities have been transformed, there remains a need for further investment. Mindful of this, the Trust's cancer services divisional team is implementing plans to maintain Mount Vernon at the *top table* of cancer centres nationally, with new research facilities, chemotherapy capacity and stereotactic body radio-surgery – the new CyberKnife treated its first patient in Autumn 2010.

The strategy's financial implications

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

Bearing in mind the current economic climate, consolidating acute services on to one main hospital site helps to ensure that the Trust has a viable financial future, at the same time as supporting the very real improvements in clinical quality being demanded of the NHS. Between 2011/12 and 2012/13, the Trust will deliver relatively modest net surpluses of around 1%. Post configuration, the achievable level of surplus grows, albeit slowly.

Achieving NHS foundation trust status

The Trust is pursuing actively its NHS foundation trust application and throughout 2010/11, has built its public membership to just over 9,750 foundation trust members whilst continuing to strengthen its governance arrangements as part of its preparations.

The Trust submitted its updated integrated business (IBP) plan and long term financial model to NHS East of England in December 2010 and had a successful board-to-board meeting with the SHA in January 2011. Following this meeting, NHS East of England submitted the Trust's application to the Department of Health for review by its foundation trust applications committee. The Trust understands that the application is now on hold, pending a decision following the Department of Health and HM Treasury's review of the Trust's outline business case for phase four of the Lister's redevelopment referred to earlier in this chapter. Subject to approval being received, the Trust expects to proceed with its foundation trust application and engage formally with Monitor later in 2011.

Current service development plans

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

Cardiology – cardiac catheterisation services

From April 2009, the Trust has provided a weekday, 9.00am to 5.00 primary percutaneous coronary intervention service for patients who have had a heart attack. With the support of Bedfordshire and Hertfordshire Heart and Stroke Network, the Trust Board approved the £4.5 million business case for the creation of a second cardiac catheter laboratory at the Lister-based service. Construction is now underway, with the expanded unit on track to open in October 2011. This represents a further step towards the Trust's ambition of having a 24-hour heart attack centre at the hospital.

Cardiology – inpatient services

In April 2011, the Trust began a 90-day consultation with its staff on proposals to move the QEII's inpatient cardiology service on the former Bramfield ward to create a single Trust-wide service on ward 9B at the Lister later this year. This is being made possible through the creation of the second cardiac catheterisation laboratory at the hospital.

Cardiology – stroke services

At the same time as consulting on changes to the Trust's inpatient cardiology services, the proposed future for acute inpatient stroke services are also being discussed. The Trust's acute stroke rehabilitation service, currently located on Bayford ward at the QEII will move to be located alongside the Lister's hyper-acute stroke unit at the Lister on ward 6A in the hospital's main tower block. Just as significantly, from April 2011 the Trust introduced a 24/7 stroke thrombolysis service.

Renal dialysis

The Trust's existing tertiary renal service is recognised widely as a flagship service. In response to recommendations made by the East of England Specialist Commissioning Group in 2009, the Trust has piloted home dialysis and developed a home dialysis training unit. The Trust is developing a competitive business case to secure at least one of the two new renal satellite services proposed by NHS East of England to complement those it provides already at the Lister, Luton & Dunstable and St Albans City hospitals. If successful, these developments would be in line with the Trust's stated objective of supporting the delivery of care closer to where people live.

Hertfordshire's satellite radiotherapy service
NHS Hertfordshire's proposal to assess the feasibility of developing a satellite cancer centre unit in Hertfordshire is consistent with the Trust's aim of providing more cancer services locally. The Trust is developing a business case, working with clinicians, stakeholders and commissioners, to secure the location of a local satellite radiotherapy unit for the benefit of those living in Hertfordshire and Bedfordshire.

Replacement of Mount Vernon's ward block
The Trust is working in partnership with Hillingdon Hospitals NHS Foundation Trust, the landlord of the Mount Vernon hospital site, to agree a site development programme that will enable the longer term future of the cancer centre to be secured. This in turn will allow a plan to be developed for the much-needed replacement of the cancer centre's existing wards. The aim of this work is to build on some of the recent improvements in treatment facilities – including the new chemotherapy units and the first ever CyberKnife in the NHS – through enhancing the quality of experience of inpatients.

Improving the Trust's information management and technology

Following the successful implementation of the iPM patient administration system (PAS) at the Mount Vernon Cancer Centre in August 2010 and the roll-out of a new bed management and electronic discharge letter system (BIMS) throughout 2010/11, the Trust intends to extend the use of IT services across multiple clinical applications to support the delivery of clinical care. IM&T plans for 2011/12 also include improving operational efficiency, resilience and disaster recovery by introducing new server and desktop management technologies.

The Trust's information strategy, which was introduced at the beginning 2010/11, embedded the importance of good data management within the Trust, leading to a number of improvements in the quality of data used within the Trust. The organisation is also in the process of reviewing its IT and information strategies in order to develop a new combined IM&T strategy, which will build on last year's achievements. This strategy will ensure that the Trust's evolving information and infrastructure requirements continue to be met.

Delivering NHS Hertfordshire's commissioning intentions

As outlined previously, the Trust is progressing actively its outline business case for the final phase of bringing together all of its emergency and inpatient care at a redeveloped Lister hospital. This work is being carried out in partnership with NHS Hertfordshire, reflecting the latter's future commissioning intentions and the health economy's QIPP (quality, innovation, productivity and prevention) programme.

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

Within this plan, the Trust's main commissioner – NHS Hertfordshire, has set significantly reduced levels of acute hospital patient activity from 2012 onwards. These commissioning intentions have been used to inform the Trust's capacity planning work, which in turn has defined the future configuration of hospital services at the Lister. The Trust Board is keen, however, to ensure that the outline business case provides sufficient flexibility to allow the Trust to respond to a range of future demand scenarios.

At the same time, the Trust's clinicians are engaging with NHS Hertfordshire to develop the new models of care that will be necessary to reduce the number of patients being referred for acute-based care. The Trust recognises that its involvement and leadership in a number of these key initiatives is essential for the successful delivery of Hertfordshire's QIPP programme.

Meeting the expectations of regulators

During 2010/11, the Trust:

- Maintained full registration without conditions with the Care Quality Commission;
- Received successful unannounced inspections of the emergency departments at the QEII and Lister hospitals (December 2010 and January 2011 respectively). The Trust demonstrated full compliance with the essential standards of quality and safety that were inspected.

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

Chapter 4: NHS Constitution

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

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

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

Patients' legal rights

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

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

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

Further information on the NHS Constitution and its accompanying documents is available on the NHS Choices website at:

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

Chapter 5: 2010/11 overview

This chapter of the annual report and accounts for 2010/11 looks at a range of important issues relating to the Trust's performance during the year – the majority of which are expanded upon in more detail in subsequent sections of the document. The areas covered in this overview are:

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

Vision and values

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

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

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

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

Delivery of the Trust's corporate objectives for 2010/11

During 2010/11, the Trust worked to four strategic objectives, namely to:

- Consolidate acute services for complex or serious conditions on to a single site;
- Work with colleagues in primary care to extend local access to specialist acute services;
- Maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally;
- Improve the quality of all aspects of the Trust's services.

Progress made during the year in delivering each of these four objectives it set out in the tables on the next two pages.

Objective 1: consolidate acute services for complex or serious conditions on to a single site		
1.1	**Phase 1: Lister Surgicentre** – ensure delivery of Trust's elements of Clinicenta's mobilisation plan, delivering the cultural change necessary through development of operational policies and staff engagement, to support the Lister Surgicentre becoming operational in April 2011.	Achieved – Trust elements met Delay in service commencement made by commissioners
1.2	**Phase 2: maternity** – develop a mobilisation plan, delivering the cultural change necessary through development of operational policies and staff engagement, to support the new service becoming operational from October 2011 and delivery of income in line with full business case (FBC) assumptions.	Achieved and service on track to open fully October 2011
1.3	**Phase 3: multi-storey car park** – secure financial closure in May 2010 and commence development.	Achieved
1.4	**Phase 4: all remaining emergency and inpatient services (OBC**) – secure outline business case (OBC) Trust approval for Phase 4 of Our Changing Hospitals Programme and progress to FBC stage and approval for the following schemes: A & E and ward block in November 2010, and ICU & ward block in November 2010.	Achieved partly – OBC approved by Trust, SHA and PCT September 2010; awaiting Department of health/HM Treasury approval since October 2010
1.5	**Phase 4: all remaining emergency and inpatient services (FBCs)** – ensure Trust full business case approval and progression of component schemes, including cardiac catheter laboratory, medical records and ward refurbishment on levels 7 and 11.	Achieved – FBCs for cath lab, medical records and ward 11 approved 2010/11

Objective 2: work with colleagues in primary care to extend local access to specialist acute services		
2.1	**Urgent care centres** – secure future profitable contracts for the urgent care centre in Stevenage and bid to secure the UCC contract for the new QEII hospital.	Met current contracts, however NHS Hertfordshire will no longer be the commissioning body for the service from October 2011
2.2	**Service development plans** – implement approved service development plans in line with business care timescales including the second cardiac catheter laboratory service, home dialysis and CT scanner.	Achieved
2.3	**QIPP schemes** – ensure delivery of the Trust elements of the approved county-wide quality, innovation, productivity and prevention (QIPP) plan as per the contract for 2010/11 agreed with NHS Hertfordshire	Hertfordshire-wide QIPP plan agreed

Objective 3: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally		
3.1	**Satellite radiotherapy service** – secure the location of a satellite radiotherapy unit within the Trust	Not achieved – NHS Hertfordshire delayed commissioning decision to 2011/12
3.2	**CyberKnife** – implement and market CyberKnife robotic radiosurgery in line with the approved business case	Achieved
3.3	**Academic partnership** – secure an academic partnership for the cancer centre that will enable further expansion of clinical research activity	Achieved through partnership with the Royal Marsden NHS Foundation Trust and the Institute for Cancer Research

Objective 4: improve the quality of all aspects of the Trust's services		
4.1	**Governance risk rating** – achieve a governance risk rating of *green* or *amber*, demonstrating performance improvement from the previous year	Achieved
4.2	**Financial risk rating** – improve the financial efficiency of the Trust and achieve a minimum finance risk rating of *three* and deliver the cost improvement plans across the Trust for 2010 /11	Achieved
4.3	**Year-end performance** – demonstrate improvement from the end-of-year achievements from the 2009/10 floodlight scorecard indicators on outcomes, quality, clinical efficiency, workforce, and specifically: • Reduce HSMR to below 100 (in rebased data) • Sustain improvements in patient experience and improve the *net promoter* by two points and improve nature and quality of interface between patients and the Trust • Ensure robust monitoring and achievement of CQUIN targets • Complete the development of benchmark *workforce cultural index* and implement a programme to ensure positive improvements during 2010/11	Achieved the *as expected* range but HSMR not yet below 100 (rebased data) Achieved Achieved expected level Achieved
4.4	**Data quality** – meet the improvements in data quality metrics as set out in the Trust's information strategy	Achieved
4.5	**NHS foundation trust application** – achieve nomination for and subsequent authorisation as a NHS foundation trust	Achieved partly – application with Department of Health technical committee
4.6	**Pathology services** – engage with NHS East of England's strategy on the configuration of pathology services	Achieved
4.7	**Patient-level costing system** – implement and rollout across the Trust the Patient Level Costing system form quarter 1 of 2010/11. As a precursor, 2009/10 information will be available 6-8 weeks after the year-end	Achieved, but further work required to embed as a decision-making tool

Further information

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

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Operational, clinical and financial performance summary

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

Activity	2010/11 Planned	2010/11 actual	% variance
A&E activity (attendances)	135,429	135,726	+ 0.2%
Outpatient activity (first appointments)	104,772	116,977	+ 11.6%
Elective activity (number of planned episodes of surgery/treatment	40,345	41,865	+ 3.8%
Non-elective activity (number of emergency admissions	47,947	46,714	- 2.6%

Patient access

In terms of existing national standards that the Trust had to achieve during 2010/11, a summary of the key patient access and clinical indicators is set out in the table below.

Standard	Standard	2010/11 outturn
18 weeks standard – admitted	≥90.0%	92.4%
18 weeks standard – admitted (data completeness)	≥90% to ≤110%	105.5%
18 weeks standard – non-admitted	≥95.0%	97.3%
18 weeks standard – non-admitted (data completeness)	≥90% to ≤110%	97.6%
18 weeks standard – all specialties, admitted	All to hit target	No
18-weeks standard – all specialties, non-admitted	All to hit target	Yes
18 weeks standard – orthopaedics, admitted	Hit target	No
18 weeks standard – orthopaedics, non-admitted	Hit target	Yes
26-week inpatient standard	≤0.03%	0 (0.0%)
13-week outpatient standard	≤0.03%	1 (0.0%)
A&E four-hour wait	≥95.0%	97.42%
Two-week rapid access chest pain clinic wait	≥98.0%	100%
PPCI heart attack service – 150 min call to balloon time	≥85.0%	97.2%
Three month maximum wait for revascularisation	≤0.10%	0.0%
Patients spending 90% hospital stay on specialist stroke unit	≥80.0% (by Q4)	91.4%
Patients with high-risk TIA seen and scanned/treated within 24 hours	≥62.5% (by Q4)	65.5%
Two-week maximum wait, referral to outpatient appt (all cancers)	≥93.0%	99.2%
Two-week wait – breast symptoms (new from January 2010)	≥93.0%	96.7%
31-day diagnosis to treatment (all cancers)	≥97.0%	99.4%
31-day second or subsequent treatment (anti-cancer drug)	≥98.0%	99.8%
31-day second or subsequent treatment (surgery)	≥94.0%	99.3%
31-day second or subsequent treatment (radiotherapy)	≥94.0%	98.8%
62-day urgent referral to treatment (all cancers)	≥85.0%	88.3%
62-day referral to treatment (from screening)	≥85.0%	99.0%
62-day referral to treatment (from hospital specialists)	≥85.0%	100%
Delayed transfers of care (inpatients)	≤3.50%	2.5%
Cancelled operations	≤0.80%	0.68%
Cancelled operations rebooked within 28 days	≥95.0%	100%
Data quality for ethnic groups	≥85.0%	92.0%

The Trust's performance against these standards during 2010/11 saw a further improvement on the previous year. The Trust's teams worked hard and were successful in delivering significant improvements against all standards – including the cancelled operations target that was delivered for the first time in the Trust's history in 2009/10. Working with its NHS and social services partners, the Trust also achieved the standard set for delayed transfers of care for the full year.

The 18-week referral to treatment standards were removed in the June 2010 revision to the national operating framework. However, patient expectation and local contract requirements around these standards remain in place, which is why the Trust has maintained rigour and control around its performance. As a result, it continues to perform well at both Trust and specialty level, with the exception of admitted orthopaedic pathways – which have remained a challenge for the Trust, in line with the case nationally.

Clinical quality indicators

In addition to these national standards, the Trust also delivered on a range of clinical indicators during 2010/11, which are set out in the table below.

Healthcare quality indicator	Trust's targets for 2010/11	2010/11 outturn	2009/10 Outturn
MRSA blood infections (post 48 hours)	3	5	7
Clostridium difficile infections	63	56	82
Emergency MRSA screening compliance	≥95.0%	96.9%	95.6%
Elective MRSA screening compliance	100%	92.0%	n/a
Infant health and inequalities – breastfeeding initiative	Improvement on 2009/10	74.8%	71.8%
Infant health and inequalities – smoking during pregnancy	Improvement on 2009/10	12.4%	12.1%
Hand hygiene compliance	≥95.0%	97.5%	95.5%
Peripheral venous catheter compliance	≥95.0%	96.1%	92.8%
Central venous catheter compliance	≥95.0%	96.1%	97.9%
Urinary catheter compliance	≥95.0%	96.4%	94.5%
Renal dialysis catheter compliance	≥95.0%	98.2%	n/a
Surgical site observation tool compliance	≥84.0%	93.0%	90.92%
Crude mortality rate (% deaths per 100 admissions)	2.0%	2.06%[1]	1.80%
Hospital standardised mortality ratio (100 = average)	100	93.2%[1]	92.4

[1]Crude mortality rate figure and hospital standardised mortality ration score only available to end of January 2011 – final year-end figure expected to change.

The main areas of underperformance during 2010/11 were around the number of MRSA blood infections recorded 48 hours post admission, MRSA screening compliance for elective patients and the Trust's crude mortality rate.

The Trust record five post 48 hours MRSA blood infections – those deemed by experts to be acquired whilst a patient is in hospital. Although fewer were recorded during 2009/10 than the previous year, this exceeded the Trust's target of three for 2010/11. Whilst the Trust's MRSA screening compliance performance for emergency patients exceeded the expected standard, the same was not quite the case for elective patients.

Finally – and for the first time since 2008/09, the Trust's crude mortality rate rose slightly to 2.06%. That said, however, the 2010/11 performance was still the second best performance achieved by the Trust since 2005/06.

Patient experience

The Department of Health measures patients' experiences of NHS acute hospital care through the use of an annual inpatient survey. These reflect the views of, on average, some 400 to 500 randomly chosen patients for each NHS trust – a fraction of those that receive treatment and care in any given year. Given the complexity of organising, compiling and reporting such national surveys, their findings are usually 12 to 18 months old by the time they are published.

The Trust has systems in place, therefore, to capture the views and experiences of thousands of patients on a regular basis. Every quarter, views are sought from approximately 1,600 people who recently have been discharged from the Trust's care. In line with the expected norm, about one third of these patients respond to these postal surveys, with the questions used mirroring those in the national annual surveys conducted by the Department of Health.

2010/11 saw NHS trusts, for the first time ever, invited to submit evidence from local questionnaires to be considered alongside data from the most recent national survey. NHS East of England asked each NHS trust in the region to submit its current patient experience data for consideration by their respective primary care trusts, before ultimately by the SHA and Department of Health. As a result of this process, the Department of Health confirmed that it was changing the national overall assessment of the Trust's performance on patient experience from under review to performing in the light of the information and evidence provided.

Real time patient experience trackers are used throughout the Trust's hospitals, where the aim is to spot potentially problematic trends as they develop – as well as see more quickly the impact that actions being taken may or may not be having on a particular issue, such as noise at night for inpatients. Ward, clinic and department staff are also able to respond to this real time data from patients who experience their services.

The Trust has implemented several initiatives during 2010/11 with the aim of improving patient experience. For example, protected meal times were introduced to allow staff to focus on assisting those patients who require help with feeding and drinking. The use of special red trays and jug lids helps to identify those patients who need extra assistance with feeding and drinking. Noise at night can often be a problem on the wards, which is why patients are now offered ear plugs to help them get a good night's sleep.

For the coming year – and to help patients and their carers to have greater access to helpful information – the Trust will launch a page on its website that will act as a portal for all patient information leaflets. During 2010/11, the Trust's patient information team has also been developing an up-to-date of suite of leaflets, which are now available in clinical areas.

Trust's finances

By the end of March 2011, the Trust reported a year-end surplus of £3.31 million. This was marginally better than the £3.30 million position that had been forecast, month-on-month, would be achieved as the 2010/11 year unfolded. The surplus was delivered on a budget of some £340 million, representing just under 1.0% of turnover.

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

- The Trust's external financing limit (cash target) was achieved;
- The Trust's capital programme for the year was delivered within the overall financing levels and capital resource limit (CRL), totalling £19.939 million against a target of £19.959 million;
- 91% of the Trust's cost improvement programmes (CIPs) were delivered (£11.526 million out of projects identified at £12.687 million). This is consistent with the forecast position, with the £1.1. million variance caused by the moratorium on service change imposed by the Government in June 2010, which led to a delay in making changes to medical services at the QEII.

Regulation and assessment-related information

The Trust's principal regulator currently is the Care Quality Commission, with whom it is required to register in order to provide services to patients. During 2010/11, the Trust maintained registration with without compliance conditions; it also has had two unannounced inspections, both of which confirmed compliance with the essential standards of quality and safety (see below for more information). Throughout the year, the Care Quality Commission did not have cause to take any enforcement action against the Trust.

