East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2014/15 annual report and accounts

27 May 2015

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Chapter 1: about the Trust

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

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. From this time, the QEII continued to provide outpatient, diagnostic and antenatal services, along with a 24/7 urgent care centre. Hertford County also provides outpatient and diagnostic services. The cancer centre provides tertiary radiotherapy and local chemotherapy services. The Trust owns the freehold for each of the Lister, QEII and Hertford County; the cancer centre operates out of facilities that the Trust leases from the Hillingdon Hospitals NHS Foundation Trust.

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

The Trust's main catchment is a mixture of urban and rural areas in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in Stevenage, Hatfield, Welwyn Garden City and Cheshunt. Over the past ten years, rates of death from all causes, early deaths from cancer and early deaths from heart disease and stroke have all improved and are generally similar to, or better than, the England average.

The birth rate is slightly above the England average, with the Trust's core catchment population forecast to rise by 10.2% over the next ten years, with the most significant growth expected in people aged 45 to 74 years (although rates of increase in those aged 75 and over are likely to have the greatest impact in terms of health needs). Black and minority ethnic groups make up approximately 6% of the population in east and north Hertfordshire.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including A&E and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,290 staff are employed by the Trust, which represents around 4,540 whole time equivalents. Its annual budget is approximately £375 million.

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

Chapter 2: chairman and chief executive's reports

Chairman's report

Looking back over the last 12 months, there is no doubt that the single most important event of the year took place during October 2014 when we completed the consolidation of emergency and inpatient services at the Lister.

Although these very important changes took place over a matter of weeks, they represented the culmination of a £150 million investment programme at the Lister that took several years to complete. These changes were not without their challenges. Last year alone saw the majority of our staff take part in consultations about changes to their roles, along with the detailed planning that is always necessary to ensure improved service happen smoothly and efficiently.

It would be a mistake, however, to see these changes – as well as the work undertaken by our colleagues at the East and North Hertfordshire Clinical Commissioning Group in building the £30 million New QEII Hospital that opens in Spring 2015 – as an end in themselves. Providing consolidated emergency and inpatient services from new facilities on a single hospital site is the starting point on a journey, the aim of which is to see the Trust becoming amongst the best performing NHS organisations in the country.

The changes we have undergone over the last few years mean that we are now better placed than ever to deliver real improvements not only in the quality of services provided by our staff, but also in how those services are experienced by our patients and their families/carers. They help us to ensure that we can attract and retain the best staff – a vital part of ensuring our patients continue to receive high quality, safe care.

Finally the creation of new facilities also helps us to deliver new services for our patients, whilst at the same time improving existing ones. Having been focussed on the design and running of new facilities, the focus of our senior clinical staff has now turned to the development of the Trust's clinical strategies going forward.

The challenges facing the NHS are greater now than ever before. As set out in NHS England's Five-Year Forward View, it is clear that the only certainty about the future is the need to embrace further change.

I believe that having completed successfully one of the most extensive service reconfiguration programmes anywhere in the NHS, the Trust is well placed to meet the challenges that lie ahead. Our staff can use our recent experience to face the future with more confidence than otherwise might have been the case.

By way of example, I would like to look at three important initiatives/projects:

- The experience gained already from bringing maternity services together in 2011;
- The impact of the Trust's ARC organisational development programme;
- The work underway to make our hospitals easier to use.

Towards the end of 2011, the Trust's new inpatient maternity service was created at the Lister. The new unit, which was opened officially in June 2012 by The Queen, since when it has been known as the Diamond Jubilee Maternity Unit, saw staff from the former QEII and Lister services brought together in to a single team. Apart from co-located midwife and consultant-led units, other new services were introduced – including: a new early pregnancy unit; women being able to go home straight from the labour suite, where it was safe for them and their babies to do so; and better support for partners to be with expectant mothers when they needed them.

Very quickly, satisfaction ratings for these new services rose dramatically, with a corresponding fall in complaints – something that has continued to be the case since 2011. Staff vacancy rates, especially for midwives, fell – today the Trust often has a choice of who to employ when maternity vacancies are advertised. On consolidation, the new service was £1 million cheaper to run than was the case previously.

In short – more satisfied mothers, highly engaged staff and savings for the taxpayer. It is these achievements that we are seeking to deliver over the next few years in the most recent round of service changes that took place last October. Although our maternity colleagues have set the bar high for their medical and surgical colleagues, I am confident that they too will deliver similar improvements in the services provided to their patients.

The second initiative that I would like to touch upon is the Trust's ARC organisational development programme (ARC stands for accelerate, refocus and consolidate). Aimed at the Trust's clinical and non-clinical leadership, the ARC programme is now in its third year. It is about ensuring that those involved in leading teams, from ward sisters through to consultants, focus on the improvements they can make together to ensure that patients receive consistently high quality care.

ARC also provides us with a natural forum through which to review major changes facing the NHS, for example the recommendations that were accepted by the Government from the Francis report as well as developing action plans following the annual publication of the national NHS staff survey.

With the *Our changing hospitals* programme now complete, ARC will be used to drive organisational culture change. A main focus for the Trust Board going forward is the need to transform outpatient management, or put more simply making our hospitals easier to use – the third strand of activity I wanted to use this report to explore briefly.

Our patients have been telling us for a while now that our administration systems were not up to scratch. For example we: cancel and rearrange too many appointments; it can be hard to speak with someone in our contact centre; and we don't always get the right health records in the right place at the right time.

We are aware keenly of these problems and our staff do their best to mitigate the problems they could cause for patients. However, completing the *Our changing hospitals* programme has had to be our priority given its complexity and risk. Now, with our consolidation programme complete, we have been able to refocus on our new transforming outpatient management programme – known as TOMP within the Trust.

The challenges we face are significant and will not be solved overnight. We are at the early stages of scoping this programme, but some of the projects underway now will bring early benefits. A new telephone system, which is linked in properly with the Lister, is now in place at the Treatment Centre. It has replaced the redundant service that the Trust inherited when it took over the running of the former Surgicentre, which had caused endless problems for both our staff and patients.

The patient administration system used by the former Surgicentre has also been merged with the Trust's patient administration system, making it much easier to track patients' progress as they move within and between services. Finally changes have been made – and will continue to be made – to make it easier for people to get in touch with the Trust's contact centre, be it by phone, email or online. These are examples of small, but significant steps that are being taken to make our hospitals easier to use – but we know that a great deal more needs to be done.

In summary, therefore, last year was one of considerable change for the Trust and its staff. I'd like to take this opportunity to thank all the Trust's staff for their outstanding work in caring for our patients. Through our service reconfiguration programme, we are now in better shape than the large majority of NHS organisations, and set to face an uncertain future with a degree of confidence and optimism. The challenges that we face are probably the most difficult in the Trust's history, but our fate remains very much in our own hands.

Ian Morfett
Chairman

Chief executive's report

As the Trust's chairman, Ian Morfett, outlined in his report, 2014/15 was one of the most significant for the Trust since it was formed in April 2000. Having consulted the public on proposed hospital changes back in 2007, last year saw the Trust deliver those proposals.

The Lister has benefited from an investment of £150 million in new facilities, including the Diamond Jubilee Unit, the much expanded emergency department, new ward block and new endoscopy and day surgery unit. Last year was also the first full year of the Trust managing the Treatment Centre, which was handed back to the NHS from the private sector in September 2013.

At the same time our colleagues in the East and North Hertfordshire Clinical Commissioning Group have reached the final stages in the opening of the New QEII Hospital that it is building, with services transferring across from the old hospital on the Howlands site in Welwyn Garden City in Spring 2015.

It is a testament to the Trust's staff, as well as the rest of the local health service, that these changes were made with minimal disruption to patients. In the lead up to these new services coming in to effect, we undertook a complex series of consultations with our staff, which resulted in new teams being created across the Trust.

For many, this meant new roles, in new services and, sometimes, in new locations. Inevitably such change brings with it disruption and uncertainty as new teams come together for the first time. It was inevitable that the Trust's performance dipped initially during the initial weeks following the completion of the *Our changing hospitals* programme in October 2014.

Although improvements in our performance were made, these were overshadowed quite quickly by one of the most difficult winter periods recorded in the history of the NHS, which saw the majority of hospital groups struggling with a number of national waiting times standards – including for A&E, diagnostic, 18-week referral to treatment and some cancer waiting times.

By the end of the year, our performance against these standards improved significantly reflecting the hard work of the Trust's staff in getting to grips with new ways of working and delivering changes for the benefit of patients. The challenge going forward is to ensure that these achievements are maintained and built upon.

Whilst there were no areas of the survey that showed significant improvement from 2013, the Trust was in the top 20% for staff feeling their role makes a difference to patients. It was also above average for a new measure of staff agreeing that feedback from patients is used to inform decisions. Staff receiving training, as well as experiencing violence from either patients or staff, were also better than the NHS average.

With the exception of the two key areas below, all other results did not change significantly from the 2013 survey results, or showed minor downturns in positive responses. Despite this outcome, however, more factors were benchmarked as being below the national average, which might indicate that other NHS organisations had improved at a faster rate.

The two areas where there was a significant adverse change were:

- Staff working extra hours (81% - compared to 74% in 2013 and 71% national average)
- Staff experiencing work related stress in last 12 months (48% - compared to 38% in 2013 and 37% national average)

An action plan has been developed to help ensure that next year's survey results, which will take place long after all the recent service changes will have had a chance to bed down, see improvements in the Trust's ratings.

Two of the factors that may have impacted on our survey results was the Trust's vacancy and turnover rates. In the run up to the final service reconfiguration changes that took place in October 2014, the Trust had held a number of vacancies open to ensure that it could meet its commitment that frontline nursing staff would continue to have a job at the Trust.

Once all the new services were in place, it was possible for the Trust to launch a major recruitment campaign, the aim of which is get its vacancy rate down to 5% - especially for nursing staff. As a result, the Trust saw its vacancy rate reduce to 8.18% in February 2015, when nearly 100 people took up their posts and we are now target now to reach 5% by June 2015.

Of course recruiting new staff brings its own challenges in terms of induction and easing people in to their new roles and teams. Whilst doing so successfully helps to reduce reliance on the use of temporary staff, which helps the Trust's finances, crucially it is also much better for patient care. Our aim is to ensure that our vacancy rate remains low and that we work to develop our staff to ensure that high quality care is provided to our patients consistently.

Strong evidence exists across different sectors that a stable, engaged workforce leads to improved experience for those using an organisation's services. This is as much true for the Trust as it is any other body and over the last 12 months we have seen rising patient experience. Whilst a great deal more work needs to be done, especially around how we can make our hospitals easier to use for our patients and their families/carers, increasingly our patients are reporting positive experiences of their care at our hospitals.

Take for example the monthly Friends and Family Test that every NHS hospitals group in the country conducts and published. The latest figures available are for March 2015, where the figures for those who would recommend our services included: 95.01% (1,142 respondents) for inpatients; 86.13% for A&E (2,429 respondents); 94.80% for outpatients (2,502 respondents); and 96.77% for mothers giving birth (166 respondents).

These ratings come on top of the feedback we get from our patients through a wide variety of means, including our PALS and complaints teams, as well as such online sources as NHS Choices, Patient Opinion and the Trust's social media channels. All such comments are fed back to our clinical teams either to reinforce good practice, but also highlight where things can be improved – something that will remain a focus for the Trust as we aim to become amongst the best performing organisations in the English NHS.

Finally I wish to turn to our working relationships with our local commissioners and public sector partners. Since its formation in April 2013, our staff have worked hard to build positive relationships with our main local clinical commissioning groups or CCGs. This approach has been welcomed by these CCGs, which in turn has led to initiatives being managed and delivered across the wider health community – which ultimately is better for local people in terms of the services they receive.

This partnership approach is also reflected in the relationships we have established with our colleagues in our local community, mental health and ambulance service NHS trusts, as well as the county council's social services teams. Through working together, the aim is to make it easier for patients to get their care where and when it is needed.

For example, throughout the recent busy winter period, delayed transfers of care – i.e. where patients were ready to be discharged but this cannot happen until the next stage in their care has been organised – was kept at an historical low, often less than a handful of patients on any given day. This performance is in stark contrast with many NHS hospital groups, where such so-called *bed blockers* were at a far higher level. Not only does this mean less stresses and strains on the flow of patients through the likes of the Lister, it is also better for our patients who are not kept in an acute hospital bed for longer than needed.

In summary, therefore, the last 12 months have seen great changes take place within the Trust, especially at the Lister and QEII. The fact that these happened smoothly and professional is a tribute to the professionalism and dedication of our staff, for which I would like to reiterate my thanks to them publicly. It has also been a year where are our performance – clinically, operationally and financially – has remained broadly on track despite one of the worst winter periods on record. Our future challenges, in common with the rest of the NHS, remain very significant, but we are now better placed to deal with them than ever before.

Nick Carver
Chief Executive

Chapter 3: NHS Constitution

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

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

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

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

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

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

Since 19 January 2010, all providers and commissioners of NHS services are under a legal obligation to have regard to the NHS Constitution in all their decisions and actions. This means that the Constitution, its pledges, principles, values and responsibilities need to be embedded and ingrained fully into everything the NHS does.

This is a duty that the Trust continues to take seriously and seeks to demonstrate through the decisions it takes. The Trust undertakes regular monitoring of performance indicators and quality metrics linked directly to key aspects of the Constitution's staff pledges, as well as appropriate patient legal rights.

Legal rights of patients and staff
The NHS Constitution sets out people's rights as a patient and what is expected from patients in return and the Trust continues to work to fulfill its duty to meet the NHS Constitution.

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

If a GP refers a patient for treatment, their consultant-led treatment should start within a maximum of 18 weeks from referral for non-urgent conditions; in addition, they should be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected. If this is not possible, the NHS has to take all reasonable steps to offer patients a range of alternatives.

Where a patient's GP refers them to see a consultant, the patient may have a choice of a number of hospitals. The patient may wish to choose a hospital that has better results for their particular condition than others, or one near to their place of work.

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

A patient can view their personal health records, without needing to give a reason, and have any factual inaccuracies corrected. The patient just needs to ask at their GP surgery or hospital and make an appointment to come in.

If a patient is unhappy with a NHS service and decides to make a complaint, they have a right to have that complaint acknowledged by the organisation receiving the complaint within three working days (this does not include weekends and bank holidays). The patient also has the right for that complaint to be investigated properly.

Same-sex accommodation
The NHS is working to ensure that all hospitals provide same-sex accommodation for all patients.

Carers' rights
If a person is looking after someone who is ill or disabled, this person will have certain rights to safeguard their well-being.

Raising issues of concern (known more commonly as whistle-blowing)
The NHS Constitution was updated in 2012 as part of a series of measures intended to highlight the importance of *whistle-blowing* in the NHS. These measures included: an expectation that staff should raise concerns at the earliest opportunity; a pledge that NHS organisations should support staff when raising such concerns; and clarity around the existing legal right for staff to raise concerns about safety, malpractice or other wrong doing without suffering any detriment.

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

People who use health and care services have the right to be treated with respect, dignity and compassion by staff who have the skills and time to care for them. In this regard, the Trust's values align fully to the NHS Constitution – and work has continued throughout 2014/15 to ensure these are embedded, including into the Trust's recruitment and appraisal processes (more detail about which is set out in chapter five of this annual report).

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

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

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

Chapter 4: future trends and projections

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

Strategic change underway

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

For fully efficient, modern and high quality services to be provided and developed, all of the Trust's emergency and inpatient services have been brought together on to one site, the Lister, with outpatient and diagnostic services provided in two of the Trust's other hospitals – Hertford County and the New QEII Hospital being built by the East and North Hertfordshire Clinical Commissioning Group (scheduled to open in May 2015). The New QEII Hospital will also have a 24/7 Urgent Care Centre.

The fourth phase of the *Our changing hospitals* programme, enabling full consolidation of all remaining emergency and planned acute hospital services, was delivered during the last year. This comprised:

- the Lister's new £19 million emergency department
- new £39 million ward and theatres blocks at the Lister
- completion of new scanning facilities at the Lister Hospital, including two new CT scanners and a second MRI scanner; and
- the opening of a new chemotherapy unit, jointly funded with Macmillan.

During 2014/15, work has progressed on the New QEII Hospital that is being built in Welwyn Garden City on behalf of the East and North Hertfordshire Clinical Commissioning Group (CCG). The Trust has worked closely with the CCG and its contractors to help ensure that the building's design and finish enable the Trust to provide the highest possible quality of services in the most efficient way possible.

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

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

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

Approximately a third of the Trust's clinical income relates to specialised services. In 2014/15 the Trust has continued to extend this element of its services portfolio, increasing activity following the opening of two new renal satellite dialysis units in 2013/14 and the launch of the Trust's 24/7 PPCI service in 2014. The Trust has further plans and ambitions over the next two years to seek to develop a hyper acute stroke unit, as well as expand its private and public partnerships to develop further the Trust's existing satellite renal services.

During 2014/15, the Trust Board initiated work to refresh the Trust's strategic direction, building on the Trust's current five-year strategic plan and relevant significant national documents, including the *Five Year Forward View* and *Dalton* report that have been issued recently. The Trust Board is scheduled to confirm the Trust's refreshed strategic direction in early 2015/16 but this work is suggesting that through existing health system collaborations a number of areas have been identified where system-working and the integration of services will benefit patients and address existing issues within the current system.

The Trust, using its recent and comprehensive experience of delivering system transformation, will work with its health system lead CCG and other system partners to develop and implement plans within the local health system. This is reflected in the Trust's objectives for 2015/16 and, in conjunction with the Trust Development Authority, the Trust stands ready to provide support to neighbouring systems and organisations, as required.

The Trust Board has also been reviewing progress against current objectives as part of the corporate planning process. The current two-year objectives and milestones have been developed with, and approved by, the Board; objectives for 2015/16 take into account progress made and additional opportunities and challenges that were identified in 2014/15. They also reflect consideration of local (both internal and external) and national priorities including Care Quality Commission domains of quality. Senior leaders from clinical and non-clinical divisions, commissioners and local authority partners have also been engaged in this process. These objectives, as part of the Trust annual planning process, are being cascaded internally and linked to directorate, divisional, team and staff objectives.

The strategy's financial implications

In implementing its consolidation strategy, the Trust has raised the necessary funds to enable the capital developments set out in the *Our changing hospitals* programme to take place. This has been provided by the Department of Health through a mixture of interest bearing loans and public dividend capital. The final tranches of funding were received in 2014/15 and the borrowings will be financed by the savings released following the consolidation of services on to the Lister site

Given the current challenging NHS financial 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.

Achieving NHS foundation trust status

The Trust remains committed to achieving NHS foundation trust status – in particular the principle of being accountable to its local communities and membership – and continues to work towards achieving this ambition. During 2014/15, the Trust focused on the final stages of its reconfiguration programme, the aim of which has been to achieve better clinical outcomes and experience for patients and to support a sustainable future. A revised foundation trust timeline will be agreed with the NHS Trust Development Authority during 2015, taking into account any new requirements from Monitor.

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

Governors

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

- **Strategic** – governors will advise on the longer term direction of the foundation trust in order to help the Board of Directors determine its policies effectively;

- **Advisory** – governors will communicate the views and suggestions of their members, as well as the local community, to the Board of Directors;

- **Ambassadorial** – governors will feed back information on the Trust, its vision, values and strategy to members, local community and partner organisations.

In line the Trust's constitution, the Council of Governors will be made up by governors elected by public members (public governors), Trust staff (staff governors) and governors nominated by partner organisations (appointed governors). All of the Trust's governors will have the same duties and responsibilities.

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

During 2014/15, the Trust has continued to develop its foundation trust membership and implemented an engagement strategy to increase involvement of members, with the additional aim of also increasing nominations for prospective governors and in recruiting and involving young people, developing an innovative approach that is fun and interactive and geared towards showing them what the NHS can do for them.

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Current service developments

October 2014 saw the Trust deliver the final stage of its *Our changing hospitals* programme, which has seen all inpatient and emergency services now based at the Lister following £150 million having been invested in new facilities at the Stevenage hospital. The programme's key projects at the Lister that completed during 2014/15 are listed below.

Lister's new fracture clinic

May 2014 saw the Lister's new £1.1 million fracture clinic move to its final location in new facilities close to the hospital's existing outpatient department. This makes the clinic much easier for patients to use, especially now that it has more consultants available and has direct access to a dedicated x-ray service.

New ward block

During July 2014, the Lister's new £18.6 million 62-bed ward block opened to patients. The Trust's new acute medical unit is located on the ground floor with 24 beds and 14 specialist trolleys that are used to manage acutely unwell patients referred by GPs, as well as those transferred from the Lister's emergency department. The block's first floor has a new 38-bed acute cardiac unit with facilities for treating cardiology patients. Over 50% of inpatients in the block have access to their own *en suite* bathroom facilities.

Endoscopy and day surgery centre

The Lister's new £20.5 million endoscopy and day surgery centre, which was built as an extension to the current theatres block towards the rear of hospital, opened in September 2014. It provides the Trust with a compliant, modern, fit-for-purpose endoscopy unit on the building's ground floor, containing a suite of four endoscopy rooms and a dedicated decontamination facility. Three of the endoscopy rooms are suitable for radiological intervention.

The centre's first floor houses a dedicated day surgery service, which has two operating theatres and a recovery area for patients. Also on the first floor are new inpatient laminar flow operating theatres, which are linked directly to the Lister's existing inpatient theatres complex.

To improve integration with the Lister's existing theatres services, the new laminar flow operating facilities makes use of the hospital's existing recovery room – which has been expanded and refurbished to accommodate the additional patients that now use the facility. They are also located close to the Trust's new admissions unit, which helps to streamline the process for patients.

Emergency department

The Trust's new £19 million, much-expanded emergency department became fully operational from October 2014. The new unit houses a dedicated children's emergency service A&E, which – for the first time for the Trust – has its own dedicated paediatric resuscitation area. The children's facility, which supports those with both major and minor injuries/illnesses, is now much bigger.

The new emergency department is also located next to the Trust's other emergency services, including the acute medical and cardiac units in the nearby new ward block, as well as the 24/7 heart attack centre, thus completing the Lister's emergency hub at the front of the hospital.

The adult service's new state-of-the-art resuscitation area, which cares for the sickest patients using the emergency department, has its own over-the-bed x-ray machine so that very ill people can be x-rayed simply without the need to move them. Separate areas with the unit have been created for adults with major and minor illness and injuries.

The project's final phase – the creation of the department's new dedicated CT scanner service – completed in December 2014.

QEII's new urgent care service

At the same time that the Lister's new emergency department opened, a new 24/7 urgent care centre came in to being at the QEII hospital from October 2014. Adults and children of all ages with minor injuries or minor illnesses can now go to the urgent care centre; no appointment is necessary.

Improving the Trust's information management and technology

The Trust plans to use technological innovations within the health economy to drive through productivity, efficiency and change over the next three years, subject to the necessary funding being available. This work has been informed by a Trust vision and drive to link the effective use of information and technology with efficiency and productivity and the Trust's clinical vision. The aim is to produce better patient outcomes and patient experience within the Trust as a whole.

The vision encompassed within the Trust's IM&T strategy describes an intuitive and future-proofed service that enables increased productivity and efficiency for Trust staff whilst supporting the use of innovative technologies and the sharing of information through the Trust's services to patients and local healthcare providers. This vision has been informed by both local and national policies.

Delivering productivity and efficiency through more effective use of information and technology
The Trust, in its drive to promote and deliver efficiency through the use of technological innovations, has proposed within its current IM&T strategy for 2014 to 2017 the following strategic objectives:

- Connection to the business – making IM&T an enabler for progress and change
- Information and knowledge – timely and meaningful information to help better manage all aspects of the business;
- Electronic patient record and clinical systems – improve patient outcomes, user experience and business processes;
- Innovative technologies – investment in innovative technologies to meet national and local objectives and patients' expectations;
- Infrastructure – creation of a strong foundation of infrastructure on which a future-proofed IM&T platform can be supported;
- Partnership working – close working relationship between patients, staff and local health providers to gain strength;
- Skills and capability – develop skills and capabilities within IM&T to create a supportive network in which staff and patients are enabled to use IM&T.

An IM&T strategic road map for the next three years (i.e. to 2017/18) is being created to plan and set programmes which will deliver each of the above objectives. To ensure successful delivery, a full governance structure will be created to ensure the direction and future procurement of IM&T are controlled and meet the needs of the Trust. Included in this work is the pivotal requirement to secure extensive clinical engagement, closing the gap between IM&T and the business, ensuring the Trust is capturing and understanding more of the opportunities and benefits available through innovation and technology.

Delivering commissioning intentions

The Trust's main commissioner for acute services is the East and North Hertfordshire Clinical Commissioning Group (CCG), which accounts for approximately 62% of the Trust's NHS clinical income and also acts as the lead commissioner and contract holder for CCGs (representing a further 14% of the Trust's NHS income). Commissioning for specialised services is undertaken with NHS England, which covers most of the remaining 24%.

East and North Hertfordshire CCG has plans to deliver savings of £60 million over the period 2014/15 to 2018/19, much of which is predicated on the successful delivery of schemes to reduce avoidable hospital admissions as well as the time that patients spend in an acute setting. Making these changes will require the improvement of out-of-hospital services and increasing the integration of care across teams within and outside the Trust.

Pathways and services will need to be developed and commissioned that facilitate individuals leaving acute hospital settings in a timely manner so that the chances of their regaining independence are maximised. This will include integrated discharge arrangements, new flexible models of home care and the development of *discharge to assess* models in all acute sites.

The Trust's clinicians are engaging with local CCGs to develop the new models of care that will be necessary to deliver these changes and thus reduce the number of patients being referred for assessment and treatment in the Trust's hospitals. The Trust recognises that its involvement and leadership in a number of these key initiatives is essential for the successful delivery of Hertfordshire's overall service improvement and savings programme.