Inspections and reviews

- **Hertford County hospital – planned review of compliance:** The Trust was notified by the Care Quality Commission on 6 December 2010 that a review of compliance for Hertford County hospital had been initiated as part of the Commission's scheduled activity for ongoing monitoring of compliance. The review involved an assessment of hospital's compliance with the 16 essential quality and safety standards. Evidence logs were collated and submitted to the Commission in time for its 13 December 2010 deadline. No areas of concern were identified during the collation of the evidence. The report is awaited and when received, the outcome will be published by the Care Quality Commission; this information will also be placed on the Trust's website.

- **QEII and Lister emergency departments – unannounced inspections on 30 December 2010 and 5 January 2011 respectively:** As part of national spot checks made at the request of the Secretary of State for the Health, teams from the Care Quality Commission completed a number of unannounced inspection visits to hospital emergency departments across the country to ensure that during the winter pressures, essential standards of care were still being met. Both of the Trust's emergency departments received an unannounced visit as part of this programme of work. These visits went well, with no areas of concern raised at the time of each visit. This means that the inspection teams did not find any high-risk patient safety concerns. The visits were observational, with inspectors free to speak with patients and the Trust staff; the teams remained on site for approximately 1-2 hours on each occasion. The Commission's findings were that the emergency departments at both the Lister and QEII were compliant with the essential quality and safety standards that were reviewed – the inspection teams focussed on outcomes 4 (care and welfare), 5 (nutrition), 10 (safety and environment), 13 (staffing) and 14 (training/supporting staff) during their visits. The final reports have been published by the Care Quality Commission, as well as through the Trust's website.

Care Quality Commission outcomes summary

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 1: Involvement and communication								
C	1	17	Respecting and involving people who use services	C	C	C	C	Compliant – no compliance conditions
C	2	18	Consent to care and treatment	C	C	C	C	Compliant – no compliance conditions
C	3	21	Fees etc. (applies to people how pay for their care)	C	C	C	C	Compliant – no compliance conditions

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 2: Personalised care treatment and support								
C	4	9	Care and welfare of people who use services	C	C	C	C	Compliant – no compliance conditions
C	5	14	Meeting nutritional needs	C	C	C	C	Compliant – no compliance conditions
C	6	24	Co-operating with other providers	C	C	C	C	Compliant – no compliance conditions

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 3: Safeguarding and safety								
C	7	11	Safeguarding vulnerable service users	C	C	C	C	Compliant – no compliance conditions
C	8	12	Cleanliness and infection control	C	C	C	C	Compliant – no compliance conditions
C	9	13	Management of medicines	C	C	C	C	Compliant – no compliance conditions
C	10	15	Safety and suitability of premises	C	C	C	C	Compliant – no compliance conditions
C	11	16	Safety, availability and suitability of equipment	C	C	C	C	Compliant – no compliance conditions

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 4: Suitability of staffing								
C	12	21	Requirements relating to workers	C	C	C	C	Compliant – no compliance conditions
C	13	22	Staffing	C	C	C	C	Compliant – no compliance conditions
C	14	23	Supporting workers	C	C	C	C	Compliant – no compliance conditions

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 5: Quality and management								
C	15	8	Statement of purpose	C	C	C	C	Compliant
C	16	9	Assessing and monitoring the quality of service provision	C	C	C	C	Compliant – no compliance conditions
C	17	19	Complaints	C	C	C	C	Compliant – no compliance conditions
C	18	17	Notification of death of a service user	C	C	C	C	Compliant
C	19	18	Notification of death or unauthorised absence of a service user who is detailed or liable to be detailed under the Mental Health Act 1983	C	C	C	C	Compliant
C	20	29	Notification of other incidents	C	C	C	C	Compliant
C	21	20	Records	C	C	C	C	Compliant – no compliance conditions

Declared registration position 2009/10 - all locations/ regulatory activities	Outcome	Regulation	CQC essential standards of quality and safety	Current registration position – March 2011				Anticipated full-year position 2010/11 - all locations /regulatory activities
				Lister	QEII	MVCC	Hertford County	
Section 5: Suitability of management								
N/A	22	4	Requirements where the service provider is an individual of partnership	Not applicable to the NHS				N/A
C	23	5	Requirement where the service provider is a body other than a partnership (nominated individual)	C	C	C	C	Compliant
N/A	24	6	Requirements relating to registered managers	Not applicable to the NHS				N/A
C	25	7	Registered Person: training	C	C	C	C	Compliant
N/A	26	12	Financial position	Not applicable to the NHS				N/A
C	27	14	Notice of absence	C	C	C	C	Compliant
C	28	15	Notice of changes	C	C	C	C	Compliant

Care quality commission registration

From 1 April 2010, the Trust has been formally registered with the Care Quality Commission under the Health and Social Care Act 2008 to provide the following regulated activities at the specified locations:

Regulatory activity	Locations			
	Lister	QEII	MVCC	Hertford (inc. UCC)
Treatment of disease, disorder or injury	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions
Surgical procedures	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	
Diagnostic and screening procedures	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions
Maternity and midwifery services	Registered - no compliance conditions	Registered - no compliance conditions		Registered - no compliance conditions
Termination of pregnancies	Registered - no compliance conditions	Registered - no compliance conditions		
Family planning services	Registered - no compliance conditions	Registered - no compliance conditions		
Assessment or medical treatment of people detained under the Mental Health Act 1983	Registered - no compliance conditions	Registered - no compliance conditions	Registered - no compliance conditions	

Listening to patients' concerns

Patient Advice and Liaison Service (PALS)

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

The Trust's PALS teams, which work closely with their complaints colleagues, aim to resolve issues locally, without the need these concerns to be escalated to a more formal level. The teams also try to make initial contact with complainants who have written to the Trust to establish if their concerns can be addressed more effectively at a local level. During 2010/11, 1,819 separate contacts was made with the Trust's PALS services – this includes those seeking direct help from the teams themselves or, as well as via comment cards.

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

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

Formal complaints and compliments

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

Principles for remedy

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

- Getting it right;
- Being customer focused;
- Being open and accountable;
- Acting fairly and proportionately;
- Putting things right;
- Seeking continuous improvement.

Principles for remedy was updated in May 2010. Further information is available from the Parliamentary and Health Service Ombudsman's website: www.ombudsman.org.uk

Dealing with complaints and compliments in 2010/11

During 2010/11, the Trust received 889 formal complaints – a 1.5% reduction on the number received the previous year and the second year in a row that such a reduction was recorded. These changes, in part at least, can be attributed to the continued improvement in some clinical services that historically have led to higher volumes of complaints being received in previous years.

Everyone who makes a formal complaint is offered an opportunity to meet with relevant staff if they remain dissatisfied after receiving the Trust's investigation response. In 2010/11, there were 36 such meetings – two more than the previous year. These meetings all form part of the *local* resolution process.

In the 12 months to the end of March 2011, just eight patients referred their complaint to the Ombudsman, which is six less than the previous year. Of these eight referrals, the Ombudsman has accepted two for further investigation (the outcomes for both are still awaited).

In addition to these complaints, during 2010/11 the Trust also received 149 letters and e-mails complimenting the standard of care provided by its staff. This was in addition to the many hundreds of cards, notes and small gifts that were given to ward staff directly.

Comments placed on NHS Choices

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

The role of the Trust's hospital volunteers

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

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

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

Education and training summary

The Trust has always recognised the importance of staff training and education. During 2010/11, it continued to focus on a wide range of internal training for both clinical and non-clinical staff, including:

- Statutory and mandatory training, such as health and safety, fire safety and infection control;
- Clinical training, such as dementia, diabetes and palliative care;
- Developmental courses, including leadership and management, customer care, and IT skills and systems.

Throughout the year, the Trust continued to progress its programme of conflict resolution training, as well as developing a number of e-learning packages. This enabled the Trust to provide staff with a mix of electronic and classroom-based training opportunities. The Trust also plays an active and on-going role in national management graduate training programmes.

Six members of the Trust's staff have completed regional *aspiring directors and senior clinical leaders* programmes last year.

Research and development summary

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

During 2010/11, the Trust had 253 active research studies, of which over 90% were funded externally. In the last three years, researchers at the Trust produced 350 publications in peer-reviewed journals.

Patient recruitment into the United Kingdom Clinical Research Network portfolio studies has risen dramatically over recent years, with over 2,500 Trust patients participating in these studies during 2010/11. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within five years; the Trust is on target to achieve this objective locally.

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

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

At the Mount Vernon Cancer Centre, the academic partnership with the Royal Marsden NHS Foundation Trust and Institute for Cancer Research has completed its first phase, and will soon employ three staff to run the Royal Marsden R&D office at Mount Vernon. The partnership's aim is to help the Trust further develop its oncology research programmes.

The cancer centre has had funding approved for statistical support and an onsite tissue collector to facilitate collection, storage and transfer of biological material to a new centre of molecular pathology. The centre is currently bidding for biomedical research centre funding, based around the integrated academic partnership.

The Experimental Cancer Medicine Centre (ECMC) re-application of the drug development unit at Sutton included the academic partnership and if successful, should allow the partnership access to ECMC information – such as details of the industrial alliances with the National Cancer Research Network by AstraZeneca and GlaxoSmithKline.

A joint bid has also been submitted for the Cancer Research UK technology hub stratified medicine scheme, which if successful will establish Institute for Cancer Research as a technology hub. This would allow the partnership access to free genotyping for a range of common tumours.

Impact of Trust research activity

Examples of how research conducted within the Trust has impacted health care practice within the wider health service and beyond are set out below.

1) Ovarian cancer response criteria

Professor Gordon Rustin chaired a committee of the Gynaecological Cancer Intergroup, which proposed definitions for response and progression of ovarian cancer that incorporated the serum marker CA125 as well as standard radiological response criteria. These were based on previous publications of Professor Rustin, which had shown clearly that using precisely defined criteria, it was possible to use serial measurements to demonstrate accurately in the majority of patients with ovarian cancer whether their tumour was responding to therapy or relapsing.

This latest publication formally describes and endorses these definitions and explains in which situations they should be used. Most clinical trials for ovarian cancer now incorporate these definitions which will make it easier, more accurate and cheaper to monitor therapy for ovarian cancer. More information can be found in the related publication (*International Journal of Gynaecological Cancer* 21(2):419-423, February 2011).

2) Renal medicine
The Trust's renal medicine team has, for many years, been at the forefront of research and development into technological aspects of haemodialysis. The unit's work on dialysis adequacy, long-term outcomes in on-line haemodiafiltration and the importance of residual renal function has been influential in shaping clinical practice in haemodialysis. The team's work has been quoted regularly in clinical guidelines produced in this area of medicine.

The unit's work has also made a major contribution to the practice of conservative kidney management, as well as in the field of end-of-life care for those patients with advanced kidney disease. As a result of publications in these areas, Professor Ken Farrington – one of the Trust's consultant nephrologists - was asked during 2010/11 to co-author a framework document (*End-of-life care in advanced kidney disease: a framework for* implementation) for NHS Kidney Care. Professor Farrington was also asked to author guidelines covering these areas for the UK Renal Association.

Clinical service developments during the year

During 2010/11, much of the Trust's attention was placed on two major projects – the building of the Lister Surgicentre and the new women's and children's unit, both of which will open their doors fully during 2011. This did not prevent, however, the Trust and its staff rolled out a number of other service developments and changes during the year, including:

- **August 2010** – the first ever CyberKnife in the NHS, which has been installed in the Mount Vernon Cancer Centre at a cost of £2.7 million, started to treat its first cancer patients. This latest radiotherapy technology from the United States uses real-time tracking capabilities to deliver high-dose radiation to tumours with pin-point accuracy – including those that move every time a patient breathes. Typically it is used with those patients who may have limited treatment options, and/or whose cancer has been described previously as inoperable.

- **September 2010** – Sir Terry Wogan was the Trust's guest of honour at a ceremony to mark the official opening of the new £1.43 million chemotherapy unit at the Mount Vernon Cancer Centre, which started treating its first patients in February 2010. Watched by invited guests and patient Brenda Campbell, Sir Terry cut the ribbon in front of a display that records the details of a wide range of organisations that supported the appeal to raise the necessary funds to create the life-saving treatment and research facility. The contributions made by patients and members of the public are acknowledged on a separate plaque within the unit.

- **September 2010** – Two new best-practice ambulatory medical services were introduced at the Lister for the benefit of specific groups of patients where the majority no longer need to be admitted to a hospital bed for their care to happen (e.g. those with newly diagnosed diabetes, anaemia, many forms of chronic obstructive pulmonary disease, epilepsy, cellulitis and urinary tract infections). An ambulatory care centre is a one-stop unit, providing diagnosis, observation, treatment and rehabilitation services not provided currently through more traditional wards or outpatient clinics. At the same time, a medical day unit was created at the Lister to complement the work of new ambulatory care centre, through providing a service that mirrors the day case approach used in surgery – i.e. patients are admitted, treated and discharged on the same day.

- **November 2011** – A second CT scanner was installed, at a cost of just over £1.9 million, in the Lister's radiology department. It was required because of the additional workload going through the hospital, which was being prior to this point through the use of a mobile CT scanning unit that visited the Lister for two days every week. In addition to the extra capacity, the new scanner also provides the Trust with: ultrafast scanning, providing a marked reduction in repeat and non-diagnostic examinations; scans with an ultra low radiation dose, which is safer for patients; enhanced imaging capabilities, thus reducing the need for multiple examinations and bringing significant cost savings; advanced imaging now being available locally for patients saving them travelling elsewhere for this service; and, finally, significantly improved patient experience and enhanced examinations.

- **February 2011** – Changes were made to times when the children's A&E and assessment unit were open at the QEII. Since Monday, 28 February 2011, the closing time has been at 8.00pm daily, instead of 11.00pm. The service reopens every morning at 8.00am, instead of 7.30am. Outside of these hours, all children needing to attend a specialist children's emergency service, whether by ambulance or as a walk-in, need to go the 24/7 service based at the Lister, or to another nearby hospital if that is considered the preferred option.

- **March 2011** – When it comes to people who have a life-limiting condition, too often in the final stages of their illness they end being admitted to, and dying in, hospital unnecessarily when it could have been so much different. With the right documentation in place, they could instead have died at home with their loved ones. A new multi-agency *Message in a Bottle* campaign, led by the Trust, aims to help such people realise this wish. When facing a life-limiting illness, it can be hard for the person involved, or their families, to talk openly about the realities of death. Indeed many people are unaware totally that there is help available to plan and express their wishes about where they would like to be cared for and die. Too often an on-call doctor or ambulance crew called out in an emergency, who rarely will be familiar with the person for whom they are caring, are faced with an extremely ill patient, who may even be in the terminal stage of their illness. Their first duty is to help the patient and family; without adequate documented information being available, invariably this may mean an unnecessary, and sometimes distressing, journey to hospital. This is where the Trust's *Message in a Bottle* campaign can make a real difference.

Foundation trust membership report

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

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

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

Public constituency	
Total members at 1 April 2010	6,549
Net increase in members recruited during 2010/11	3,216
Total members at 31 March 2011	9,765

Staff constituency

The Trust's staff constituency has four classes:

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

Staff membership is an opt-out scheme, with this right being explained at induction as and when new staff join the Trust. To date, around 90 members – or 1.8% of the Trust's workforce – have chosen to opt out of membership. None of these relate to the 2010/11 year.

Staff constituency	
Total members	5,080

Membership engagement

The Trust's foundation trust office team has continued to work hard to achieve the target it set itself to increase its public membership to 8,000 members by the end of 2010/11. Due to a variety of successful recruitment campaigns, the quota was met and exceeded a number of months ahead of plan.

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

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

- Involvement committee meetings;
- Staff awards nominations committee and celebration dinner

In order to maximise engagement with members, a number of exclusive events on various aspects of the Trust's work were held throughout 2010/11, including:

- 14 dedicated tours of the phased changes taking place already, along with those planned, at the Lister;
- A showcase of maternity service developments at Campus West in Welwyn Garden City;
- Information stations on awareness days, such No Smoking Day, Climate Week and Bike Week.

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

- Taking part in PEAT (patient environment action team) inspections;
- Joining the Trust's readers panel for patient information;
- Informing decisions on the Trust's priorities for its annual quality account;
- Participating in web and print media development surveys/workshops;

Plans for 2010/11
The Trust is seeking to become authorised as a NHS foundation trust during 2011/12. The public membership target for the year is to achieve 10,000 public members – which is in line with the Trust's current membership strategy.

Opportunities created through existing and new links with the local community will be used to help the Trust meet its recruitment goals, with the aim of moving towards increased engagement with existing and new members. During the year, there will be a particular focus on further youth engagement and the Trust's first elections to its new Council of Governors.

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

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

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

Members making a difference – involving the community in the decisions made by the Trust
Over the last 12 months, as the Trust moves towards achieving NHS foundation trust status, the number of supporters from local communities has risen by over 3,000 people. This means that almost 10,000 local residents have signed up to show their interest in the way their local hospital services are run.

As a public member, people can choose the level of involvement they have in the Trust's decision-making processes; when they become public members – and at any point subsequently – they can decide to:

- Receive regular updates from the Trust via our member newsletter, *Grapevine*;
- Take an occasional interest in particular services the Trust provides and be given an opportunity to have an input into plans for changes to/ developments;
- Take an active interest in being regularly updated on and involved in all aspects of the Trust's work;
- All of the above plus state an interest in standing for election as a public governor to represent the views of fellow local residents on the Council of Governors.

The Trust is delighted that, to date, it has over 300 public members who are considering the role of governor. These individuals, together with those who wish to be involved occasionally and regularly, have interacted with the Trust in a number of ways this year by:

- Attending talks from our clinical specialists on themes including A&E and maternity care;
- Taking tours around the Lister to find out about the progress being made towards bringing together all emergency and inpatient services on to one, redeveloped hospital site;
- Participating in workshops to help improve the value of the Trust's website;
- Completing surveys to help the Trust improve its publications, for example patient status information for relatives;
- Being part of the PEAT inspection teams assessing the quality of the food and environment at the QEII and Lister.

More than 50 members have signed up to sit on the Trust's *readers' panel*, which monitors patient information before it is printed. In addition, over 70 public members attended the Trust's annual general meeting in September 2010, which was held for the first time at a community venue (the John Henry Newman School in Stevenage). During the year, members also became volunteers at the Trust's hospitals, got involved in fundraising projects and contributed to the Trust's choices of priorities for the 2011/12 quality account proves.

Efforts have been made to encourage more young people to take an interest in health care – both to encourage healthy lifestyle choices and promote the health service as an exciting career option by inviting schools and colleges into the Trust and by attending events held by universities.

It is the Trust's aim to continue to offer its members ways – both existing and new – to participate and engage, which enable them to feel that they are making a difference to help the Trust improve continuously improve the care it offers to everyone who uses its hospitals.

Chapter 6: operational performance for 2010/11

In the previous chapter, the Trust's overall operational performance for 2010/11 was reviewed. Here the report seeks to provide a more detailed look at that performance.

Performance overview

The 2010/11 year represented one of significant success for the Trust's operational teams – which comprise doctors, nurses, other healthcare professionals, managers and support staff. As highlighted in the previous chapter, excellent progress was made against delivering all national patient access standards expected of the NHS, whilst also managing an effective efficiency programme. During 2010/11, new technologies and service enhancements were introduced that have had considerable benefit for the local community.

The Trust's performance was particularly impressive when set against a background of increases in patient activity documented elsewhere in this report. It was also achieved alongside improvements in the quality of services provided to patients, as evidenced by better outcomes, patient safety and patient experience data gathered throughout the year.

Particularly pleasing were the changes that the Trust and its staff have made around achieving the standards for delayed transfers of care and cancelled operations. Historically, these have been areas that have been extremely challenging for the Trust. More importantly, they caused disruption to the care that patients received and were often at the heart of complaints. For the second year in a row, not only did the Trust deliver both standards, but also managed to improve on the position achieved in 2009/10.

Good progress also continued to be made in delivering against the national A&E and 18-weeks waiting times standards to ensure that patients received their treatments in a timely and effective manner. The Trust's excellent performance in achieving cancer waiting times is worthy of particular note, with every standard met – which is a very strong performance when compared with other cancer centres nationally. For the first time, 2010/11 saw the Trust deliver against ethnicity data quality indicator and stroke care performance standards.

The Trust's strong operational performance during 2010/11 was delivered at the same time as major improvements were made to many clinical services. Examples of the latter include the:

- New CyberKnife radiotherapy unit at the Mount Vernon Cancer Centre;
- Lister's new CT scanner;
- Introduction of further changes to children's overnight emergency services;
- Commissioning of the new maternity unit at the Lister;
- Development of new ambulatory models of medical care.

Indeed, the last of these changes – ambulatory models of medical care – has led to significant improvements in patient treatment options, resulting in fewer people needing to be admitted as full inpatients and having faster access to more senior doctors and specialist nurses. This initiative was also a key part of the Trust's efficiency programme last year, as well as supporting further improvements in 2011/12 onwards.

In conclusion, 2011/12 will represent a year of significant challenge for Trust as its operational teams seek to improve performance further across all national standards in order to consolidate the organisation's position as one of the better performing NHS trusts in the health service. This is because such improved performance will need to be delivered at the same time as driving further efficiencies and delivering on major core elements of the Trust's strategic change programme. The latter includes the:

- Final reconfiguration of women's and children's services from October 2011;
- Opening of the Lister Surgicentre, along with the reconfiguration of emergency surgical and trauma services remaining with the Trust (earliest date will be mid-July 2011).

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

Management arrangements

The Trust's clinical services are organised into five clinical divisions, with each having a divisional chair, who is a clinician, and a divisional director, who is a full-time general manager. Between them, the divisional chairs and directors provide leadership to their clinical services and have regular interaction with the Trust's executive directors.

Service and financial performance issues are considered at the weekly meetings of the Trust's executive committee. In addition, each division meets formally with the executive director team through a bi-monthly performance management system. While this places even greater responsibility for the performance of each division on to those running them, it also encourages them to take equal responsibility in empowering front line staff to develop their services using the NHS business planning processes.

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

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

Activity planning

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

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

Although the Trust has developed longer-term activity plans through the integrated business plan required as part of the application process to become a NHS foundation trust, for the purposes of this annual report, the information available on activity plans is limited to the year ahead (i.e. 2010/11). This information, along with comparisons against previous years, is set out in the table on the next page.

Activity	2008/09 actual	2009/10 actual	2010/11 actual	2011/12 planned
A&E attendances	136,786	136,946	135,726	136,545
Outpatients – first appointments	106,429	113,169	116,977	109,815
Outpatients – follow-up appointments	233,024	255,190	254,514	236,963
Elective inpatients (i.e. planned admissions)	17,166	14,182	13,113	13,458
Elective day cases	24,075	31,882	28,752	25,309
Average length of stay for elective patients (days)	2.4	2.8	2.8	2.7
Non-elective inpatients (i.e. emergency admissions)	44,200	47,677	46,714	47,154
Average length of stay for non-elective patients (days)	5.4	4.7	4.7	4.5
Births	5,810	5,635	5,576	5,600

The planned figures for 2011/12 may be affected by the timing of the opening of the Lister Surgicentre, which was due to start clinical services from 18 April 2011. In March 2011, NHS Hertfordshire deemed that the Surgicentre's operator, Clinicenta, was not being ready to provide clinical services; the earliest start date for services to commence was mid-July 2011. The plan may also need to alter should NHS Hertfordshire make further changes to its referral processes during the year.

Emergency preparedness – major incident plan

The Trust has a comprehensive major incident plan, which covers its two hospitals with accident and emergency departments – the Lister in Stevenage and QEII in Welwyn Garden City. The plan complies with Department of Health guidelines.

Business continuity planning and emergency preparedness have been identified as one of the Trust's key strategic risks. The Board's risk and quality committee receives regular reports on the Trust's approach to emergency planning. The director of operations is accountable to the Board for emergency planning and preparedness, with this duty discharged through the Trust's emergency planning committee. The Trust's risk register, along with formal and informal tests, audits and training exercises, are used to provide assurance on emergency preparedness.

The Trust has a statutory obligation to undertake a formal live exercise of its major incident plan every three years. Such a test – called the *Emergo* exercise – took place during 2010 at the Lister and proved extremely successful. On 5 January 2011, however, the Trust had to invoke its major incident plan when the power supply at the QEII was affected severely following the failure of one of the main power cables. This caused disruption and a loss of power to the tower block's lifts, critical care units and a number of wards and departments.

Immediately following a major incident being declared, the Trust was required to go on a formal divert for ambulance vehicles and obstetrics, as well as move intubated patients to the QEII's theatres recovery area on the evening of 5 January 2011.

A hospital control centre was established, which continued on in to the next day until the incident was declared over. During the same period, the Lister was placed on to major incident standby so that its staff could provide their colleagues at the QEII with any necessary support that was required.

For the next 24 hours, the QEII site was managed on reduced power. The following day (6 January), a plan was put in place to reduce the power manually at 9.00pm to enable faulty cabling to be replaced and thus restore the hospital site to a normal electricity supply again. During this period of intensive repair work, a formal divert was agreed the East of England NHS Ambulance Service.

A comprehensive operational plan was produced prior to the power reduction to ensure that all staff were aware of the processes that would be followed. Additional site management staff and matrons were made available so that the impact on the QEII's ability to care for patients safely was assessed directly and constantly.

The whole incident, from the major failure in part of the hospital's power supply to its full repair within 48 hours, was managed very successfully and without significant disruption to patient services. Indeed it is a testament to the professionalism of the Trust's staff that the incident was handled without the need for wholesale cancellation of outpatient appointments and elective surgery.

A debrief was held following the incident, with the aim of capturing any learnings from the event. The outcome of this meeting was shared subsequently with the Trust's risk and quality committee. A separate briefing paper was also shared with the Board in February 2011 covering an in-depth review that had been undertaken of all critical infrastructure systems on the QEII site. This work was conducted by the Trust's estates team and verified by external specialists.

For further information, please contact:

Jude Archer, Company Secretary
Tel: 01438 314333
E-mail: jude.archer@nhs.net

Chapter 7: clinical performance for 2010/11

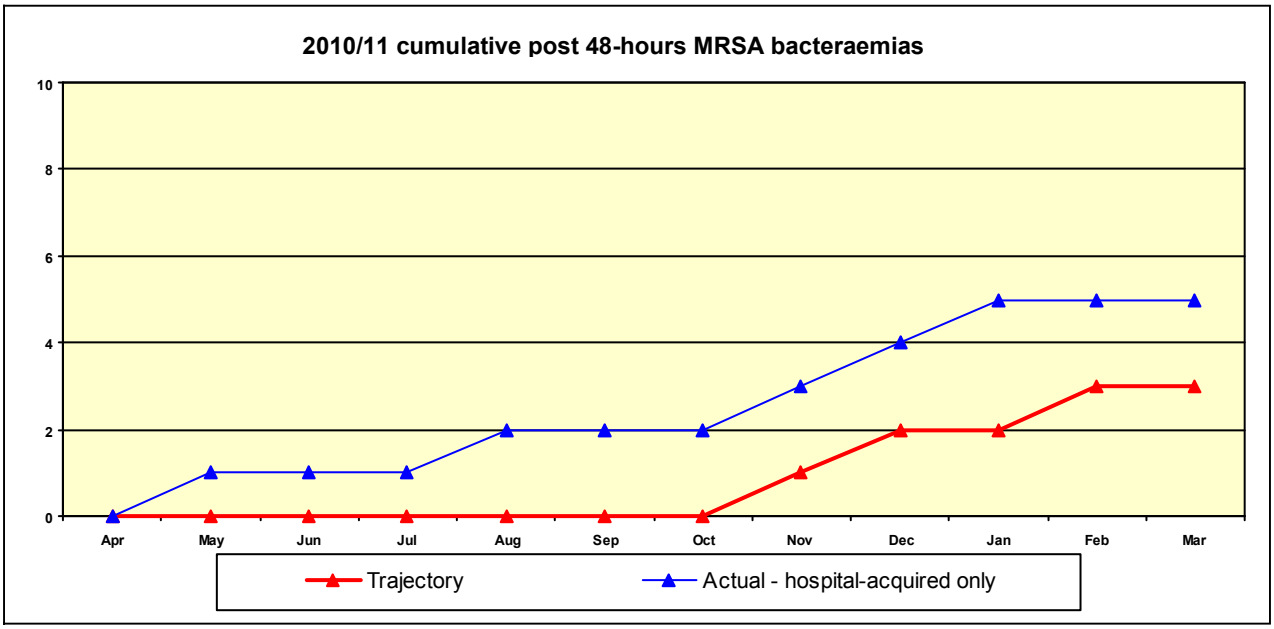
This chapter considers in more detail the Trust's performance during 2010/11 for two important clinical areas – hospital-acquired infection and mortality rates.

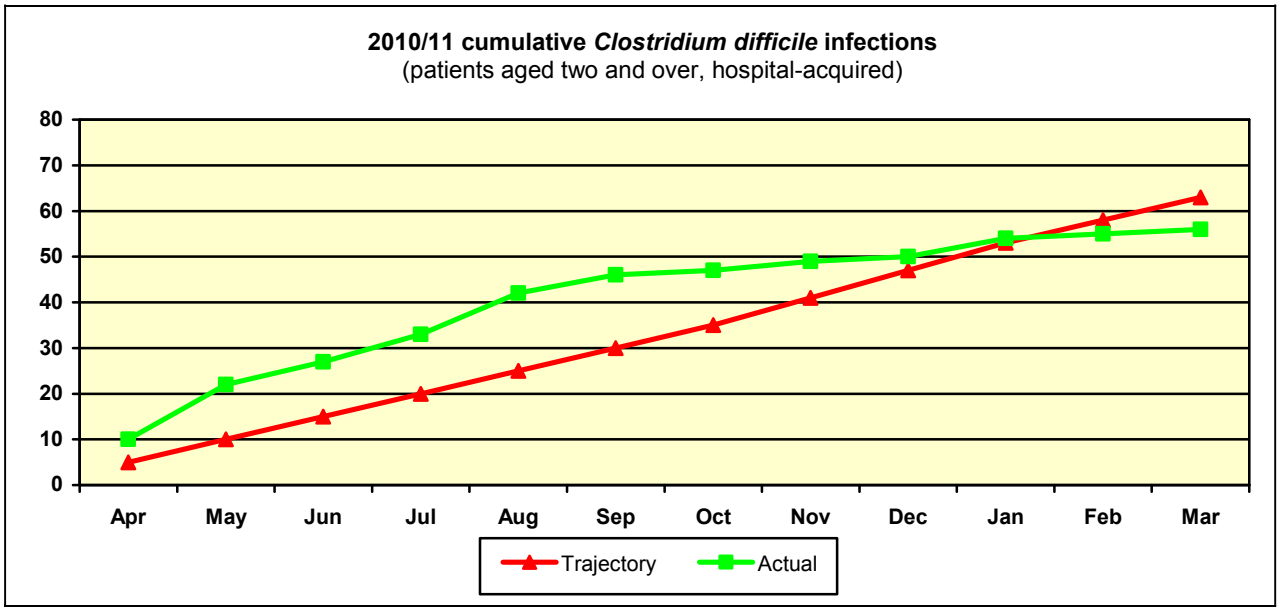
Hospital-acquired infections (MRSA bacteraemias and *Clostridium difficile*)

The formal targets set for the Trust, as part of the contracts agreed with NHS Hertfordshire and NHS East of England for 2009/10, were for no more than three post 48-hours MRSA bacteraemias (blood infections) or 63 *C. difficile* infections. The Trust's performance against both of these targets during 2010/11 is shown in the tables and graphs below.

MRSA blood infections (Full year target 2010/11: 3 post 48-hours cases)	**2009/10**	**2010/11**	**Cumulative ytd % change**
April to June	1	1	0%
July to September	0	1	+50.0%
October to December	3	2	0%
January to March	3	1	-28.6%
Total (12 month period)	**7**	**5**	**-28.6%**

***C. difficile* infections** (Full year target 2009/10: 63 cases)	**2009/10**	**2010/11**	**Cumulative ytd % change**
April to June	16	27	+68.8%
July to September	22	19	-21.1%
October to December	20	4	-13.8%
January to March	24	6	-31.7%
Total (12 month period)	**82**	**56**	**-31.7%**





As can be seen from these tables and graphs, in the 12 months since April 2010, the Trust has had just five post-48 hours MRSA blood stream infections throughout the year – that's an average of just under one infection every other month. Whilst nearly 30% down on the number of similar infections recorded in 2009/10, this improved performance was not quite good enough to meet the target set for the Trust in 2010/11 of having no more than three post 48-hour MRSA bacteraemias.

In relation to reducing *C. difficile* infections, a relatively poor start to 2010/11 was more than made up in the second half of the year. This resulted in the Trust recorded just 56 cases – which was better than the target of no more than 63 infections and just over 30% down on the position achieved in 2009/10.

Although disappointed not to have achieved what was a very stretching MRSA target for the year, the Trust's performance in the second half of the year – especially around the prevention of *C. difficile* infections in the last three months of 2010/11 – was impressive. The challenge is to maintain this improved performance in to 2011/12 and beyond.

Mortality rates

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

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

There remains a small group of patients, however, whose death may have been preventable and it is this group where changes in mortality rates are important for NHS organisations, both to establish their cause and introduce improvements in the care of patients that otherwise might not happen.

The importance of measuring mortality rates

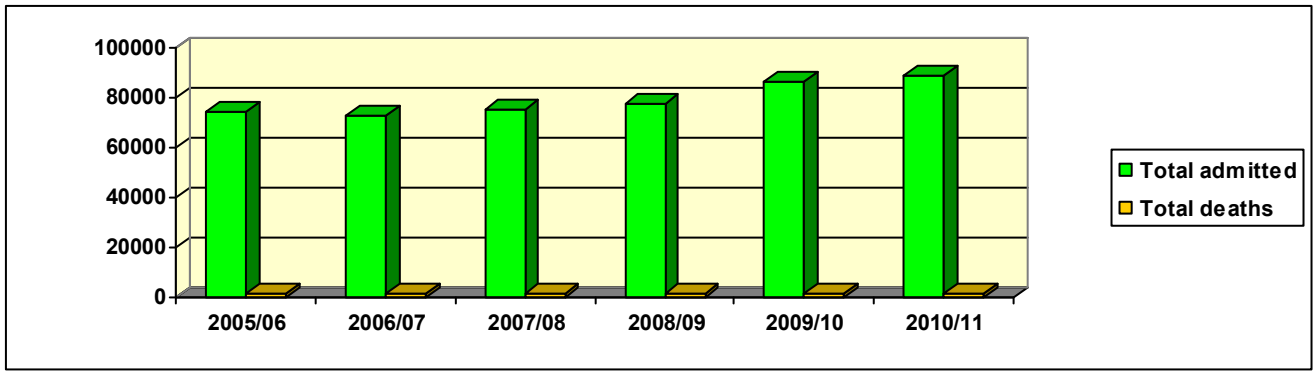
Not only do mortality rates help the Trust better understand the risks of hospital treatments for individual patients, changes in patterns over time can pinpoint where changes in clinical care may need to be made. They can also help those people wishing to make a choice about the hospital where they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

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

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

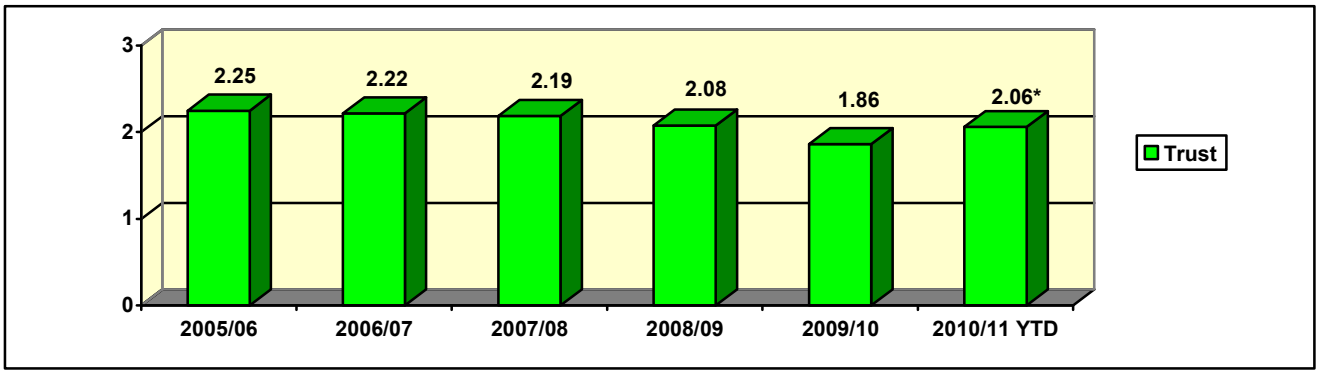
Crude mortality rates

A hospital's crude mortality rate looks at the number of deaths that occur in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period. The crude mortality rate can then be set as the number of deaths for every 100 patients admitted. What it describes best is how a hospital or Trust's mortality rate changes over time. In the case of the Trust's hospitals, the historical crude mortality rate is set out in the charts below.



Total annual patients admitted and death by year

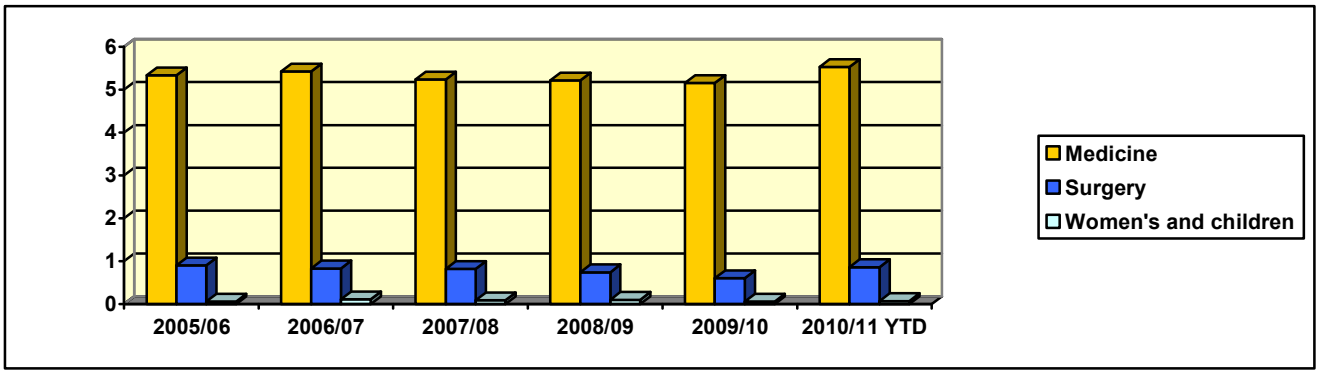
What this graph shows is that since 2005/06, the number of people being admitted to the Trust's hospitals has grown year-on-year from around 70,000 to just over 88,500 admissions five years later. At the same time, the number of deaths recorded has remained at a very small number and, perhaps less obviously from the graph above, have been falling.



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

*Please note that 2010/11 figure is to the end of January 2011, as full-year position – which is expected to be lower – was not available at the time of this report's publication

The graph at the bottom of the previous page shows that up until 2009/10, the Trust's crude mortality rate had been falling as fewer patients die as an overall percentage of those that have been treated. Although the rate increased slightly in 2010/11, it remained lower than that achieved two years previously and in each of the years stretching back to 2005/06. This suggests that the particularly rapid decrease in the crude mortality rate recorded in 2009/10 may have been ahead of the underlining trend reduction that has been taking place every year since 2005/06.



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

*Please note that 2010/11 figures are to the end of January 2011, as full-year position was not available at the time of this report's publication

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

During a period when the number of people being admitted to the Trust's hospitals has been rising year-on-year, those dying have been falling – both in absolute numbers and broadly as a percentage of those admitted. In summary, therefore, fewer people overall are dying today in the Trust's hospitals compared to just six years ago.