Meeting the expectations of regulators

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions*. The CQC has not taken enforcement action against the Trust during 2014/15, nor has it received an inspection or been requested to participate in a special review in 2014/15.

The Trust continues to monitor its compliance against all CQC requirements, including the two new regulations – *Duty of Candour* and *Fit and Proper Persons*. It has also an established programme of quality and safety audits to support embedding the standards and continuous improvement.

During 2015/16, the Trust will seek to improve further upon this performance with regulators such as the CQC and continue a programme of self-assessment against all standards required by Monitor.

Chapter 5: organisational development

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six.

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

2014/15 was a year of considerable change for the Trust, with more to come - not least of which is the opening of the New QEII Hospital in Spring 2016. As a result, the Trust and its staff have been going through a period of major change in both where and how its services are provided to patients, for example:

1. The *Our changing hospitals* programme – the bringing together of the Trust's emergency and inpatient services onto the redeveloped Lister hospital – was completed on time by October 2014. The programme's successful completion has transformed patient care services, which in turn is resulting in improving patient experience. The *Our changing hospitals* programme has been one of the largest transformation projects across the whole of the NHS in recent years.

2. Following staff consultation held in 2013, the Trust enabled the smooth TUPE transfer of more than 200 staff to a newly formed consortium with six other NHS Trusts, known as *Transforming Pathology Partnership.* This new NHS organisation was created to consolidate pathology services into a hub and satellite model covering all the partnership hospitals; the Partnership is hosted by the Cambridge University Hospitals NHS Foundation Trust (CUH). This new way of working for pathology staff resulted in their TUPE transfer to one of two different organisations: either CUH or Public Health England, which is now the provider of microbiology services. Under these new arrangements, the Trust will retain its own capability to provide emergency pathology services to its hospitals through a so-called *hot laboratory* that is being created currently at the Lister.

In line with its strategic vision of being amongst the best performing NHS organisations, the Trust is participating actively in a pilot that aims to develop enhancements for the employee staff record (ESR) and use of mobile technologies in providing real-time data for managers and staff with the view of increasing better decision-making and human resources planning for the benefit of patients and improved service provision, providing local and regional leadership. The Trust is also engaged with the East of England streamlining programme, which seeks to improve and strengthen recruitment and human resourcing processes across the region.

People strategy for 2014 to 2019

In 2014, the Trust's People strategy was developed in consultation with a wide cross section of staff. The strategy focuses on four key ambitions to support the Trust's vision *to become amongst the best*:

- ***Our culture*** – the Trust wants to be known as an organisation where people feel engaged, valued and supported, as well as being empowered to deliver excellent patient care and services of which they are proud;
- **People performance** – the Trust wants to ensure that it has the people it needs and is clear about what standards are expected of staff. This will enable and support the delivery of safe, consistent and high quality patient care;
- **Developing our people** – the Trust wants to develop its people so that everyone has the skills and knowledge they need to deliver high quality patient care so that the Trust can build its workforce for the future;
- **Making a difference to our communities** – the Trust wants to transform the way it works with local communities, making a positive difference to them and making them proud of the Trust's hospitals and services.

Vision and values

The Trust's vision is: *to become amongst the best*, which translates to becoming amongst the best performing organisations in the English health service. Underpinning its vision, the Trust works to the following core values:

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

The Trust has satisfied itself that its vision and values are in line with the principles and values set out in the NHS Constitution and during 2014/15 has continued to implement a Trust-wide, long-term organisation development programme to embed these values further and develop a customer-focused culture. All projects and reports brought to the Trust Board and its committees for approval must demonstrate how they will help the Trust achieve its vision and values, with the latter being used as the yardstick.

The ARC programme

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

ARC – it's all about you

- **A**ccelerate – quality, staff training, communication
- **R**efocus – on our patients, on our staff, on our values, on our partners
- **C**onsolidate – services, patient pathways, our hospitals, our teams

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

ARC is a Trust-wide programme of activities to aid in delivering the highest quality of healthcare to patients, based on the recognition that an engaged and effective workforce is essential in achieving this aim.

Quarterly ARC briefing sessions with the Trust's clinical and non-clinical leadership, have taken place to improve further staff engagement. They also provide an invaluable forum for on-going, regular face-to-face communication between the Trust's leadership and executive directors.

Topics covered by the ARC sessions during 2014/15 included:

- Updates and engagement on the Trust's *Our changing hospitals* programme;
- Managing and leading change;
- Building new teams;
- Appraisals and supporting staff through the Trust's employee relations advisory service.

During 2014/15, almost 850 attendances were recorded across the three sets of meetings. At the end of each session, those attending were charged with taking the programme out in to their teams so that those working in frontline roles had the same opportunity to experience the ARC programme and – perhaps most importantly – consider changes that could be made locally that would help deliver improved standards of care and better patient experience.

Other key ARC programme activities during the year included:

- A *Big Thank You* event and other initiatives designed to recognise the contribution of the Trust's staff contribution during a year of significant change;
- Support for building new teams;
- Interview skills support for staff changing roles;
- Leadership development (see chapter 10 for further information);
- The launch of a new appraisal framework (again see chapter 10);
- Equality and diversity work, including a focus on behaviours and support for reducing workplace bullying.

Delivering excellence in customer care training

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

To improve the level of customer care that the Trust provides to its patients and visitors, a programme of training called *Delivering excellence in customer care* was launched across the Trust in February 2012 and continued through 2014/15. Around 2,700 staff have since completed this training programme since its launch.

National 2014 NHS staff survey

The 2014 national staff survey was conducted in autumn 2014 during a particularly challenging time when the Trust was bringing together the final remaining inpatient and emergency services at the Lister. This work involved consultation with over 3,000 of staff about potential changes to their roles, teams and/or work location.

Feedback for the majority of the indicators which make up the staff survey did not change significantly, with the exception being staff reporting working extra hours and experiencing work related-stress – which staff reported as being worse than during 2014.

Stronger areas of performance were where staff reported that they felt their role makes a difference to patients, and that the Trust uses patient feedback to help inform decision-making. The number of people receiving training was also reported positively.

Results from the 2014 national survey, along with information gleaned through the Trust's own internal quarterly surveys, are communicated to staff through a variety of methods. The Trust is working to engage with its divisions and teams to develop action plans to make improvements, where necessary, during 2015/16.

A number of corporate initiatives are also underway to ensure sufficient staff are recruited to reduce vacancy levels, thus improve the way bank or agency staff are used. In addition, the Trust will continue its work to embed its core values, reduce bullying and harassment and focus on staff health and well-being.

Trust's response to the Francis report

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

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

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

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

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

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

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

Dealing with staff concerns

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

In 2014, four cases were raised and investigated using the Trust's *raising concerns* policy – of these one case was upheld, one partially upheld and two cases were not upheld.

Freedom to Speak Up

On 11 February 2015, Sir Robert Francis QC published his final report - *Freedom to Speak Up*, which was commissioned by the Secretary of State for Health, the Rt Hon Jeremy Hunt MP in June 2014 to examine the culture around staff raising concerns within the NHS. Sir Robert's report makes a number of key recommendations under five overarching themes, with actions for NHS organisations, healthcare professionals and system regulators to help foster a culture of safety and learning in which all staff feel safe to raise a concern.

The report's five themes were:

- Culture
- Handling cases
- Measures to support good practice
- Measures for vulnerable groups
- Extending legal protection

The Trust has a *raising concerns* policy and associated management guidance, both of which were revised in February 2015 in line with best practice. This work was supported through training being provided to a number of staff across the organisation during 2014. The policy identifies a number of key individuals to whom concerns can be reported, along with their role and responsibilities within the process.

Chapter 6: 2014/15 overview

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

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

Further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15 is covered in this chapter.

The areas covered in this chapter are:

- Delivery of the Trust's corporate objectives for 2014/15;
- Operational, clinical and financial performance summary;
- Regulation and assessment-related information;
- Listening to patients' concerns;
- Education and training summary;
- Research and development overview;
- Clinical service changes during the year;
- FT membership activities.

Delivery of the Trust's corporate objectives for 2014/15

During 2014/15, the Trust worked to six strategic objectives, namely to:

- Improve continuously the quality of our services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.

- Excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.

- Provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.

- Consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable.

- Support the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services

- Improve staff engagement and organisational culture to be amongst the best nationally.

The Trust set a number of stretching and challenging two year objectives in 2014/15, with agreed milestones for the reporting year. Of these year one milestones, the Trust met 34 out of 50 of these in full and 14 met partially. These assessments were made on progress evidenced to date and a full evaluation of the Trust's clinical outcomes strategy, improvement priorities and *Quality Account* priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee and Board during May through to July 2015.

Only two objectives were not met during 2014/15. Of these, one – the delivery of one case has been outside the complete control of the Trust – namely the agreement of a memorandum of understanding with Hillingdon Hospitals NHS Foundation Trust regarding the Mount Vernon Cancer Centre site and the other relates to the reduction in bullying and harassment and the 2014 actions have not yet had a positive impact on reducing this.

Progress made during the year in delivering each of the Trust's six strategic aims, along with their respective annual objectives, is set out in the tables on this and the next two pages. Please note that each objective listed in the tables below has been rated as either *Achieved* or *Partly achieved*, with the latter meaning that at least one or more elements have been achieved, but additional work is still required on other elements - details of which are explained at the notes that follow each table.

Strategic aim 1: To improve continuously the quality of services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.		
Two year objective (2014 to 2016)	**2014/15 milestones:**	**Year-end review**
1.1 Reduce mortality	Achieve HSMR and SHMI within the *as expected range* or better.	**Partly achieved**
1.2 Minimise hospital acquired infections in patients	1.2.1 Sustain a zero tolerance approach to hospital acquired avoidable infections.	**Achieved**
	1.2.2 Ensure full compliance with the hygiene code	**Achieved**
1.3 Further improve the safety and clinical outcomes for patients by: • **Implementing the improving patient outcomes strategy** • **Providing seven-day consultant delivered care for high risk specialties** • **Reducing clinical variation in order to improve outcomes for our high risk patients** • **Ensuring a zero tolerance approach to avoidable falls and hospital acquired pressure ulcers** • **Delivering the *Quality Account* key priorities**	1.3.1 Implement the priorities set out in the Improving patient outcomes strategy	**Achieved**
	1.3.2 Develop plans for the delivery of seven-day consultant working	**Partly achieved**
	1.3.3 Deliver agreed pathways to improve patient outcomes and ensure achievement of agreed CQUIN targets	**on track to deliver 90%**
	1.3.4 Develop and implement plans to reduce clinical variation and improve outcomes for high risk patients (respiratory, genito-urinary and the frail elderly)	**Achieved**
	1.3.5 Ensure a zero-tolerance approach to avoidable falls	**Achieved**
	1.3.6 Ensure a zero tolerance approach to hospital acquired avoidable pressure ulcers	**Partly achieved**
	1.3.7 Develop and implement plans to promote clinical research across all our hospital sites	**Achieved**
	1.3.8 Design safe clinical processes	**Achieved**
	1.3.9 Deliver key priorities agreed within the *Quality Account*	**Partly achieved**

Strategic aim 1 (contd.): To improve continuously the quality of services in order to provide the best care and optimise health outcomes for each and every individual accessing the Trust's services.		
Two year objective (2014 to 2016)	**2014/15 milestones:**	**Year-end review**
1.4 Implement an interim electronic patient record (EPR), in line with the Trust's IM&T strategy, to allow modern safe clinical note taking and recording of clinical observations	Implement the EPR within the Lister's emergency department in 2014, and within the Trust's acute units (AAU, SSU and SAU) within 2015	**Partly achieved**
1.5 Ensure the delivery of safe services at the Lister and QEII during the final phase of the *Our changing hospitals* consolidation programme	Provide safe services at both the Lister and QEII hospitals before consolidation of acute services Identify and effectively manage any identified risks	**Achieved**
1.6 Continuously improve and sustain high levels of operational performance across all Trust service	Demonstrate progress towards achieving upper quartile performance on national and contractual targets and maintain/achieve a governance rating of *emerging concerns* or *green*	**Partly achieved**

Notes to annual objective one

1.1 Improvements demonstrated in HSMR (as expected), however the SHMI is 112.9 and above expected.

1.2 and 1.3 Remain compliant with the hygiene code. 12 c diff against a ceiling of 15. MRSA 5 – 4 were avoidable and of those 3 were contaminants and not infections.

1.3 1.3.1 Improvement patient outcomes on track for delivery and 1.3.3 CQUIN delivery forecast at 90%. 1.3.2 gap analysis for 7 day services undertaken, business case for 7 day respiratory service approved and 5 standards in the process of approval for implement in 2015/16.1.3.4 – Clinical improvements seen in GU and pathway changes agreed for frail elderly and respiratory. 1.3.5 – falls reduced by 7% (includes x 1 reduction in death from fall and serious harm from fall). 1.3.6: Rate of pressure ulcers ha reduced from 3% to 1.8% and safety thermometer demonstrates reduction in rate and positive benchmarking.

1.4 IM&T strategy reviewed. E observations piloted and plans in place to roll out across the Trust, EPR not yet implemented – new CIO commences in May 2015.

1.5 Consolidation of services and sites effectively managed ensuring patient safety

1.6. Partly met as delivery against some of the core targets has been inconsistent and challenging – A&E, Stroke, 62 day cancer, RTT. Improvement plans in place and improvements demonstrated. Remain compliant with CQC and IMR band 5. TDA rating 3 based on the challenges with the core targets and SHMI.

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2015

Strategic aim 2: To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end position**
2.1 Build a reputation as a hospital that is *easy to use* and improve levels of patient, carer and customer satisfaction	Improve the efficiency of outpatient services, improve levels of customer service and ensure that patients receive their care and treatment more quickly Priority areas in 2014/15 will include: 2.1.1 outpatient services 2.1.2 outpatient pharmacy 2.1.3 communication with GPs, incl. discharge summaries 2.1.4 front-of-house and signage	**Partly achieved**
2.2 Provide development programmes that enable the organisation to become even more customer focused	We will develop a values based customer service programme and charter that builds on the *JUICE* training programme	**Partly achieved**

Strategic aim 2 (contd.): To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end position**
2.3 Build a reputation as a hospital which is *easy to use* and improve levels of patient, carer and customer satisfaction	The Trust has a three-year patient and carer experience strategy, which has seven ambitions. In 2014/15, the strategy's year three priorities were implemented, with a particular emphasis on: 2.3.1 Getting the administrative processes right to ensure a good patient experience from initial referral through to discharge from care 2.3.2 Improve the way the Trust communicates with patients and users of its services throughout their pathway 2.3.3 Review food service to ensure that patients are happy with the quality and quantity of food provided 2.3.4 Minimise the impact of noise at night to promote sleep 2.3.5 Ensure patients understand the plan at discharge, including the use and possible side effects of medications 2.3.6 Engage with patients and users to inform service improvements that will impact on patient experience and outcomes 2.3.7 Keep patients and visitors informed about patient experience feedback through the use of *You said, We did* boards and through the use of *safe staffing* boards.	**Partly achieved**

Notes to annual objective two

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2015.

2.1 The new model for outpatient pharmacy has now been implemented and MVCC site went live in November 2014 and Lister site in February 2015 and the new signage rolled out in march 2015; the impact of these projects will be assessed. A business case to improve services in outpatients was approved through the Board committee in Feb 2015, subject to funding and focused work to improve the service through the contact centre has commenced but these benefits are yet to be realised. Overall feedback from the GP shows that improvements are still required for the discharge letters.
2.2 The in house customer service programme has been developed but the review of the customer service charter has not yet been undertaken.
2.3 A new meal service is being rolled out based on customer feedback (2.3.3), the patient experience and safe staffing boards rolled out (2.3.7), 2.3.5 and 2.3.6 improvement demonstrated. The challenges remain with 2.3.1, 2.3.2 (particularly Drs Communication) and 2.3.4. The FFT for outpatients is 90%.

Strategic aim 3: To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end position**
3.1 Provide responsive specialist input to primary care, developing and embedding services and models that help GPs to provide high quality care for their patients in the community, reducing emergency admissions for patients with acute conditions and long term conditions	3.1.1 Confirm priority pathways with commissioners for integration by March 2016 and support delivery of *Better Care Fund* plans.	**Achieved**
	3.1.2 Pilot alternative models of care for patients with respiratory conditions	**Achieved**
	3.1.3 Develop and assess rapid access services	**Achieved**
	3.1.4 Seek to develop and implement discharge to assess models with partner organisations.	**Achieved**
	3.1.5 Develop integrated care pathways which support improved outcomes and quality of life for: a) the frail elderly b) people with dementia c) patients at the end of their lives	**Achieved**
3.2 Play a leading role in clinical and academic networks in order to develop innovative, effective ways of providing high quality integrated care		**Achieved**

Notes to annual objective three

*Assessment has been made on progress evidenced to date and a full evaluation of the clinical outcomes strategy, improvement priorities and Quality Account priorities will be presented through the Trust's risk and quality committee in the medical director's reports to the committee during May through to July 2015.

3.1: 3.1.1, 3.1.2 and 3.1.5 –The Trust priority areas and better care fund are aligned and the frail elderly pathway and interface geriatrician implemented. The respiratory services reviewed and business case for a 7 day service was approved in Q4. Progress with dementia care pathway.

3.1.3 and 3.1.4 – examples include patient navigators and halo.

3.2 Established leading role within the AHSN – both executive and clinical engagement and leadership across the work streams, for example the diabetes pathway.

Strategic aim 4: To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services		
Two-year objective (2014 to 2016)	**2014/15 milestones:**	**Year-end position**
4.1 Complete the programme of acute consolidation and achieve the clinical and efficiency benefits expected from the *Our changing hospitals* programme of investment	Complete delivery of all elements of the programme's phase four, including : a) Chemotherapy unit b) Pathology *hot lab* c) Health records d) Emergency department e) New ward block f) New theatres block	**a) Achieved (June 2014)** **e, f) Achieved September/ October 2014**
4.2 Enhance the provision of a range of specialist and hyper acute services: • **Robotic surgery** • **Cardiology (PPCI)** • **Renal services** • **Stroke care (Hyper Acute)** • **Vascular surgery** • **Paediatrics**	4.2.1 Provide and expand robotic surgery service successfully	**Achieved**
	4.2.2 Extend provision of primary percutaneous coronary intervention (PPCI) service to a 24/7 basis	**Achieved**
	4.2.3 Develop and deliver strategies that support the further development of renal services and paediatrics	**Achieved**
	4.2.4 Achieve further improvements in acute stroke service and make progress towards the development of a hyper-acute stroke unit (HASU) at the Lister	**Partly achieved**
	4.2.5 Work with partners to implement the outcomes of the review of vascular surgery, maintaining the quality of local services	**Achieved**

Strategic aim 4 (contd.): To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services		
Two-year objective (2014 to 2016)	**2014/15 milestones:**	**Year-end position**
4.3 Provide and enhance local access to specialist services within the New QEII and Hertford County hospitals, developing services that support local access to specialist care	Reach agreement with commissioners and conclude the design of pathways for services to be provided from the New QEII Hospital, including children's services, 24/7 urgent care centre and rapid assessment	**Achieved**
4.4 Promote positively the Trust's maternity service and increasingly be chosen by local women as the provider that they choose to care for them and their babies	Work with women and their partners to identify and prioritise areas for further service and quality development Raise awareness amongst women and GPs of the high quality of maternity services provided by the Trust	**Achieved**
4.5 Improve the financial efficiency and sustainability of the Trust	Implement service line reporting, ensuring that it is used to inform decision making at all levels of the Trust and support service improvements Deliver the financial forecast and the cost improvement programme across the Trust for 2014/15 Ensure the provision of accurate, clear and visible workforce reporting from all workforce systems Control pay spend through the clear identification of flexible and permanent budget and associated resourcing plans and controls	**Partly achieved**
4.6 Make progress towards becoming a NHS foundation trust	Agree and progress along a pathway for the Trust to achieve authorisation as a NHS foundation trust	**Achieved**

Notes to annual objective four

4.1: All completed with the exception of b) pathology hot lab which is scheduled to complete in July 2015.
4.2 Not yet implemented by partners, quality of local service maintained.
4.3 Pathways agreed. New QEII scheduled to open in May 2015.
4.4 Birth rate increased 2% from the previous year – increase due to out of area referrals – total 5321.
4.5 Assessed as partly met. The CIP programme delivered 97% (TBC), greater visibility of workforce reporting but SLR roll out is not yet complete, continuity of services rating has been 1 during 2014/15 and deficit of 3.6m (2.1 due to change programme)
4.6 In 2014/15 - Agreed with Board and TDA to focus on the delivery of the consolidation programme. Assessment against the QGAF and BGAF in Q3. Preparing for CQC CIH inspection – potentially September to December 2015; required to achieve 'good' for FT application.

Strategic Aim 5: To provide leading local and tertiary cancer services and support the continued development of the Mount Vernon Cancer Centre		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end review**
5.1 Develop a medium-long term vision for cancer services, including the Mount Vernon Cancer Centre (MVCC), and a supporting strategy to achieve delivery	5.1.1 Engage with staff and stakeholders in order to develop and agree the future vision and strategy for tertiary cancer services provided by the Mount Vernon Cancer Centre	**Partly achieved**
	5.1.2 Agree a *Memorandum of Understanding* with Hillingdon Hospitals NHS Foundation Trust regarding the Mount Vernon site development plan, which will enable the development of a business case to address the cancer centre infrastructure including reprovision of wards and clinical areas	**Not achieved**

Strategic Aim 5: To provide leading local and tertiary cancer services and support the continued development of the Mount Vernon Cancer Centre		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end review**
5.2 Further improve the quality and efficiency of cancer services provided by the Trust	5.2.1 Assess services provided by the Cancer Centre against the new cancer commissioning specification and develop, agree and progress delivery of an action plan to support delivery of the specification.	**Achieved**
	5.2.2 Relocate the Lister's chemotherapy services into the new Lister Macmillan Cancer Unit in order to improve further patient and carer satisfaction with cancer services provided at the Lister	**Achieved**
	5.2.3 Develop stratified follow up care for cancer patients	**Achieved**
	5.2.4 Develop clear pathways for integration/in-reach across Trust sites	**Achieved**

Notes to annual objective five

5.1. MVCC Vision supported by stakeholders. MVCC strategy has not yet been agreed.

5.2. Head of terms provisionally agreed with HHT. However currently not proved possible to identify a workable solution in terms of the MVCC Clinical Strategy & Vision from a financial perspective and within THHFT current objectives. The project is currently on hold. Dialogue between both Trusts continues.

5.3: New Lister Chemotherapy service in place since July 2014, delivery against commissioning intentions, 5.23 and 5.2.4year one milestones achieved and improvements demonstrated. Plans in place to further develop and audit in 2015/16.

Strategic aim 6: To improve staff engagement and organisational culture to be amongst the best nationally		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end review**
6.1 Embed an organisational culture that embraces innovation, lean systems and ways of working and is customer focused	6.1.1 Develop a performance culture where staff are clear about their objectives, appraised regularly and performance is linked to the reward systems in the organisation	**Achieved**
	6.1.2 Evolve the ARC programme to ensure it remains relevant and meaningful to all staff as the new organisation takes shape and to develop new strategies to improve staff engagement	**Achieved**
6.2 Develop strategies that support effective staff recruitment, retention and development	6.2.1 Deliver the key operational performance requirements in relation to vacancy management, rostering, sickness absence, temporary staffing efficiency, job planning (electronic) and employee relations management as set out in the 2014/15 annual priorities	**Partly achieved**
	6.2.2 Develop strategies to retain staff, ensure effective recruitment, induction, training and exit management. New induction programme in place Exit management system and reporting in place	**Achieved**
	6.2.3 Develop and deliver a robust talent management and succession planning process, giving opportunities for staff development and progression. Talent management and succession planning systems in place. Proactive measures to retain identified individuals	**Partly achieved**
6.3 A zero tolerance attitude to bullying and harassment	Ensure that clearly understood and firmly established mechanisms and processes for staff exist for them to raise concerns about bullying and/or harassment	**Not achieved**

Strategic aim 6 (contd.): To improve staff engagement and organisational culture to be amongst the best nationally		
Two-year objective (2014 to 2016)	**2014/15 milestones**	**Year-end review**
6.4 Support increased engagement between operational and corporate areas across the Trust	Increase the visibility of the Board and senior teams in the organisation (clinical areas) to help provide strong and inspirational leadership	**Achieved**
	Communicate, openly, honestly, regularly and with authenticity to staff as the Trust undergoes the large scale consolidation of services through delivering the *Our changing hospitals* programme	**Achieved**
	Identify and test ways for corporate areas to support operational teams during periods of acute organisational pressure and change	**Achieved**
6.5 Become the rotation of choice for trainee doctors and develop excellent multi-professional training facilities	Listen and respond to feedback from trainee doctors	**Partly achieved**
	Co-locate the Lister/QEII education centres and libraries at the Lister	**Achieved**

Notes to annual objective six
6.1: Achieved and the ARC programme is currently be reviewed again to ensure it meets the needs of the organisation and leaders.
6.2: 6.2.1 partly achieved – the vacancy and sickness rates have improved by not reached the milestones set. The ERS has now been brought back in house and improvements in the management of cases is expected. Plans are in place for the consultant job planning. 6.2.2 achieved. 6.2.3 Work commenced on exploring developing a coaching culture and the draft leadership strategy will be considered by the RAQC in April 2015.
6.3: The results of the staff survey do not demonstrate a reduction in bullying and harassment – action plans are in place and the ERS service has now been brought back in house. This will continue to be a priority for 2015/16.
6.4: Achieved. Regular programmes in place.
6.5: Educational facilities and handover improved. Internal trainee survey completed and report to RAQC in February 2015; further improvements required including in relation to hours worked and feedback from supervisors. GMC survey undertaken in March 2015; awaiting outcome.