Hospital standardised mortality ratio (HSMR)

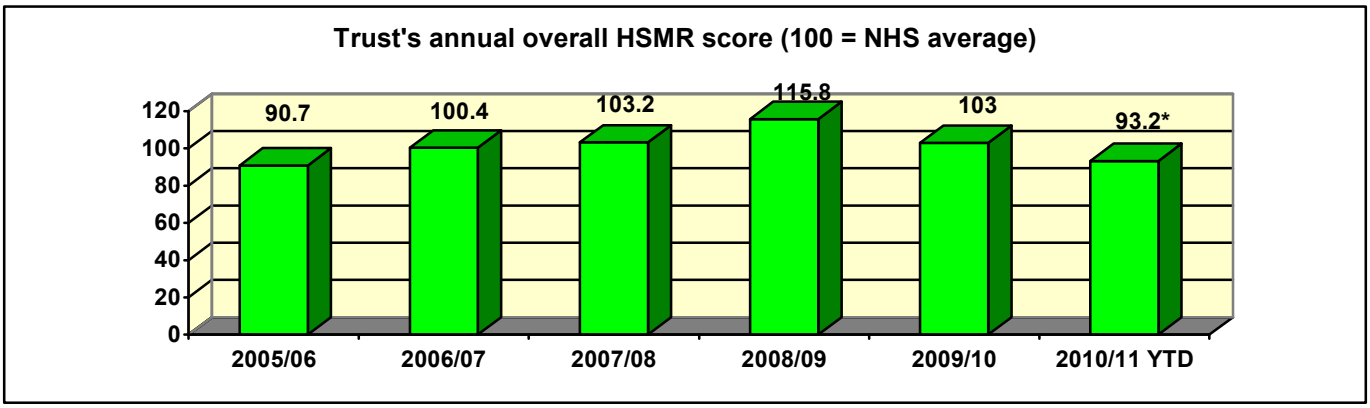
While crude mortality rates are very important, it is very hard to use this information to compare and contrast what is happening between different hospitals and NHS trusts. This is because every hospital is different, both in the treatments and operations offered and the make-up of local populations.

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

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

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

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



*Please note that 2010/11 figure is to the end of January 2011, as the full-year position – which is expected to be lower – was not available at the time of this report's publication

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

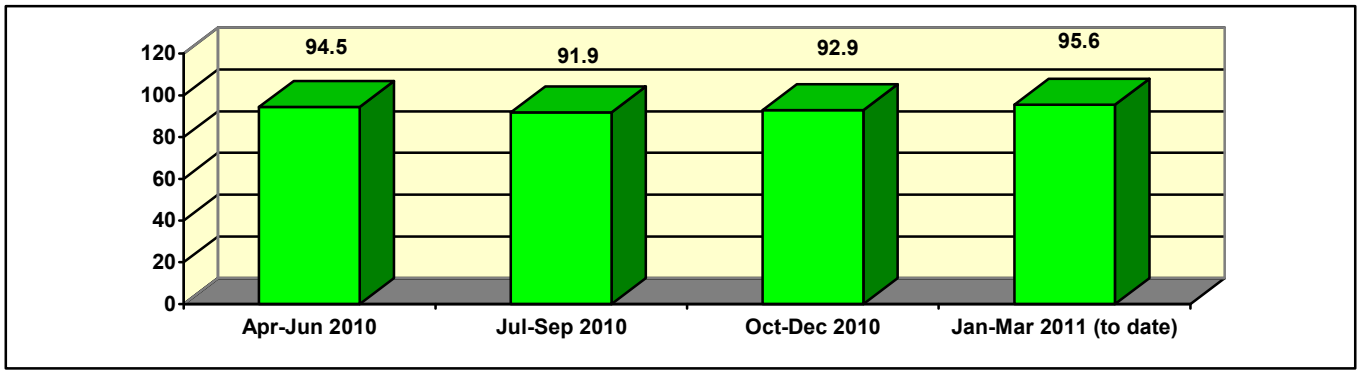
There are several reasons why any individual HSMR score needs to be treated with caution, namely:

1. *The quality of the clinical coding* – every clinical procedure undertaken in the NHS has its own unique code and unless these are used properly on our computer records, this can have a direct skewing effect on the resulting HSMR score. Despite improvements made during the last year or so, this remains an important issue. For example some of the change in the Trust's own HSMR scores recorded during 2009/10 was due, in part, to inadequate clinical coding – an issue that continues to attract significant attention from the Trust's clinical coding team;

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

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

Below is a chart showing the HSMR scores achieved by the Trust for each quarter in 2010/11, with the overall year-to-date score being 92.9 – although these figures have yet to be rebased. This is the process whereby the Trust's performance for the full year is compared against changes in HSMR scores recorded by other similar NHS trusts and a final comparison score is made. Although the Trust has performed well this year and it is anticipated that when the final rebased HSMR score for 2010/11 is released later in 2011, it is likely to be between 101 and 103.



Trust's quarterly HSMR scores for 2010/11

*For Q4 only data for January 2011 is available – February and March data is not expected to be published until end of June 2011, which is after this report is published.

Interpreting and using HSMR scores

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

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

Working through the Trust's HSMR scores

For each of the three years to 2007/08, the Trust's annual HSMR score has been recorded at or around the national average that would be expected for district general hospitals such as the Lister and QEII. During 2008/09, however, the Trust began to notice that its quarterly HSMR score was rising and needed to be investigated. Following further investigation, what was uncovered was a significant deterioration in the quality of the data recorded against patients treated at the Trust's hospitals. While this had no direct effect on the quality of care they received, it did skew adversely the resulting HSMR score. Once this data entry problem was resolved, the Trust's HSMR rating began to improve quite quickly.

That is not the whole story, however. By improving the quality of the Trust's data, it did allow one or two clinical areas to be identified where the HSMR score was still higher than it should have been – for example for older patients with broken hips, where the death rate was higher than expected. By looking at the clinical pathways involved, changes were made that had an impact on the chances that this vulnerable and often frail group of patients had in not just surviving their surgery, but going on to recover a good quality of life afterwards. More changes will be made during 2011/12 to ensure that the HSMR score for these patients continues to fall.

Chapter 8: financial performance for 2010/11

Review of 2010/11

During 2010/11, the Trust continued to maintain its strong financial position, delivering a fourth consecutive year on plan, delivering a surplus of £3.31 million. This strong performance was in line with the target position agreed for the Trust by NHS East of England target.

Although the overall outcome was positive, the winter months proved to be particularly challenging and costly for the Trust. Emergency admission levels were high in December 2010 and January 2011, with those above a threshold set nationally being reimbursed at just 30% of the national tariff. In a situation similar to that faced by many NHS organisations across the country, the Trust would have lost an estimated £1.6 million of income without the very positive intervention by NHS East of England and NHS Hertfordshire. This followed guidance from the Department of Health advising that NHS trusts should not be penalised unduly for what was a particularly severe winter period.

The Trust had another successful year when it came to delivering its annual cost improvement programme (CIPs). Although in June 2010 the new Coalition Government introduced a review of all proposed and new hospital service change, which meant the Trust's entire CIPs programme could not be delivered entirely, 91% of it was delivered, with the variance from due entirely to the national moratorium that was in force at the time.

During 2010/11, the Trust drew down loans of £14.3 million from the Department of Health to support its strategic investments set out in the *Our changing hospitals* programme. It was also able to spend capital up to the level of its depreciation provision of £5.7 million. The capital programme was managed successfully during the year, thus ensuring delivery of the remaining two statutory duties on top of the Trust's surplus requirement – i.e. not to exceed its external financial limit (EFL) and to achieve a 3.5% return on net relevant assets.

Turning to 2011/12, towards the end of 2011 the Trust launched *The Big Challenge* campaign with the aim of promoting the need for efficiency and productivity, while at the same time allowing all staff to have a say in where such improvements might be found. Across the Trust, posters and leaflets are being used encouraged staff to send in their ideas for saving money and/or improving productivity. To date, the response has been very encouraging and it is clear that *The Big Challenge* will make a positive contribution in the work being undertaken to make the Trust ever more efficient in how it uses resources.

Capital spending

The Trust's total capital expenditure during 2010/11 was £19.8 million, with projects including:

- **Lister's new maternity unit – £7.9 million**. 2010/11 was the most significant year for this building project, during which it was completed. Work continues in 2011/12 to refurbish the former maternity buildings at the hospital, with full completion of the overall project due by October 2011 when the Trust's inpatient maternity and gynaecological services will be brought together finally at the Lister. This project represents phase three of the Trust's *Our changing hospitals* programme

- **Planning and enabling works for phase four of the *Our changing hospital* project – £2.8 million**. This started in 2009/10 and involves extensive preparation work prior to the anticipated major construction that will commence over the coming financial years as the Trust's remaining inpatient and emergency services are consolidated at the Lister.

- **Lister electrical infrastructure upgrade – £2.9 million**. A major electrical upgrade of the Lister site started during 2010 and will be completed by the middle of 2011. This work will provide the required power supply to service the site on the completion of the Trust's *Our changing hospitals* capital investment programme in 2014.

- **Lister multi-storey car park – £0.4 million**. Costs associated with work on the new multi-storey car park project at the Lister site, which started in September 2010. This project represents phase two of the Trust's *Our changing hospitals* programme and is critical to providing the necessary infrastructure for the future of the organisation.

In addition to the strategic items above, the Trust also used its capital spending to invest in new technology, medical equipment and estates maintenance, including:

- Medical equipment – £1.0 million plus an additional £80,000 on mattresses during 2010/11;
- IM&T – £1.2 million, which included investment in the Trust's new Data Warehouse and £110,000 on a cardiology imaging system;
- Estates maintenance – £1.3 million, of which the most significant element was the completion of the replacement lift project at the Lister (£500,000).

Financial implications of *Our changing hospitals* programme

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

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

Looking to the future

Overall, 2010/11 was an important year in terms of consolidating the Trust's continued good financial performance. It supported the progress being towards achieving NHS foundation trust status and is key to future plans to invest and modernise the Trust's hospital facilities, particularly at the Lister.

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

Going concern

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

Better payment practice code

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

The Trust has adopted the national *NHS Better payment practice code*. The target set is that at least 95% of all trade creditors should be paid within 30 days of a valid invoice being received or the goods being delivered, whichever is the later, unless other terms have been agreed previously. The Trust's performance against this target for non-NHS creditors is set out in note 10 in the annual accounts shown below.

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

Chapter 9: workforce review

Workforce statistics

In the table below, a summary of workforce-related statistics is provided for 2010/11, alongside figures provided for the previous two years. The figures are the average for the years ending 31 March.

Activity	31 March 2011	31 March 2010	31 March 2009
Staff employed (full time equivalents)	4,739.01	4,657.91	4,506
Vacancy rate	8.48%	7.79%	8.5%
Turnover rate	10.0%	8.87%	8.7%
Sickness rate	4.54%	5.27%	5.7%

During 2010/11, the Trust maintained a steady vacancy rate and successful recruitment continued for newly qualified nurses and support workers. Sickness levels continue to decrease, following the introduction of an improved absence policy and robust management of the processes involved.

Recruiting and retaining staff

The Trust's staff are its most important and valuable resource. It cannot strive to deliver high quality, ever-improving services if the Trust does not recruit and retain an excellent workforce. That is why the Trust works hard to ensure that its staff are trained well, motivated and supported. The Trust continues to develop recruitment and retention strategies that underpin its core business of putting patients first and promoting the Trust as an employer of choice.

The Trust enjoys a generally positive reputation as being a good employer, both locally and nationally. Within Hertfordshire, it continues to work in partnership with the education sector in promoting careers within the NHS. The Trust also works in partnership with the local community to develop pathways into employment for disadvantaged groups.

A highly skilled workforce

The Trust is committed to having a highly skilled and flexible workforce, which is achieved through continued investment in the personal development of its staff. In 2010/11, the Trust supported its staff in various training programmes; further increased emphasis was also placed on all staff completing the Trust's annual appraisal process, which helps identify people's development needs.

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

- 72 candidates completed apprenticeships in 2010/11, with a further 159 commencing apprenticeship programmes last year in a range of roles and subjects;
- 2,176 members of staff received IT skills and systems related training;
- There were 499 attendances on the Trust's in-house management and personal skills development courses;
- Over 100 lines managers at various levels throughout the organisation completed, or are in the process of completing, comprehensive leadership and management development programmes;
- 436 staff members completed e-learning programmes in the subject of equality and diversity.

Medical education and training

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

Medical education board	
Chairman and director of education	John Saetta
Clinical tutors	Shahid Khan, Tim Lane, Deepak Jain, Diane Harvey and Nicola Anyanena (Mount Vernon Cancer Centre)
Undergraduate tutors	Mary Lynch
Associate clinical tutor for SAS doctors	Amin Salem
Centre manager	Christine Crick
Foundation programme representation	FY1 – Poppy Flannagan FY2 – Michele Cheminant

The Trust has in excess of 300 medical training posts and there are active postgraduate centres run by the clinical tutors at the QEII and Lister, as well as the Mount Vernon Cancer Centre. The Trust's well-stocked medical libraries contain facilities for CD-ROM and online literature searches.

The Trust's medical education board, which comprises clinical tutors, consultant staff and other senior staff, oversees and plans for high quality multi-disciplinary education and training throughout the organisation. All consultants are required to contribute to the Trust's education programmes for junior medical staff.

Very close links exist between the Trust and the UCL Partners (UCLP) academic health sciences cluster, which amongst others includes University College London and the Royal Free Hampstead NHS Trust, as well as with Cambridge University Hospitals NHS Foundation Trust, in respect of linked foundation programme posts, the teaching of medical students and rotational training posts.

Nursing and midwifery education and training

Mandatory training remains a priority for the Trust's nurse education team. The programme was redesigned in 2009 to provide acute care, theatre, midwifery and general pathways. Clinical skills training are offered to the Trust as part of the internal training programme. Newly registered nurses continue to be offered a preceptorship programme, which is now delivered in-house.

Since 2009, clinical support workers recruited by the Trust are employed as apprentices in health and social care. In 2010/11, the Trust exceeded the NHS East of England target for such apprenticeships – see below for more detail.

Quality clinical leadership remains a high priority within the Trust's nurse education programme and significant progress has been made within the organisation when supporting county and region-wide initiatives. During 2010/11, 11 clinical managers completed the Trust's effective leader programme.

Apprenticeships

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

Apprenticeships were first implemented in the Trust back in August 2009 for all new clinical support workers recruited into band two positions and existing clinical staff who did not already possess a level two qualification. These clinical support workers are employed into a vacancy on a one-year, fixed-term contract; they are interviewed prior to the end of their contract, subject to set conditions being met, with the aim of gaining a substantive post within the organisation. Apprenticeships are now also being promoted in non-clinical areas.

Apprenticeships commenced between August 2009 and April 2010		
Health and social care	86	Level two
Health award	15	Level three
Business and administration	5	Level two
Customer care	7	Level two/three

Apprenticeships commenced between April 2010 and March 2011		
Health and social care	79	Level two
Health award	48	Level three
Business and administration	19	Level two
Customer care	8	Level two/three
Decontamination	13	Level three

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

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

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

Improving staff experience

The Trust is aware that staff work best for patients when they are able to have a healthy balance between their work and other aspects of their lives. Through undertaking an annual staff survey, the Trust aims to provide its staff an opportunity to give feedback on areas of their work life – including their training and development, health and wellbeing, flexible working opportunities, communication and the way they are managed. Results are communicated back to staff, with action plans developed to address areas for improvement.

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

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

Equal opportunities

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

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

The Trust's *single equality scheme* outlines how the Trust can meet the duties placed upon it by relevant equality and human rights legislation and requirements. Progress on delivering the scheme is monitored by the Trust Board, with action plans reviewed annually. The scheme is published on the Trust's website.

Disability policy

The Trust's recruitment procedures adhere to the statutory requirements for the Disability Discrimination Act. Furthermore, the Trust is committed to gaining and retaining the nationally recognised *Disability Two Ticks Standard*, which marks commitment to the employment, development and retention of people with a disability. In order to use the *Two Ticks Standard* award symbol, organisations such as the Trust must take action on five set areas.

Occupational health policy

The Trust's occupational health team provides an organisation-wide service offering clinical assessment and implementation of the health status of workers, including 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 is focussing currently on achieving full accreditation as an occupational health service.

The team also supports the Trust in the formulation and delivery of its workforce strategy. This work 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 interventions to understand and improve the health and wellbeing of staff.

During 2010/11, the team's achievements included: an effective staff vaccination campaign to support the Trust's swine 'flu response; support for the changes in the Trust absence management policy; work to develop a Health and well-being strategy; and contributing to the Trust's sustainability agenda.

Health and safety

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

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

The Trust has an accredited local security management specialist and it is a partner in local crime and disorder partnerships. It is also committed to conflict resolution training, with all staff required to attend training that is delivered to a nationally agreed syllabus. The Trust continues to deliver such training.

Whistle-blowing policy and procedure

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

Chapter 10: staff, patient and public engagement

Engaging with the Trust's staff

Informing and consulting staff

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

- **Trust Brief** – monthly cascade briefing process, which reports discussions that take place on strategic issues taken in public session at Trust Board meetings;
- **Quarterly open staff briefings** – quarterly meetings open to all staff and held on each of the Trust's four hospitals sites through which the executive team presents and discuss major strategic issues – especially the on-going *Our changing hospitals* programme. Those attending are expected to carry the discussion back to their teams;
- **Road shows/briefings** – where the views and input of staff is required on specific projects and changes, the Trust seeks to take issues out to them – either in full, open-house session which anyone can attend, or to individual departmental and/or team meetings;
- **Workshops** – dedicated time where invited staff can debate specific issues relating to aspects of major strategic projects being worked on by the Trust.

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

- **The Knowledge Centre** – the Trust's staff Intranet service has grown to become one of the single biggest sources of general information within the Trust;
- **Trust Bulletin** – weekly newssheet issued through the Trust's all staff e-mail service, carrying a wide range of operational information;
- **Our changing hospitals e-newsletter** – issued roughly every month electronically to all Trust staff, provide general updates on the *Our changing hospitals* programme, providing links through to dedicated information pages on the Trust's Intranet service, the Knowledge Centre;
- **Surgical services bulletin** – a weekly electronic bulletin provided to all staff outlining changes being made to the Trust's surgical services in preparation for the opening of the Lister Surgicentre in 2011;
- **Grapevine** – now published for the Trust's staff, volunteers and public members, the Trust's quarterly newsletter has been an unqualified success since its launch in 2003. Grapevine provides staff with a unique platform through which their contributions can be recognised by their colleagues;
- **Patient Safety Matters** – bi-monthly newsletter produced in-house at the Trust and aimed at highlighting and promoting patient safety issues.

Trust Partnership

Running alongside all of these staff communication and involvement activities, the Trust also has a history of positive working relationships between staff and management side representatives through *Trust Partnership*. With the chair of this group alternating between staff side representatives and the Trust's director of human resources, Trust Partnership meets every month.

This very important forum is used to discuss and agree a wide range of issues, including new and updated Trust policies and change management issues. Through Trust Partnership, staff side representatives are invited to sit on a wide range of committees and project groups – ranging from the likes of the equality and diversity committee through to various *Our changing hospitals* project groups.

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

Listening to staff

The 2010 NHS staff survey, published by the Care Quality Commission, found that the Trust is in the best performing 20% of NHS trusts in the following areas:

- Quality of job design;
- Agreeing their role makes a difference to patients;
- Appraised in the last 12 months;
- Having well structured appraisals;
- Percentage of staff suffering work-related stress;
- Reporting errors, near misses or incidents witnessed;
- Experiencing physical violence from patients/relatives;
- Experiencing physical violence from staff;
- Staff job satisfaction.

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

- Effective team work;
- Percentage of staff working extra hours;
- Percentage of staff receiving job relevant training and development;
- Fairness and effectiveness of incident reporting.

The Trust is working in partnership with staff side representatives to address issues of concern and develop action plans to make improvements where necessary.

Patient and public engagement

Overview and scrutiny

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

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

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

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

Recent examples of work with the county council's health scrutiny committee include the Trust's participation in a NHS budget scrutiny workshop, discussion of priorities for *quality accounts*, fact-finding visits to the new Lister Surgicentre and maternity unit and a briefing on progress and learning from the Trust's *Our changing hospitals* programme.

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

Hertfordshire LINk

The Hertfordshire LINk was established in early 2008, since when the Trust has sought to work closely with the LINk since its creation.

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

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

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

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

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

Involvement committee

Under new terms of reference agreed in June 2010, the purpose of the Trust's *Involvement committee* has been to provide a forum that enables stakeholders, and through them, the wider community to be informed of, as well as involved in, the planning, monitoring and shaping of the Trust's services and to support continuous improvement in line with the organisation's strategic aims. It also allows members to share local priorities and identify areas that the group can work on collaboratively.

The committee's membership consists of managers from across the Trust, including clinical, nursing, strategic, engagement, governance and voluntary services, as well as representatives from Hertfordshire LINks, disability organisations and patient groups. With the addition of the Trust's 12 appointed shadow governors, local authorities are now represented and the group has broadened to include representation from the county council, university, black and minority ethnic (BME) groups and local commissioners.

The committee has adopted three Trust-led work streams as standing agenda items in order to provide structure for each of its meetings:

- Membership – recruitment and engagement;
- Public/patient experience;
- Service development and redesign.

Topics for discussion under the latter two themes are decided by the committee itself.

Local strategic partnerships

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

The Trust is a member of several district LSPs, including North Hertfordshire, Welwyn Hatfield's Welhat Alliance and East Hertfordshire; it also has links with the Stevenage LSP. The Trust contributes to the development of all sustainable community strategies locally, including the county-wide plan, *Herts Forward*.

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

Annual report and accounts – public consultation

Consultation process

As in previous years, the Trust conducted a consultation on the contents of its 2009/10 annual report and accounts, with the aim of helping to improve further the content of, and access to, the 2010/11 document. On 7 April 2011, the Trust issued its questionnaire – via e-mail – to 487 people, including: Trust and other NHS staff locally; FT members; patient group representatives; local authority councillors; MPs; and newspaper editors.

The response deadline was set as 20 April 2011, by when feedback from eight individuals was received – the same as last year (although the questionnaire was sent to more people this time round).

Outcome findings
The response rate, at eight out of 487 people, was just 1.64% – which is lower than previous annual report consultations undertaken over the last four years. While this would suggest that it is important not to draw too many hard and fast conclusions from such a low response level, feedback of note included:

- Overall people appeared happy with the report's content – including those who had received it only as part if the consultation process;
- As was the case last year, there was no preference from respondents suggesting additional routes in how the document is shared with people other than those used already (hard copy mailing, e-mail with PDF attachment and downloaded via the Trust's website);
- No suggestions were made about additional formats required other than those available already (normal and large print versions);
- There was recognition for the clear layout and readability of the report despite its comprehensive nature; this led some to suggest a need for a summary document, which of course was produced last year.

Actions for 2010/11 annual report
Following this year's consultation, the following actions were considered in terms of developing the 2010/11 annual report and accounts:

1. Broadly speaking, the annual report meets people's information needs;

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

    - Future projects, including *Our changing hospitals* and related programmes
    - Clinical, operational and financial performance overview for 2009/10
    - Impact of the Government's health reforms, including on staff development and levels of frontline clinical staff
    - Progress towards achieving NHS foundation trust status – including one request seeking assurance that the Trust would continue holding board meetings in public
    - Staffing arrangements
    - Future for the Mount Vernon Cancer Centre and its new academic research project
    - Setting the report in the context of the health needs of the local population

3. Some desire to see an executive summary report, along the same lines of the annual review produced for 2009/10;

4. Preference to continue receiving the full report and/or annual review as PDF attachments sent by e-mail, or downloaded from the Trust's website.

Where consultation respondents raised questions in their completed questionnaires, responses from the Trust were sent prior to this report being compiled.

Chapter 11: sustainability

Environmental impact

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

- Heating, cooling and lighting buildings;
- Powering equipment; procuring goods and commissioning services;
- Sending waste to landfill;
- Patient, staff and visitor travel.

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

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

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

National and international targets

The Trust, along with the NHS in general, is subject to a number of national and international schemes and targets. These are set out below

The Kyoto Protocol established a framework for nations to work towards the achievement of sustainable emissions levels. This commits the UK government to reducing emissions of CO_2 in stages, reaching a 60% reduction in emissions by 2050.

In April 2001, the Secretary of State for Health set mandatory energy targets for healthcare organisations. These are set out in the following table.

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

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

The NHS carbon reduction strategy has been developed in response to the need to take action on climate change, in consultation with the NHS and other organisations. It establishes that the NHS should have a target of reducing its 2007 baseline carbon footprint by 10% by 2015 and that healthcare regulators should ensure that sustainability and the environmental impact of services are an integral part of quality standards.

The European energy performance of buildings directive took effect in 2006 and will be implemented through *Building Regulations*. One of the main provisions is for certain buildings to display an energy certificate and an energy label. The Trust has complied with this requirement for all of its relevant buildings

The carbon reduction commitment was implemented from April 2010 and applies to any estate that uses more than 6,000MWh per year – equivalent to an annual electricity bill of £500,000; all of the Trust's hospital sites fall within this reduction commitment. The Trust has been advised that major changes are proposed and the scheme will now be a carbon tax on all carbon emissions. This tax is expected to be £12/Tonne of carbon for phase 1 of the carbon reduction scheme, which equates to a carbon tax of £204,000.00 for the entire Trust at present CO_2 emission levels payable in the summer of 2012. As a result, the Trust needs to consider very seriously energy saving schemes with a reasonable pay back (five years or less) that will reduce its carbon emissions so that on-going revenue savings can be achieved, together with a reduction in carbon tax (i.e. creating double savings).

The EU emission trading scheme is a statutory requirement for NHS installations of 20 megawatts or more thermal capacity per site to register with the Department for Environment, Food and Rural Affairs. The Trust's hospital sites just fall outside of the threshold for this scheme at the present time.

What is the Trust's current position?

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

The Trust has signed up to the *Good corporate citizenship assessment model* and produced a Board-approved sustainable development management plan, as required under the NHS carbon reduction strategy. This includes:

- A number of initiatives set out through the Trust's *green transport plan*, which between them seek to promote more sustainable forms of transport;

- In terms of the Trust's energy consumption, it has seen a 30% reduction in the cost paid for electricity Trust wide over the past two years but with a 3.5% increase in CO_2 emissions. With gas there has been 22% reduction in cost paid for gas over the past two years, but with an increase in CO_2 emission as the direct result of the very bad winter (worst in 20 years). The Trust has been registered with the carbon reduction scheme from April 2010 and complies with the Government target for 10% of the electricity supply purchased to come from a renewable resource;

- The Trust invested £1.7 million in 2009/10, £2.9 million in 2010/11 and plans to spend a further £0.7 million in 2011/12 for energy infrastructure upgrade work, the aim of which is both to provide greater security of energy supply and improve the efficiency of energy provision at the Lister. Business cases have also been developed for the development of a combined heat and power plant at the Lister, which on its final approval will become operational in 2012 and deliver an estimated 19% reduction to the Trust's total carbon emissions;

- A programme of initiatives for more sustainable procurement is being progressed, including catering, estates and pharmacy; a sustainable procurement policy has been introduced for IT;

- Waste initiatives now include more recycling and targets for reducing the amount of waste produced;

- A draft health and wellbeing strategy is out for consultation currently and sustainability objectives have been included in the Trust's new recruitment and engagement plans.

Chapter 12: governance and the trust board

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

The trust board

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

The Trust Board is responsible for the leadership of the Trust, setting its strategic direction, defining its objectives and monitoring its performance. Its members are accountable individually and collectively for the Board's actions. To this end, both executive and non-executive members function as a team, working closely together, although with different responsibilities.

The chairman and non-executive directors are appointed by a national body, the Appointments Commission, on behalf of the Secretary of State. The normal term of office served by the chairman and non-executive directors is four years, renewable for a further four-year period. The executive directors are appointed by the Board on permanent contracts.

The role of the NHS trust board

The Board's role includes:

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

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

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

- **Setting and maintaining values** – in setting the Trust's values and standards, the Board ensures that its obligations to patients, the local community and the NHS are understood and met.

The role of the NHS trust chairman

The chairman's role is key in creating the conditions for overall board and individual director effectiveness. The main responsibilities of an NHS chair are:

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

The role of non-executive directors

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

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

The time commitment required of non-executive directors is two and a half days per month. To add most value, non-executive duties should not extend into operational matters – which are the responsibility of the chief executive and his/her executive director colleagues.

Through focusing on strategy, as well as scrutiny of performance, risk and financial management, the non-executive directors enrich the governance of the Trust.

The chairman and non-executive directors appoint the Trust's chief executive. Together with the chief executive, the chairman and non-executive directors appoint all other executive directors and determine their remuneration.

The Trust Board 2010/11

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

Key to principal committee membership

AC – Audit committee
EC – Executive committee
FTC – Foundation trust committee
FPC – Finance and performance committee
RAQC – Risk and quality committee
RC – Remuneration committee
CTC – Charity trustee committee

Notes to Committee attendance

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

Richard Beazley, chairman

Appointed Chairman of the Trust on 1 April 2002, in 2006 Richard was reappointed for a second term which was extended to run until 30 September 2011. He is a former chief executive, international lawyer and economist. He became a solicitor in 1974 and spent 25 years working in the oil industry, including 21 years with the Mobil Oil Corporation. Of those 25 years, he spent 12 living and working abroad in Norway, Indonesia, Canada and the USA. After various assignments with Mobil working as an international lawyer and economist, Richard became chief executive of Mobil's subsidiary companies. He left the oil industry in 2000. Richard chairs the *Foundation Trust Committee* as well as the Trust Board. He lives in Standon, near Ware.

Committee membership: FTC, RC, CTC, RAQC
Attendance: Trust Board 10 out of 11; FTC 3 out of 4; RC 0 out of 1; CTC 2 out of 3; RAQC 3 out of 8

Nick Carver, chief executive

The chief executive is the accountable officer for the Trust and carries full responsibility for its performance, as well as for leadership of the executive team. Nick was appointed as the Trust's chief executive in November 2002, having been chief executive of the George Eliot Hospital NHS Trust in Warwickshire for the previous three and a half years. Nick started his NHS career as a qualified registered nurse in 1982, before joining the national management trainee scheme. Prior to becoming an NHS chief executive, Nick was director of operations and nursing at the Royal United Hospitals NHS Trust in Bath. He has also worked at the Morriston Hospital in Swansea, the Singleton Hospital in Swansea and the Gloucester Royal Hospital. In addition to holding his registered general nurse (RGN) qualification, Nick has a BA (Hons) in political theory and government, as well as an MSc in health care management. He sits on the national advisory group for NHS emerging leaders.

Committee membership: EC, FTC, FPC, CTC, RAQC (core attendee)
Attendance: Trust Board 11 out of 11; FTC 3 out of 4; FPC 9 out of 11; CTC 0 out of 3; RAQC 9 out of 10

Alison Murray, non-executive director and vice-chair (to 30 June 2010)

Alison is an adviser on research projects for applied service developments. She has experience of working in various NHS trusts – especially in developing acute services for older people, stroke services and adult mental health. She is a research psychologist, who originally trained as a nurse. Alison has experience in human resource development and staff training, having worked for the former Department of Employment and as a university officer in personnel at the University of Cambridge. Alison chaired the Trust's *Risk and Quality Committee* and was the Trust's vice-chair until her term of office ended on 30 June 2010. She lives in Ashwell, near Baldock.

Committee membership: FTC, RAQC, RC

Attendance: Trust Board 3 out of 3; FTC 1 out of 1; RAQC 1 out of 2; RC 0 out of 0

Stephen Brooker, non-executive director and vice-chair (to 31 December 2010)

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

Committee membership: AC, FTC, RC, CTC

Attendance: Trust Board 5 out of 8; AC 5 out of 5; FTC 2 out of 2; RC 0 out of 0; CTC 2 out of 2; RAQC 1 out of 1

Ian Morfett, non-executive director and vice-chair

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

Committee membership: FTC, FPC, RAQC, RC

Attendance: Trust Board 8 out of 11; FTC 0 out of 4; FPC 4 out of 4; RAQC 9 out of 10; RC 1 out of 1

Michael Gibbons, non-executive director (to 30 April 2010)

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

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

Attendance: Trust Board 0 out of 1; AC 1 out of 1; FTC 0 out of 1; FPC 1 out of 1; RC 0 out of 0; CTC 0 out of 0

Alison Bexfield, non-executive director

A charted accountant and the chief financial adviser to the BBC Trust, Alison provides its trustees with corporate governance as well as financial expertise. She also sits as an independent member of the audit committee of the Medical Research Council. Previously, she worked for seven years within the BBC's group finance function and, prior to that, for ten years as an auditor within public practice for Touche Ross (now Deloittes) and KPMG, including several years managing healthcare audits in both public and private sectors. Alison was appointed from 1 February 2008 and is due to serve until 31 January 2012. From 1 July 2010 to 31 December 2010 she chaired the *Finance and Performance Committee* and from 1 January 2011 she has chaired the *Audit Committee.* She lives in Letchworth.

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

Attendance: Trust Board 10 out of 11; AC 6 out of 6; FTC 3 out of 4; RAQC 4 out of 4; FPC 8 out of 8; RC 1 out of 1

Dyan Crowther, non-executive director

Dyan joined Network Rail as Route Director – London North Eastern in December 2004, from Arriva Trains Northern where she had been Commercial Director from March 2002 and Managing Director from October 2003. She took over the role of Route Director, Midland & Continental in May 2008 and was promoted to become Director of Operational Services in July 2010. Prior to joining Network Rail, she held a number of strategic roles within the former infrastructure company, Railtrack, and has over 20 years' experience in the rail industry. Dyan lives near Baldock and was appointed as a non-executive director from 1 July 2010.

Committee membership: FTC, RAQC, RC

Attendance: Trust Board 6 out of 8; FTC 0 out of 3*; RAQC 4 out of 8; RC 1 out of 1

**Although FTC membership has been extended to all Board members, it is recognised that Dyan's existing commitments with Network Rail conflict with FTC meetings.*

Julian Nicholls, non-executive director

Julian has spent 20 years successfully managing substantial business to business services companies in the UK and Europe, most recently as Group Managing Director of Reliance Security Group plc. He is currently chairman of Whitehill Pelham Ltd and advisor to a number of private equity owned companies. During his early career he had senior roles in sales, marketing and business development in the computer industry, and prior to that spent some time working in Africa, the Middle East and South East Asia. Julian was appointed as a non-executive director from 1 July 2010 and has chaired the *Finance and Performance Committee* from 1 January 2011. He lives in Barley, near Royston.

Committee membership: AC, FTC, FPC, RC

Attendance: Trust Board 6 out of 8; AC 2 out of 3; FTC 3 out of 3; FPC 7 out of 8; RC 1 out of 1

Douglas Smallwood, non-executive director

Between 2004 and 2010, Douglas was the chief executive of the national medical charity, Diabetes UK. Before that, he worked in corporate banking for 17 years and social housing for 10 years. Douglas is a member of the GP commissioning support team at NHS East of England, with responsibility for public and patient involvement. He lives in Hertford, where he is also secretary of the local RSPB group. In addition, he chairs the British Pain Society's patient liaison committee. Douglas was appointed as a non-executive director from 13 January 2011 and currently chairs the *Charity Trustee Committee.*

Committee membership: AC, FTC, CTC, RC, RAQC (from 1 April 2011)

Attendance: Trust Board 3 out of 3; AC 1 out of 1; FTC 2 out of 2; CTC 1 out of 1; RC 0 out of 0

James Quinn, medical director

A practising ear, nose and throat (ENT) surgeon with the Trust, James was appointed medical director from 1 April 2007 and reappointed from 1 April 2011. Prior to this, he was deputy medical director with a remit for clinical efficiency, and had been clinical director for surgical specialties for three years. James trained in ENT surgery in London and Cambridge and was appointed as an ENT consultant covering the former East Hertfordshire and North Hertfordshire NHS Trusts in 1998. He has a specialist interest in ear surgery and balance disorders.

Committee membership: EC, FTC, FPC, RAQC (core attendee)
Attendance: Trust Board 9 out of 11; FTC 3 out of 4; FPC 0 out of 11*; RAQC 10 out of 10
**It is recognised that FPC meetings conflict with James' clinical commitments*

Sue Greenslade, director of nursing (to 27 March 2011)

Appointed director of nursing in September 2008, Sue was also the Trust's director of infection prevention and control (DIPC). After qualifying as a general registered nurse, she held a number of posts in district general and London hospitals. A former director of nursing, patient services and governance at Hillingdon Hospital NHS Trust, she was the East of England Strategic Health Authority's deputy chief nurse from 2007 to 2008. Sue left the Trust on 27 March 2011 to take up a post at the Royal College of Nursing and from 28 March 2011, Philippa Davies has been Acting Director of Nursing.

Committee membership: EC, FTC, FPC, RAQC (core attendee)
Attendance: Trust Board 7 out of 10; FTC 2 out of 4; FPC 6 out of 11; RAQC 5 out of 10

Paul Traynor, director of finance

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

Committee membership: EC, FTC, FPC, CTC, required to attend AC
Attendance: Trust Board 9 out of 11; FTC 3 out of 4; FPC 11 out of 11; CTC 2 out of 3; AC 6 out of 6

Neil Dardis, director of operations

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

Committee membership: EC, FTC, FPC, RAQC (core attendee)
Attendance: Trust Board 10 out of 11; FTC 3 out of 4; FPC 10 out of 11; RAQC 9 out of 10

Stephen Posey, director of strategic development

Stephen joined the Trust in January 2008 from the East of England Strategic Health Authority (SHA), where he had been its provider development and foundation trust lead. Prior to his time at the SHA, he had undertaken a number of senior management roles within acute trusts, the Department of Health, strategic health authorities and primary care trusts across the East of England. Stephen has lead director responsibility for business development, partnerships, involvement, sustainability and facilities as well as strategic development. He is responsible for delivery of the Trust's *Our changing hospitals* programme to consolidate acute services at the Lister hospital. This forms part of the Hertfordshire-wide *Delivering quality health care for Hertfordshire* (DQHH) programme.

Committee membership: EC, FTC, FPC, CTC
Attendance: Trust Board 11 out of 11; FTC 2 out of 4; FPC 10 out of 11; CTC 3 out of 3

Janet Lynch, director of human resources and organisational development (to 3 September 2010)
Janet took up her post on 1 October 2007, joining from Barnet, Enfield and Haringey Mental Health NHS Trust where she had been director of human resources for over five years. Prior to that, she had held a similar post at Riverside Community Healthcare NHS Trust in west London. Janet originally joined the NHS in 1986 on a personnel management training scheme with the former Mersey Regional Heath Authority. She then held a range of human resources posts in health organisations in the North-west. Janet left the Trust on 3 September 2010 to take up a post as director of human resources and organisational development at Heatherwood and Wexham Park NHS Foundation Trust.
Committee membership: EC, FTC, FPC (attendee)
Attendance: Trust Board 3 out of 4; FTC 1 out of 1; FPC 3 out of 4

Alex O'Grady, interim director of human resources and organisational development (from 6 September 2010)
Alex has worked at Board and senior level for over 25 years, including eight as HR Director of an acute NHS Trust, and she was one of the first Secretary of State Beacon Award winners for her work in organisation development. She has also worked at national level with the Department of Health and the Home Office, developing national leadership and organisation development strategies and programmes. This work included developing a national HR leadership programme for HR Directors in the NHS. A former member of the Board Development Faculty of the Clinical Governance Unit, she has worked with NHS Trust boards to develop robust governance arrangements and culture. In 2002 Alex became an independent consultant, working primarily in the NHS in the field of organisation and leadership development.
Committee membership: EC, FTC, FPC (attendee)
Attendance: Trust Board 6 out of 7; FTC 0 out of 3; FPC 5 out of 7

	Title	Appointment date	Term(s) of office	Term of office ends
Richard Beazley	Chairman	1 April 2002	Four years, plus four years, plus 18 months	30 September 2011
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Murray[1]	Vice-chairman	1 August 2000	Four years plus two years plus seven months	30 June 2010
Stephen Brooker[1]	Non-executive director and vice-chairman	17 April 2000	Four years plus four years	31 December 2010
Ian Morfett	Non-executive director and vice-chairman	1 August 2005	Four years plus four years	31 July 2013
Alison Bexfield	Non-executive director	1 February 2008	Four years	31 January 2012
Dyan Crowther	Non-executive director	1 July 2010	Four years	30 June 2014
Michael Gibbons	Non-executive director	1 June 2007	Four years	30 April 2010 (resigned)
Julian Nicholls	Non-executive director	1 July 2010	Four years	30 June 2014
Douglas Smallwood				
Neil Dardis	Director of operations	6 June 2008	n/a	n/a
Sue Greenslade	Director of nursing	22 September 2008	n/a	n/a
James Quinn	Medical director	1 April 2007	Four years plus four years	31 March 2015
Paul Traynor	Director of finance	1 May 2009	n/a	n/a
Janet Lynch[2]	Director of human resources	1 October 2007	n/a	3 September 2010
Alex O'Grady	Director of human resources	6 September 2010	n/a	When substantive appointment is made
Stephen Posey[2]	Director of strategic development	21 January 2008	n/a	n/a

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

Remuneration and interests

The remuneration of individual directors can be found in the accounts section of this annual report. All the Trust's directors – both executive and non-executive – make annual declarations of directorships and/or other interests they hold that are relevant and material to NHS business matters. This register of directors' interests can be inspected at the Trust's premises; alternatively, a copy can be supplied on request.