Further information

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

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Operational, clinical and financial performance summary

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

Activity	2014/15 planned	2014/15 Actual	% variance
A&E activity (attendances)	118,282	122,668	+3.71%
Outpatient activity (first appointments)	117,143	114,317	-2.41%
Elective activity (number of planned episodes of surgery/treatment	34,766	34,565	-0.58%
Non-elective activity (number of emergency admissions)	40,732	43,071	+7.29%
Number of births	5,400	5,288	-2.07%

Patient access

In terms of existing nationals and local standards set for the Trust to achieve during 2014/15, a summary of the main patient access and clinical indicators is set out in the table below.

Standard	Standard	2014/15
18 weeks standard – admitted	≥90.0%	88.00%
18 weeks standard – non-admitted	≥95.0%	95.62%
18 weeks standard – open pathways	≥92.0%	94.16%
A&E four-hour wait	≥95.0%	92.33%
Two-week rapid access chest pain clinic wait	≥98.0%	100%
PPCI heart attack service – 150 min call to balloon time	≥80.0%	99.60%
Patients spending 90% hospital stay on specialist stroke unit	≥80.0%	74.15%*
Patients with high-risk TIA seen and scanned/treated within 24 hours	≥63.0%	67.88%*
Two-week maximum wait, referral to outpatient appointment (all cancers)	≥93.0%	97.40%*
Two-week wait – breast symptoms	≥93.0%	94.40%*
31-day diagnosis to treatment (all cancers)	≥96.0%	96.78%*
31-day second or subsequent treatment (anti-cancer drug)	≥98.0%	99.00%*
31-day second or subsequent treatment (surgery)	≥94.0%	94.60%*
31-day second or subsequent treatment (radiotherapy)	≥94.0%	95.90%*
62-day urgent referral to treatment (all cancers)	≥85.0%	81.40%*
62-day referral to treatment (from screening)	≥90.0%	93.70%*
Choose and Book slot issues	≤5.0%	11.10%
DNA (did not attend) rate – outpatients	≤7.2%	7.74%
New to follow-up outpatient appointment ratio	≤1.75	1.84
Pre-operative bed days	≤6.0%	4.84%
Delayed transfers of care (inpatients)	≤3.5%	2.52%
Cancelled operations	≤0.8%	1.56%

*Data only confirmed six weeks after month end - year-end outturn not confirmed until May 2015 for stroke standards and June 2015 for cancer standards

Overall the Trust's performance against standards set for it to be achieved during 2014/15 was broadly positive, although some areas saw performance slip slightly in comparison to the previous year.

Looking back across the year, emergency admissions were over 5% higher than in 2013/14 and related income correspondingly showed a £3.2 million increase versus plan. At the same time A&E attendance grew by 3.3%, which in line with previous years suggests that higher acuity levels resulted in more admissions. The level of elective admissions was almost exactly in line with those expected for the year overall and outpatient numbers were slightly below plan, due mainly to a reduction in the ratio of new to follow-up attendances.

Areas of specific focus for 2014/15 include:

- Regaining and maintaining the Trust's four-hour A&E standard performance, which like many NHS trusts across the country came under significant period during the recent winter months;

- Delivering sustained improvements across the Trust's 18-week referral to treatment standards, which were the focus of considerable operational focus during the last quarter of 2014/15 that yielded improvements that will need to be built upon and maintained throughout the coming year;

- Recovering the one cancer waiting time standard – 62-day urgent to treatment for all cancers – that the Trust just failed to deliver for the year, but where real; progress has been made during the last few months of 2014/15;

- Continuing to build on the improving performance of the Trust's acute inpatient stroke service, which will continue to represent an area of considerable attention for the coming year in line with standards set by local commissioners. To ensure that this happens, the Trust will continue to work closely with the Beds and Herts Heart and Stroke Network;

- Work to reduce further again the ratio of new to follow-up outpatient appointments, cancelled operations and the number of patients that do not attend (DNA) their outpatient appointment.

Clinical quality and patient experience indicators

In addition to the operational standards listed above, the Trust also worked to deliver a range of clinical indicators during 2014/15 – a summary of which are set out in the table below.

Healthcare quality indicator	2014/15 Standard	2014/15	2013/14 Outturn
MRSA blood infections (post 48 hours)	0	5[1]	2
Clostridium difficile infections	≤12	12	14
Net promoter score (*Friends and Family Test*) - inpatients	≥93.0	95.01	80.71
Number of inpatient falls	≤888	919	n/a
Pressure ulcers – grades two to four	≤24	54	45
Never Events	0	1	1
NPSA safety alerts outstanding	0	0	0
Hospital standardised mortality ratio (100 = expected NHS average)	≤93	92.31[2]	88.96
Summary hospital-level mortality rate (100 = expected NHS average)	≤105	112.90[3]	111.78
Summary hospital-level mortality rate – adjusted for palliative care	≤96	100.51[3]	100.43

[1]Of these five cases, only one was an avoidable blood stream infection – three were contaminated samples and one was an unavoidable case, although each of these four cases counted against the Trust's results for the year
[2]Rolling 12-month score, provided three months in arrears – means final 2014/15 position not known until at least July 2015
[3]Rolling 12-month score, provided six months in arrears – means final 2014/15 position not known until at least October 2015

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

Trust's financial performance

At the end of March 2015, the Trust reported a year-end deficit of £3.6 million against turnover of £375 million. This was in line with the year-end forecast, although not as good as the £0.5 million surplus planned at the start of the year.

In common with much of the rest of the NHS the Trust experienced a notable increase in emergency admissions during 2014/15, which has resulted in significantly increased costs above expectations by circa £2.1 million while the Trust was only reimbursed at marginal rates in accordance with national tariff rules. The Trust had also expected to be supported for significant one-off change costs of a further £2.1 million resulting from the consolidation of all remaining inpatient and emergency services from the QEII to the Lister by October 2014, but unfortunately no funding was made available.

Other financial issues of significance during 2014/15 were:

- The Trust met its external financing limit by achieving a year-end cash balance of £0.6 million against a requirement of no less than £0.6 million.
- The Trust's capital programme for the year totalled £28.6 million, of which £19.9 million related to completing phase four of the *Our changing hospitals* programme. The Trust came in on target against the Capital Resource Limit set by the Department of Health.

- Against a target of £26.1 million, the Trust delivered savings of over £25.0 million (96%) in 2014/15 – which is one of the highest percentage levels of savings achieved in the NHS.

Regulation and assessment-related information

Care Quality Commission registration

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions*. The Trust is registered to provide the regulated activities at the specified locations set out in the table below.

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

During October 2014, the Trust consolidated its acute inpatient services onto the Lister Hospital site. From that date, the QEII hospital no longer provides surgery nor has it had inpatient beds.

Inspections and reviews

The Trust has not received an inspection or been requested to participate in a special review by the CQC during 2014/15.

As in previous years, the Trust continues to monitor compliance against all the CQC requirements, including the two new regulations – *Duty of Candour* and *Fit and Proper Persons* – and has maintained a positive CQC Intelligence Monitoring Report during 2014 (band five - *bands range from one to six, with the higher the band the lower the risk profile.)* This approach is supported by an established programme of quality and safety audits to support embedding the standards and continuous improvement.

During 2015/16, the Trust will seek to improve further upon its performance with regulators such as the Care Quality Commission and continue a programme of self-assessment against the standards required by Monitor.

Listening to patients' concerns

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

The Trust's PALS teams, who work closely with their complaints colleagues, aim to resolve issues locally, without the need for these concerns to be escalated to a more formal level. The teams also try to make initial contact with complainants who have contacted the Trust by email to establish if their concerns can be addressed more effectively at a local level. During 2014/15, a total of 2,306 separate contacts were made with the Trust's PALS services – this includes those seeking direct help from the team themselves. The numbers using the Trust's PALS service during the year increased by around 34% compared with 2013/14 (1,715 separate contacts).

In addition to raising issues of concern, patients and visitors are also encouraged to feedback positive experiences of the Trust's services and these are then forwarded to the individuals concerned as well as to the Chief Executive's office for acknowledgement. Whenever appropriate, all relevant concerns are directed initially through to the service in question to help facilitate the earliest possible resolution. Concerns of a more serious nature can be escalated to the appropriate line manager.

During the year, the Trust's PALS service was brought together onto the Lister site and increased its opening hours, which may in part account for the increased activity.

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

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

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

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

Dealing with complaints and compliments

During 2014/15, the Trust received 1,180 formal complaints – an increase of some 37% on the number received the previous year. A particular increase was noted in October 2014 around the time when many services were being centralised at the Lister. This along with operational challenges such as the centralisation of the medical records service, along with telecommunication difficulties with the Treatment Centre and aspects of the appointments service, have contributed to this increase. The majority of complaints reported to the Trust, however, were of a low or moderate severity and related to delays and communication problems, rather than clinical treatment.

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 2014/15 there were 20 such meetings organised – four fewer than the previous year; this may indicate greater satisfaction with the initial complaint response. These meetings form part of what is known as the *local resolution* process.

In the 12 months to March 2015, a total of 10 complainants asked the Ombudsman (PHSO) to consider an investigation of their complaint, compared with 17 in the previous year. Of these 10 cases, nine related to complaints received in previous financial years. To date the Trust has received decisions on five investigations – two have been upheld and three were not upheld. The remaining five still being looked in to by the Ombudsman.

In addition to these complaints, during 2014/15 the Trust received formally 133 letters and e-mails complimenting the standard of care provided by its staff. This was in addition to the many hundreds of cards, notes, messages and small gifts that were given to ward staff directly.

Comments placed on NHS Choices

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

The total comments being made continues to grow year-on-year, with 2014/15 seeing, on average, between five and 10 comments being made each week on the Trust's four hospitals. Such means of online commentary are an increasing trend within healthcare, building on the success of such services as TripAdvisor in the holiday sector.

The vast majority of comments received through NHS Choices continue to positive of the care and treatment received at the Trust's hospitals and staff. Using the new five star rating system introduced in 2013/14, ratings for the Trust's hospitals at the end of March 2015 are as follows:

- Lister – overall rating of 3.5 stars based on ratings provided by 352 people (cleanliness – four stars; staff co-operation – four stars; dignity and respect – four stars; involvement in decisions – 3.5 stars; and same sex accommodation – four stars). Since the NHS Choices service started, the Lister has had 682 reviews.

- QEII – overall four stars based on 86 ratings (cleanliness – four stars; staff co-operation – four stars; dignity and respect – four stars; involvement in decisions – four stars; and same sex accommodation – four stars). Since the NHS Choices service started, the QEII has had 323 reviews.

- Hertford County – overall four stars based on 18 ratings (cleanliness – four and a half stars; staff co-operation – four stars; dignity and respect – four stars; involvement in decisions – three and a half stars; and same sex accommodation – four stars). Since the NHS Choices service started, Hertford County has had 60 reviews.

- Mount Vernon Cancer Centre – overall three stars based on five ratings (cleanliness – four stars; staff co-operation – four stars; dignity and respect – four stars; involvement in decisions – four stars; and same sex accommodation – four and a half stars). Since the NHS Choices service started, Mount Vernon has had 23 reviews.

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

The level of commentary on the Trust's hospital services through NHS Choices compares very favourably with that of nearby NHS hospitals. Based on those involved in star grading system introduced in 2012, no hospitals bordering the Trust received anything like the number of reviews of the Lister (3.5 stars based on 352 ratings):

- Addenbrooke's – 4 stars/111 ratings
- Bedford hospital – 4.5 stars/116 ratings
- Luton and Dunstable – 3.5 stars/130 ratings
- Princess Alexandra – 4 stars/157 ratings
- Watford General – 3.5 stars/160 ratings

Whilst it is difficult to draw any conclusions from the differences in levels of ratings made against different hospitals, it would seem that people in Hertfordshire appear more willing to use such services than perhaps those living in neighbouring areas. This seems to be particularly true of those being cared for at the Lister where the level of ratings left by patients and their relatives is running at between twice and five times the level of any other hospital locally. The slowing down in the number of ratings received for the QEII, especially during 2014/15, most likely reflects the switch in activity that has been taking place between the two hospitals since 2011/12 and that accelerated significantly last year.

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

Comments placed on social media channels/networks

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

This approach has led to a steady rise in followers of the Trust's social media channels, thus increasing the means through which people can feed back about the hospital services they receive. In total, membership of these services stands at some 2,780 followers of the Trust's Twitter feed and nearly 3,880 people who receive the Trust's postings on its Facebook channels.

The role of the Trust's hospital volunteers

Volunteering within the Trust is an excellent example of the local community and NHS staff working together to improve services for patients. The role of 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 750 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.

Volunteers support services in a wide variety of ways, working alongside other staff in all areas as an integral part of services. Duties range from providing therapies, gardening, giving support and advice, to helping on the wards and supporting people attending appointments

Reflecting on their role, one of the Trust's volunteers of three years' standing says:

> *"I like doing it, I love it! I am able to deal with people who are anxious with a smile and they talk to me. People feel worried and upset. I just talk to them, I am not medical, just a nice lady talking to them and making a cup of tea. I am their advocate."*

Education and training summary

The Trust remains committed to the development of its staff and recognises the importance of a workforce that is competent and fit for practice. During 2014/15 the Trust has continued to focus on a wide range of training and education for both clinical and non-clinical staff, including:

- The rollout of the Trust's non-medical statuary training programme (called *Vital*);
- An increased portfolio of clinical training for all staff including an on-going focus on dementia and simulation training;
- An enhanced multi-professional approach to learning across clinical groups including allied health professionals;
- A continued commitment to deliver a high quality learning environment for all pre-registration students;
- Continued development of leadership programmes, including a focus on change management in line with changes delivered through the Trust's *Our changing hospitals* programme.

Research and development overview

The National Institute for Health Research (NIHR) lists the Trust as one of the top 100 performers for research nationally. The number of new studies delivered in the NHS has increased, and the number of patients engaged in research activity has hit an all-time high. The Trust is one of the top 100 performing NHS organisations committed to delivering clinical research to time and target.

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

During 2014/15, the Trust had some 250 active research studies, that between them recruited around 2,000 participants; over 90% of these studies were funded externally. Patient recruitment into UK Clinical Research Network Portfolio studies has risen and been maintained over recent years. Up to the final quarter of 2014/15, 1,417 of the Trust's patients had participated in these studies, with the number likely to rise as reporting is completed for the year. Over the last three calendar years, i.e. 2012 to 2014, researchers at the Trust contributed to around 500 publications in peer-reviewed journals.

Systems are in place within the Trust to ensure that the principles and requirements of the national research governance framework are applied consistently through a full set of policies and standard operating procedures that have been ratified by the Trust. In connection with this work, the Trust hosted an MHRA Good Clinical Practice Inspection during 2013/14. The organisation provided corrective and preventative actions in response to the inspection report, which have been reviewed by the MHRA GCP Inspectorate and were considered acceptable. The inspection is now closed.

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

Impacts of research – cancer

It has been a challenging year for research activity at the Mount Vernon Cancer Centre. Transfer to the Eastern Region Comprehensive Research Network has resulted in the Trust having to find £160,000 worth of savings last year and a further 10% budget cut for 2015/16.

A review of the R&D working structure across the Trust, which was commissioned by the Trust's director of nursing, recommended a full scale workforce review, which is underway currently. This process aims to restructure the department across Trust so that there is a more hierarchical and equitable workforce on both main hospital sites involved in research (i.e. the Lister and Mount Vernon Cancer Centre). This will allow more efficient and productive working, which in turn will hopefully boost recruitment.

Recruitment to cancer trials has fallen nationally, as the studies themselves become more focussed and eligibility criteria are narrowed and tightened. There is also a nationally recognised problem with follow-up for patients in cancer trials as patients are now living much longer with cancer. Nevertheless the Trust has 103 trials open, ranging from large phase III to much smaller phase Ib/II trials (both academic and commercial). The cancer centre team is thus delighted that Division 1 continues to lead in trial recruitment for the Trust.

Research processes within the Trust have been changing substantially since the MHRA inspection of 2013 with the incorporation of standard operating procedures (SOPs) drawn up originally in conjunction with the Mount Vernon Cancer Centre/Royal Marsden Hospital Foundation Trust Academic alliance now being adopted across the whole of the Trust, ratified and uploaded in October 2014 and a new SOPs working party established to maintain and develop these for the future.

The workforce review mentioned previously includes the Trust/Mount Vernon R&D administrative team; the previous structure of R&D admin being shared between Trust and the West Hertfordshire Hospitals NHS Trust is to be dissolved soon. The new national Health Research Agency (HRA) proposals for streamlining R&D approvals (particularly in the pharmacy and IRMER requirements) are welcomed and implementation is expected within 2015 at all NHS trusts. It is not expected, however, that this will reduce any R&D administrative workload as costing and contracting for studies will remain a local concern for the foreseeable future. Exciting times lie ahead as processes and working practice are amalgamated within the new HRA framework across the whole of the Trust.

Impacts of research – renal medicine

R&D in the Trust's renal medicine service has continued to perform well. Along with other research active units within the Trust, the team has benefitted greatly from the new facilities available in the Lee Haynes Centre at the Lister. In the 11 months up to the beginning of March 2015, the unit has been responsible for the recruitment of 343 patients into 11 portfolio studies, 47 of whom were recruited into interventional studies.

Work has continued on seven grant-funded projects – three funded by NIHR Research for Patient Benefit, three by the British Renal Society and one from the East of England CLAHRC. Many of the projects involve collaboration with the University of Hertfordshire and with other renal units across the country. The combined grant value is in excess of £900,000. Some of the research capacity funding associated with the award of these grants has been used to fund work on the development of future grant applications within the unit, and other tranches to fund similar work in other disciplines.

The team is also pleased to report the award of an East of England CLAHRC fellowship to its research sister, Jocelyn Berdeprado, along with the award of a PhD to Dr Sivakumar Sridharan, for work carried out in the unit on new concepts of adequacy of haemodialysis treatment.

The research work carried out in the unit during the past and previous years has had considerable impact on patient care. The *SELFMADE* project, one of the NIHR studies referred to earlier, was completed successfully during the course of the year and has led to increased shared care in haemodialysis, increased availability of exercise on dialysis, and increased interest in peer-support. The Lister Area Kidney Patient Group is keen to help the team extend these initiatives. Work on haemodialysis adequacy also continues to inform the Trust's dialysis programme; previous work on end-of-life care has also helped improve practices. Findings from the team's research have been influential in informing nephrology practices generally, not just locally.

Impacts of research – cardiology

The cardiology team had the highest number of commercial studies in 2014 in the Eastern CRN. It is very active in research, with many on-going multicentre studies recruiting in a variety of cardiac conditions, including: SPIRE (lipid lowering); FOURIER (lipid lowering); ACCELERATE (acute coronary syndrome); GLORIA (atrial fibrillation); SOCRATES (heart failure); stent registries including e-Ultimaster and Biomatrix, PIONEER AF (atrial fibrillation and PCI); RESPIRE (pacing); Global Leaders (PCI); and Report HF (heart failure).

The commercial research income funds two cardiology research fellows, who work on in-house projects, CRN and commercial studies, as well as towards a postgraduate MD at the University of Hertfordshire. These junior doctors also support the cardiology on-call rota, which contributes significant savings to the Trust.

Professor Diana Gorog has been appointed as co-lead for Cardiology for Division 2 in the Eastern CRN. The cardiology team has produced seven peer-reviewed publications, with 12 abstracts presented at national and international conferences in cardiology.

Impacts of research – nursing

The current review of the Trust's R&D research workforce, structure, capacity, planning, development, accountabilities, job descriptions and roles, skill mix, finance and research governance is underway. There is also continued collaboration with the University of Hertfordshire regarding student placement within research and Masters of Clinical Research programme.

Recruitment strategy to allow research nurses to spend more time face-to-face with patients in clinics has been successful, with the implementation of clinical trials assistants (band 3/4) supporting teams. Research nurse education and training continues in partnership with ECRN Workforce Development.

2014/15 has seen progress with a more joined up research nursing/AHP structure between the Lister and Mount Vernon, including sharing good practice, portfolio trials and training. A successful award for Learning Disability involving researchers from the Trust, Addenbrooke's and Research for Patient Benefit currently is in the recruitment phase. A study investigating the value of the Waterlow score in predicting outcomes in acute medical admissions is also in the process of being evaluated. A Research for Patient Benefit submission is being progressed that investigates the role of tele-health, looking at reducing clinic attendance to improve patient experience with thyroid cancer.

This is the Trust's second year working in partnership with the Eastern CRN, with a 10% reduction in funding each year from 2015 to 2016. This change has had a significant impact on research nurse capacity to focus on nursing research due to the demand to recruit to portfolio trials to maintain funding.

Clinical service developments during the year

During 2014/15, much of the Trust's attention continued to be placed on completing the £150 million *Our changing hospitals* programme by October 2014. Whilst the projects within the programme did bring clinical benefits for patients, other important clinical and service developments that took place during the year included:

- **June 2014** – A new aromatherapy service was launched at the Lister's Diamond Jubilee Maternity Unit, the aim of which was to help improve the experience of women during labour and birth. The service is offered to women giving birth in the unit's midwife-led unit and uses a variety of essential oils to help women relax, and improve physical and psychological well-being during labour and birth. Aromatherapy oils can be administered by inhalation or in combination with other therapies, such as massage or compresses.

- **August 2014** – The results of a national peer review audit showed that the Trust's dedicated diabetes service for children and young people was the fourth best performing out of 147 NHS organisations across the country – and the best in the East of England. The national audit, which was carried out on behalf of NHS England, reviewed every aspect of the service in great detail, is proof of the high quality care that babies from birth through to young people aged up to 19 receive from the innovative multi-disciplinary team that works out of clinics at both the Lister and QEII hospitals.

- **October 2014** – Following the Trust's diabetes team becoming the first in the UK to provide a seven-day-a-week diabetes outreach team consisting of both specialist doctors and nurses, this achievement – which had brought real benefits to the care of hospital patients – won one of the prestigious national *Quality in Care Diabetes* awards in the *best inpatient care initiative* category. Following negotiations with local clinical commissioning groups, the Trust developed its diabetes outreach team to deliver seven-day, proactive ward rounds specifically targeting high-risk patients and delivering a comprehensive set of interventions. The latter includes patient education and direct clinical input, as well as access to smoking cessation and structured education programmes. The team's focus on supporting its colleagues in the Trust's emergency department colleagues has meant that readmission is avoided as much as possible and diabetic emergencies are dealt with by specialists.

- **December 2014** – Following a highly detailed audit carried out in 2014 by the Royal College of Paediatrics and Child Health, the Trust's epilepsy service for children and young people was rated as the best performing in the East of England. Those involved in this annual review – called Epilepsy 12 – looked at the whole service, from the support given to young patients in the community through to the care provided by their specialist hospital-based colleagues. In total the audit examined a range of indicators from the following 12 separate areas, with the Trust's service scoring highly in all 12. A 100% rating was achieved in the following important areas: having input from a consultant with expertise in epilepsy; input from a specialist nurse; appropriate first assessment; accuracy of diagnosis; information and advice; and patient experience in terms of the provision of the service, as well as information provided to the families of children with epilepsy.

Foundation trust membership report

Membership profile

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

Public constituency

The Trust set itself a challenging target to secure and retain a public membership of 11,000 people by 31 March 2015. The composition of this membership is monitored against a range of criteria including age, gender and ethnicity to help us make it more representative of the local communities served by the Trust.

Public members are local residents who are aged 14 and over living in the following local authority defined areas: Broxbourne; Bedfordshire; East Hertfordshire; the Mount Vernon Cancer Centre catchment area; North Hertfordshire and South Cambridgeshire; Stevenage; and Welwyn Hatfield.

The Trust has made significant progress in both recruiting and involving public members in 2014/15. By the end of the year, it had 11,378 public members in total – including 388 new young members aged between 14 and 16. Many of the new public members were recruited from communities the Trust had identified as a priority so that public membership better reflected the diversity of the communities served by the Trust's hospitals.

The Trust continues to offer prospective members flexibility in the ways they can get involved. Member satisfaction with involvement events, including the 2013/14 AGM attended by some 400 public members, staff and partners, consistently has been very strong throughout the year, averaging out at over 90%.

The Trust is offering more and varied opportunities for members to engage, sharing their views of services provided, what they think and becoming involved with the work of the Trust. A programme of workshops was delivered through the year that have sought member views on a variety of issues that are important to members ranging from way-finding/signage and sustainable development to complaints and catering/food.

The Trust has been particularly successful in recruiting and involving young people, developing an innovative approach that is fun and interactive and geared towards showing them what the NHS can do for them. The Trust's engagement team has worked with these new recruits to help redesign the offer being made to young people to ensure the Trust stays relevant and continues to attract new young members. This work has been showcased as best practice at regional and national events across the country. In particular, the Trust won the 2014 Inspiring Hertfordshire Community Champion Award and following being shortlisted for two NHS Sustainability Development awards for its work in the community and public health, the Trust won both categories and was named the awards' overall winner.

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

In the coming 2015/16 year, the engagement team aims to develop further the range and quality of the Trust's involvement programme for all members.

Staff constituency

The Trust's staff constituency has four classes:

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

Staff membership is an opt-out scheme, with this right being explained at induction as and when new staff join the Trust. The total staff members as of 31 March 2015 stood at 5,289 staff members.

Governors – making a real difference in Trust decision-making

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

Ahead of authorisation to become a NHS foundation trust, the Trust has secured nominations from many of the organisations selected to hold an appointed governor position on the Council of Governors. These individuals, who represent key partner organisations, have been participating in the work programme of the Trust's Involvement Committee in 2014/15 as a way to understand better the appointed governor role.

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

Contacting the Trust

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

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

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

Chapter 7: operational performance for 2014/15

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six.

In the previous chapter, the Trust's overall operational performance for 2014/15 was reviewed. Here the annual report seeks to provide further information on the Trust's operational management and performance.

Performance overview

The 2014/15 year represented a challenging period for the Trust, characterised by significant growth in emergency activity – including higher than usual volumes of patients being brought to the Lister's emergency department by ambulance. Despite these challenging circumstance, however, operational performance was maintained broadly across a number of key indicators.