For further information, please contact:

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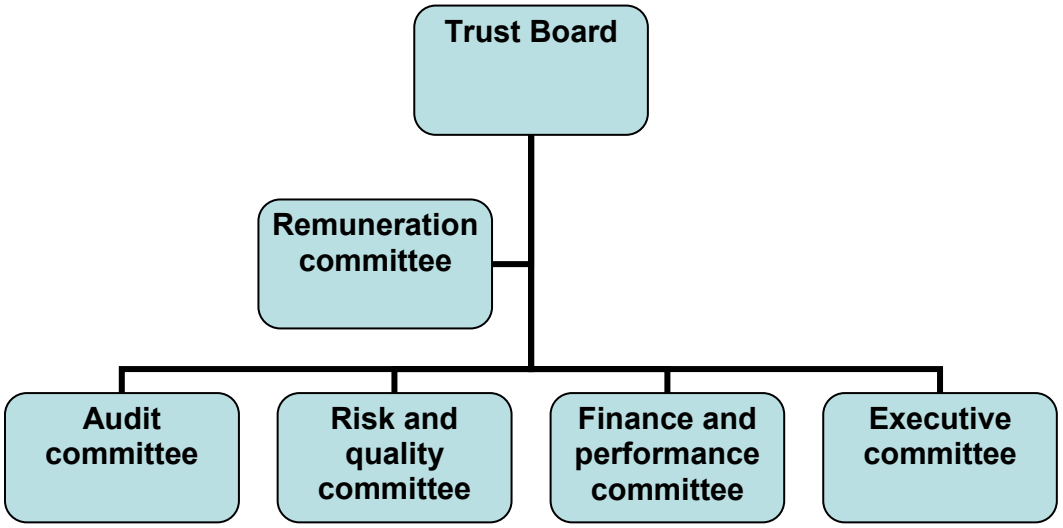
Governance structure

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



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

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

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

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

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

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

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

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

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

External auditor

Owing to the special accountabilities attached to public money and the conduct of public business, the Audit Commission – independently of the Trust – appoints external auditors. The *Audit Commission Act 1998* sets out the role of the Audit Commission in the appointment of external auditors for NHS bodies. It appoints auditors from its own staff, as well as from private firms of auditors. For 2010/11, the Trust's external auditor was Grant Thornton UK LLP.

Private finance initiative (PFI) schemes

Currently the Trust is involved in one PFI scheme, which is the new Hertford County hospital that opened in November 2004. The hospital is an £8.5 million PFI scheme, which was built, and is operated, by Ryhurst Ltd. The scheme involves an annual unitary payment of approximately £1 million. This fee is payable until 2034, when the hospital reverts to NHS ownership. Further information is provided in note 24 of the accounts section. The capital investment associated with the Trust's plans to reconfigure its acute hospital services will be funded through Trust borrowing.

Fixed assets

As set out in note 1 of the 2010/11 accounts section, fixed assets are stated at the lower of replacement cost and recoverable amount. An annual review is carried out for any potential impairments and a formal revaluation of land and building values is carried out at least every five years. It is the directors' opinion that there are no fixed assets where the market value is significantly different from the value included in the financial statements.

The Department of Health has changed the policy for recording the brought-forward values for land and buildings. For land (freehold and leasehold), buildings and dwellings, the cost, valuation and depreciation is shown as previous years' cost, valuation and depreciation. It is no longer the *closing net book* value bought forward into the cost and valuation opening balance.

Post balance sheet events

There have been no post balance sheet events to the 2010/11 accounts.

Transition to International Financial Reporting Standards

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

In accordance with Department of Health policy, the Trust values its land and building assets using modern equivalent asset methodology (MEA). This has reduced the asset values shown on the balance sheet by £2 million. IFRS states if values fall below their historical cost, the shortfall should be charged to the operational costs of the organisation in the year of revaluation. As such, in 2010/11 the Trust has recorded an impairment cost of £2 million, which forms part of retained deficit total for the year shown under the annual accounts section of this report in the *Statement of comprehensive income*.

Accounting standards issued but not yet adopted.

IFRIC 19 *Extinguishing financial liabilities with equity instruments* is effective from 1 July 2010. Neither the Treasury FReM, nor the Department of Health's manual for accounts, require this standard to be applied in 2010/11. The application of the IFRIC 19 would not have had a material impact on the Trust accounts in 2010/11, however, had it been applied.

Pension liabilities

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Although the scheme is a defined benefit scheme, it is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. The cost to the NHS body, therefore, of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The full accounting policy can be viewed under note 1.5 and valuation details under note 9 in the annual accounts contained in this report.

Severance payments

Special severance payments when staff leave public service employment are exceptional and will always require Treasury approval. The Trust has no delegated authority to make such payments unless so approved. No such severance payments were made during 2010/11.

Information governance

All NHS trusts are required to carry out an annual self-assessment against information governance requirements defined in the *Connecting for Health* information governance toolkit. The latter seeks assurance on all aspects of information relevant to the Trust's business and comprises a total of 45 measures, which cover:

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

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

For 2010/11 the Trust achieved the minimum level two compliance for all the statement of compliance measures against the Information Governance Toolkit; overall the Trust's score improved from the previous year.

Serious untoward incidents relating to the Data Protection Act reported to the Information Commission Office (ICO) during 2010/11				
Date of Incident	**Nature of incident**	**Nature of data involved**	**Number of people potentially affected**	**Notification step**
14/05/2010	Loss of unencrypted USB stick	Minimum patient identifiers and limited clinical information using medical abbreviations	200	PCT, SHA and ICO informed immediately
Further action on information risk	All Trust USB sticks now encrypted; technical solution on Trust network only permits encrypted Trust USB sticks to be used.			

Summary of other personal data-related incidents in 2010/11		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secure NHS premises	3
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1
IV	Unauthorised disclosure	15
V	Other	7

Remuneration report

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

The Trust's *Remuneration committee* agrees the remuneration package and conditions of service for executive directors. In addition when undertaking its nomination responsibilities, the committee reviews the structure, size and composition (including skills, knowledge and experience) required of the Board of Directors compared to its current position and makes recommendations for change when appropriate. It also considers succession planning arrangements for directors and other senior executives. This is a committee of the Trust Board, consisting of the chairman and all the non-executive directors. Remuneration for executive directors does not include any performance-related bonuses and none of them receive personal pension contributions other than their entitlement under the NHS pension scheme.

During 2010 the Trust reviewed the *Remuneration committee* and its terms of reference to ensure it meets the latest national guidance. The committee is now chaired by the vice chairman, Ian Morfett, and meets quarterly to agree the remuneration policy and practice for executive directors. Details of directors' remuneration are given in the annual accounts.

Every year, the *Remuneration committee* considers the contribution of each director against the functions of the post as defined in the current job description and as foreseen for the future. This is carried out in parallel with a review at least every two years of remuneration for individual posts within regional and national markets. In 2011, the committee took into account a benchmarking report prepared by an external body.

The Trust is in the process of recruiting into the recently vacant posts of director of human resources and director of nursing; all other executive directors hold permanent contracts. The notice period for executive directors is generally three months, although it is six months in the case of the director of finance. There are no arrangements for termination payments or compensation for early termination of contract. The Trust is also not liable for any compensation payments to former senior managers or amounts payable to third parties for the services of a senior manager.

The remuneration and terms of office of non-executive directors are those set out by the Appointments Commission. The level of remuneration is paid for a minimum of two and a half days per month for non-executive directors and four days per week for the chairman.

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

Nick Carver
Chief Executive

Salary and pension entitlements of senior managers

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

Remuneration

Name and title	2010/11			2009/10		
	Salary	Other remuneration	Benefits in kind	Salary	Other remuneration	Benefits in kind
	(bands of £5000)	(bands of £5000)	Rounded to the nearest	(bands of £5000)	(bands of £5000)	Rounded to the nearest
	£000	£000	£000	£000	£000	£000
Executive directors						
Nick Carver	155-160	0	2.4	160-165	0	0.9
Chief executive						
Paul Traynor	135-140	0	3.9	125-130	0	6.6
Director of finance						
Sue Greenslade (01/04/10 to 27/03/11)	105-110	0	0.1	100-105	0	0.1
Director of nursing						
James Quinn	50-55	0	0.2	50-55	0	0.3
Medical director						
Neil Dardis	105-110	0	0.4	100-105	0	0.4
Director of operations						
Stephen Posey	90-95	0	0.4	95-100	0	0.4
Director of strategic development						
Janet Lynch (01/04/10 to 03/09/10)	40-45	0	0.1	95-100	0	0.3
Director of human resources						
Alex O'Grady (from 06/09/10)	75-80	0	0	0	0	n/a
Interim director of human resources						
Non-executive directors						
Richard Beazley	20-25	0	0	25-30	0	0
Chairman						
Alison Murray (term ended 31/06/10)	0-5	0	0	6-10	0	0
Vice-chair						
Stephen Brooker (term ended 31/12/10)	0-5	0	0	6-10	0	0
Michael Gibbons (resigned 30/04/10)	0-5	0	0	6-10	0	0
Ian Morfett	6-10	0	0	6-10	0	0
Alison Bexfield	6-10	0	0	6-10	0	0
Douglas Smallwood (from 13/01/11)	0-5	0	0	0	0	0
Julian Nichols (from(01/07/10)	0-5	0	0	0	0	0
Dyan Crowther (from 01/07/10)	0	0	0	0	0	0

Notes to remuneration table

Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. The medical director's remuneration quoted in the table above relates to senior manager duties only. Please note that the director of finance salary figures for 2010/11 reflect a full year salary; while the figures shown in 2009/10 are for part-year only. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, having the effect of reducing the salary paid during 2010/11.

Pension benefits

Name and title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2011	Lump sum at aged 60 related to accrued pension at 31 March 2011	Cash equivalent transfer value at 31 March 2011	Cash equivalent transfer value at 31 March 2010	Real (decrease) in cash equivalent transfer value	Employer's contribution to stakeholder pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Nick Carver Chief executive	0-2.5	7.5-10	45-50	145-150	792	853	(61)	0
Paul Traynor Director of finance	0-2.5	5-7.5	30-35	95-100	384	430	(46)	0
Sue Greenslade Director of nursing	0-2.5	5-7.5	35-40	115-120	580	641	(61)	0
Neil Dardis Director of operations	0-2.5	5-7.5	15-20	55-60	183	206	(23)	0
Stephen Posey Director of strategic development	0-2.5	0-2.5	15-20	45-50	139	167	(28)	0
Janet Lynch Director of human resources	0-2.5	10-12.5	30-35	95-100	442	466	(24)	0

Notes to pensions table

As non-executive members of the Board do not receive pensionable remuneration, there are no entries in respect of pensions for these individuals. This also applies to the medical director; in the same way remuneration for this role is not pensionable and thus this post is not listed above.

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

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

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

The Government Actuary has undertaken a review of all common market valuation factors following the change announced by the Chancellor in the budget of the move from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI) for the up-rating of public sector pensions. This has had the effect that the 31st March 2011 CETV figures are lower than the previous year. The real reduction in CETV also takes into account the increase in accrued pension due to inflation, along with any contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

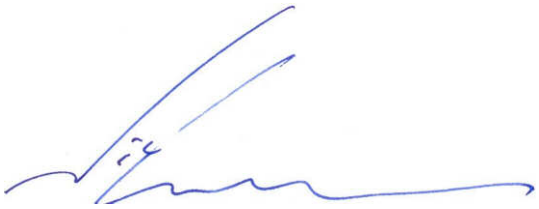
Chapter 13: annual accounts for 2010/11

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

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

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

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

Signed  Chief Executive

Date: 26 May 2011

Statement of directors' responsibilities in respect of the accounts

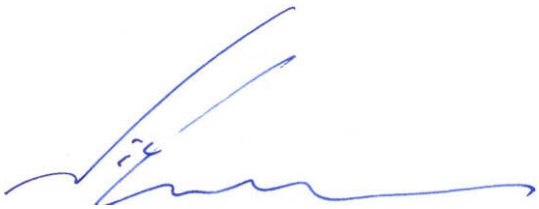
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised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

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

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

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

By order of the Board

Date: 26 May 2011  Chief Executive

Date: 26 May 2011 Finance Director

Statement of internal control

Scope of responsibility

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

In undertaking this role I, and my team, have developed strong links with the Strategic Health Authority, local primary care trusts and partner organisations.

From 1 April 2010 to January 2011 the responsibility for ensuring that there is a comprehensive risk management system in place was delegated to the director of finance, who was also responsible for corporate and information governance. Due to organisational changes, from January 2011 the risk management and corporate governance responsibilities have been delegated to the company secretary. In addition, I have delegated: clinical governance and health and safety and security management to the director of nursing; clinical governance and the co-ordination of the management of all clinical risks to the medical director; financial and IM&T risks to the director of finance; emergency planning to the director of operations; estates and sustainability management to the director of strategic development; and human resources and organisational development to the director of human resources.

More detail on individual director accountabilities are set out in the Trust's *risk management strategy* and *corporate governance assurance* map.

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 the East and North Hertfordshire NHS Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

- Leadership is given to the risk management process;
- Staff are trained and equipped to manage risk in a way appropriate to their authority and duties.

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

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

Support and training to staff is provided through the Trust's risk management team.

The risk and control framework

Objectives

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

- Maintain and seek continually to improve the quality of healthcare provided by the Trust through the minimisation of risk;
- Identify and control risks which may affect adversely the Trust's operational ability;
- Develop a fair and just culture;
- Provide and maintain a safe and secure environment for patients, staff and visitors;
- Encourage and support innovation and service developments within a framework for risk management;
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer of risk. Otherwise ensure the organisation accepts openly the remaining risks;
- Create awareness throughout the Trust about the importance of actively managing risk;
- Ensure risk management systems and processes are clear and understood by all staff;
- Develop all staff to ensure they have the knowledge and skills in risk management appropriate to their role;
- Support compliance with regulatory bodies including, registration with the Care Quality Commission, Monitor (on gaining NHS foundation trust status) and the Health and Safety Executive, as well as maintaining and improving compliance with NHS Litigation Authority's risk management standards.

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

Board assurance and reporting

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

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

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

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

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

- Provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused;
- Review and monitor the *board assurance framework* and the *corporate risk register*, ensuring appropriate action is taken to mitigate risks where possible and advising the Board where acceptance of risk may need to be considered;
- Monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS Litigation Authority (NHSLA), Clinical Negligence Scheme for Trusts (CNST), Health and Safety Executive (HSE), Strategic Health Authority (SHA), the risk elements of the Auditors Local Evaluation (ALE), and ensure action is taken for compliance;
- Monitor and advise the Board on compliance with the *Hygiene Code*;
- Endorse, monitor and receive reports on the implementation of the Trust's key quality, clinical outcome, patient safety and patient experience strategies and indicators;
- Provide regular risk management reports to the Trust Board;
- Liaise with the *Audit committee* and the *Finance and performance committee*.

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

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

<u>Assurance framework and risk register</u>

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

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

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

- **Business and service delivery plans** – i.e. principal risks to the Trust achieving key performance standards;
- **Adverse incident forms** – if it is apparent from an adverse event form, or subsequent investigation into the adverse event, that there is a significant risk then it will be transferred to the *risk register*;
- **Health and safety risk assessments** – Health and safety risk assessments are a legal obligation for the Trust, and managers are responsible for ensuring these assessments are undertaken. Any risk identified from these assessments will be included on the *risk register*;
- **Local risk assessments** – where local assessments have identified risks;
- **External assessment/audit** – significant risks identified by any internal/external audit, e.g. Care Quality Commission, NHS Litigation Authority, HSE notices will be placed on the *risk register*;
- **External guidance/alerts** – NICE, NSFs, etc that are not yet implemented;
- **Results of feedback** – learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices etc.

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

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

Control measures - information governance

The *assurance framework* and *risk register* include the risks associated with the management and control of information. In this respect the Trust also has an *information governance statement of compliance* (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage. This year, the Trust achieved the minimum level two compliance for all the statement of compliance measures against the *Information Governance Toolkit*. Overall the Trust's score improved from the previous year and work continues to improve areas of risk, including data quality risks relating particularly to clinical coding accuracy and information governance mandatory training in order to achieve 95% compliance by the end of June 2011.

The Trust self-reported one information governance serious incident (SI) relating to the Data Protection Act to the Information Commission Office (ICO) in May 2010. The Trust undertook both an internal serious incident investigation and a disciplinary investigation. An action plan was developed to implement the lessons learnt and mitigate the risks of reoccurrence. This included completing the roll out of encrypted memory sticks and implementation of port control.

The management of this incident was monitored by the information governance steering group and is now closed. The ICO found the Trust in breach of the seventh data protection principle of the Data Protection Act and I have signed an undertaking to ensure that personal data is processed in accordance with this principle.

Control measures – business continuity

Business continuity planning and emergency preparedness have been identified as one of the Trust's key strategic risks. The *Risk and quality committee* receives regular reports on the Trust's approach to emergency planning and its position against these works. On 5 January 2011, the Trust invoked its own major incident plan when the power supply at the QEII was affected severely following the failure of one of the main power cables, causing disruption and a loss of power to the lifts in the hospital's tower block, critical care units and a number of wards and departments. The incident was managed successfully in that power was restored without major disruption to patient services. Lessons learnt from the incident have been reported fully to both the *Risk and quality committee* and Board.

Control measures – equality and diversity

The Trust's *Policy of policies* sets out the requirements for equality impact assessments (EIA). EIAs undertaken for policies and service development consultations are considered and published on the Trust website. Training on EIA has been provided to support the embedding of this process. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Control measures – NHS Pension

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

Control measures – climate change

The Trust has undertaken a climate change risk assessment and developed an *adaptation plan* to support its emergency preparedness and civil contingency requirements, based on the UK Climate Projections 2009 (UKCP09), to ensure that this organisation's obligations under the Climate Change Act are met.

Control measures – Care Quality Commission

The Trust has an established assurance process to ensure that it complies with the Care Quality Commission registration requirements and associated essential standards of quality and safety. Each outcome measure has an identified accountable lead executive director and outcome lead. Compliance reports are completed for each of the core outcomes and an established process is in place to undertake a formal internal review of compliance twice a year. The *Risk and quality committee* has held directors to account, and has requested and received reports relating to specific outcomes during the reporting year; this has been informed by internal and external reviews, *board assurance framework*, *risk register* and internal assurance map.

The Trust is compliant fully with the Care Quality Commission's essential standards of quality and safety.

Review of effectiveness

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

The Trust's head of internal audit, through assessments of the overall adequacy and effectiveness of the organisation's risk management, control and governance processes, along with outcomes of the risk-based audit assignments that have been reported throughout the year, has provided me with an overall opinion that:

> *Based on the work undertaken in 2010/11, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and inconsistent application of controls put the achievement of particular objectives at risk.*

Where individual weaknesses have been identified, comprehensive action plans have been put in place to address these and evidence collated to support implementation.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The *assurance framework* itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the external auditors, Care Quality Commission inspections, quality risk profile, self-assessment against the Care Quality Commission essential standards of quality and safety and NHS Litigation Authority and Clinical Negligence Scheme for Trusts assessments.

Further evidence is provided by a range of audit reports including clinical audit, internal audit and external audit. In addition, the process undertaken by the Trust Board and management to assess the organisation's position against Monitor's new *quality governance framework* are sources of evidence and assurance for me.

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

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

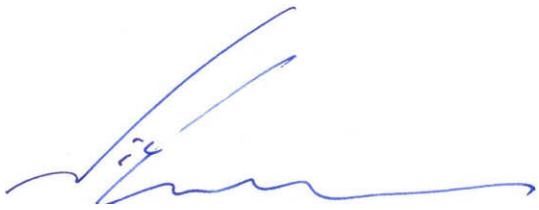
The processes adopted to maintain and review the effectiveness of the system of internal control include:

- The Board reviews regularly the Trust's objectives and receives reports on key matters of concern;
- The *Audit committee* provides an independent and objective review of the Trust's system of internal control and comments, where appropriate, on the overall risk management process;
- The *Risk and quality committee* provides assurance on the progress of all areas of risk management;
- Following the introduction of a new risk management database in 2009, I am confident that executive directors, senior managers of the Trust and identified risk leads are engaged fully in maintaining and reviewing the effectiveness of the system of internal control. This is supported by the successful NHS Litigation Authority level two assessment achieved in January 2011 and recent risk maturity and assurance stock-take report;
- The *Finance and performance committee* highlights the major financial risks to the Board and to the *Risk and quality committee*, while providing proactive risk management within the areas of activity covered by its own remit;

- Internal audit, through its annual audit plan, provides assurance and comment on matters related to internal control;
- The Board has appointed a senior information risk owner, who is supported by an information governance steering group, to provide information governance assurance via the information governance toolkit submission and IGSoC;
- The Board and all senior staff, clinical and other, are, through various meetings and review processes, including bi-monthly performance reviews with each clinical division, involved in the self-assessment process required to ensure continued compliance with Care Quality Commission registration and regulations.

During the reporting year, the Trust has had one significant control issue – the May 2010 information governance level three serious incident, which was reported to the Information Commissioner's Office. The Trust was found in breach of the seventh data protection principle of the Data Protection Act and I have signed an undertaking to ensure that personal data is processed in accordance with this principle and can confirm that the learning from this serious incident has been implemented, including completing the roll out of encrypted memory sticks and implemented port control.

With the exception of the internal control issues that I have outlined in this statement, my review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.



26 May 2011 **Date** **Chief Executive**

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

We have audited the financial statements of the East and North Hertfordshire NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies. We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers; and
- the table of pension benefits of senior managers.

This report is made solely to the Board of Directors of the East and North Hertfordshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body, for our audit work, for this report, or for the opinions we have formed.

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

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

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view of the state of East and North Hertfordshire NHS Trust as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters
In our opinion:

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

Matters on which we report by exception
We have nothing to report in respect of the Statement on Internal Control on which we report to you if, in our opinion, the Statement on Internal Control does not reflect compliance with the Department of Health's requirements.

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

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

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

We report if significant matters have come to our attention which prevent us from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Basis of conclusion
We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

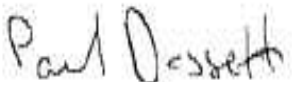
- securing financial resilience; and
- challenging how it secures economy, efficient and effectiveness;

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

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

Conclusion
On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, we are satisfied that, in all significant respects, East & North Hertfordshire NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Certificate
We certify that we have completed the audit of the accounts of East & North Hertfordshire NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



Paul Dossett

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

Registered Auditor, Chartered Accountants
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

Date: 26 May 2011

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	Note	2010-11 £000	2009-10 £000
Revenue			
Revenue from patient care activities	3	**305,306**	297,007
Other operating revenue	4	**35,003**	34,305
Operating expenses	6	**(333,602)**	(344,405)
Operating surplus/(deficit)		**6,707**	(13,093)
Finance costs:			
Investment revenue	11	**22**	22
Other gains and losses	12	**(97)**	0
Finance costs	13	**(1,455)**	(1,121)
Surplus/(deficit) for the financial year		**5,177**	(14,192)
Public dividend capital dividends payable		**(3,718)**	(5,028)
Retained surplus/(deficit) for the year		**1,459**	(19,220)
Other comprehensive income			
Impairments and reversals		**(4,238)**	(66,238)
Gains on revaluations		**2,819**	16,338
Receipt of donated/government granted assets		**1,007**	3,635
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**(535)**	(622)
Total comprehensive income for the year		**512**	(66,107)

The notes on pages 7 to 35 form part of these accounts.

Reported NHS financial performance position

Retained surplus for the year	**1,459**
IFRIC 12 adjustment	**(37)**
Impairments	**1,906**
Reported NHS financial performance position	**3,328**

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(deficit), but adjusted for the following:-

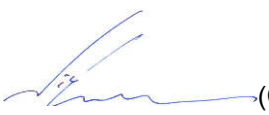
a) Impairments to Fixed Assets 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.

b) The revenue cost of bringing PFI assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	Note	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Property, plant and equipment	14	**147,014**	135,706
Intangible assets	18	**3,739**	3,743
Trade and other receivables	22	**2,047**	1,736
Total non-current assets		**152,800**	141,185
Current assets			
Inventories	19	**4,636**	4,270
Trade and other receivables	20	**12,795**	21,649
Cash and cash equivalents	21	**7,226**	3,761
		24,657	29,680
Total current assets		**24,657**	29,680
Total assets		**177,457**	170,865
Current liabilities			
Trade and other payables	22	**(26,046)**	(31,825)
Borrowings	23	**(2,627)**	(2,058)
Provisions	26	**(163)**	(184)
Net current liabilities		**(4,179)**	(4,387)
Total assets less current liabilities		**148,621**	136,798
Non-current liabilities			
Borrowings	23	**(27,976)**	(16,551)
Provisions	26	**(1,182)**	(1,296)
Total assets employed		**119,463**	118,951
Financed by taxpayers' equity:			
Public dividend capital		**145,034**	145,034
Retained earnings		**(82,433)**	(84,872)
Revaluation reserve		**49,074**	51,101
Donated asset reserve		**7,788**	7,688
Total taxpayers' equity		**119,463**	118,951

The financial statements on pages 1 to 5 were approved by the Board on 26th May 2011 and signed on its behalf by:

Signed:  (Chief Executive) Date: 26 May 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2010

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Total
	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009						
As previously stated	145,034	(66,647)	102,110	4,554	7	185,058
Prior period adjustment						0
Restated balance	145,034	(66,647)	102,110	4,554	7	185,058
Changes in taxpayers' equity for 2009-10						
Total comprehensive income for the year:						
Retained surplus/(deficit) for the year	0	(19,220)	0	0	0	(19,220)
Transfers between reserves	0	1,006	(1,006)	0	0	0
Impairments and reversals	0		(66,238)	0	0	(66,238)
Net gain on revaluation of property, plant, equipment	0		16,224	114	0	16,338
Receipt of donated/government granted assets	0		0	3,635	0	3,635
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(615)	(7)	(622)
Reserves eliminated on dissolution	0	(11)	11	0	0	0
Balance at 31 March 2010	145,034	(84,872)	51,101	7,688	0	118,951

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2011

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11						
Balance at 1 April 2010	145,034	(84,872)	51,101	7,688	0	118,951
Total comprehensive income for the year:						
Retained surplus/(deficit) for the year	0	1,459	0	0	0	1,459
Transfers between reserves	0	980	(980)	0	0	0
Impairments and reversals	0	0	(3,866)	(372)	0	(4,238)
Net gain on revaluation of property, plant, equipment	0	0	2,819	0	0	2,819
Receipt of donated/government granted assets	0	0	0	1,007	0	1,007
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(535)	0	(535)
Reserves eliminated on dissolution	0	0	0	0	0	0
Balance at 31 March 2011	145,034	(82,433)	49,074	7,788	0	119,463

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	Note	2010-11 £000	2009-10 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**6,707**	(13,093)
Depreciation and amortisation		**6,222**	6,078
Impairments and reversals		**1,906**	21,757
Transfer from donated asset reserve		**(535)**	(615)
Transfer from government grant reserve		**0**	(7)
Interest paid		**(568)**	(1,121)
Dividends paid		**(3,718)**	(5,028)
(Increase)/decrease in inventories		**(366)**	(72)
(Increase)/decrease in trade and other receivables		**8,543**	(8,419)
Increase/(decrease) in trade and other payables		**(8,317)**	10,343
Increase/(decrease) in provisions		**(135)**	10
Net cash inflow from operating activities		**9,739**	9,833
Cash flows from investing activities			
Interest received		**22**	22
(Payments) for property, plant and equipment		**(18,290)**	(18,133)
Net cash (outflow) from investing activities		**(18,268)**	(18,111)
Net cash (outflow) before financing		**(8,529)**	(8,278)
Cash flows from financing activities			
Loans received from the DH		**14,271**	6,790
Other loans received		**0**	5,850
Loans repaid to the DH		**(2,051)**	(1,678)
Capital element of finance leases and PFI		**(226)**	(173)
Net cash inflow from financing		**11,994**	10,789
Net increase in cash and cash equivalents		**3,465**	2,511
Cash and cash equivalents at the beginning of the financial year		**3,761**	1,250
Cash and cash equivalents at the end of the financial year	21	**7,226**	3,761

NOTES TO THE ACCOUNTS

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010/11 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Key sources of estimation uncertainty

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

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

The estimation of partly completed spells - note 1.4 page 7

Provision for impairment of receivables - note 1.7 page 8

The estimation of the "holiday pay accrual" under employee benefits - note 1.5 page 8

The valuation of property, plant and equipment – note 1.7 page 8

The calculation of provisions – note 1.17 page 13

Notes to the accounts - 1. accounting policies (contd.)

1.4 Revenue

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

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

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

1.5 Employee benefits

Short-term employee benefits

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

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

Retirement benefit costs

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

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

1.6 Other expenses

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

Notes to the accounts - 1. accounting policies (contd.)

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

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

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

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

Notes to the accounts - 1. accounting policies (contd.)

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

The Mount Vernon site has not been subject to MEA valuation and will continue to be held at historic cost.

Capital expenditure is agreed annually with the Department of Health through the Capital Resource Limit which the Trust is not permitted to exceed. Capital is financed from a combination of internally generated resources and loans from the Department of Health, the loans are applied for during the year as the funding requirement arises.

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

1.8 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

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

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

Measurement

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

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

1.9 Depreciation, amortisation and impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but limited to the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Donated assets

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

1.11 Government grants

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

Notes to the accounts - 1. accounting policies (contd.)

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

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

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The Trust as lessor

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

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

Notes to the accounts - 1. accounting policies (contd.)

1.14 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Notes to the accounts - 1. accounting policies (contd.)

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.15 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.16 Cash and cash equivalents

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 1.8% (previously 2.2%) in real terms.

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

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

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 26.

1.19 Non-clinical risk pooling

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

Notes to the accounts - 1. accounting policies (contd.)

1.20 Contingencies

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

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

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

1.21 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

The Trust has no held to maturity investments

Available for sale financial assets

The Trust has no available for sale assets

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.22 Financial liabilities

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

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

Notes to the accounts - 1. accounting policies (contd.)

Financial guarantee contract liabilities
The Trust currently has no financial guarantee contract liabilities

Financial liabilities at fair value through profit and loss
The Trust currently has no contracts containing embedded derivatives

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

1.23 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.

1.24 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.25 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 31 to the accounts.

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

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

Notes to the accounts - 1. accounting policies (contd.)

1.27 Losses and special payments

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

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

1.28 Subsidiaries

For 2009-10 and 2010-11 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.29 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

2. Operating segments

The East and North Hertfordshire NHS Trust provides healthcare services only. The services are managed and resourced as one business unit, divisions in reporting are for management purposes only. Capital resource allocations are distributed based on the operational and strategic need of the whole organisation. Services are provided largely for Primary Care Trusts and as such provide the same level of risk for each service area. Therefore the Trust considers a single segment reporting to be the most appropriate reporting format.

3. Revenue from patient care activities

	2010-11 £000	2009-10 £000
Strategic health authorities	**160**	0
NHS trusts	**9**	0
Primary care trusts	**298,806**	290,776
Non-NHS:		
Private patients	**3,918**	4,112
Overseas patients (non-reciprocal)	**390**	239
Injury costs recovery	**1,497**	1,355
Other	**526**	525
	305,306	297,007

Injury cost recovery income is subject to a provision for impairment of receivables of 7.8% to reflect expected rates of collection.

4. Other operating revenue

	2010-11 £000	2009-10 £000
Education, training and research	**16,704**	15,778
Transfers from donated asset reserve	**535**	615
Transfers from government grant reserve	**0**	7
Non-patient care services to other bodies	**11,670**	12,222
Income generation	**2,906**	2,946
Other revenue	**3,188**	2,737
	35,003	34,305

5. Revenue

	2010-11 £000	2009-10 £000
From rendering of services	**340,333**	331,312

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

6. Operating expenses

	2010-11 £000	2009-10 £000
Services from other NHS trusts	**12,113**	6,808
Services from PCTs	**1,104**	4,045
Services from other NHS bodies	**51**	49
Services from foundation trusts	**992**	1,311
Purchase of healthcare from non NHS bodies	**5,358**	5,025
Trust chair and non executive directors	**51**	58
Employee benefits	**218,008**	213,937
Supplies and services - clinical	**53,981**	50,006
Supplies and services - general	**9,142**	8,243
Consultancy services	**722**	1,511
Establishment	**5,024**	5,333
Transport	**1,137**	3,202
Premises	**10,104**	9,449
Provision for impairment of receivables	**3**	(82)
Depreciation	**5,429**	5,179
Amortisation	**793**	899
Impairments and reversals of property, plant and equipment	**1,906**	21,757
Audit fees	**219**	220
Other auditor's remuneration	**0**	16
Clinical negligence	**5,952**	5,452
Education and Training	**876**	905
Other	**637**	1,082
	333,602	344,405

7. Operating leases

7.1 As lessee

The trust leasing arrangements have been classified as operating leases, therefore all associated costs are charged to the Income Statement in the accounting period to which it relates

Payments recognised as an expense	2010-11 £000	2009-10 £000
Minimum lease payments	**4,418**	4,396
	4,418	4,396

Total future minimum lease payments	2010-11 Total £000	2009-10 Total £000
Payable:		
Not later than one year	**3,316**	3,456
Between one and five years	**5,607**	8,874
After 5 years	**32**	208
Total	**8,955**	12,538

8. Employee costs and numbers

8.1 Employee costs

	2010-11 Total	2010-11 Permanently employed	2010-11 Other	2009-10 Total	2009-10 Permanently employed	2009-10 Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**185,740**	**167,023**	**18,717**	182,889	162,702	20,187
Social security costs	**14,292**	**13,702**	**590**	13,805	13,511	294
Employer contributions to NHS Pension scheme	**18,663**	**18,353**	**310**	17,749	17,595	154
Employee benefits expense	**218,695**	**199,078**	**19,617**	214,443	193,808	20,635
Of the total above:						
Charged to capital	**687**			507		
Employee benefits charged to revenue	**218,008**			213,936		
	218,695			214,443		

8.2 Average number of people employed

	2010-11 Total	2010-11 Permanently employed	2010-11 Other	2009-10 Total	2009-10 Permanently employed	2009-10 Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**726**	**687**	**39**	708	669	39
Administration and estates	**1,066**	**964**	**102**	983	947	36
Healthcare assistants and other support staff	**1,018**	**1,001**	**17**	1,131	993	138
Nursing, midwifery and health visiting staff	**1,763**	**1,533**	**230**	1,655	1,521	134
Nursing, midwifery and health visiting learners	**0**	**0**	**0**	7	7	0
Scientific, therapeutic and technical staff	**576**	**548**	**28**	554	520	34
Other	**9**	**6**	**3**	0	0	0
Total	**5,158**	**4,739**	**419**	5,039	4,658	381
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**18**			14		

Note: the number of staff employed refers to whole time equivalent, a member of staff employed at half full time hours will be shown as 0.5 wte.

8.3 Staff sickness absence

	2010-11 Number	2009-10 Number
Total days lost	**38,876**	42,100
Total staff years	**4,800**	4,639
Average working days lost	**8**	9

Note: The sickness absence figures are provided to the Trust from data extracted centrally from the electronic staff record system and are analysed on a calendar year basis.

8.4 Management costs	**2010-11**		2009-10	
	£000		£000	
Management costs	**14,590**	4.29%	14,739	4.45%
Income	**339,774**		331,312	

9. Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

9. Pension costs (continued)

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

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

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

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

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

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

10. Better Payment Practice Code

10.1 Better Payment Practice Code - measure of compliance	2010-11 Number	2010-11 £000	2009-10 Number	2009-10 £000
Total Non-NHS trade invoices paid in the year	**75,906**	**103,702**	79,243	93,228
Total Non NHS trade invoices paid within target	**51,076**	**68,657**	67,963	78,756
Percentage of Non-NHS trade invoices paid within target	**67%**	**66%**	86%	84%
Total NHS trade invoices paid in the year	**2,855**	**37,078**	2,937	35,943
Total NHS trade invoices paid within target	**1,376**	**8,447**	1,242	15,128
Percentage of NHS trade invoices paid within target	**48%**	**23%**	42%	42%

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.

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

The Trust had no finance or compensation claims made under this legislation.

11. Investment revenue

	2010-11 £000	2009-10 £000
Interest revenue:		
Bank accounts	**22**	22
Total	**22**	22

12. Other gains and losses

	2010-11 £000	2009-10 £000
Loss on disposal of property, plant and equipment	**(97)**	0
Total	**(97)**	0

13. Finance costs

	2010-11 £000	2009-10 £000
Interest on loans and overdrafts	**568**	328
Interest on obligations under PFI contracts:		
- main finance cost	**730**	667
- contingent finance cost	**157**	126
Total	**1,455**	1,121

14. Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	36,293	92,507	11,563	38,910	113	10,465	2,897	192,748
Additions purchased	0	10,668	6,048	1,578	0	682	92	19,068
Additions donated	0	822	0	144	0	5	36	1,007
Reclassifications	0	7,164	(8,864)	1,700	0	0	0	0
Disposals other than by sale	0	0	0	0	0	(13)	0	(13)
Revaluation/indexation gains	789	2,030	0	0	0	0	0	2,819
Impairments	0	(4,238)	0	0	0	0	0	(4,238)
At 31 March 2011	37,082	108,953	8,747	42,332	113	11,139	3,025	211,391
Depreciation at 1 April 2010	0	23,321	0	24,868	110	6,952	1,791	57,042
Impairments	0	2,852	0	0	0	0	0	2,852
Reversal of impairments	0	(946)	0	0	0	0	0	(946)
Charged during the year	0	1,588	0	2,694	3	892	252	5,429
Depreciation at 31 March 2011	0	26,815	0	27,562	113	7,844	2,043	64,377
Net book value								
Purchased	37,082	78,254	8,747	11,032	0	3,281	880	139,276
Donated	0	3,884	0	3,738	0	14	102	7,738
Total at 31 March 2011	37,082	82,138	8,747	14,770	0	3,295	982	147,014
Asset financing								
Owned	37,082	75,574	8,747	14,770	0	3,295	982	140,450
Private finance initiative	0	6,564	0	0	0	0	0	6,564
Total 31 March 2011	37,082	82,138	8,747	14,770	0	3,295	982	147,014

14.1 Revaluation reserve balance for property, plant & equipment

	Land	Buildings excluding dwellings	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2010	12,025	38,407	632	0	0	37	51,101
Movements - revaluations/impairments	789	(2,650)	(152)	0	0	(14)	(2,027)
At 31 March 2011	12,814	35,757	480	0	0	23	49,074

15. Property, plant and equipment continued

2009-10	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	73,039	102,325	1,577	36,812	113	11,078	2,714	227,658
Additions purchased	0	2,248	7,708	1,884	0	621	140	12,601
Additions donated	0	17	3,350	213	0	0	43	3,623
Reclassifications	0	1,071	(1,072)	1	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	(1,234)	0	(1,234)
Revaluation/indexation gains	0	16,338	0	0	0	0	0	16,338
Impairments	(36,746)	(29,492)	0	0	0	0	0	(66,238)
At 31 March 2010	36,293	92,507	11,563	38,910	113	10,465	2,897	192,748
Depreciation at 1 April 2009	0	0	0	22,406	107	7,231	1,541	31,285
Disposals other than by sale	0	0	0	0	0	(1,179)	0	(1,179)
Impairments	0	21,757	0	0	0	0	0	21,757
Charged during the year	0	1,564	0	2,462	3	900	250	5,179
Depreciation at 31 March 2010	0	23,321	0	24,868	110	6,952	1,791	57,042
Net book value								
Purchased	36,293	66,417	9,153	11,697	3	3,502	1,021	128,086
Donated	0	2,769	2,410	2,345	0	11	85	7,620
Total at 31 March 2010	36,293	69,186	11,563	14,042	3	3,513	1,106	135,706
Asset financing								
Owned	36,293	62,616	11,563	14,042	3	3,513	1,106	129,136
Private finance initiative	0	6,570	0	0	0	0	0	6,570
Total 31 March 2010	36,293	69,186	11,563	14,042	3	3,513	1,106	135,706

The Department of Health has changed the requirement for buildings to be recorded at carrying value rather than net book value from the 1st April 2010. This has meant that the closing net book value as at 31st March 2010 (£69,186) has been restated in the opening balance as at 1st April 2010 at carrying value (£92,507) with accumulated depreciation as at 1st April 2010 (£23,321).