As highlighted in the previous chapter, excellent progress was made against delivering the vast majority of patient access standards expected of the NHS, whilst also managing an effective efficiency savings programme.

The Trust has worked well with the whole health system across Hertfordshire in reducing the number of post-acute patients awaiting transfer to other providers. This achievement was sustained during the exceptional busy period immediately after Christmas and the New Year, when many Trusts were overwhelmed with exceptionally high levels of emergency demand.

The Trust's performance against the national four-hour A&E waiting time standard has been inconsistent over the year, due mainly to unusually high volumes of demand experienced over the winter in particular. Whilst the Trust's performance reflected that achieved nationally, it remains committed to delivering this important standard going forward, with plans being implemented that already are showing improved performance.

Good progress continued with regards to the 18-week referral to treatments standards and although the Trust did not quite achieve the admitted standard for several months, which affected the year-end position, the total number of patients waiting over 18 weeks has been reduced significantly.

Cancer waiting time performance continues to be strong across the majority of the standards and during the last quarter of 2014/14, the Trust is expecting to have achieved all of the standards – a level of achievement exceeds that exceeds the national average across some of the these very important standards.

The Trust's good operational performance during 2014/15 has been delivered during a period of reconfiguration and consolidation as the *Our changing hospitals* programme was concluded. The Lister's new emergency department, which only opened fully in its final format in October 2014, has led to improved patient experience.

During 2014/15, the Trust's specialist stroke unit was relocated into the Lister's Strathmore wing, which has facilitated an increase in the number of stroke beds available and enabled the creation of a stroke *step-down* ward for those patients that that are no longer in the acute phase of their condition.

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

Management arrangements

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

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

Clinical division	Specialties
Cancer services Dr Catherine Lemon, divisional chair Ella Stracey, divisional director	Clinical haematology Mount Vernon Cancer Centre Oncology Palliative care
Medicine Dr Jon Baker, divisional chair* Joanna Carter / Alison Pirfo (interim) , divisional director *Jon Baker is also the Trust's deputy medical 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 Dr Mike Chilvers, divisional chair John Fitzmaurice, divisional director	Anaesthetics Audiology Breast surgery Colorectal surgery Critical care, including intensive care and high dependency units Ear nose and throat (ENT) Gastroenterology General surgery Oral and maxillofacial surgery (OMFS) Ophthalmology Plastic surgery Sterile services Theatres Trauma and orthopaedics Upper gastro-intestinal surgery Urology Vascular surgery
Women's and children's services Mr Rob Sattin/Dr Linda Struthers, divisional chairs Christine Bell, divisional director	Child health, include acute and community services Gynaecology Maternity/obstetrics Neonatal intensive care, including special care baby units
Clinical support services Dr Tim Walker, divisional chair Eilish Midlane, divisional director	Health records Outpatients Pathology Pharmacy Private patients Radiological imaging

Activity planning

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

- Commissioning plans of clinical commissioning groups (CCGs) locally and specialised commissioning groups (SCGs) regionally/nationally;
- Choices made by patients through the national *Patient Choice* and *Free Choice* initiatives;
- Increasingly, the impact of decisions made by GPs through practice-based commissioning.

Although the Trust has developed longer-term activity plans through the integrated business plan required as part of the application process to become a NHS foundation trust, for the purposes of this annual report, the information available on activity plans is limited to the year ahead (i.e. 2015/16). This information, along with comparisons against the previous year's performance, is set out below.

Activity	2014/15 actual	2015/16 planned
A&E attendances (including the eye casualty service)	130,124	133,585
Outpatients – first appointments	114,317	121,046
Outpatients – follow-up appointments	250,323	266,953
Elective inpatients (i.e. planned admissions)	11,377	11,602
Elective day cases	23,188	24,329
Average length of stay for elective patients (days)	2.0	1.9
Non-elective inpatients (i.e. emergency admissions)	42,701	44,034
Average length of stay for non-elective patients (days)	3.8	3.6
Births	5,288	5,400

Emergency preparedness

Currently the Trust is revising its major incident and mass casualties plan to reflect the changes made through all emergency and inpatient services being brought together at the Lister. The plan complies with Department of Health guidelines and relevant legislation (Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2012).

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

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

The Trust has reviewed its business continuity plans taking into account the changes to the Trust. The review has made the document much more intuitive, easier to read from a user perspective and the use of flow charts has created consistency across all likely incidents including:

- Loss of power/water
- IT/telecoms
- Diagnostic equipment
- Fire

The key priorities identified for the forthcoming year include:

- Implementation of a training strategy for senior staff
- Testing the new major incident plan
- Continuing to develop the working relationships with NHS Hertfordshire and South Midlands
- Maintain and review of the risk register in relation to emergency and business continuity planning
- Embed the revised business continuity plans
- Continuing to identify key risks and appropriate actions to mitigate

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

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

Tel: 01438 314333
E-mail: jude.archer@nhs.net

Chapter 8: clinical performance for 2014/15

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

This chapter considers in more detail the Trust's performance during 2014/15. Unlike in previous reports, which focussed principally on reductions in hospital-acquired infections and improvements in the Trust's mortality rates, this year's report takes a wider look at performance around improving the quality of care and patients' experience of that care. The chapter also reflects on the Trust's performance around delivering commissioning for quality and innovation (CQUIN) and quality, innovation, productivity and prevention (QIPP) standards set for it by commissioners. A more detailed analysis of the Trust's clinical performance can be found in its 2014/15 Quality Account, will be available via the Trust's website.

Reducing hospital-acquired infections

During the 12 months to the end of March 2015, the Trust recorded five hospital-associated blood infections (bacteraemias) caused by Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteria strains, along with 12 cases of infections due to the bacteria *Clostridium difficile*. The targets for these two important causes of hospital-associated infections were none and 12 cases respectively.

Although the MRSA target was missed, three of the five recorded against the Trust were not blood stream infections but rather contaminants – i.e. these three patients were not affected. The Trust continues to work with its staff, especially doctors in training, to make sure that blood samples are collected properly and thus reduce the chances of contamination. The Trust has invested in a closed circuit blood culture system to ensure that an optimal technique can be safely practised. Of the two remaining MRSA cases, one was deemed as being unavoidable. In reality, therefore, the Trust had just one avoidable MRSA blood stream infection in 2014/15.

The Trust remains amongst the better performing NHS organisations in the country, especially for *Clostridium difficile*. This means that as a result of the Trust's proven infection prevention measures, its patients now have a very low chance of acquiring an infection that risks their recovery and discharge home.

During 2014/15, the Trust supported its local clinical commissioning group deliver a comprehensive educational programme for GPs to improve both the use of antibiotics in the community and awareness and understanding amongst primary care practitioners of *C. difficile*.

Levels of Norovirus infection outbreaks across the country rose in 2014/15 compared to the previous year. Where a Norovirus infection is suspected, the Trust's infection prevention team works with their clinical colleagues to contain the outbreak to individual wards or even bays within those wards.

By minimising the numbers of staff, patients and their visitors accessing these areas, the virus' spread can be kept in check. Strict hygiene is enforced and as soon as the last symptomatic patient has been symptom-free for 72 hours, then the ward or ward area is deep cleaned thoroughly. The latter includes the use of hydrogen peroxide vapour, which is shown to further reduce any organism or viral load in the environment, before reopening for new admissions. Symptomatic staff are sent home and told not to return to work until they too have been symptom-free for 72 hours.

Falling mortality rates

One of the single most important indicators when it comes to measuring the quality of NHS services is the mortality rate.

Crude mortality is a simple analysis of the percentage of patients who died against the number of admissions to hospital. The latest available year of data (March 2013 to April 2014) shows that the percentage of patients who die after admission to the Trust has fallen to 1.93% when compared to the percentage from the previous year when it was 2.00%.

Whilst an important measure, crude mortality makes no adjustment for the complexity of patients treated. This is why additional mortality measures have been adopted across the NHS that adjust for the complexity of services provided and the case mix of patients admitted for treatment to enable comparisons between the performance of different hospitals to be made.

The two main mortality measures used are:

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

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

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

HSMR

The most recent published data, for the rolling annual 12-month period from December 2013 to November 2014, is 91.9. Statistically speaking, this rating is better than the national position and represents a considerable improvement on the Trust's performance over the last three to four years, where recorded mortality was in line roughly with expected national levels.

SHMI

In use for around three years now, SHMI provides an overall rating that includes deaths following patient discharges (up to 30 days) that may be due to other causes. Unlike HSMR it does not make adjustment for palliative care. The Trust is one of a handful of hospital groups in the country that has an NHS hospice providing end-of-life care (Michael Sobell House at the Mount Vernon Cancer Centre) which contributes toward higher SHMI scores than otherwise might be the case.

The Trust's most recently published SHMI score, which was for the 12 months to June 2014, was 112.9. This value is slightly above the expected range for mortality on this measure – although certainly an improvement on the same rolling period three years ago (for the 12 months ending in June 2011), when the Trust's score was measured at 120.27.

The Trust is pursuing an active programme of measures designed to improve quality of care and promote patient safety, with the aim also of reducing mortality. These measures include the development of enhanced seven-day services.

For some patients who are approaching the end of their life, an admission to hospital may be neither helpful nor desirable. This is why the Trust is developing ways of caring for these patients in a more suitable, patient-focussed environment.

Reducing numbers of pressure ulcers

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

The Trust has reduced hospital acquired pressure ulcers year-on-year, with a total reduction of some 81% since 2011. During 2014/15, the overall number of hospital acquired pressure ulcers reduced slightly again, with a total of 104 for both avoidable and unavoidable pressure ulcers compared to last year's figure of 121.

In addition to the on-going reduction in the number of hospital-acquired pressure ulcers, the Trust has not recorded an unavoidable grade four – the very worst form of pressure ulcer – since October 2011.

The Trust's tissue viability nursing team continues to support the reduction in pressure ulcer incidence through innovative means, such as supporting the *World Stop the Pressure* month, when all inpatient wards were visited with a mobile display stand and pressure ulcer prevention discussed with the staff on duty. Another initiative was promoting the use of mirrors to aid the inspection of skin in such areas as heels. Display boards have also been located by wards to display the *Topic of the month* resources sent out by the Trust's tissue viability team, through which a different aspect of pressure ulcer prevention is highlighted each month. This overall approach has proved to be a popular and effective initiative with ward teams.

Preventing patient falls

Nationally 30% of people aged between 65 and 79 years of age, as well as 50% of those over the age of 80, will fall every year. It is well researched that people over the age of 65 who are admitted to hospital following an episode of acute illness are at a significantly higher risk of falling.

During 2014/15, 76% of inpatient falls in the Trust's hospitals involved a person over the age of 65, which is in keeping with the findings of national studies. In terms of harm:

- 98% of all falls recorded in the Trust during last year resulted in little or no injury to the patients involved;
- 0.8% resulted in a moderate level of harm, such as cuts requiring suturing or a small bone fracture;
- 1.2% resulted in a more severe injury being sustained by the patient involved, for example a fractured hip.

The total number of serious harm incidents caused by falls for 2014/15 at the Trust was 14, with two of these incidents contributing to the death of a patient. This is an improvement on 2013/14, when 16 severe harm falls incidents were recorded of which three of these contributed to the death of the patients involved.

The Trust has worked to reduce continually the number of patient falls incidents and since March 2011, the figure recorded has fallen by 55.4% (from 2,058 in 2010/11 to 919 during 2014/15). This much improved performance over recent years now places the in the top 10% of NHS trusts in terms of harm from falls per 1,000 bed days.

Improving patient experience

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

Patient and carer experience strategy

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

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

An evaluation of progress made during 2013/14 against delivering the strategy has been undertaken, which summarised the key actions towards achieving the seven ambitions. The Trust's patient experience committee considered the Trust's priorities for improving patient experience and agreed that the main focus for 2014/15 would be to manage safely the final phase of *Our changing hospitals* programme through focussing on the following key themes:

- improving communication and information pre- and post-operatively, actively promoting shared decision making – *no decision about me without me*
- improving staff attitude
- enforcing current policies, e.g. silent night campaign, red tray and jug procedure and intentional rounding
- Discharge planning and information at discharge
- Treating patients with respect and dignity
- Improving access – a transforming outpatient management (TOMP) work stream, led by the director of operations

Patient experience feedback

The Trust encourages patients actively to share their experiences, including letting the Trust know if there is anything that could have been done to improve their care. All such feedback is shared with the relevant ward or department teams, who are encouraged to display their *You Said – We Did* posters with details of the actions they have taken as a result of patient feedback.

New easy-read posters encouraging patients to feedback their experience have been produced and displayed in wards/clinic areas on all sites – see below.

The annual inpatient experience survey is undertaken in all NHS acute hospitals and results published by the Care Quality Commission. The results of the survey undertaken in July 2013 were received in April 2014 and reflected the views of 320 patients. This is only a small percentage of the number of inpatients who receive treatment and care in the Trust each year.

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

During 2014/15, 8,259 inpatients, 3,022 maternity patients, 4,703 outpatients and 360 A&E patients completed these surveys. Ward and department staff access the results of these surveys in real-time to enable prompt actions to be taken to address any problems areas. The highest performing areas of the electronic surveys are patients saying they have been treated with respect and dignity, along with feeling that hospital staff have done all they can to control their pain.

Patients are also surveyed following their discharge home from hospital using questions that mirror the national inpatient survey. 850 patients who had been in hospital during May 2014 were sent the survey, the response rate was 37%. The table below shows the Trust's performance against a range of patient experience indicators.

Patient experience indicator	2011/12 outturn		2012/13 outturn		2013/14 outturn		2014/15 outturn
Food quality	52	▲	54	▼	52	▶	52
Ward noise – other patients	56	▼	52	▲	54	▲	59
Ward noise – staff	78	▶	78	▶	78	▶	78
Patients' worries and fears	67	▼	64	▼	63	▲	64
Pain control	88	▶	88	▶	88	▲	90
Patient's awareness of danger signals	52	▲	53	▲	54	▲	55
Understanding nurses	81	▼	80	▶	80	▶	80
Understanding doctors	79	▼	77	▲	78	▲	81
Awareness of medication side effects	46	▲	48	▼	46	▲	53
Patients treated with dignity and respect	89	▲	90	▲	91	▶	91

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

Friends and Family Test (FFT)
The test is one simple question that is asked of patients when they are leaving hospital:

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

It was implemented across the NHS in April 2013 for inpatients, A&E and maternity services. NHS England produced new guidance for the Friends and Family Test in July 2014 for its roll-out to all NHS services, with the Trust asking the question of outpatients, day case patients and children the question from October 2014.

Between April 2014 and March 2015, the Trust received 53,141 responses from patients to the Friends and Family Test, which has given the Trust invaluable information about patient experience and enabled it to take actions to improve services for patients.

Throughout 2014/15, the Trust's inpatient wards consistently achieved higher scores under the Family and Friends Test than the national average for the proportion of patients who would recommend the wards to their friends and family. More information about the latest ratings can be found on Trust's website.

Carers
The Trust is working to improve the experience of carers and hosted quarterly focus groups throughout 2014/15; a dedicated survey is also available to capture comments and suggestions from carers. A carers policy is now in place at the Trust, which includes a carer's agreement that details the discussion with carers about how care will be provided to their relative or friend. There is also a carers page on the Trust website, which has a wealth of information to support carers and details of benefits available to them. In November 2014 the Trust supported the national *Carers Rights Day* with a display stand providing advice and information to family carers from Carers UK, Carers in Hertfordshire, Crossroads Care and Money Advice.

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

In 2014/15, the stories of 24 patients were recorded, with the key themes emerging shared within the Trust and with the Trust Board. Every Board meeting includes a patient story – this may be an audio recording or a patient and/or their relative attending in person to talk about their experiences.

Kissing it Better
The Trust continues its work with the charity *Kissing it Better*, with the aim of making a difference to patients. Through well-established links with North Herts and Oaklands colleges, student beauticians and hairdressers visit weekly as part of their timetable to provide hand and arm massages, manicures and hairstyling to patients. The initiative also hosts regular visits from Pets as Therapy (PAT) dogs as well as visits from singers, choirs and drama students who entertain our patients.

Through *Kissing it Better*, the Trust has developed close links with Stevenage Day Care Centre and groups of young adults have spent time maintaining two garden areas at the Lister.

Trust's 2014/15 CQUIN performance

A proportion of the Trust's income from its commissioners in 2014/15 was conditional on achieving specific quality improvement and innovation goals agreed through the commissioning for quality and innovation (CQUIN) payment framework.

The CQUIN framework is a way of improving quality by providing a financial incentive. The Trust receives either a full or part payment depending upon the results it achieves. The maximum potential value of the CQUIN payment to the Trust in 2014/15 amounted to approximately £7.0 million of which some £6.0 million was received from the Trust's commissioners (subject to final confirmation). The Trust main CQUINs for 2014/15 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met – the final position will only be known once all outturn figures have been received, which can take up to two months after formal year-end.

	CQUIN scheme	Percentage value with 100% scheme achievement	Actual scheme achievement*	Percentage value awarded with actual achievement	Approximate value (£000s)
1	Friends and Family phased expansion	10%	91%	9.1%	636
2	NHS Safety Thermometer	5%	60%	3%	209
3	Diagnosis and care of dementia	5%	100%	5%	349
4	Implementation of individual care for patients at end-of-life	10%	100%	10%	568
5	Unscheduled care	10%	79%	7.9%	449
6	Implementation of acute chest team	20%	83%	16.5%	938
7	Diabetes Care	12.5%	94%	11.7%	666
8	Seven-day working in stroke	15%	66%	9.9%	565
9	Workforce	12.5%	100%	12.5%	710
	Other schemes with specialist commissioning				860
	Totals	**100%**	**n/a**	**90%**	**5,950**

*Final scheme achievement subject to outturn position agreed for 2014/15, which is not available until June 2015

Chapter 9: financial performance for 2014/15

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

Review of 2014/15

Having delivered a surplus for the past seven years, the Trust produced a deficit in 2014/15 of £3.6 million. In common with much of the rest of the NHS the Trust has experienced a significant increase in emergency admissions which has resulted in significantly increased costs above expectations by circa £2.1 million while the Trust has only been reimbursed at marginal rates in accordance with national tariff rules. The Trust had also expected to be supported for significant one off change costs of a further £2.1 million resulting from the consolidation of all remaining inpatient and emergency services from the QEII hospital to the Lister by October 2014, but unfortunately no funding was made available.

Excluding drug expenditure (which is a cost passed directly on to commissioners) the Trust's clinical income ended the year very close to the original plan. Emergency admissions were over 5% higher than in 2013/14 and related income correspondingly showed a £3.2 million increase versus plan. This is despite the fact that A&E attendance levels grew by only 3.3%, but with higher acuity levels resulting in more admissions.

Elective activity levels, although very much in line with plan in absolute terms were weighted toward specialties with lower tariffs (for example more endoscopy work and less complex orthopaedic work than planned) resulting in a negative income variance of £2.2 million. The number of outpatient procedures recorded grew substantially and this was responsible partly for the drop in outpatient follow-up activity, while the number of first attendances was broadly in line with plan. Activity levels (and income) at the Mount Vernon Cancer Centre were relatively stable, but the Trust's maternity services did not achieve some of the ambitious growth targets set at the beginning of the year.

The funding mechanism for emergency activity, where any over-achievement of the agreed plan is reimbursed at 30% of the national tariff, continues to be a significant pressure for the Trust, although the local clinical commissioning group (CCG) did recognise the pressure being generated by exceptional growth levels at the beginning of the year and adjusted the level of threshold reductions accordingly. Penalties for readmissions also continue to be challenging and the total amount of funding withheld from the Trust under these two headings was similar to that applied in 2013/14.

Against a target of £26.1 million, the Trust delivered savings of over £25.0 million (96%) in 2014/15, which is one of the highest percentage levels of savings achieved in the NHS.

During the year, the Trust drew down long-term capital investment loans of £1.9 million and received £6.9 million of Public Dividend Capital from the Department of Health. This was to support its strategic investments in the *Our changing hospitals* programme which was largely completed in October 2014.

Despite the 2014/15 deficit, the good financial performance of the Trust in previous years means that it still achieved its statutory breakeven duty. Successful management of the Trust's capital programme and working capital also enabled delivery of the Trust's other two statutory duties – i.e. not to exceed its external financial limit (EFL) and to achieve a 3.5% return on net relevant assets. The value for money opinion from the external auditors is generally very positive but with an *except for* caveat as a result of the in-year deficit.

Capital spending

The Trust's total capital expenditure during 2014/15 was £28.6 million.

The most significant investment related to the final phase to complete the Trust's *Our changing hospitals* programme, which brought all of the Trust's inpatient and emergency services on to a redeveloped Lister hospital site. The most significant capital spend relating to the programme in 2014/15 were around finalising works on: the new emergency department (£3.8 million); additional theatre capacity (£7.4 million); new ward block (£2.6 million); and other schemes (£4.7 million).

The Trust invested a further £0.9 million during 2014/15 on new information technology, £1.1 million on medical equipment and £1.5 million on estates maintenance. The Trust also received and spent additional funding following a successful bid to the Department of Health of £768,000 for the Trust's renal service from the national nursing technology fund.

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

The Trust began planning and implementing its *Our changing hospitals* programme in 2009/10, which resulted in a consolidation of acute inpatient and emergency services from the QEII on to the Lister site in October 2014.

The total Trust investment involved in this work is nearly £88 million, which has been financed through a combination of Department of Health loans (£63.5 million), Public Dividend Capital (£17.3 million) and operational capital funding. Other projects in the programme, including the creation of the Lister's Treatment Centre (formerly independent of the Trust, but returned to the NHS in September 2013) and a multi-storey car park, were funded by private sector partner organisations.

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

Looking to the future

2014/15 was a challenging year for the Trust and the NHS as a whole. It is expected to be just as challenging in 2015/16 with the Trust currently projecting a deficit of £8.0 million and so the whole health economy will need to work closely together in order to contain costs. The Trust will continue to ensure it has sound financial management in place to support its ambition to become a NHS foundation trust and for future investment in local health facilities.

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 95% of all trade creditors should be paid within 30 days of a valid invoice being received or the goods being delivered, whichever is the later – unless other terms have been agreed previously.

The Trust's detailed performance against this target for non-NHS creditors is set out in note 11 in the annual accounts shown below. Due to the more challenging financial environment its overall performance in relation to the code has reduced by a few percentage points to 71.1% of non-NHS trade invoices paid within target in 2014/15. The Trust has also signed up to the Government's *prompt payment code*.

Chapter 10: workforce review

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

Workforce statistics

In the table below, a summary of workforce-related statistics is provided for 2014/15, alongside figures provided for the previous two years. The figures are the average for the years ending 31 March.

Activity	31 March 2015	31 March 2014	31 March 2013	31 March 2012
Staff employed (full time equivalents)	4,582.82	4,797.40	4,703.04	4,730.01
Vacancy rate	7.11%	5.64%	8%	8%
Turnover rate	12.91%	10.63%	10.3%	10%

The Trust delivered successfully the final phases of the *Our changing hospitals* programme in October 14 which was one of the biggest such programmes within the NHS nationally. With more than 3000 staff involved in the consultation process, the Trust's turnover rate was high for the months of October, November and December 14 and the rate is now stabilising with some key measures being put in place including the introduction of exit interviews and proactive approaches from the feedback received. The Trust also conducted the smooth TUPE transfer for 223 pathology staff to the Cambridge University Hospitals NHS Foundation Trust and Public Health England last year.

With the recent introduction and use of *Vacancy Predictor*, work is being undertaken to ensure that the current vacancy level of 8.18% continues to be reduced, with a projection to reach below the 5% target after June 2015. Since September 2014, the Trust has continued to engage in various recruitment campaign activities resulting in an increase in staff numbers joining the Trust.

The sickness rate reported for 2014/15 was 3.55%%, which was slightly lower than in the previous year and compares favourably with the 4% average achieved by large acute NHS trusts across the country. The aim for 2014/15 is to maintain a sickness absence rate below 3.5%, particularly in areas that are above this threshold currently. If achieved, this would place the Trust in the top 20% performing NHS organisations in the English Health Service.

The Trust has begun a programme to encourage staff to become *health and well-being champions* in their local areas, giving employees a platform to learn and participate in health-related activities in line with the 2009 review by Dr Steve Boorman, which made clear that the NHS needs to:

"….support and improve the health and well-being of its workforce if it is to meet the challenge of delivering high-quality care without excessive cost."

The Trust has approved the implementation of electronic staff record (ESR) self-service, which will allow staff and managers have access to real time data on sickness and, therefore, increase opportunities to manage individual sickness absence rates more effectively.

During 2014/15, the Trust's workforce and organisational development team was short-listed for the national Healthcare People Management Association 2014 Excellence in HR Awards for the CIPD award for best improvement of HR capability in a team.

Recruiting and retaining staff

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

Within Hertfordshire, it continues to work in partnership with the education sector in promoting careers within the NHS. The Trust also works in partnership with the local community to develop pathways into employment for disadvantaged groups. Additional work has been undertaken to review a number of workforce schemes associated with recruitment, including streamlining the total recruitment process, in order to reduce the gap between a member of staff leaving and their replacement starting in post. This work involved the procurement of a new recruitment system and the implementation of an electronic DBS (previously CRB) system, which have all contributed to reducing the length of time to recruit.

The Trust continues to work on reducing the length of time that it takes to fill vacancies so that wards, departments and other areas can be staffed appropriately in order to deliver excellent patient care. The Trust reached the projected target reduction and is on track to have a 5% vacancy rate by June 2015. This is a result of continuous recruitment activities that have taken place since September 2014 to reduce the vacancy rates.

A variety of recruitment campaigns continue to be used, including cohort nurse and overseas recruitment, to maintain safer staffing levels. The Trust's priority areas for recruitment remain being its emergency department, renal and inpatient ward services.

The project where auto enrol all eligible Trust staff to the NHS Professionals Bank in order to make it easier for those staff to undertake additional shifts to help improve our staffing levels.

A highly skilled workforce

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

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

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

Additional management and leadership development initiatives available to staff include:

- A regional nurses day
- Preceptorship programmes, incorporating leadership development
- NHS graduate trainee scheme
- Quarterly ARC sessions for leaders and line managers

During 2014/15, the following development opportunities were provided to the Trust's staff:

- 41 managers completed an internal leadership and management development programme
- 71 attended bespoke leadership and management courses developed in partnership with the University of Hertfordshire including change leaders and handling challenging conversations.
- Over 240 managers attended in house management skills courses including appraisal and core management skills for new managers
- 32 managers are accessing national leadership development programmes
- 12 managers/staff trained to conduct *patient stories* to gain valuable feedback from patients on their experience of being treated here

In addition during 2014, the Trust's organisational development team supported the *Our changing hospitals* programme by providing specific training interventions to support individual staff, managers and teams. The following figures illustrate how many were trained through this activity:

- 75 managers trained on preparing for OCH 1:1s
- 277 staff attended interview skills workshops and drop in sessions
- 17 managers attended *conducting effective interviews* workshops
- 47 staff attended *moving through change* workshops
- 28 managers attended *building and developing high quality team* sessions
- 57 managers were given 1:1 support with team building
- 163 staff attended bespoke team building sessions for their department

A number of staff also undertook training to become an accredited coach and a coaching network has been established this year working with our partner organisations across Bedfordshire and Hertfordshire to offer a coaching service to managers. A number of the Trust's staff accessed 1:1 coaching during the year.

Appraisals and professional revalidation

Staff appraisals

The Trust recognises the importance of regular appraisal for all staff and continues to monitor closely and take steps to achieve improved completion rates. Compliance rates continue at around an average of 70% (against a target of 90%).

In 2014 a new process for appraisals was designed and launched to improve the quality of appraisals, as well as the consistency of ensuring they are completed. The development and implementation of the new appraisal framework, process and policy introduced the following changes during the year:

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

Over 1,000 managers have been trained as part of the new appraisal process launch to understand how to implement effectively the new processes with their staff.

Professional revalidation

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

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

The administrative duties for the revalidation process in the Trust is co-ordinated by a revalidation officer and necessary information is provided by the Trust's medical staffing team in collaboration with the employee relations advisory service on on-going Maintaining High Professional Standards (MHPS) investigations, disciplinary action or information that impacts on the revalidation process.

The Trust's employee relations advisory service (ERAS) was launched on 1 April 2015, replacing the previous service offered by Capsticks. The new dedicated onsite team aims to forge excellent working relationships with staff, managers and staff side.

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

Medical education and training

The Trust's medical education team delivers high quality education and training, actively promotes the development of clinical educators and supports trainers in developing the workforce of the future. The team has nurtured excellence in medical education and has developed an outstanding learning environment in the Trust. A strong governance structure coordinates educational activities across the Trust.

Medical education board members	
Chairman and director of medical education	Shahid Khan
College tutor (Mount Vernon)	Nicola Anyamene
Foundation training programme directors	Tim Lane (F1) and Deepak Jain (F2)
Deputy director (nurse education)	Carolyn Fowler
Dental tutor	Kevin Jones
Undergraduate tutor	Mary Lynch
Associate clinical tutor for SAS doctors	Farrukh Shaikh
Trainee representatives	Ben Wheelan and Oren Green
Medical and dental education manager	Christine Crick
Library resources manager	Joan Lomas

Along with many other departments in the Trust, 2014/15 has been a challenging year for the medical education service. Consolidation of educational services at the Lister site was a key step in their streamlining, with the final merging of the QEII and Lister's education teams having led to improvement in delivery of education. Equally, the bringing together of the Lister and QEII hospital libraries, along with their relocation within the Lister Education Centre, has been a significant development. This change has led to 24 hours library access and availability of library outreach service to the Trust staff.

Development of multidisciplinary education and training is at the heart of the educational philosophy. Trainees and students are valued and there is commitment to education. Active involvement of trainees at every level of the organisation has been a priority. Development of educational faculty groups, educational leads and trainee representatives in every department has helped with improving quality of training in the Trust. Trust trainee forum and trainee representation at the Trust's education committee has encouraged trainees to work with the education team to improve standards of care in the Trust.

Trainer selection, appraisal and training have been established in line with General Medical Council recommendations. Trainer education is ongoing in collaboration with the University of Hertfordshire.

For undergraduate education, links have been strengthened with the Cambridge Medical School and student numbers visiting the Trust are proposed to increase even further by 2017/18. Historic links with University College London are still maintained with continued medical student intake.

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

The Trust's non-medical education and training team has continued to develop and deliver education that reflects service requirements, innovation of education provision and the learning needs of individuals within the Trust. During this year when the Trust's *Our changing hospitals* programme completed, this has required an increase in learning opportunities within wards and departments as staff moved teams and specialisms. The education team secured funds from Bedfordshire and Hertfordshire Workforce Partnership to support this work and following this project, a comprehensive competency programme has been developed.

£434,831 (Bedfordshire and Hertfordshire Workforce Partnership funding) was spent on commissioning continuing professional development, which included bespoke leadership programmes run locally, (58 attendees). Thirty two staff were also supported to undertake National Leadership Academy Programmes, including the Nye Bevan and Frontline Leaders programmes. A further £51,434 was invested in emergency and community education in support of the Lister's expanded emergency department service. A total of 220 university-run specialist courses were commissioned for Trust staff.

The non-medical education team take responsibility for developing and delivering the Trust's statutory training programme, *Vital*. This was developed further to be available for all non-medical and medical staff, with 86% overall compliance by the end of the year.

The team is also responsible for the placements of pre-registration nurses, ensuring a high quality learning environment on the wards that leads to meaningful and creative learning opportunities. Throughout the year students have been involved actively in education initiatives, including *International Nurses Day*, *NHS Change Day*, and *Dementia week*. One student nurse received the Elaine Anderson Prize from the University of Hertfordshire, for *the most caring nurse of the year* after being nominated by the Trust. The education team provides regular education forums and drop-in surgeries for students. These have proved invaluable in providing a safe place for students to raise concerns and have their voice heard.

The team delivered a huge variety of innovative learning opportunities during 2014/15, including:

- A patient safety day, using a patient journey film made by the education team
- Two bespoke leadership programmes, supporting ward staff in transition to ward sisters and managers
- Dementia training, with an objective to ensure all clinical staff has dementia awareness training
- The use of patients' stories and learning from incidents
- Ward-based teaching and learning
- The launch of a new diabetes e-learning module for all clinical staff

During the recruitment of overseas nurses, the team has been instrumental in providing induction training, as well as bespoke education programmes to meet the needs of these new nurses.

The team has continued to drive forward opportunities for band one to four staff, increasing the number of apprenticeships for those in both clinical and non-clinical roles. The team now has two members who have been recruited through the *Princes Trust*, who have proved an invaluable addition. The latter part of the year has been spent preparing for the new national *Care Certificate* for clinical support workers – a national mandatory requirement that was launched in April 2015. The Trust has been a key leader in this development across Bedfordshire and Hertfordshire, with one of the education team's members leading the project for the local Workforce Partnership.

A new aspect to the team's work has been to develop volunteering opportunities for school students; this has included bespoke experience days; opportunities working with the team; and an exciting project where school children have worked alongside a learning disability team of clients working in the Trust's gardens.

The education team has delivered an innovative and comprehensive education and training programme throughout 2014/15. Its vision is to continue this work, developing a new ward accreditation programme and expanding on its opportunities to engage with young people, exposing them to the huge variety of NHS careers.

Equality and diversity

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

The Trust's equality and diversity annual report, which was produced in September 2014 and presented subsequently to the Trust's risk and quality committee, contains the most recent data and summary of the Trust's workforce profile in terms of equality and diversity; it can also be located on the Trust's website.

Key ethnicity data for this year shows the profile of the workforce as 69% white. This means that the Trust's ethnic representation is higher than that of the local communities served (as reflected in the 2011 Census, which recorded 80% white for these communities overall).

The Trust also adopted the equality delivery system (EDS) to help it meet Equality Act 2010 requirements and has been working on implementing this system throughout the organisation. Evidence on equality performance was gathered and presented for assessment to the Trust's first RAGP (red, amber, green, purple) panel in March 2012. This has provided the Trust with firm equality objectives, which were published in April 2012 on the Trust's website. Progress on delivering the scheme is monitored by the Trust Board, with action plans reviewed annually.

The launch of the EDS2 in November 2013 has seen this work continue and engagement events to review our objectives and progress are being set up currently. Progress has been made against the equality delivery system actions, examples of which include:

- An EDS2 engagement event in 2014 focusing on the Trust's objective to ensure it has a representative and supported workforce
- Increasing the number of staff completing equality and diversity training – something on which work continues to ensure that training levels increase further

Equality impact assessments

The Trust ensures that equality impact assessments (EIAs) are completed for all policies and changes to services. A summary of EIAs are available for all staff to access on the Trust's staff intranet (the *Knowledge Centre*). All Trust policies are ratified through appropriate committees and the Trust's clinical governance process ensures all clinical policies have an EIA attached. The Trust has a guide to assist managers in completing the EIA process.

Raising issues of concerns policy and procedure

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

Several cases have been investigated and supported under the policy, which were raised via a variety of routes. Further to the publication of the Robert Francis QC's *Freedom to speak up* report, a review of the Trust's current policy is being carried out to identify any additional improvements that could be made to Trust practice.

Chapter 11: staff, public, patient and GP engagement

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

Engaging with the Trust's staff

Informing and consulting staff

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

- **Trust Brief** – a monthly cascade briefing process, which reports discussions that take place on strategic issues taken in public session at Trust Board meetings. The future of *Trust Brief* is underway, the aim of which is to provide a vehicle that better suits the information needs of the Trust's members – staff and public;

- **Focus groups/briefings** – where the views and input of staff is required on specific projects and changes, the Trust seeks to take issues out to them – either in full open-house sessions that anyone can attend, or to individual departmental and/or team meetings. This process has been used to develop a number of key strategies across the Trust, including the organisation's new people strategy, nursing and midwifery ambitions and the health and well-being strategy.

- **Workshops** – dedicated time where invited staff can debate specific issues relating to aspects of major strategic projects being worked on by the Trust. The ARC programme is a good example of this approach and forms part of the Trust's people strategy. Each quarter, executives – including the chief executive – meet with around 300 of the Trust's clinical and non-clinical leadership in open discussion on various topics of importance to the Trust and its staff – see chapter five of this annual report for more information.

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

- **The Knowledge Centre** – the Trust's staff intranet service has grown to become one of the single biggest sources of general information within the Trust. This format means that pages can be updated quickly to reflect new priority areas for the Trust. The chief executive also has an *AskNickCarver* service whereby all staff are able to pose questions to him directly around issues they would like to raise; the service is used consistently by the Trust's staff.

- **Trust Bulletin** – a weekly newssheet issued through the Trust's all staff e-mail service, carrying a wide range of operational information.

- ***Our changing hospitals* e-newsletter** – issued electronically on a periodic basis to all Trust staff throughout 2014, providing general updates on the Trust's *Our changing hospitals* programme, along with links through to dedicated information pages on the Knowledge Centre.

- **Patient Safety Matters** – bi-monthly newsletter produced in-house at the Trust and issued electronically to all staff, with the aim of highlighting and promoting patient safety issues.

Trust Partnership
Running alongside all of these staff communication and involvement activities, the Trust also has a history of positive partnership working relationships between staff and management side representatives through what is known locally as *Trust Partnership*.

Trust Partnership meets every month, with the chair of this group alternating between the chair of staff side and the Trust's director of workforce and organisation development. This very important forum is used to discuss and agree a wide range of issues, including new and updated Trust policies and change management issues. Through *Trust Partnership*, staff side representatives are invited to sit on a wide range of committees and project groups.

Public and patient engagement

Health scrutiny committee
The Trust values the county's health scrutiny committee and has continued to support and inform the committee's work programme during 2014/15, including providing reports on our response to Francis, finance, patient experience, performance and workforce. The Trust always ensures that Board-level directors present the Trust's contributions to the committee's debates.

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

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

The Trust has also worked in partnership with Healthwatch Hertfordshire during 2014/15 in continuing to support local community groups, such as the Stevenage Health Involvement Partnership, as well as finding patient representatives for the annual Patient-Led Assessment of the Core Environment (PLACE).

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

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

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

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

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

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

Hertfordshire Health and Well-Being Board
From March 0215, the Trust has been invited to sit on the county's health and well-being board to help determine health and social care priorities.

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

Patient experience feedback

Patients and carers are encouraged actively to share their experience of the Trust's services. Patient experience data, including survey responses and Friends and Family Test scores, are monitored closely and a monthly patient experience dashboard compiled.

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

Feedback from patients and carers is encouraged through the use of patient experience surveys, the national Friends and Family Test, post-discharge telephone calls, discussions with staff and volunteers in the Trust's Patient Advice and Liaison Service (PALS) team, as well as written compliments or concerns.

The Trust also welcomes comments through social media channels and websites such as NHS Choices and Patient Opinion. All this feedback is shared with the appropriate teams and used to make changes and improvements to services. Further information about this work is set out in chapter eight of this document.

Clinical commissioning group, GP and Local Medical Committee engagement

Clinical commissioning groups and GPs

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

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

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

The Trust's annual GP survey was conducted in November 2014, giving GPs and practice managers an opportunity to voice their opinions on the Trust, its services and communication with the primary care community. Their feedback is shared with the Trust's clinical divisions and Board committees to help inform priorities and improve the quality of the services provided and, hence, patient experience.

Local Medical Committee

The Trust has continued to develop its relationship with the Bedfordshire and Hertfordshire Local Medical Committee (LMC), with liaison meetings with the Trust's chief executive, and a presentation by the medical director at an area meeting. The Trust and LMC have also worked together to identify ways that they can work together to ease communication difficulties between hospital clinicians and GPs. This has resulted in a jointly funded secure web-based directory holding contact information for GPs and consultants.

Chapter 12: sustainability

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

Environmental impact – context

In 2012 the carbon footprint of the health and care system was 32 million tonnes of CO_2 emissions, which represents 40% of the public sector in England. These 32 million tonnes were driven largely by emissions from:

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

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

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

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

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

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

- **Goal 2: Communities and services are ready and resilient for changing times and climates** – the focus is on multiagency and community planning to prepare for periods of extreme events such as floods, heat waves, etc.

- **Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments** – every contact and decision counts towards helping people to be well can help build the medium and long term benefits of helping people to be well and reducing their care needs. Supporting communities and people to be independent and self-manage conditions and events.

The Trust's own *sustainable development strategy* sets out its response to the current demands for carbon reduction and covers the five year period from 2009 to 2014. The Trust strategy for the next five years is currently being updated and it will incorporate the themes and requirements of the new national strategy.

The Trust's current position

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

The Trust commissioned independent energy consultants to establish the organisation's carbon footprint baseline (2007) and in accordance with NHS requirements. This position is reassessed every year to identify reductions in carbon associated with initiatives and changes in the Trust activities and the results, recorded in tonnes of CO_2 emissions (tCO_2e), are shown in the table below – note that figures for 2014/15 will not be available for some months yet due to the way these figures are calculated.

Scope	2007 baseline	2012/13	2013/14	2015 target
Procurement, estates, catering, wages, etc.	58,231	45,105	45,170	52,407
Utilities	16,382	15,344	16,090	14,743
Travel	8,309	8,226	8,261	7,479
Total footprint	**82,922**	**68,675**	**69,521**	**74,629**

The Trust has continued to achieve meeting the 2015 target, albeit with a slight increase in 2013/14. Overall since 2007, carbon emissions at the Trust have reduced by 16.1%.

The increase in utilities generated carbon emissions in 2013/14 is the direct result of the Treatment Centre transferring to Trust ownership in 2013, as well as the completion of the new build extension to the Lister's emergency department. There has also been slight increases in waste production across the Trust's sites as departments began to de-clutter ahead of the opening of new facilities built through the *Our changing hospitals* programme. The impact of other new buildings created as part of the programme is also illustrated in the predicted 2014/15 carbon emissions levels, where a small increase in emissions is predicted (16,500 tonnes). This is impacted further by double running the Lister and QEII sites post consolidation. The carbon emissions are expected to reduce again by 25% on closure of the old QEII hospital building in Spring 2015 once the new hospital opens.

The Trust remains confident, therefore, that it can continue to deliver further reductions and thus remain exceeding the NHS 2015 target in coming years.

Trust's *Our changing hospitals* programme

The completion of the *Our changing hospitals* programme, culminating in the consolidation of inpatient and emergency services on to the Lister site in October 2014, has ensured a more sustainable future for clinical services as follows:

- Creating a critical mass of clinical and specialist staff to allow the Trust to sustain a wider range of high quality services than would otherwise be possible, as well as introduce new technologies;
- Allowing the Trust to achieve best clinical practice and improve outcomes and productivity across the organisation;
- Providing the means for the Trust's response to the challenging economic conditions forecast for the NHS through enabling quality improvements alongside increased productivity (QIPP Quality Innovation Productivity and Prevention);
- Creating a critical mass of clinical and specialist staff to allow the Trust to sustain a wider range of high quality services than would otherwise be possible and introduce new technologies;
- Enabling viable 24/7 medical staffing rotas for all services to be maintained;
- Facilitating the modernisation of the Trust's facilities, improving the ability to attract patients through choice;
- Improving the experience of patients and their relatives who access the services provided by the Trust;
- Improving the ability to attract and retain high quality staff, as well as allow the Trust to prepare for a future in which more acute care is provided in the community;
- Enabling reductions in estate and related costs from the reshaping of the QEII site, to offset the income loss and support the revenue consequences of the capital investment at the Lister.

In addition by working to meet BREEAM standards (environmental assessment method and rating system for buildings), the Trust has created opportunities to increase the green spaces and biodiversity of the site and explore new technologies in the following ways at the Lister:

- Creation of a plaza by the main hospital entrance – a popular green space amenity for patients and staff to use all year round;
- Creation of a green wall along the side of the multi-storey car park:
- Creation of a green roof on the new emergency department roof;
- Creation of relaxation garden for use by patients undergoing outpatient chemotherapy;
- Planting 73 new trees ;
- Erection of Swift and hawk nesting boxes
- Use of a wind turbine and photovoltaic cells, generating power for use by the multi-storey car park

During 2014/15, the Trust also began working with the RSPB's urban advisory unit to identify further opportunities for environmental enhancement. As a result of this collaboration, 18 new trees from NHS Forest were secured for planting at the Lister to enhance further the biodiversity of the site. Further initiatives from this partnership will develop in the forthcoming year.

On-going initiatives

During the last year work, the Trust has continued on the implementation of its green travel plan focusing on the introduction of new criteria for those staff requiring on-site parking permits at the Lister. The changes were introduced during September and October 2014 in support of the final implementation of the *Our changing hospitals* programme.

Staff members who live within a boundary area of some three to four miles of the Lister no longer qualify automatically for on-site parking where alternative transport is available and working patterns allow. Consequently, staff are encouraged to use alternative forms of transport, supported by initiatives such as WalkBUDI, BikeBUDi and the introduction concessionary travel passes with local bus services.

The number of car share parking spaces has also increased in the last year from 8 to 16, with 17 active car share buddy groups formed. This equates to a reduction of 11.69 tonnes of CO_2 per annum through this initiative alone.

Working with the Trust's procurement partner, Hertfordshire NHS Procurement, carbon reduction initiatives continue to be included within all purchasing, including:

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

The Trust's engagement team continues to work with local community groups that have a positive sustainability impact in terms of promoting public health and reducing inequalities. The young member's conference held in conjunction with Hertfordshire County Council, Priory and Nobel Schools is a recent examples of the team's work.

The team also continues to encourage email as the primary method of communication with the Trust's public members, with over 75% of new members since 2012 utilising this service. Work continues to request email information for those members joining prior to this date, however currently this stands at 41%. Unfortunately a lack of demand for the car share scheme meant this was not utilised for this year's AGM, which is thought to be due to the time of year that it was held.

Other new schemes this year included:

- A pilot to install energy saving control equipment that will switch off air conditioning units when rooms are not in use;
- Initial discussions of further use of local suppliers for catering ingredients with assistance of the Essex and Sussex Purchasing Organisation (ESPO);
- Negotiations with other bus companies to secure discounts for staff, in addition to those offered by Arriva already.
- Purchase and promotion of a personalised travel planning service has also been purchased, allowing staff to review alternative ways of travelling to work from their home address using different forms of transport to the private car. The scheme provides costs of options and savings of both money and carbon to support staff to make informed choices on their chosen method of travel.

Carbon reduction commitment energy efficiency scheme

Like all NHS organisations, the Trust is mandated to participate in the carbon reduction commitment scheme – with which it registered on 30 July 2010 and submits an annual report annually. For 2014/15, the Trust pays the carbon tax for the preceding year's emissions (2013/14) at a new cost of £12.00 per tonne. Based on the tonnes of carbon produced in 2013/14, the Trust's costs under the scheme were £80,904.

The Trust is also registered for the EUETS (European Union Energy Trading Scheme) scheme for the operation of the energy centre. In 2013/14 the Trust paid 42,255 Euros (currently @ 5.06 Euros/tonne) in carbon tax for the EUETS scheme.

The total carbon emissions CRC/EUETS cost for the Trust for 2013/14, therefore, was £116,821, which represents a saving of £42,970 compared to the previous year. This is due largely to the requirement to change from the CRC scheme to the EUETS scheme for gas consumed (Lister site only) meaning that the Trust paid a reduced tax levy.

The Trust's current ERIC benchmark position for 2013/14 is 6th out of 37 comparable sized NHS trusts across the country – a marked improvement from the 17th place achieved in 2011/12. This is largely the result of the installation of the CHP unit, however a number of other initiatives such as lighting replacement have assisted in achieving such an improvement.

Sustainable development management

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

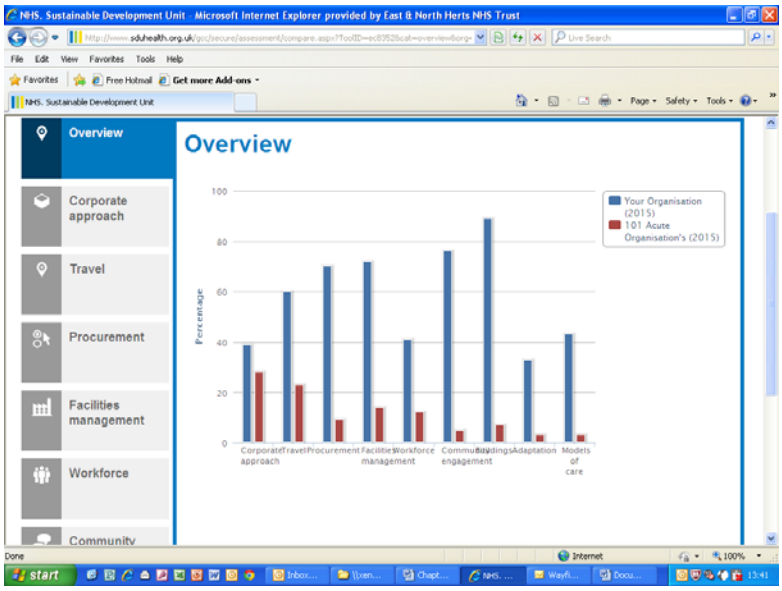
The Trust registered for the *Good Corporate Citizen* scheme in 2010, which represents a valuable tool used to identify how the organisation contributes to sustainable development and ensuring that day-to-day activities support, rather than hinder, progress with sustainable development. It is an extremely valuable self-assessment tool that also enables the Trust to nationally benchmark its progress against other similar Trusts.

The Trust achieved a *Good Corporate Citizen* score of 50% in 2014, but throughout the year this increased to 62% by March 2015.

A number of actions were also implemented to assist with achieving the goals set out in the model including:

- Exploration of the use of electric vehicles and pool bicycles, with electric bicycle trial sessions underway within the Trust;
- A review of business and staff travel practices with activity to reduce the numbers of parking permits required on an on-going basis;
- Inclusion of sustainability on all Trust inductions for new staff;
- Where possible, inclusion of sustainable development clauses within tendering documents and contracts.

Comparatively the score achieved by the Trust is considerably higher when reviewed alongside the scores of NHS trusts across the country. A graphical representation of the scores can be seen on the next page, alongside the average scores for other NHS trusts.



The Trust's return for the NHS Sustainability Reporting Framework for 2014/15 can be found in the appendix included at the end of this year's annual report and accounts (see page 162 onwards).

Chapter 13: governance and the trust board

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

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

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2014/15, please go to chapter six of this annual report

This section of the 2014/15 annual report is used to set out how the Trust is managed and decisions are made, along with the governance arrangements that are put in place as appropriate checks and balances.

The Trust Board

The Trust's board consists of a non-executive chairman, five non-executive directors and five executive directors – the chief executive and the medical, nursing, finance and operations directors. In addition, two further executive directors – for strategic development and workforce and organisational development *(from January 2014)* – and a non-executive director designate participate in board meetings, but do not have voting rights.

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

The chairman and non-executive directors were, until 1 October 2012, appointed by a national body, the Appointments Commission, on behalf of the Secretary of State for Health. This function was taken over by the NHS Trust Development Authority on 1 October 2012. The normal term of office served by the chairman and non-executive directors is four years, renewable for a further four-year period. The executive directors are appointed by the Board on permanent contracts.