15. Property, plant and equipment (cont.)

The land and building assets held by the Trust were revalued in year using modern equivalent assets valuation methodology, in accordance with DH guidance. The revaluation was carried out by an independent qualified valuer. The effective date for the valuation was 1st April 2010. The building assets using MEA and valued in component parts as required under International reporting standards.

The building assets using MEA and valued in component parts as required under International reporting standards.

Basis for valuation

The East and North Hertfordshire NHS Trust has revalued its land and building assets during 2010, as at a valuation date of 1st April 2010, in line with HM Treasury adopted standard approach to valuation based on modern equivalent assets. The trust will record the new values in the annual accounts for the year ending 31st March 2011.

Professional valuations were carried out by DTZ Project and Building Consultancy, 1 Colmore Square, Birmingham, B4 6AJ. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Existing Use Value of the properties has been primarily derived using the Depreciated Replacement Cost (DRC) approach because the specialised nature of the asset means that there are no market transactions of this type of asset except as part of the entity.

In certain circumstances the Existing Use Value has been derived from comparable recent market transactions on arm's length terms. This has been in respect of non specialist properties.

Existing Use Value is defined in UKPS 1.3 of the Red Book and in undertaking the valuations our surveyors have applied the conceptual framework of Market Value, which is detailed in PS3.2 together with the supplementary commentary which is included in items 2-5 of UKPS 1.3. Under UKPS1.3 the term "Existing Use Value" is defined as follows:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

Definition of MEA

Modern equivalent assets - A structure similar to an existing structure with an equivalent productive capacity, which could be built using modern materials, techniques and designs. Replacement cost is the basis used to estimate the cost of constructing a modern equivalent asset.

The economic lives of fixed assets range from:	**Min life (years)**	**Max life (years)**
Software licences	3	8
Licences and trademarks	2	8
Development expenditure	5	8
Buildings excl	19	90
Plant and machinery	5	20
Transport equipment	7	7
Information technology	5	8
Furniture and fittings	7	10

16. Intangible assets

2010-11	Computer software - purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Gross cost at 1 April 2010	880	448	4,776	6,104
Additions purchased	73	125	675	873
Disposals other than by sale	(94)	(11)	(84)	(189)
Gross cost at 31 March 2011	859	562	5,367	6,788
Amortisation at 1 April 2010	365	353	1,643	2,361
Disposals other than by sale	(94)	(11)	0	(105)
Charged during the year	144	33	616	793
Amortisation at 31 March 2011	415	375	2,259	3,049
Net book value				
Purchased	404	177	3,108	3,689
Donated	40	10	0	50
Total at 31 March 2011	444	187	3,108	3,739

16. Intangible assets (contd.)

2009-10	Computer software - purchased	Licences and trademarks	Development expenditure (internally generated)	Total
	£000	£000	£000	£000
Gross cost at 1 April 2009	607	386	3,654	4,647
Additions purchased	277	68	0	345
Additions internally generated	0	0	1,203	1,203
Additions donated	0	12	0	12
Disposals other than by sale	(4)	(18)	(81)	(103)
Gross cost at 31 March 2010	880	448	4,776	6,104
Amortisation at 1 April 2009	160	122	1,257	1,539
Disposals other than by sale	(1)	(5)	(71)	(77)
Charged during the year	206	236	457	899
Amortisation at 31 March 2010	365	353	1,643	2,361
Net book value				
Purchased	459	83	3,133	3,675
Donated	56	12	0	68
Total at 31 March 2010	515	95	3,133	3,743

The Trust accounts for intangible fixed assets in accordance with IAS 38. All intangible assets with a value of over £5,000 and amortised on a quarterly basis over its economic useful life. The Trust does not consider that its Intangible fixed assets have an active market, and therefore use book value as a prudent indicator of fair value intangible assets.

The Trust does not hold intangible assets with an indefinite useful life

16.1 Revaluation reserve balance for intangible assets	2010-11 £000	2009-10 £000
At 1 April	**0**	2
Changes	**0**	(2)
At 31 March	**0**	0

17. Impairments

The Trust has revalued its land and building assets using MEA as previously stated in the accounts, in accordance with Department of Health guidance.

The MEA revaluation of the Trust's land and buildings, used for carrying out Trust activity, created an impairment of £2m overall which was charged to the income statement and is reflected in the overall surplus reported.

Details of the basis for valuation is included under note 15

18. Commitments

18.1 Capital commitments

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

	31 March 2011 £000	31 March 2010 £000
Property, plant and equipment	**7,378**	12,015

The capital commitments figures shown above largely relate to the Trust's Maternity new build project totalling £16.4m. The commitment remaining on the scheme amounts to £4.4m and is due for completion during 2011.

The project is funded through a Department of Health capital investment loan and payable over 25 years from when the loan was first utilised in September 2009.

The other commitments relate to smaller projects commenced in 2010/11 and will be completed in 2011/12.

19. Inventories

19.1 Inventories

	31 March 2011 £000	31 March 2010 £000
Drugs	**1,392**	1,286
Consumables	**3,168**	2,887
Energy	**76**	97
Total	**4,636**	4,270
Of which held at net realisable value:	**0**	0

19.2 Inventories recognised in expenses

There were no inventories recognised in expenses during 2010/11 (2009/10 nil).

20. Trade and other receivables

20.1 Trade and other receivables

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS receivables-revenue	**5,175**	**507**	13,716	526
Non-NHS receivables-revenue	**2,157**	**0**	1,927	0
Provision for the impairment of receivables	**(284)**	**(186)**	(372)	(193)
Prepayments and accrued income	**4,200**	**0**	5,056	0
Operating lease receivables	**0**	**0**	0	0
VAT	**0**	**0**	270	0
Other receivables	**1,547**	**1,726**	1,052	1,403
Total	**12,795**	**2,047**	21,649	1,736

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

The year on year decrease in NHS receivables relates to settlement of 2009/10 invoices to PCT's for over performance against activity that remained outstanding at the previous year end.

20.2 Receivables past their due date but not impaired	31 March 2011 £000	31 March 2010 £000
By up to three months	**2,035**	11,933
By three to six months	**266**	396
By more than six months	**402**	224
Total	**2,703**	12,553

The decrease year-on-year on debts outstanding up to three months relates to issue described under 22.1.

20.3 Provision for impairment of receivables	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**(565)**	(903)
Amount written off during the year	**98**	256
Amount recovered during the year	**(3)**	0
(Increase)/decrease in receivables impaired	**0**	82
Balance at 31 March	**(470)**	(565)

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non NHS debt over 180 days, and all overseas patient debt over 60 days, reflects the risk in the recovery of this category of debt. Also the figures quoted includes a provision relating to the NHS Injury cost recovery scheme to reflect the risk of write offs over a significant period, this is calculated at 7.8% of total receivables under this category.

21. Cash and cash equivalents	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**3,761**	1,250
Net change in year	**3,465**	2,511
Balance at 31 March	**7,226**	3,761
Made up of		
Cash with Government banking services	**7,138**	3,488
Commercial banks and cash in hand	**88**	273
Cash and cash equivalents as in statement of financial position	**7,226**	3,761
Cash and cash equivalents as in statement of cash flows	**7,226**	3,761

22. Trade and other payables

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Interest payable	**0**		0	
NHS payables-revenue	**185**	**0**	3,577	0
NHS payables-capital	**1,651**	**0**	0	0
Non NHS trade payables - revenue	**9,758**	**0**	9,981	0
Non NHS trade payables - capital	**4,263**	**0**	2,612	0
Accruals and deferred income	**6,194**	**0**	8,541	0
Social security costs	**1,457**	**0**	2,087	0
Tax	**0**	**0**	2,575	0
Other	**2,538**	**0**	2,452	0
Total	**26,046**	**0**	31,825	0

23. Borrowings

	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Loans from:				
Department of Health	**2,422**	**19,590**	1,832	7,960
PFI liabilities	**205**	**8,386**	226	8,591
Total	**2,627**	**27,976**	2,058	16,551

The figures in the table above relate to the trust's outstanding loans and long term liabilities. The Department of Health section relates to two loans, which are explained below.

The first, the Trust's working capital loan commenced on 22nd March 2007 and is payable over 5 years, final settlement of the loan will be made in March 2012. The interest rate charged is fixed at 5.45% and the loan repayments are made twice a year typically in September and March.

The second relates to a capital investment loan obtained in order to fund a major capital project and commenced 2nd September 2009. The loan is payable over 25 years, final settlement of this loan will be made in September 2034. The interest rate is fixed at 4% per annum for the funds drawndown at 31st March 2010. The interest rate for this loan is fixed at the National loan fund rate prevailing at the date the loan is utilised. The loan repayments are made twice a year typically in September and March.

The PFI liability above relates to the Hertford County Hospital PFI scheme which commenced in November 2004. In accordance with IFRS this scheme was brought on to the balance sheet, recognising both the asset and the liability the scheme represents. The loan repayments are made monthly and carry an implicit interest rate of 7.59%. The scheme is scheduled to run until March 2033.

24. Private Finance Initiative contracts

24.1 PFI schemes on - statement of financial position

The Trust has one PFI scheme, this relates to Hertford County Hospital. The hospital largely provides outpatient and therapy services to the local community. The facility became operational on 1st November 2004 with a contract period of 28.5 years. The contract is due to end 31st March 2033.

The contract is paid in the form of an annual unitary charge that covers repayment of capital, cost of financing and service costs. The future commitment of the elements at 31st March 2011 are as follows.

	£000
Capital	8,817
Lifecycle replacement Costs	4,506
Interest	8,860
Contingent Rental	10,193
Service	2,646

The Lessor is obligated to maintain Hertford County Hospital for the period of the contract. Life cycle capital replacement costs are incurred by the lessor as part of the required routine maintenance; these costs are part of the annual unitary charge, charged monthly. This element is subsequently capitalised as a capital enhancement of the asset in the year the costs are incurred.

The contingent rental costs relates to the effects of inflation on the finance charge over the period of the contract. The cost is charged annually to the Income statement under finance costs.

The Trust are financially committed to the PFI scheme for the term of the contract stated above.

The terms of the contract are such that the asset becomes a Trust property at the end of the PFI contract period. The fair value of the current asset will be reviewed annually to ensure carrying values are appropriately recorded.

Total obligations for on-statement of financial position PFI contracts due:

	31 March 2011 £000	31 March 2010 £000
Not later than one year	**842**	878
Later than one year, not later than five years	**3,372**	3,337
Later than five years	**13,238**	14,114
Sub total	**17,452**	18,329
Less: interest element	**(8,861)**	(9,512)
Total	**8,591**	8,817

25. Charges to expenditure

The total charged in the year to expenditure in respect of the service element of on-statement of financial position PFI contracts was £89k (prior year £87k).

The trust is committed to the following charges

	31 March 2011	31 March 2010
	£000	£000
Later than five years	**2646**	2735
Total	**2646**	2735

26. Provisions

	Current	**Non-current**	Current	Non-current
	31 March 2011	**31 March 2011**	31 March 2010	31 March 2010
	£000	**£000**	£000	£000
Pensions relating to other staff	**112**	**1,140**	109	1,247
Legal claims	**51**	**42**	75	49
Total	**163**	**1,182**	184	1,296

	Pensions relating to former directors	**Pensions relating to other staff**	**Legal claims**	**Total**
	£000	**£000**	**£000**	**£000**
At 1 April 2010	**0**	**1,356**	**124**	**1,480**
Arising during the year	**0**	**0**	**136**	**136**
Used during the year	**0**	**(104)**	**(151)**	**(255)**
Reversed unused	**0**	**(50)**	**(16)**	**(66)**
Unwinding of discount	**0**	**50**	**0**	**50**
At 31 March 2011	**0**	**1,252**	**93**	**1,345**
Expected timing of cash flows:				
Within one year	**0**	**112**	**42**	**154**
Between one and five years	**0**	**340**	**51**	**391**
After five years	**0**	**800**	**0**	**800**

Pensions relating to other staff: This provision is for the constructive obligation with the NHS Pensions Agency relating to staff that have retired early. The obligation is assessed using information provided by the Pensions Agency on pension enhancement and an assessment of expected lives using Government Actuary Department tables. The Trust is invoiced quarterly to reflect payment s made on behalf of the trust by the Pension agency, this cost is charged to the provision.

The Treasury discount rate has reduced to 1.8% from 2.2% and is used to calculate the amount of unwinding of the provision for pensions relating to staff that have retired early.

£64m is included in the provisions of the NHS Litigation Authority at 31/3/2011 in respect of clinical negligence liabilities of the trust (31/03/10 £45.7m).

27. Contingencies

27.1 Contingent liabilities

	2010-11 £000	2009-10 £000
Other	**(39)**	(54)
Total	**(39)**	(54)

£39k of the 2010/11 (£54k 2009/10) net contingent liability relates to Liabilities to Litigation Authority Third Parties Scheme. The value is calculated by NHS Litigation authority on a claim by claim basis and communicated to the Trust via an annual report.

28. Financial instruments

28.1 Financial assets

	Loans and receivables £000	Total £000
Embedded derivatives	**0**	**0**
Receivables	**8,595**	**8,595**
Cash at bank and in hand	**7,226**	**7,226**
Total at 31 March 2011	**15,821**	**15,821**
Embedded derivatives	0	0
Receivables	23,721	23,721
Cash at bank and in hand	3,761	3,761
Total at 31 March 2010	27,482	27,482

28.2 Financial liabilities

	Other £000	Total £000
Payables	**26,046**	**26,046**
PFI and finance lease obligations	**8,591**	**8,591**
Other borrowings	**22,012**	**22,012**
Total at 31 March 2011	**56,649**	**56,649**
Payables	33,986	33,986
PFI and finance lease obligations	8,817	8,817
Other borrowings	9,792	9,792
Total at 31 March 2010	52,595	52,595

28.3 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

29. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

29.1 Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000
Turnover	246,307	270,257	286,332	309,074	331,312	340,309
Retained surplus/(deficit) for the year	(22,379)	(1,527)	2,003	2,070	(19,220)	1,459
Adjustment for:						
Adjustments for Impairments	0	0	0	0	21,758	1,906
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*	0	0	0	0	(38)	(37)
Other agreed adjustments	8,557	22,379	0	0	0	0
Break-even in-year position	(13,822)	20,852	2,003	2,070	2,500	3,328
Break-even cumulative position	(23,100)	(2,248)	(245)	1,825	4,325	7,653

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement has been aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %
Materiality test (I.e. is it equal to or less than 0.5%):						
Break-even in-year position as a percentage of turnover	-5.61%	7.72%	0.70%	0.67%	0.75%	0.98%
Break-even cumulative position as a percentage of turnover	-9.38%	-0.83%	-0.09%	0.59%	1.31%	2.25%

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

29.2 Capital cost absorption rate

Untill 2008/09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets of £109,742,000, that is £3,718,000.

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

29.3 External financing

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

	£000	**2010-11 £000**	2009-10 £000
External financing limit		**9,629**	10,827
Cash flow financing	**8,529**		8,278
External financing requirement		**8,529**	8,278
Undershoot		**1,100**	2,549

29.4 Capital resource limit

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

	2010-11 £000	2009-10 £000
Gross capital expenditure	**20,948**	17,784
Less: book value of assets disposed of	**(97)**	0
Less: donations towards the acquisition of non-current assets	**(1,007)**	(3,635)
Charge against the capital resource limit	**19,844**	14,149
Capital resource limit	**19,957**	14,405
Underspend against the capital resource limit	**113**	256

30 Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the East and North Hertfordshire NHS Trust.

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

Related party organisation	Code	Income	Expenditure	Debtors	Creditors
		£000's	£000's	£000's	£000's
Strategic health authorities					
East of England Strategic Health Authority	Q53	13,239	32	455	12
Primary care trusts					
Barnet PCT	5A9	2,539	1	207	0
Bedfordshire PCT	5P2	22,176	0	461	0
Berkshire East PCT	5QG	1,449	0	89	0
Brent Teaching PCT	5K5	1,356	0	13	0
Buckinghamshire PCT	5QD	2,085	0	206	0
Hertfordshire PCT	5P3	241,630	1,578	459	102
Harrow PCT	5K6	3,457	0	112	0
Hillingdon PCT	5AT	6,351	43	526	0
Luton PCT	5GC	5,416	0	231	0
North East Essex PCT	5PW	1,607	0	22	0
South East Essex PCT	5P1	15,465	0	31	0
NHS trusts					
The Hillingdon Hospital NHS Trust	RAS	422	10,066	285	1,259
West Hertfordshire Hospitals NHS Trust	RWG	535	1,536	84	349
Other NHS bodies					
NHS Business Services Authority	ST1450	0	11,444	0	0
NHS Litigation Authority	ST1150	0	1,853	0	0
NHS Blood and Transplant	033NBT	0	1,851	0	20
NHS foundation trusts					
Hertfordshire Partnership NHS Foundation Trust	RWR	2,165	15	105	14
Luton and Dunstable Hospital NHS Foundation Trust	RC9	256	1,023	282	555

In addition, the trust has had a number of material transactions with other government departments and other central and local authority bodies. The Pensions agency is the largest other central government body the trust has had transactions with, and this entirely involves the payments of employees and employers pension contributions. The transactions with local authorities although not material in the context of the above disclosures, relate in the main to the payment of business rates.

31 Third party assets

The Trust held £3k cash and cash equivalents at 31 March 2011 (£3k - at 31 March 2010) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

32 Intra-Government and other balances

	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other central government bodies	**4,244**	**0**	**82**	**0**
Balances with local authorities	**60**	**0**	**1,082**	**0**
Balances with NHS trusts and foundation trusts	**993**	**507**	**1,796**	**0**
Balances with public corporations and trading funds	**0**	**0**	**20**	**0**
Intra government balances	**5,297**	**507**	**2,980**	**0**
Balances with bodies external to government	**3,298**	**5,740**	**23,066**	**0**
At 31 March 2011	**8,595**	**6,247**	**26,046**	**0**
Balances with other central government bodies	1	0	2,283	0
Balances with local authorities	123	0	1,156	0
Balances with NHS trusts and foundation trusts	13,716	526	3,577	0
Balances with public corporations and trading funds	0	0	0	0
Intra government balances	13,840	526	7,016	0
Balances with bodies external to government	7,809	1,210	24,809	0
At 31 March 2010	21,649	1,736	31,825	0

33 Losses and special payments

There were 447 cases of losses and special payments (2009-10: 2,495 cases) totalling £80,809 (2009-10: £268,915) accrued during 2010-11.