The role of the NHS trust board

The Board's role includes:

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

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

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

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

The role of the NHS trust chairman

The chairman's role is key in creating the conditions for overall board and individual director effectiveness, with his/her main responsibilities being:

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

The role of non-executive directors

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

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

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

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

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

The Trust Board 2014/15

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
FPC – Finance and performance committee
RAQC – Risk and quality committee
RC – Remuneration committee
CTC – Charity trustee committee

Notes to committee attendance

1. The executive committee (EC) is a weekly meeting that is attended by all executive directors, unless absent from the Trust.
2. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. In particular, the chairman attends all Board committees regularly although he is no longer a designated member. The committee attendance figures listed below do not take into account these additional attendances; rather they reflect attendances that are *expected*.

Ian Morfett, chairman

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 Ian 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. Originally appointed a non-executive director from 1 August 2005, Ian was reappointed from 1 August 2009. Ian became chairman of the Trust on 1 April 2012. Ian lives in Letchworth.

Committee membership: RC, CTC, IC
Attendance: Trust Board 11 out of 12; FPC 9 out of 11; RAQC 5 out of 11; RC 7 out of 7; CTC 3 out of 4; IC 2 out of 3

Nick Carver, chief executive

The chief executive is the accountable officer for the Trust and carries full responsibility for its performance, forward planning and leadership of the executive team and clinical directors. Nick was appointed as the Trust's chief executive in November 2002, having been a successful chief executive of a hospital trust in the Midlands for the previous three and a half years. Nick has led the organisation through financial turnaround and major service change and has been instrumental in securing public and political support for a major reconfiguration of hospital services that will bring substantial quality and financial benefit to the local health economy. Nick started his NHS career as a qualified registered nurse in 1982, before developing his interest in health service management. In addition to holding his registered general nurse (RGN) qualification, Nick holds a BA (Hons) in political theory and government, as well as an MSc in health care management. In 2013, Nick was presented with the *Inspirational Leader of the Year* award by Health Education, East of England.

Committee membership: EC, FPC (core attendee), RAQC (core attendee), AC, RC
Attendance: Trust Board 10 out of 12; FPC 9 out of 11; RAQC 11 out of 11; AC 4 out of 6; IC 2 out of 3; RC 5 out of 7

Alison Bexfield, vice chairman

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

Committee membership: AC, FPC, RC,
Attendance: Trust Board 9 out of 12; AC 5 out of 6; FPC 10 out of 11; RC 5 out of 7

Dyan Crowther, non-executive director

Dyan Crowther joined Network Rail as route director for London North Eastern in December 2004, from Arriva Trains Northern where she had worked as its commercial director from March 2002 and was promoted to managing director in October 2003. Dyan took over the role of route director for Midland and Continental in May 2008. She has over 20 years' experience in the rail industry. Prior to joining Network Rail, Dyan held a number of strategic roles within the former infrastructure company, Railtrack, including executive for West Coast (South) in the Midland Zone. Dyan has a masters degree in transport and logistics from Salford University and is a member of the Chartered Institute for Marketing. Dyan was appointed as a non-executive director in July 2010. She chairs the Board's *risk and quality committee*. Originally from Wiltshire, Dyan is married and has three children.

Committee membership: RAQC, RC
Attendance: Trust Board 9 out of 12; RAQC 6 out of 11; RC 6 out of 7

Julian Nicholls, non-executive director

Julian has spent 20 years successfully managing substantial business to business services companies in the UK and Europe. 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. He spent parts of his early career working in Africa, Middle East and South East Asia. Julian was appointed as a non-executive director in July 2010 and chairs the Board's *finance and performance committee*.

Committee membership: AC, FPC, RC
Attendance: Trust Board 10 out of 12; AC 6 out of 6; FPC 9 out of 11; RC 5 out of 7

Stuart Gavurin, non-executive director

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

Committee membership: FPC, RAQC, RC, CTC
Attendance: Trust Board 11 out of 12; FPC 9 out of 11; RAQC 9 out of 11; CTC 2 out of 4; FTC 1 out of 1; RC 6 out of 7, AC 1 out of 6

Bob Niven, non-executive director

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

Committee membership: RAQC, RC, AC, CTC, RC,
Attendance: Trust Board 11 out of 12; RAQC 10 out of 11; AC 6 out of 6; CTC 2 out of 4; RC 6 out of 7

John Gilham, non executive director (designate)

From 1 December 2014

John joined the Trust on 1 December 2014 as a designate non-executive director. John lives in Brentwood and has previously held chief executive roles at Southend University Hospital and the Princess Alexandra Hospital in Harlow. John started his NHS career as a medical laboratory scientific officer and has since held a range of managerial roles. In total, John has worked for the NHS for over 30 years. John holds a masters degree in business administration and has particular interests in patient safety and the quality of care patients receive. John is passionate about the NHS – two of his three sons also work for the NHS. John recognises the importance of staff engagement and the role it plays in providing high quality of services for patients.

Committee membership: RAQC
Attendance: Trust Board 5 out of 5; RAQC 4 out of 4

John Watson, director of operations

The Trust's director of operations is responsible for the day-to-day running of hospital operations, its divisions and divisional management teams. John joined the Trust at the start of February 2013, having previously been the director of operations at Ipswich Hospital NHS Trust for three years. Prior to this role, he held acting director of operations and divisional manager posts at Kings College Hospital in central London. John has also completed the Public Service Leaders scheme, which included a two-day a week secondment to the Department of Health. Having started his NHS career in 1990, John has a BSc in social policy and economics and MSc in health policy, planning and financing – both from the London School of Economics.

Committee membership: EC, FPC (core attendee), RAQC (core attendee)
Attendance: Trust Board 9 out of 12; FPC 10 out of 11; RAQC 8 out of 11, AC 3 out of 6

Jane McCue, medical director

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

Committee membership: EC, RAQC (core attendee)
Attendance: Trust Board 10 out of 13; RAQC 10 out of 11

Angela Thompson, director of nursing

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

Committee membership: EC, RAQC (core attendee), FPC (attendee)
Attendance: Trust Board 11 out of 12; RAQC 9 out of 11; FPC 9 out of 11

Paul Traynor, director of finance

Paul was appointed as the Trust's finance director in May 2009. He joined from Dartford and Gravesham NHS Trust, where he had been finance director since mid-2005. Previously, Paul held a similar role at Kent Ambulance NHS Trust, and prior to that he held a number of senior finance positions in both acute hospitals and primary care trusts. He joined the NHS in 1990 and completed his accountancy qualification in 1995. Paul left the Trust on 31 October 2014 to take up a new post at the University Hospitals of Leicester NHS Trust.

Committee membership: EC, CTC, FPC (core attendee), AC (core attendee)
Attendance: Trust Board 7 out of 12; CTC 2 out of 4; FPC 5 out of 11; AC 4 out of 6

Tony Ollis, director of finance (from October 2014)

Tony joined the Trust in November 2014 as finance director responsible for the Trust's strategic financial planning, maintaining and developing its financial systems and ensuring strong financial controls. He has been working in the NHS for a number of years, most recently as the finance director at the former Barnet and Chase Farm NHS Trust, where he provided the financial leadership for a major site redevelopment and significant clinical reconfiguration together with the subsequent integration with the Royal Free NHS Foundation Trust. Prior to this role, Tony had been the finance director of Buckinghamshire PCT where he was a key player in delivering a significant financial turnaround. He also brings significant experience from the private sector, most recently with GE and Schering Plough. Tony is a member of the Chartered Institute of Management Accountants.

Committee membership: EC, CTC, FPC (core attendee), AC (core attendee)
Attendance: Trust Board 6 out of 12; CTC 1 out of 4; FPC 6 out of 11; AC 2 out of 6

Stephen Posey, deputy chief executive

Stephen joined the Trust as its director of strategic development in 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, Stephen undertook a number of senior management roles across both primary and secondary care. Stephen was responsible for the delivery of the Trust's acute consolidation programme, which completed in 2014. Called *Our changing hospitals*, it was a £150 million investment programme to reconfigure the Trust's acute services across east and north Hertfordshire. Appointed deputy chief executive in 2014, Stephen's executive lead responsibilities include: involvement and engagement; the Trust's NHS foundation trust application; major strategic projects; IM&T; business development; and the leadership of the Trust's transformation programme office.

Committee membership: EC, CTC, FPC (core attendee), RAQC (attendee)
Attendance: Trust Board 6 out of 13; CTC 3 out of 4; FPC 7 out of 11; RAQC 0 out of 11

Tom Simons, director of workforce and organisation development
Thomas joined the Trust in February 2013, and has been a full board member since January 2014. He is responsible for staff recruitment, medical staffing, managing organisational and cultural change and leadership and management development. He also oversees the development and governance of the Trust's workforce. Before joining the Trust, Thomas had extensive experience of leading large-scale organisational mergers including the recent merger of three acute hospital Trusts in London to create Barts Health NHS Trust. Before that, Thomas held senior change management roles in the health sector. Thomas holds a master's degree in human resource management and is a full member of the Chartered Institute of Personnel and Development. He is also vice-president of the healthcare people management association (HPMA) for the East of England.
Committee membership: EC, FPC (attendee), RAQC (core attendee), RC
Attendance: Trust Board 10 out of 12; FPC 8 out of 11; RAQC 10 out of 11; RC 7 out of 7

	Title	Appointment date	Term(s) of office	Term of office ends
Ian Morfett	Chairman	1 April 2012	Four years	31 March 2016
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chairman	1 February 2008	Four years plus four years	31 January 2016
Dyan Crowther	Non-executive director	1 July 2010	Four years plus two years	30 June 2016
Julian Nicholls	Non-executive director	1 July 2010	Four years plus two years	30 June 2016
Stuart Gavurin	Non-executive director designate*	15 August 2012	n/a	Ended 31 May 2013
	Non-executive director	1 June 2013	Two years	31 May 2015
Bob Niven	Non-executive director designate*	1 September 2013	n/a	Ended 5 January 2014
	Non-executive director	6 January 2014	Four years	5 January 2018
John Gilham	Non-executive director designate*	1 December 2014	n/a	
Jane McCue	Medical director	1 April 2012	Four years	31 March 2016
Angela Thompson	Director of nursing	30 August 2011	n/a	n/a
Paul Traynor	Director of finance	1 May 2009 to 31 October 2014	n/a	n/a
Tony Ollis	Director of finance	20 October 2014	n/a	n/a
John Watson	Director of operations	4 February 2013	n/a	n/a
Stephen Posey*	Director of strategic development	21 January 2008	n/a	n/a
Tom Simons*	Director of workforce and organisation development	02 January 2014	n/a	n/a

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

Remuneration and interests

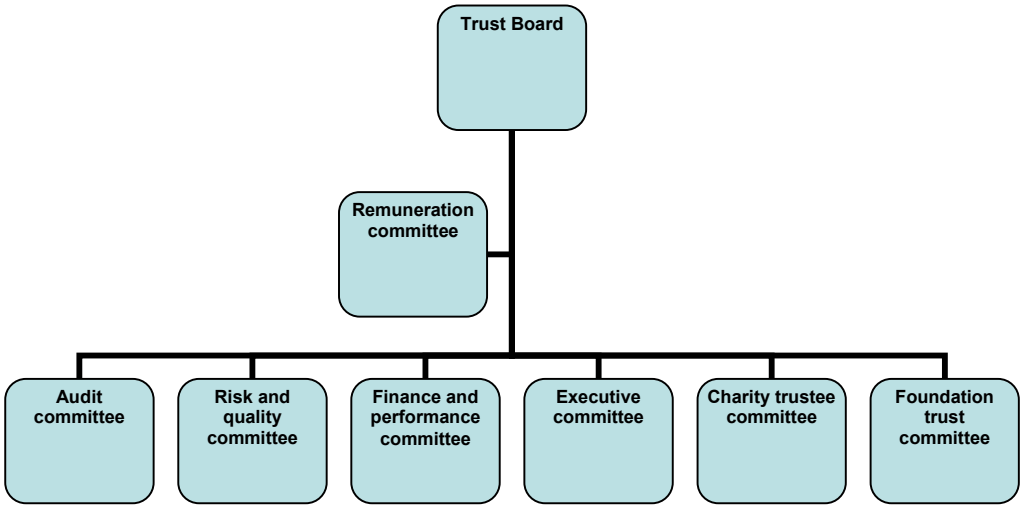
The remuneration of individual directors can be found in the accounts section of this annual report. All the Trust's directors – both executive and non-executive – make annual declarations of directorships and/or other interests they hold that are relevant and material to NHS business matters. This register of directors' interests, along with expenses incurred by directors in pursuing Trust work, is published on the Trust's website.

For further information, please contact:

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

Governance structure

The Trust Board has a number of formal board assurance committees (see diagram on the next page) that are supported by a system of line accountability through executive directors, rather than through sub-committees. An internal review of the each committee is undertaken annually to ensure that it continues to meet its terms of reference and operate effectively.



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

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

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

The *finance and performance committee* meets monthly and has a membership of three non-executive directors who hold the executive to account for effective progress in managing financial, performance, strategic development, data quality and marketing strategy.

The *charity trustee committee* provides stewardship of the Trust's charitable funds on behalf of the Board, which is the corporate trustee, and is responsible for the charity's strategy.

The Trust's *executive committee* comprises all executive directors and is also attended by the director of strategic estates, the director of business development and partnerships, the associate director for public affairs and the company secretary. This committee meets weekly and covers all major service, performance and organisational issues. Each fortnight it also meets with the divisional chairs and directors of the Trust's five clinical divisions. In addition, each division meets with the executive on a bi-monthly basis through a performance review system introduced in 2007/08 as part of the performance management framework.

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

- **Division of surgery** (divisional chair, Dr Michael Chilvers and divisional director, John Fitzmaurice)
- **Division of medicine** (divisional chair, Dr Jon Baker and divisional director, Jo Carter/ Alison Pirfo)
- **Division of clinical support services** (divisional chair, Dr Tim Walker and divisional director, Eilish Midlane)
- **Division of cancer services** (divisional chair, Dr Catherine Lemon and divisional director, Ella Stracey)
- **Division of women's and children's services** (divisional chairs, Mr Rob Sattin/Dr Linda Struthers and divisional director, Christine Bell)

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 2014/15, the Trust's external auditor was Grant Thornton UK LLP.

Private finance initiative (PFI) schemes

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

Fixed assets

As set out in note 15 of the 2014/15 accounts section, fixed assets are stated at the lower of replacement cost and recoverable amount. An annual review is carried out for any potential impairments and a formal revaluation of land and building values is carried out at least every five years. It is the directors' opinion that there are no fixed assets where the market value is significantly different from the value included in the financial statements.

Post balance sheet events

There have been no post balance sheet events to the 2014/15 accounts.

Pension liabilities

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

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

The full accounting policy can be viewed under note 1.8 and valuation details can be viewed under note 10.6 in the annual accounts contained in this report.

Special severance payments and exit packages

Special severance payments when staff leave public service employment are exceptional and will always require HM Treasury approval. The Trust has no delegated authority to make such payments unless so approved. No such payments were made during 2014/15.

Information governance

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

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

For 2014/15, the Trust achieved the minimum level two compliance for all requirements in the information governance toolkit and thus achieved a *satisfactory* rating. Overall, the Trust's score was 85%, similar to the previous year.

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

The Trust reported one information governance serious incident to the Trust's commissoners and the Information Commissioner during 2014/15. This was a disclosure in error. A patient had received 26 letters concerning 13 patients (duplicates and one of which was her own). The letters were from the Trust's breast unit service and contained sensitive personal data. All of the letters had been posted in one handwritten envelope.

A full investigation has been completed and the main learning identified was that there were no standard operating procedures in place for the staff to follow and that different practices were in place on different sites; actions have been implemented to prevent reoccurrence, including the: implementation of standard operating procedures; additional training for staff; and review of the team structure and leadership.

Remuneration report

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

The remuneration committee is a committee of the Trust Board, consisting of the chairman and all the non-executive directors. It is chaired by the vice chairman. The committee is supported by the chief executive, director of workforce and organisational development and the company secretary. The remuneration committee aims to meet quarterly to fulfil its duties and it met four times during 2014/15. Details of directors' remuneration are given in the annual accounts.

Every year, the Board's remuneration committee considers the performance and contribution of each director against the functions. This is carried out in parallel with a detailed review at least every two years of remuneration for individual posts within regional and national markets. In April 2013, the committee took into account a benchmarking report prepared by an external body.

Executive Director and CEO pay is then set based on the following principals;

- what they bring to the role – their experience, capability
- their marketability and importance to the organisation – their previous salary history, how in demand are they by other organisations and how important are they to the Trust
- the 'going rate' for the job and what it means for the person you wish to appoint or retain
- pay keeps track with inflation

This is also set against an outline pay framework which is as follows;

- **Median pay** – for those performing at that 'meet expectation' or 'professional talent' or where pay is significantly below median and incremental movement needs to be made (i.e. not large increases based on one year's exceptional performance)
- **Upper quartile pay** – for those performing at 'exceeds expectation' or 'ready now' for more senior roles

The committee also pays due consideration to what is happening in the financial environment and with its other employees when determining executive director's remuneration. Remuneration for executive directors does not include any performance-related bonuses and none of them receive personal pension contributions other than their entitlement under the NHS pension scheme.

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate. During 2014/15 the Trust recruited a new director of finance. Non-executive directors were involved in the recruitment of this post.

All the Trust's executive directors hold permanent contracts. The notice period for executive directors is six months. 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 nonexecutive directors and three and half days per week for the chairman.

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

Salary and pension entitlements of senior managers

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

Nick Carver
Chief Executive

Remuneration tables

Name and title	2014/15						2013/14					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Executive directors												
Nick Carver Chief executive	180-185	4	0	0	0	180-185	175-180	8	0	0	0	175-180
Paul Traynor (to 31/10/14) Director of finance	80-85	67	0	0	0	85-90	130-135	92	0	0	0	140-145
Anthony Ollis (from 1/11/14) Director of nursing	60-65		0	0	0	60-65	n/a	n/a	n/a	n/a	n/a	n/a
Angela Thompson Director of nursing	115-120	1	0	0	0	115-120	110-115	3	0	0	0	110-115
John Watson Director of operations	105-110		0	0	0	105-110	105-110	0	0	0	0	105-110
Jane McCue Medical director	135-140	2	0	0	0	135-140	115-120	2	0	0	0	115-120
Stephen Posey Director of strategic development	115-120	62	0	0	0	120-125	105-110	56	0	0	0	110-115
Tom Simons (from 2/1/14) Director of workforce and organisation development	85-90	45	0	0	0	90-95	20-25	1	0	0	0	20-25

Name and title	2014/15						2013/14					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ian Morfett Chair	20-25	0	0	0	0	20-25	20-25	0	0	0	0	20-25
Alison Bexfield Vice-chair	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Dyan Crowther	0-5	0	0	0	0	0-5	0	0	0	0	0	0
Julian Nicholls	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Stuart Gavurin	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Bob Niven	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
John Gilham (from 1/12/14)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Karen Pettit (to 31/10/13)	0	0	0	0	0	0	0-5	0	0	0	0	0-5

Notes to remuneration tables (pages 90 and 92)

- Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, having the effect of reducing the salary paid during 2013/14 and 2014/15.
- Dyan Crowther did not draw a salary from the Trust in 2013/14.
- Karen Pettit was on sabbatical from 01/03/13 until her resignation on 31/10/13 so did not draw a salary in 2013/14
- Jane McCue's contract changed during 2014/15, which included working an additional PA in her medical director role and the full-time effect of her Clinical Excellence Award

Pay multiples

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

The mid-point of the banded remuneration of the highest paid director in the Trust in 2014/15 was £182,500 (2013/14 – £177,500). This was 6.5 times (2013/14 – 6.3 times) the median remuneration of the workforce, which was £28,076 (2013/14 – £28,076). The slightly increased multiple is due to an increase in the remuneration of the highest paid director, while the median was unchanged.

In 2014/15, 20 employees (2013/14 – 20 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £13,076 to £249,906 (2013/14 – £11,905 to £264,932). The lowest paid employee is part of a salary sacrifice scheme, which has had the effect of reducing pay; otherwise the lowest paid employee would have been £14,294, which is the bottom of the *Agenda for Change* pay scales. There has been an apparent reduction in the salary of the highest paid employee, which was caused by that person's remuneration for 2013/14 having included a backdated clinical excellence award increase that was effective from 1 April 2012.

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

Pension benefits

Name and title	Real increase in pension at age 60	Real increase in pension lump sum at aged 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at aged 60 related to accrued pension at 31 March 2015	Cash equivalent transfer value at 1 April 2014	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2015	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver	2.5-5	7.5-10	60-65	190-195	1,162	79	1,272	0
Chief executive								
Anthony Ollis (from 1/11/14)	0-2.5	n/a	10-15	n/a	156	25	185	0
Director of finance								
John Watson	0-2.5	5-7.5	30-35	100-105	514	49	577	0
Director of operations from 04/02/13								
Stephen Posey	2.5-5	7.5-10	25-30	75-80	275	44	327	0
Director of strategic development								
Angela Thompson	2.5-5	7.5-10	45-50	135-140	785	70	876	0
Director of nursing								
Jane McCue	2.5-5	12.5-15	55-60	175-80	1,102	128	1,260	0
Medical director								
Tom Simons	2.5-5	n/a	5-10	n/a	61	23	86	0
Director of workforce and organisation development (from 2/1/14)								

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

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

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

There are no lump sums to be disclosed in respect of Tom Simons or Anthony Ollis as they are members of the 2008 section of the NHS Pension scheme.

Off-payroll engagements

In line with national guidance, the two tables below set out off-payroll engagements with the Trust. For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	18
Of which, the number that have existed:	
- for less than one year at the time of reporting	13
- for between one and two years at the time of reporting	3
- for between two and three years at the time of reporting	0
- for between three and four years at the time of reporting	1
- for four or more years at the time of reporting	1

NB: *These figures include high value agency workers, as well as independent contractors.*

All recent off-payroll engagements for independent contractors have been subject to a risk based assessment as to whether assurance was required that the individual is paying the right amount of tax and, where necessary, that assurance was sought. Work is in hand to establish a similar process in respect of high value agency workers.

For all new off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements between 1 April 2014 and 31March 2015	15
Of which:	
Number of new engagements that include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations.	6
Number for whom assurance has been requested	6
Of which:	
- assurance has been received	0
- assurance has not been received	6
- engagements terminated as a result of assurance not being received	0

NB: *These figures include high value agency workers, as well as independent contractors.*

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

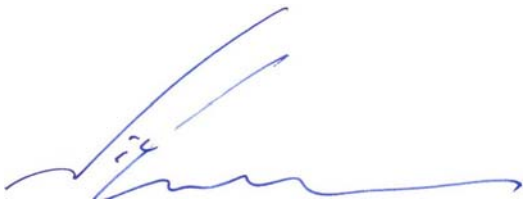
Chapter 14: annual accounts for 2014/15

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

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

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

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

Signed  Chief Executive

Date: 27 May 2015

Statement of directors' responsibilities in respect of the accounts

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

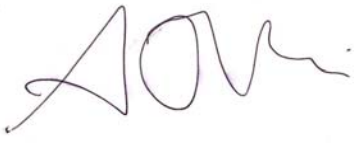
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

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

By order of the Board

Date: 27 May 2015  Chief Executive

Date: 27 May 2015  Finance Director

Annual governance statement 2014/15

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

Executive summary

My annual governance review of 2014/15 confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of the organisation's objectives. The Trust has a programme that regularly monitors and tests various aspects of its governance and risk management structures to ensure they remain fit for purpose. Overall, no significant internal control issues have been identified that would impact on the delivery of the Trust's strategic and annual objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2015/16. The report below summarises the key areas that informed this opinion.

1. Scope of responsibility

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

In undertaking this role I, and my team, have developed strong links with the NHS Trust Development Authority, local clinical commissioning groups (CCGs) and partner organisations.

2. The governance framework of the organisation

2.1 The purpose of the system of internal control

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

The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of the East and North Hertfordshire NHS Trust
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The system of internal control has been in place in the East and North Hertfordshire NHS Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

2.2 Capacity to handle risk

We have established clear leadership and accountability arrangements and from 1 April 2014 to 31 March 2015, the responsibility for ensuring that there is a comprehensive risk management and corporate governance systems in place has been delegated to the Company Secretary.

In addition, I have delegated: clinical governance and health and safety to the director of nursing; clinical governance and the co-ordination of the management of all clinical risks to the medical director; financial and information risks to the director of finance; facilities, estates and security management, emergency planning to the director of operations; sustainability and IT management to the director of strategic development; and workforce and organisational development to the director of workforce and organisational development.

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

- Quality governance and risk management strategy
- Corporate governance assurance map
- Annual plan
- Board assurance framework

We have an approved an assurance framework, along with an a quality governance and risk management strategy, that ensure that:

- Leadership is given to the risk management process
- The principle risks to achieving the strategic and annual objectives are effectively Mitigated against, reviewed and monitored
- Staff are trained and equipped to manage risk in a way appropriate to their authority and duties

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

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

The operational risk management team provides support and training to staff on risk management and the risk register. The health, safety and security team provides mandatory training on health and safety to all staff across the organisation. The Company Secretary ensures the Board receives support and training on risk management and during 2014, the Board continued a development programme to review key areas of strategic significance and potential risks facing the Trust in the future. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff though governance half-days, patient safety newsletter, weekly *Trust Bulletin* and the organisational development programme (ARC).

3. Risk assessment

3.1 Risk profile

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

A full comprehensive record of the principle risks identified in 2014/15 and how these have been mitigated and reviewed is discussed at Trust Board each quarter in the public session.

These risks include:

- Risk that service pathway changes and changes to the coding service model do not deliver the reductions in mortality set, (particularly in SHMI), has remained at ***amber*** throughout the year. Improvements in hospital mortality have been made. Improvements in out of hospital deaths are required and actions are in place. This is covered further in section five.

- Risk that demand management does not reflect CCG commissioning intentions, leading to insufficient capacity and delivery of performance targets. The risk was rated as ***amber*** in 2014/15 and was monitored closely to ensure that the delivery of the acute consolidation programme was not put at risk; this completed in October 2014.

- Linked to the above risk is the risk of breaching the TDA performance framework, which was increased to ***amber*** in September 2014. The risk increased to reflect the increased levels of emergency activity experienced, requiring additional ward capacity to be opened. This impacted on the ability to deliver some key performance targets, including for A&E and stroke. The Trust is working jointly with commissioners and partners. This will be an ongoing focus in 2015/16.

Other operational key risks, including infection control, mortality and performance, that have been managed during 2014/15 are discussed in section five.

3.2 Risks escalated to the Board assurance framework (BAF) during 2014/15

In January 2015, the risk that the new pathology service impacts adversely on the overall financial position and on quality was formally added to the Board's assurance framework. The risk reflects the service transfer from the Trust to the new service run by a NHS consortium. The Trust is working with the Board of the consortium and operational team to support improvements to the service.

***Assurance framework ratings:**

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

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

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

4. The risk and control framework

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

The objectives of this strategy are to:

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

The aims of this strategy are to:

- Support the delivery of the Trust's vision, values and strategic and annual objectives
- Provide a framework to support the Trust to take responsibility for the appropriate and effective management of its risks, in such a way that informed business decisions are taken to improve safety and quality
- Have a clear operational and corporate structure which enables responsive and effective management and provides for appropriate escalation and delegation
- Provide a framework to support a consistent approach to quality governance and risk management
- Provide an open culture and proactive culture rather than reactive approach to quality governance and risk management, thus supporting a learning organisation
- Have a Board assurance framework (BAF) and risk register that is truly reflective of the risks faced
- Support compliance with regulatory bodies including, registration with the Care Quality Commission, Monitor (on gaining Foundation Trust Status), Health and Safety Executive and maintaining and improving compliance with NHS Litigation Authority's risk management standards and achieve year-on-year improvement in compliance with national standards, regulation requirements and accreditation schemes
- Provide and maintain a safe and secure environment for patients, staff and visitors
- Encourage and support innovation and service developments within a framework for risk management
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer of risk. Otherwise, ensure the organisation accepts openly the remaining risks

Through a process of risk identification, assessment, learning and control the organisation maintains a dynamic corporate risk register that informs the Board assurance framework and, thereby, provides assurance both to the Board and to the community we serve. The quality governance and risk management strategy also sets out the Board's appetite for risk.

4.2 Board assurance and reporting

The Trust Board has established three committees to discharge its responsibilities on Board assurance. These are the: *audit committee*; *risk and quality committee*; and the *finance and performance committee*. These are constituted as key assurance committees under Monitor's Code of Governance and an annual review of each of the committees is undertaken to ensure they continue to meet their terms of reference and requirements of the code.

In addition, the Board has established the Charity Trustee Committee to provide assurance and support for its responsibility as a Corporate Trustee.

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

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

This includes:

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

The FPC also will oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T strategy for the Trust. The committee will review the delivery of the benefits realisation on major projects (including the consolidation programme), and ensure it is prepared for the forthcoming major changes.

The *risk and quality committee*, a formal committee of the Board, is chaired by a non-executive director. The purpose of the committee is to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, information governance, health and safety, staff governance and patient and public safety.

The committee also ensures that the Trust has an effective management and clinical governance framework that includes the assessment and monitoring of quality indicators, which drive forward the development of quality of services and care, patient safety and patient experience. The Trust's finance and performance committee will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny.

The principal objectives of the RAQC are to:

- Provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- Review and monitor the Board assurance framework and 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), Trust Development Authority (TDA) 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 and finance and performance committees
- Receive, annually, divisional presentations on progress with divisional objectives, governance structures, quality, safety and risk
- To review the quality risk assessment of the CIP programme
- To work with the audit committee when appropriate, and specifically in agreeing the annual internal audit plan and providing a review of effectiveness on clinical audit

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

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

The purpose of the *Charity Trustee Committee* (CTC) is to:

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

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

Directors' attendance at the Board and its committees is recorded and monitored. A review of attendance during 2014/15 has not highlighted any issues. These are reported in full in the Trust's annual report.

4.3 Board development

During 2014/15 the Board had a series of development sessions to consider key areas of strategic significance and risk, including a strategic view of the *Five Year Forward View* and *Dalton report*, strategic risks, the Trust's operating plan and Care Quality Commission. As this has been a significant period of transition for the Trust, implementing the acute consolidation, the Board has increased its time out in the Trust and undertaken training on undertaking the *15 steps challenge* (initial review of clinical and non-clinical areas).

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

Although now required to meet the corporate governance code and Monitor's code of governance, we have developed our corporate governance structures in line with the principles and best practice to ensure compliance with on becoming a NHS foundation trust.

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

4.4 Assurance framework and risk register

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

The assurance framework links to the Trust's corporate risk register, which provides a record of all identified risks to the organisation. Each risk is aligned with a corporate objective to facilitate a clear means of assessing compliance. The risk and quality committee, with additional oversight provided by the audit committee, determines whether or not any risks from the corporate risk register should be transferred to the assurance framework. This approach is 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 or safe service delivery
- **Adverse incident forms** – if it is apparent from an adverse event form, or subsequent investigation into the adverse event, that there is a significant risk then it will be transferred to the risk register
- **Health and safety risk assessments** – Health and Safety risk assessments are a legal obligation for the Trust, and managers are responsible for ensuring these assessments are undertaken. Any risk identified from these assessments will be included on the risk register
- **Local risk assessments** – where local assessments have identified risks
- **External assessment/audit** – significant risks identified by any internal/external audit (e.g., Care Quality Commission, NHS Litigation Authority, Health and Safety Executive notices) will be placed on the risk register
- **External guidance/alerts** – NICE, quality strategies, etc. that are not yet implemented
- **Results of feedback** – Learning from 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.

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

Care Quality Commission

The Trust is compliant fully with the registration requirements of the Care Quality Commission (CQC). We have not received an Inspection during 2014/15.

As in previous years, we continue to monitor compliance against all the essential standards of quality and safety on an on-going basis (now compliance regulations) and have maintained a positive CQC Intelligence Monitoring Report, maintaining a band 5 throughout 2014/15. *(bands range 1-6, the higher the band the lower the risk profile)*

We have an established programme of quality and safety audits to support embedding the standards and continuous improvement.

During 2015/16, the Trust will seek to improve further upon performance with regulators such as the Care Quality Commission, NHS Litigation Authority risk management standards and, continue a programme of self-assessment against the standards required by Monitor.

Clinical audit

The risk and quality committee and audit committee considered the clinical audit assurance following an evidence-based self-assessment against the Audit Committee Handbook 2010 criteria. The self-assessment demonstrates that the Trust's clinical audit systems and processes are compliant with requirements, and that there are plans in place to continue to strengthen these. It is clear that processes and monitoring have led to a continued improvement in clinical audit activity across the Trust. Approximately 415 (84%) of the audits included in the Trust's clinical audit forward plan, and an additional 96 (89%) of those that were approved in year, have been completed or are in progress for 2014/15. The outcome and learning from the clinical audits are discussed in the Trust's Quality Account.

Information governance

The assurance framework and risk register include the risks associated with the management and control of information. In this respect the Trust also has an information governance statement of compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage. For 2014/15 the Trust achieved the minimum level two compliance for all requirements in the Information Governance Toolkit and achieved a *satisfactory* rating, 85%. Overall the Trust's score has been maintained in 2014/15.

The Trust has reported one information governance serious incident to the Information Commissioner Officer serious relating to a patient from a breast clinic receiving letters relating to 12 other patients as well as her own letter. A full investigation had been completed and actions implemented to mitigate the risk of reoccurrence. Information governance training remains a priority for the Trust and the e-learning package is supported by an increased number of face-to-face training sessions delivered on the Trust's statutory and mandatory training day and a number of other training and awareness activities across the organisation.

Performance

A&E performance – the pressures on the A&E standard have continued in 2014/15 and we failed to deliver the 95% target to be seen within four hours and achieved 92.33%. The Trust had a particularly challenging year in 2014/15, experiencing significant growth in emergency admissions and an unprecedented growth in the volume of ambulance conveyances to the Trust. The level of growth was outside of normal variation and did not reflect the seasonal patterns of the previous years. The level of demand has been in excess of planned growth.

The Health System Resilience Group has acknowledged that A&E performance is a system-wide responsibility and has developed a system-wide recovery plan. The Trust expects to recover performance of the four-hour standard and deliver this from April 2015, based on the wider system also delivering their respective components of the recovery plan.

18 week referral-to-treatment time – the Trust has achieved consistently the aggregated performance against all three RTT standards (non-admitted, admitted and open) until the national campaign during the summer/autumn to reduce *back logs*, at which time the admitted performance dropped, as planned, below the standard. The Trust is expecting to deliver the aggregated performance going forward.

Cancer waits – cancer targets have been met for each quarter from quarter two in 2014/15, with the exception of the 62 day wait from referral to first definitive treatment. This is related primarily to the growth in urology cancer cases following a significant increase in out-of-area referrals, coupled with national screening campaign and a change in clinical guidance. Recovery actions have been implemented and the Trust has achieved the standard since January 2015 in-line with the submitted recovery trajectory.

Infection control – we have a zero tolerance approach to avoidable hospital-acquired infections and continue to remain compliant with the requirements of the Hygiene Code. During 2014/15 we have had 12 cases of C. difficile infection against a target of 15 and we have had five cases of MRSA bacteraemia against a ceiling of zero. Root cause analysis have been completed on all cases and actions taken. Of the MRSA cases, four have been deemed as avoidable and one unavoidable. Three of the avoidable cases were blood culture contaminants and were not infections; we take this as seriously as any other case and actions have been put in place.

We have continued to review our data quality both internally and with the support of external experts and our 2014/15 internal audit programme undertaken by PricewaterhouseCooper has included a focus on data quality – specifically we have reviewed our access policy (includes the 18-week target) and cancer waiting times.

Safer staffing

Ensuring safe staffing levels remains a priority and we have continued to invest in nursing and medical posts. We undertake a formal review of the nursing establishment twice a year and report this to the risk and quality committee and Board. In addition, safer staffing is reported each month to RAQC and Board.

Mortality

We have continued to reduce mortality and the year-to-date performance shows HSMR improved to the *better than expected* range (92), however the SHMI is within the *above expected* range (113). We have continued to see a reduction in the number of people dying in hospital and have further improvements to make. This includes supporting ways to reduce the number of deaths in the community.

Mortality monitoring includes reviewing all deaths and *alerts* that show higher than expected mortality with certain diagnoses. We not received any CQC mortality outlier alerts during 2014/15.

Reducing mortality remains an improvement priority for the Trust in 2015/16 and the Trust's operating plan and clinical outcomes strategy set out the priorities and actions, including progress towards 7 day services.

Never events

We had one never event in 2014/15 – wrong site surgery grommet in right ear instead of left. A full apology was given and an investigation and root cause analysis was undertaken and actions implemented.

Pensions

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

Equality and diversity

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

Sustainability

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

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

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

The Trust delivered a revised forecast of £3.6 million deficit in 2014/15 against a planned surplus of £0.5 million, maintained a continuity of services rating of 1 and delivered 96% of its CIP programme. This is the first time we have had a deficit in seven years, of which £2.1 million is due to the costs of redundancy associated with the change programme. System working within east and north Hertfordshire has proved strength in 2014/15, the relationships and joint leadership structures put in place during the year will be used to address the current demand pressures being experienced to develop and implement a sustainable configuration of service through 2015/16.

Annual Quality Account

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

The formulation of the Quality Account 2014/15 has been led by the Trust's head of quality and patient safety on behalf of the medical director and was designed to meet all relevant Department of Health and Monitor requirements. It provides a *look-back* against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a look forward to future priorities. The account includes a section on mandated topics, for example clinical audits, and reports against the achievement of national standards.

The 2014/15 and 2015/16 priorities for improvement were identified for a range of reasons including feedback on survey data, a review of clinical outcomes and following input from staff, key external stakeholders and involvement committee. For 2014/15 these were to:

- Improve safety – safety thermometer
- Improve safety – medications

- Improve outcomes – mortality
- Improve clinical outcomes – stroke
- Improve experiences – communication
- Improve experiences – reduce delays

The priorities for 2015/16 will remain the same as 2014/15 as the review showed that they all remain of significant importance and required further improvement.

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

An overview of 2014/15 shows that we have made on the current priorities include:

- A reduction in harm from patient falls and reduction in preventable hospital acquired pressure ulcers
- Implementation of the year one goals of the medicines optimisation strategy
- Reducing in hospital deaths

Throughout the year the Trust ensures ongoing engagement with the county's Health and Well Being Board and Health Scrutiny Committee, along with our commissioners. The Trust will continue to monitor performance against priorities, including by the use of floodlight scorecards at ward, divisional and Trust level.

6. Significant issues

There no significant control issues to report.

Review of effectiveness

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

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

The opinion is set out as follows:

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

The head of internal audit, 1 April 2014 to 31 March 2015, overall opinion is:

Improvement required – there are weaknesses in the framework of governance, risk management and control that potentially put the achievement of organisational objectives at risk and there is non-compliance with controls that may put the achievement of organisational objectives at risk.

Improvements are required in those areas to enhance the adequacy and effectiveness of governance, risk management and control.

Our opinion is based on:

- All audits undertaken during the year-to-date
- Any follow-up action taken in respect of audits from previous periods
- Any significant recommendations not accepted by management and the resulting risks
- The effects of any significant changes in the organisation's objectives or systems
- Any limitations which may have been placed on the scope or resources of internal audit
- What proportion of the organisation's audit needs have been covered to date

The rating received was the second highest award and equivalent to the rating awarded last year, although improvements have continued to be demonstrated. The Trust's internal audit programme is directed to areas of perceived high risk and where individual weaknesses have been identified the executive director lead has ensured comprehensive action plans have been put in place to address these and evidence collated to support implementation. There was only one high risk report and finding identified during 2014/15 and this compares to six areas in 2013/14.

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

Risk Management – the Trust delivered successfully a large complex change programme in October 2014 (Our changing hospitals). Overall this programme was delivered ahead of schedule and in excess of £2.0 million under budget. The primary reason for this rating was in relation to the revisions to the business case for the medical records library project and the likely impact this had on the overspend and delays in delivery for this project. This case has been scrutinised by the Trust's finance and performance committee and additional governance regarding the monitoring and reporting of the project through the reporting committee was agreed. This will be subject to further review in 2015 to ensure the learning and good governance structures that supported the Our changing hospitals programme are applied consistently across all Trust projects.

The areas identified as high risk during the previous year have been reviewed by internal audit and the actions taken had reduced the risks to medium or low. Monitoring systems are in place to ensure the actions are implemented in full.

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

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

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

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

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

- the Board 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
- the finance and performance committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the risk and quality committee for further scrutiny, while providing proactive risk management within the areas of activity covered by its own remit
- Internal audit, through its annual audit plan, provides assurance and comment on matters related to internal control
- the Board has appointed a senior information risk owner, who is supported by an information governance steering group, to provide information governance assurance via the information governance toolkit submission and IGSoC
- the Board ensures that all senior staff, clinical and other, through various meetings and review processes, including bi-monthly performance reviews with each clinical division, are held to account in all areas for delivery against finance, performance, quality, governance and risk issues
- I am confident that executive directors, senior managers of the Trust and identified risk leads are engaged fully in maintaining and reviewing the effectiveness of the system of internal control. This is supported by the positive CQC engagement and recent internal audit reports
- The evidence-based self-assessment review against the Department of Health board governance assurance framework and Monitor's quality governance framework and desktop review undertaken by the Trust Development Authority.

Conclusion

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

My review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2015/16.

Accounting officer: Nick Carver
Organisation: East and North Hertfordshire NHS Trust

Signature 

Date 27 May 2015

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

We have audited the financial statements of East and North Hertfordshire NHS Trust for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Trust and Consolidated Statement of Comprehensive Income, the Trust and Consolidated Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Trust and Consolidated Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 90 and 91
- the table of pension benefits of senior managers and related narrative notes on pages 92 and 93
- the pay multiples narrative notes on page 92.

This report is made solely to the Board of Directors of East and North Hertfordshire NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust's directors and the Trust as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of Directors and auditor

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust and Group's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the directors; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report which comprises About the Trust, Chairman and chief executive's reports, NHS constitution, Future trends and projections, Organisational development, 2014/15 overview, Operational performance for 2014/15, Clinical performance for 2014/15, Financial performance for 2014/15, Workforce review, Staff, public, patient and GP engagement, Sustainability, Governance and the Trust Board, and Annual accounts for 2014/15 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view of the financial position of East and North Hertfordshire NHS Trust as at 31 March 2015 and of its expenditure and income for the year then ended;
- give a true and fair view of the financial position of the Group as at 31 March 2015 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters
In our opinion:

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

Matters on which we report by exception
We report to you if:

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

We have nothing to report in these respects.

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

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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.

Basis for qualified conclusion

In considering the Trust's arrangements for securing financial resilience, we identified the following matters:

- The Trust delivered a deficit of £3.613 million in 2014-15 and is projecting a deficit of £8 million for 2015-16. The deficit plans in both years have been agreed with relevant stakeholders and include the provision of additional cash support and drawdown from the approved working capital facility. The actual and planned deficits are evidence of weakness in arrangements in respect of the Trust's strategic financial planning.

Qualified conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that in all significant respects East and North Hertfordshire NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of East and 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
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP

27 May 2015

Trust name	East and North Hertfordshire NHS Trust
This year	2014-15
Last year	2013-14
This year ended	31 March 2015
Last year ended	31 March 2014
This year commencing:	1 April 2014
Last year commencing:	1 April 2013

Accounts 2014-15

Statement of Comprehensive Income for year ended

31 March 2015

	NOTE	2014-15 £000s	2013-14 £000s	Consolidated 2014-15 £000s	Consolidated 2013-14 £000s
Gross employee benefits	10.1	**(229,396)**	(227,011)	**(229,396)**	(227,011)
Other operating costs	8	**(163,148)**	(132,963)	**(166,222)**	(133,887)
Revenue from patient care activities	5	**337,555**	316,720	**337,555**	316,720
Other operating revenue	6	**38,495**	48,593	**40,966**	49,271
Operating surplus/(deficit)		**(16,494)**	5,339	**(17,097)**	5,093
Investment revenue	12	**26**	28	**106**	108
Other gains and (losses)	13	**0**	0	**0**	0
Finance costs	14	**(2,758)**	(2,498)	**(2,758)**	(2,498)
Surplus/(deficit) for the financial year		**(19,226)**	2,869	**(19,749)**	2,703
Public dividend capital dividends payable		**(3,430)**	(3,127)	**(3,430)**	(3,127)
Transfers by absorption - gains		**0**	40,425	**0**	40,425
Transfers by absorption - (losses)		**0**	(18,014)	**0**	(18,014)
Net Gain/(loss) on transfers by absorption		**0**	22,411	**0**	22,411
Retained surplus/(deficit) for the year		**(22,656)**	22,153	**(23,179)**	21,987

Other Comprehensive Income

	2014-15 £000s	2013-14 £000s		
Impairments and reversals taken to the revaluation reserve	**(691)**	(14,665)	**(691)**	(14,665)
Net gain/(loss) on revaluation of property, plant & equipment	**7,273**	6,208	**7,273**	6,208
Net gain/(loss) on revaluation of financial assets	**0**	0	**148**	117
Total comprehensive income for the year	**(16,074)**	13,696	**(16,449)**	13,647

Financial performance for the year

	2014-15 £000s	2013-14 £000s
Retained surplus/(deficit) for the year	**(22,656)**	22,153
Impairments (excluding IFRIC 12 impairments)	**19,297**	781
Adjustments in respect of donated gov't grant asset reserve elimination	**(254)**	(414)
Adjustment re absorption accounting	**0**	(22,411)
Adjusted retained surplus/(deficit)	**(3,613)**	109

The retained deficit of £22.7m includes £19.3m of impairments relating to the revaluation of the Trust's buildings. This relates to the value of the new buildings at Lister resulting from the Our Changing Hospital initiative being reduced under the Modern Equivalent Asset(MEA) approach to valuation. Neither the impairment nor adjustments t donated assets are counted by the Department of Health towards the Trusts financial performance and so they are removed to produce the final adjusted retained deficit of £3.6m. This approach is entirely consistent with the accounting standards applied in previous years.

The notes on pages 119 to 160 form part of this account.

Statement of Financial Position as at 31 March 2015

		31 March 2015	31 March 2014	Consolidated 31 March 2015	Consolidated 31 March 2014
	NOTE	£000s	£000s	£000s	£000s
Non-current assets:					
Property, plant and equipment	15	**179,172**	184,701	**179,407**	184,701
Intangible assets	16	**6,388**	4,708	**6,392**	4,715
Other Investments - Charitable		**0**	0	**2,738**	2,905
Investment property	18	**0**	0	**0**	0
Other financial assets	24.2	**2,293**	0	**2,293**	0
Trade and other receivables	22.1	**1,352**	1,436	**1,352**	1,436
Total non-current assets		**189,205**	190,845	**192,182**	**193,757**
Current assets:					
Inventories	21	**4,244**	4,890	**4,653**	4,890
Trade and other receivables	22.1	**40,725**	40,073	**41,647**	39,972
Other financial assets	24	**0**	0	**0**	0
Other current assets	25	**0**	0	**0**	0
Cash and cash equivalents	26	**600**	4,289	**1,583**	4,741
Sub-total current assets		**45,569**	49,252	**47,883**	**49,603**
Non-current assets held for sale	27	**11,913**	0	**11,913**	0
Total current assets		**57,482**	49,252	**59,796**	**49,603**
Total assets		**246,687**	240,097	**251,978**	**243,360**
Current liabilities					
Trade and other payables	28	**(60,069)**	(49,782)	**(61,493)**	(49,800)
Other liabilities	29	**(203)**	(203)	**(203)**	(203)
Provisions	35	**(284)**	(363)	**(284)**	(363)
Borrowings PFI	30	**(307)**	(275)	**(307)**	(275)
Other financial liabilities	31	**(145)**	(140)	**(145)**	(140)
DH revenue support loan	30	**0**	0	**0**	0
DH capital loan	30	**(8,488)**	(2,510)	**(8,488)**	(2,510)
Total current liabilities		**(69,496)**	(53,273)	**(70,920)**	**(53,291)**
Net current assets/(liabilities)		**(12,014)**	(4,021)	**(11,124)**	**(3,688)**
Total assets less current liablilities		**177,191**	186,824	**181,058**	**190,069**
Non-current liabilities					
Trade and other payables	28	**0**	0	**0**	0
Other liabilities	29	**(5,218)**	(5,420)	**(5,218)**	(5,420)
Provisions	35	**(831)**	(899)	**(831)**	(899)
Borrowings PFI	30	**(7,404)**	(7,711)	**(7,404)**	(7,711)
Other financial liabilities	31	**(2,745)**	(2,891)	**(2,745)**	(2,891)
DH revenue support loan	30	**0**	0	**0**	0
DH capital loan	30	**(53,580)**	(54,352)	**(53,580)**	(54,352)
Total non-current liabilities		**(69,778)**	(71,273)	**(69,778)**	**(71,273)**
Total assets employed:		**107,413**	115,551	**111,280**	**118,796**
FINANCED BY:					
Public Dividend Capital		**169,916**	161,980	**169,916**	161,980
Retained earnings		**(106,292)**	(83,636)	**(106,292)**	(83,636)
Revaluation reserve		**43,789**	37,207	**43,789**	37,207
Charitable Funds Reserve		**0**	0	**2,848**	3,245
Other reserves		**0**	0	**1,019**	0
Total Taxpayers' Equity:		**107,413**	115,551	**111,280**	**118,796**

The notes on pages 119 to 160 form part of this account.

The financial statements on pages 115 to 118 were approved by the Board on 27th May 2015 and signed on its behalf by

Chief Executive:  Date: 27th May 2015

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2015

						Consolidated					
	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves	Public Dividend capital	Retained earnings	Revaluation reserve	Charitable Funds Reserve	Other Group reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**161,980**	**(83,636)**	**37,207**	**0**	**115,551**	**161,980**	**(83,636)**	**37,207**	**0**	**0**	**115,551**
Changes in taxpayers' equity for 2014-15											
Retained surplus/(deficit) for the year	0	(22,656)	**0**	**0**	**(22,656)**	0	(22,656)	**0**	0	**0**	**(22,656)**
Net gain / (loss) on revaluation of property, plant, equipment	0	**0**	7,273	**0**	**7,273**	0	**0**	7,273	0	**0**	**7,273**
Impairments and reversals	0	**0**	(691)	**0**	**(691)**	0	**0**	(691)	0	**0**	**(691)**
Reclassification Adjustments											
New temporary and permanent PDC received - cash	13,936	0	0	0	**13,936**	13,936	0	0	0	0	**13,936**
New temporary and termanent PDC repaid in year	(6,000)	0	0	0	**(6,000)**	(6,000)	0	0	0	0	**(6,000)**
Other movements	0	0	0	0	**0**	0	(936)	0	0	1,021	**85**
Charitable Funds Adjustment	0	0	0	0	0	0	0	0	2848	0	2,848
Net recognised revenue/(expense) for the year	**7,936**	**(22,656)**	**6,582**	**0**	**(8,138)**	**7,936**	**(23,592)**	**6,582**	**2,848**	**1,021**	**(5,205)**
Balance at 31 March 2015	**169,916**	**(106,292)**	**43,789**	**0**	**107,413**	**169,916**	**(107,228)**	**43,789**	**2,848**	**1,021**	**110,346**
Balance at 1 April 2013	**151,139**	**(105,787)**	**45,664**	**0**	**91,016**	**151,139**	**(105,787)**	**45,664**	0	**0**	**91,016**
Changes in taxpayers' equity for the year ended 31 March 2014											**0**
Retained surplus/(deficit) for the year	0	22,153	0	0	22,153	0	22,153	0	0	0	22,153
Net gain / (loss) on revaluation of property, plant, equipment	0	0	6,208	0	6,208	0	0	6,208	0	0	6,208
Impairments and reversals	0	0	(14,665)	0	(14,665)	0	0	(14,665)	0	0	(14,665)
Reclassification Adjustments											
New temporary and permanent PDC received - cash	15,940	0	0	0	15,940	15,940	0	0	0	0	15,940
New temporary and permanent PDC repaid in year	(5,100)	0	0	0	(5,100)	(5,100)	0	0	0	0	(5,100)
Charitable Funds Adjustment	0	0	0	0	0	0	(166)	0	3245	0	3,079
Net recognised revenue/(expense) for the year	**10,841**	**22,153**	**(8,457)**	**0**	**24,537**	**10,841**	**21,987**	**(8,457)**	**3,245**	**0**	**27,616**
Transfers between reserves in respect of modified absorption - PCTs & SHAs	0	0	0	0	**0**	0	0	0	0	0	**0**
Transfers between reserves in respect of modified absorption - Othe Bodies	0	0	0	0	**0**	0	0	0	0	0	**0**
Balance at 31 March 2014	**161,980**	**(83,634)**	**37,207**	**0**	**115,553**	**161,980**	**(83,800)**	**37,207**	**3,245**	**0**	**118,632**

Statement of Cash Flows for the Year ended 31 March 2015

			Consolidated	
	2014-15 £000s	2013-14 £000s	**2014-15 £000s**	2013-14 £000s
Cash Flows from Operating Activities				
Operating surplus/(deficit)	**(16,494)**	5,339	**(16,494)**	5,339
Depreciation and amortisation	**7,361**	7,664	**7,361**	7,664
Impairments and reversals	**19,297**	781	**19,297**	781
Donated Assets received credited to revenue but non-cash	**(219)**	(1,173)	**(219)**	(1,173)
Interest paid	**(2,729)**	(2,077)	**(2,729)**	(2,077)
Dividend (paid)/refunded	**(3,399)**	(3,155)	**(3,399)**	(3,155)
(Increase)/Decrease in Inventories	**646**	(26)	**646**	(26)
(Increase)/Decrease in Trade and Other Receivables	**(568)**	(19,447)	**(568)**	(19,447)
Increase/(Decrease) in Trade and Other Payables	**14,045**	10,232	**14,045**	10,232
(Increase)/Decrease in Other Current Liabilities	**(202)**	(203)	**(202)**	(203)
Provisions utilised	**(216)**	(224)	**(216)**	(224)
Increase/(Decrease) in movement in non cash provisions	**51**	331	**51**	331
NHS Charitable Funds, ENH Pharma subsidiary - net adjustments for working capital movements, non-cash transactions and non-operating cash flows			**(469)**	233
Net Cash Inflow/(Outflow) from Operating Activities	**17,573**	(1,958)	**17,104**	(1,725)
Cash Flows from Investing Activities				
Interest Received	**26**	28	**26**	28
(Payments) for Property, Plant and Equipment	**(29,133)**	(37,474)	**(29,133)**	(37,474)
(Payments) for Intangible Assets	**(2,729)**	(1,458)	**(2,729)**	(1,458)
(Payments) for Other Financial Assets	**(2,293)**	0	**(2,293)**	0
Proceeds of disposal of assets held for sale (PPE)	**0**	2,700	**0**	2,700
Rental Revenue	**0**	484	**0**	484
Net Cash Inflow/(Outflow) from Investing Activities	**(34,129)**	(35,720)	**(34,129)**	(35,720)
Net Cash Inform / (outflow) before Financing	**(16,556)**	(37,678)	**(17,025)**	(37,445)
Cash Flows from Financing Activities				
Gross Temporary and Permanent PDC Received	**13,936**	15,940	**13,936**	15,940
Gross Temporary and Permanent PDC Repaid	**(6,000)**	(5,100)	**(6,000)**	(5,100)
Loans received from DH - New Capital Investment Loans	**7,794**	23,165	**7,794**	23,165
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(2,588)**	(2,137)	**(2,588)**	(2,137)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT	**(275)**	0	**(275)**	0
Net Cash Inflow/(Outflow) from Financing Activities	**12,867**	31,868	**12,867**	31,868
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(3,689)**	(5,810)	**(4,158)**	(5,577)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**4,289**	10,099	**4,289**	10,099
Cash and Cash Equivalents (and Bank Overdraft) at year end	**600**	4,289	**131**	4,522

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 Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2014-15 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 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.

1.1.1 Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements the directors have considered the Trust's overall financial position and expectation of future financial support. The Trust will submit a financial plan for 2015-16 to the NHS Trust Development Authority (NHS TDA) which will deliver a £8m deficit. This includes a savings target of £18.1m and an expectation that emergency activity will be paid at marginal tariff. The plan will include a requirement for £8m of cash support from the Department of Health to maintain the Trust's cash flows in 2015-16.

The Directors have received confirmation from the NHS TDA that they will make sufficient cash financing available to the organisation up to the period of 12 months from the date the board will approve the accounts such that the organisation is able to meet its current liabilities. The trust is expected to receive £11.9m for land sale at QE11. The trust also has an interim revolving working capital facility of £19.7m upon which £6m has been drawn down in April 2015. Both of these factors are built into the cash flow forecast.

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

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

1.4 Charitable Funds

Under the provisions of IFRS 10 those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements.

1.5 Pooled Budgets

The Trust has no pooled budgets.

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

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Transforming Pathology Partnership (tPP)

East & North Hertfordshire NHS Trust has a 19.14% shareholding in the Transforming Pathology Partnership (tPP). tPP made a £4.9m deficit in 2014/15, however, Trust management have made a judgement not to reflect any of the tPP deficit in its accounts, based on sections 17.3 and 17.4 of the Joint Venture (JV) partnership agreement, on the following grounds;

1.Section 17.4 of the JV agreement requires a notice to be sent to the Partnership Management Board without undue delay, setting out the quantum and nature of any liability, details of the circumstances and steps taken to minimise any liability. No notice has been sent and there are no plans to send any such notice.

2.The tPP Director of Finance has confirmed in writing that it will not be recharging Partners any of the 2014/15 deficit.

3.The Trust therefore has no liability for a share of the deficit.

It is not unusual for new businesses to make a deficit in their first year of operation and so it is the judgement of Trust management that tPP's 2014/15 deficit does not merit an impairment to the investment value.

1.6.2 Key sources of estimation uncertainty

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

Estimation techniques in the following areas are explained in more detail under the relevant note:
Provision for impairment of receivables - note 22.3
The valuation approach of property, plant and equipment including - note 15.3
The calculation of provisions - note 35
PFI - note 30
Pensions - note 10.6
Property, plant and equipment - note 15.1
Accruals note - 28
Joint Venture accounting

1.7 Revenue

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

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

The NHS 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 NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which is not accrued for at the year end on the grounds of immateriality. No accruals are necessary in respect of annual leave earned but not taken as staff have not been permitted to carry forward annual leave since 2011-12.

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

Retirement benefit costs

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

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

1.9 Other expenses

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

1.10 Property, plant and equipment

Recognition

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

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

1.11 Intangible assets

Recognition

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

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

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

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

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

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

1.12 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS 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 NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

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

1.13 Donated assets

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

1.14 Government grants

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

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

1.15 Non-current assets held for sale

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

1.16 Leases

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

The trust as lessee

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

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

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

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

1.17 Private Finance Initiative (PFI) transactions

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

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

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

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

Services received

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

PFI Asset

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

PFI liability

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

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

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

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

Lifecycle replacement

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

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

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

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

1.18 Inventories

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

1.19 Cash and cash equivalents

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

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

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

1.20 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS 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.

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.

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

1.21 Clinical negligence costs

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

1.22 Non-clinical risk pooling

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

1.23 Carbon Reduction Commitment Scheme (CRC)

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

1.24 Contingencies

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

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

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

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

1.25 Financial assets

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

Financial assets are initially recognised at fair value.

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

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

1.26 Financial liabilities

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

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

Financial guarantee contract liabilities

The Trust currently has no financial guarantee contract liabilities

Financial liabilities at fair value through profit and loss

The Trust currently has no contracts containing embedded derivatives

Other financial liabilities

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

1.27 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. 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.

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

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

1.30 Public Dividend Capital (PDC) and PDC dividend

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 Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.31 Losses and Special Payments

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

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

1.32 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

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

From 2013-14, the Trust consolidates the results of East and North Hertfordshire NHS Trust Charitable Funds over which it considers it has the power to exercise control in accordance with IAS 27 requirements.

From 2014-15, the Trust consolidates the results of ENH Pharma Ltd over which it considers it has the power to exercise control in accordance with IAS 27 requirements.

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

1.33 Associates

The trust has no associates.

1.34 Joint arrangements

The trust has no joint arrangements.

1.35 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 SOCNE/SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IFRS 15 Revenue from Contracts with Customers

2. Pooled budget

The trust has no pooled budgets

3. Operating segments

The East and North Hertfordshire NHS Trust provides healthcare services only. The services are managed and resourced as one business unit. Divisions in reporting are for management purposes only. Capital resource allocations are distributed based on the operational and strategic need of the whole organisation. Services are provided largely for Clinical Commissioning Groups. Therefore the Trust considers single segment reporting to be the most appropriate reporting format. Details of revenue from the single segment are disclosed in notes 5 and 6.

4. Income generation activities

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

5. Revenue from patient care activities

	2014-15 £000s	2013-14 £000s
NHS Trusts	**2,864**	323
NHS England	**85,645**	77,467
Clinical Commissioning Groups	**238,465**	233,044
Foundation Trusts	**3,062**	0
Department of Health	**763**	0
NHS Other (including Public Health England and Prop Co)	**803**	272
Non-NHS:		
Local Authorities	**288**	0
Private patients	**3,648**	3,168
Overseas patients (non-reciprocal)	**236**	437
Injury costs recovery	**1,781**	1,146
Other	**0**	863
Total Revenue from patient care activities	**337,555**	316,720

NHS England and Clinical Commissioning Groups income has increased by £14 million from 2013/14 to 2014/15 due to the Treatment Centre being transferred to the Trust. This was transferred mid 2013/14 and so only six months income was received for the Treatment Centre in 2013/14 as opposed to 12 months in 2014/15. Foundation Trust income was posted into other in 2013/14 and corrected in 2014/15.

6. Other operating revenue

	2014-15 £000s	2013-14 £000s
Recoveries in respect of employee benefits	**0**	3,363
Education, training and research	**16,018**	18,487
Receipt of donations for capital acquisitions - Charity	**768**	1,173
Non-patient care services to other bodies	**17,848**	17,766
Income generation	**2,351**	2,320
Rental revenue from operating leases	**410**	484
Other revenue	**3,571**	5,678
Total Other Operating Revenue	**40,966**	49,271
Total operating revenue	**378,521**	365,991

Recoveries in respect of employee benefits has dropped to zero because the Treatment Centre is now run by the Trust so seconded staff costs are no longer charged to a private sector organisation.

The other operating revenue note includes other entities within the consolidated accounts in the SOCI and so for 2014/15 other revenue includes £634k consolidated charity revenue and £1837k ENH Pharma revenue. For 2013/14 other operating revenue includes £678k of consolidated charity revenue.

7. Overseas visitors disclosure

	2014-15 £000	2013-14 £000
Income recognised during 2014-15 (invoiced amounts and accruals)	**236**	437
Cash payments received in-year (re receivables at 31 March 2014)	**15**	0
Cash payments received in-year (for invoices issued 2014-15)	**88**	0
Amounts added to provision for impairment of receivables (for invoices issued 2014-15)	**124**	0
Amounts written off in-year (irrespective of year of recognition)	**264**	0

8. Operating expenses

	2014-15 £000s	2013-14 £000s
Services from other NHS Trusts	**4,746**	5,393
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**196**	53
Services from NHS Foundation Trusts	**9,246**	4,866
Total Services from NHS bodies*	**14,188**	10,312
Purchase of healthcare from non-NHS bodies	**5,325**	3,754
Trust Chair and Non-executive Directors	**57**	49
Supplies and services - clinical	**71,066**	58,594
Supplies and services - general	**12,504**	19,081
Consultancy services	**692**	862
Establishment	**5,019**	4,940
Transport	**631**	823
Service charges - ON-SOFP PFIs and other service concession arrangements	**98**	101
Business rates paid to local authorities	**1,540**	1500
Premises	**13,856**	13,485
Impairments and Reversals of Receivables	**221**	(4)
Depreciation	**6,312**	6,526
Amortisation	**1,049**	1,138
Impairments and reversals of property, plant and equipment	**19,297**	781
Impairments and reversals of financial assets	**0**	0
Audit fees	**130**	137
Other auditor's remuneration [quality account fee]	**12**	0
Clinical negligence	**7,505**	8,114
Education and Training	**907**	1,037
Change in Discount Rate	**0**	0
Other	**5,813**	2,657
Total Operating expenses (excluding employee benefits)	**166,222**	133,887
Employee Benefits		
Employee benefits excluding Board members	**228,253**	226,028
Board members	**1,143**	983
Total Employee Benefits	**229,396**	227,011
Total Operating Expenses	**395,618**	360,898

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

Other operating expenses is shown consolidated in the SOCI and so for 2014/15 other operating expenses includes £1259k charity expenditure and £1815k ENH Pharma Expenditure. For 2013/14 other operating expenses includes £924k of charity expenditure.

9 Operating Leases

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

9.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2014-15 Total £000s	2013-14 £000s
Payments recognised as an expense					
Minimum lease payments				**3,735**	4,201
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**3,735**	4,201
Payable:					
No later than one year	0	4,021	0	**4,021**	3,703
Between one and five years	0	12,162	0	**12,162**	10,145
After five years	0	1,574	0	**1,574**	268
Total	**0**	**17,757**	**0**	**17,757**	14,116
Total future sublease payments expected to be received:				0	0

9.2 Trust as lessor

The Trust does not act as a lessor.

10 Employee benefits and staff numbers

10.1 Employee benefits

	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure 2014-15			
Salaries and wages	**199,848**	170,619	29,229
Social security costs	**13,701**	13,701	0
Employer Contributions to NHS BSA - Pensions Division	**18,974**	18,974	0
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**232,523**	**203,294**	**29,229**
Employee costs capitalised	**3,127**	2,991	136
Gross Employee Benefits excluding capitalised costs	**229,396**	**200,303**	**29,093**

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

10.2 Staff Numbers

	2014-15 Total Number	Permanently employed Number	Other Number	2013-14 Total Number
Average Staff Numbers				
Medical and dental	**720**	687	33	721
Ambulance staff	**0**	0	0	0
Administration and estates	**985**	942	43	993
Healthcare assistants and other support staff	**381**	269	112	435
Nursing, midwifery and health visiting staff	**2,279**	2,043	236	2,233
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**601**	581	20	749
Social Care Staff	**0**	0	0	1
Other	**3**	1	2	8
TOTAL	**4,969**	**4,523**	**446**	5,140
Of the above - staff engaged on capital projects	**44**	41	3	32

10.3 Staff Sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	42,947	41,889
Total Staff Full Time Equivalent average	4,628	4,772
Average working Days Lost	9.28	8.78

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**7**	6

	£000s	£000s
Total additional pensions liabilities accrued in the year	**319**	325

10.4 Exit Packages agreed in 2014-15

	2014-15							
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	Number	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	.....	.....	.....	.....	0	0
£10,000-£25,000	0	0	.....	.....	0	0	0	0
£25,001-£50,000	0	0	.....	.....	.....	.....	0	0
£50,001-£100,000	0	0	.....	.....	.....	.....	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	.....	.....	.....	.....	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**8**	**362,379**	**8**	**362,379**	**0**	**0**

	2013-14							
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	0	0	.....	.....	.....	.....	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	.....	.....	.....	.....	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	2	2	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Totals	**0**	**0**	**3**	**61,306**	**3**	**61,306**	**0**	**0**

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

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

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

Exit packages relate to the Our Changing Hospitals programme.

10.5 Exit packages - Other Departures analysis

	2014-15		2013-14	
	Agreements	Total value of agreements	Agreements	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	8	362	3	61
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	8	362	3	61
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

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

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

10.6 Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

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

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

b) Accounting valuation

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

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

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

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

c) Scheme provisions

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

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

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

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

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

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

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

11 Better Payment Practice Code

11.1 Measure of compliance

	2014-15 Number	2014-15 £000s	2013-14 Number	2013-14 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**63,961**	**162,741**	68,401	158,897
Total Non-NHS Trade Invoices Paid Within Target	**45,475**	**91,591**	53,735	110,883
Percentage of NHS Trade Invoices Paid Within Target	**71.10%**	**56.28%**	78.56%	69.78%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,827**	**35,938**	2,960	**28,479**
Total NHS Trade Invoices Paid Within Target	**1,559**	**16,477**	1,767	**12,942**
Percentage of NHS Trade Invoices Paid Within Target	**55.15%**	**45.85%**	59.70%	45.44%

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

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

	2014-15 £000s	2013-14 £000s
Amounts included in finance costs from claims made under this legislation	**77**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**77**	0

12 Investment Revenue

	2014-15 £000s	2013-14 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**26**	28
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**80**	80
Subtotal	**106**	108
Total investment revenue	**106**	108

Other financial assets includes £80k consolidated charity investments for 2014/15 and £80k for 2013/14.

13 Other Gains and Losses

The Trust has no other Gains and Losses.

14 Finance Costs

	2014-15 £000s	2013-14 £000s
Interest		
Interest on loans and overdrafts	**1,815**	1,572
Interest on obligations under finance leases	**0**	1
Interest on obligations under PFI contracts:		
- main finance cost	**590**	608
- contingent finance cost	**258**	298
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**77**	0
Total interest expense	**2,740**	2,479
Other finance costs	**0**	0
Provisions - unwinding of discount	**18**	19
Total	**2,758**	2,498

15.1 Property, plant and equipment

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2014	**36,284**	**86,900**	**0**	**42,805**	**54,406**	**113**	**11,871**	**3,557**	**235,936**
Additions of Assets Under Construction	0	0	0	11,390	0	0	0	0	**11,390**
Additions Purchased	268	10,138	0	0	2,599	0	1,113	647	**14,765**
Additions - Non Cash Donations (i.e. physical assets)	0	124	0	0	24	0	60	11	**219**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	52,157	0	(52,157)	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	(11,913)	0	0	0	0	0	0	0	**(11,913)**
Disposals other than for sale	0	0	0	(728)	0	0	0	0	**(728)**
Upward revaluation/positive indexation	2,328	4,945	0	0	0	0	0	0	**7,273**
Impairments/negative indexation	0	(691)	0	0	0	0	0	0	**(691)**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2015	**26,967**	**153,573**	**0**	**1,310**	**57,029**	**113**	**13,044**	**4,215**	**256,251**
Depreciation									
At 1 April 2014	**0**	**0**	**0**	**0**	**39,064**	**113**	**9,358**	**2,700**	**51,235**
Reclassifications	0	0	0	**0**	0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	**0**	0	0	0	0	**0**
Disposals other than for sale	0	0	0	**0**	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	**0**	0	0	0	0	**0**
Impairments	0	19,293	0	0	4	0	0	0	**19,297**
Reversal of Impairments	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	2,360	0	**0**	2,849	0	914	189	**6,312**
Transfers to NHS Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	**0**	0	0	0	0	**0**
At 31 March 2015	**0**	**21,653**	**0**	**0**	**41,917**	**113**	**10,272**	**2,889**	**76,844**
Net Book Value at 31 March 2015	**26,967**	**131,920**	**0**	**1,310**	**15,112**	**0**	**2,772**	**1,326**	**179,407**
Asset financing:									
Owned - Purchased	26,967	123,846	0	1,310	13,338	0	2,646	1,242	**169,349**
Owned - Donated	0	1,518	0	0	1,774	0	126	84	**3,502**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	6,556	0	0	0	0	0	0	**6,556**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2015	**26,967**	**131,920**	**0**	**1,310**	**15,112**	**0**	**2,772**	**1,326**	**179,407**

Revaluation Reserve Balance for Property, Plant & Equipmen

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	14,624	21,938	0	0	480	143	0	23	**37,208**
Movements (revaluation)	2,328	4,253	0	0	0	0	0	0	**6,581**
At 31 March 2015	**16,952**	**26,191**	**0**	**0**	**480**	**143**	**0**	**23**	**43,789**

Additions to Assets Under Construction in 2014-1

	£000's
Land	0
Buildings excl Dwellings	11,390
Dwellings	0
Plant & Machinery	0
total	**11,390**

Property, plant and equipment includes for 2014/15 consolidated fixed assets of £235k relating to ENH Pharma.

15.2 Property, plant and equipment prior-year

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:									
At 1 April 2013	34,963	74,617	0	13,304	46,789	113	11,163	3,314	**184,263**
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0	0	0	**0**
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0	0	0	**0**
Additions of Assets Under Construction	0	0	0	31,094	0	0	0	0	**31,094**
Additions Purchased	0	3,642	0	0	1,886	0	702	243	**6,473**
Additions - Non Cash Donations (i.e. Physical Assets)	0	77	0	0	123	0	6	0	**206**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	(1,593)	1,593	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Revaluation	1,321	4,887	0	0	0	0	0	0	**6,208**
Impairments/negative indexation charged to reserves	0	(14,664)	0	0	0	0	0	0	**(14,664)**
Reversal of Impairments charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	36,410	0	0	4,015	0	0	0	**40,425**
At 31 March 2014	**36,284**	**104,969**	**0**	**42,805**	**54,406**	**113**	**11,871**	**3,557**	**254,005**
Depreciation									
At 1 April 2013	0	0	0	0	32,960	113	8,432	2,478	**43,983**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	0	0	0	0	0	0	0	0	**0**
Disposals other than for sale	0	0	0	0	0	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/negative indexation charged to operating expenses	0	436	0	0	345	0	0	0	**781**
Reversal of Impairments charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Charged During the Year	0	1,889	0	0	3,489	0	926	222	**6,526**
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	15,744	0	0	2,270	0	0	0	**18,014**
At 31 March 2014	**0**	**18,069**	**0**	**0**	**39,064**	**113**	**9,358**	**2,700**	**69,304**
Net Book Value at 31 March 2014	36,284	86,900	0	42,805	15,342	0	2,513	857	**184,701**
Asset financing:									
Owned - Purchased	36,284	80,225	0	42,805	15,219	0	2,507	857	**177,897**
Owned - Donated	0	77	0	0	123	0	6	0	**206**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	6,598	0	0	0	0	0	0	**6,598**
PFI residual: interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2014	**36,284**	**86,900**	**0**	**42,805**	**15,342**	**0**	**2,513**	**857**	**184,701**

15.3 (cont). Property, plant and equipment

In 2014/15 the Trust received donated assets from East and North Hertfordshire NHS Trust Charitable Fund of £219K.

The land and building assets held by the Trust were revalued in year using the modern equivalent assets valuation methodology, in accordance with DH guidance and International Financial Reporting Standards. The revaluation was carried out by an independent qualified valuer. The effective date for the valuation was 1st April 2014.

Basis for Valuation
The Trust has revalued its land and building assets during 2014, as at a valuation date of 1st April 2014, in line with HM Treasury adopted standard approach to valuation based on modern equivalent assets. The Trust has recorded the new values in the annual accounts for the year ending 31st March 2015.

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 tangible fixed assets range from:	**Min life (years)**	**Max life (years)**
Buildings exc dwellings	19	90
Dwellings	20	90
Plant & Machinery	5	20
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	7	10

There have been no changes to asset lives/residual values other than those advised by the independent valuer during their review on a MEA basis.

There have been no write-downs to recoverable amount or any reversals of write-downs.

Property is held at existing use value and is not materially different from its open market value.

16.1 Intangible non-current assets

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	**0**	**1,990**	**1,172**	**0**	**7,672**	**10,834**
Additions Purchased	0	605	50	0	0	**655**
Additions Internally Generated	0	0	0	0	2,074	**2,074**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	**0**
Additions Leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation & indexation gains	0	0	0	0	0	**0**
Impairments charged to reserves	0	0	0	0	0	**0**
Reversal of impairments charged to reserves	0	0	0	0	0	**0**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**0**	**2,595**	**1,222**	**0**	**9,746**	**13,563**
Amortisation						
At 1 April 2014	**0**	**951**	**624**	**0**	**4,544**	**6,119**
Reclassifications	0	0	0	0	0	**0**
Reclassified as Held for Sale and Reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Revaluation or indexation gains	0	0	0	0	0	**0**
Impairments charged to operating expenses	0	0	0	0	0	**0**
Reversal of impairments charged to operating expenses	0	0	0	0	0	**0**
Charged during the year	0	211	152	0	689	**1,052**
Transfer to NHS Foundation Trust	0	0	0	0	0	**0**
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	**0**
At 31 March 2015	**0**	**1,162**	**776**	**0**	**5,233**	**7,171**
Net Book Value at 31 March 2015	**0**	**1,433**	**446**	**0**	**4,513**	**6,392**
Asset Financing: Net book value at 31 March 2015 comprises:						
Purchased	0	1,370	446	0	4,513	**6,329**
Donated	0	63	0	0	0	**63**
Government Granted	0	0	0	0	0	**0**
Finance Leased	0	0	0	0	0	**0**
On-balance Sheet PFIs	0	0	0	0	0	**0**
Total at 31 March 2015	**0**	**1,433**	**446**	**0**	**4,513**	**6,392**

Revaluation reserve balance for intangible non-current assets	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2014	0	0	0	0	0	**0**
Movements (specify)	0	0	0	0	0	**0**
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

For 2014/15 intangible assets includes £4k held within the charity accounts.

16.2 Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation:						
At 1 April 2013	0	1,880	858	0	6,631	9,369
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0	0	0	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0	0	0	0	0
Additions - purchased	0	110	314	0	0	424
Additions - internally generated	0	0	0	0	1,041	1,041
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions Leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	0	1,990	1,172	0	7,672	10,834
Amortisation						
At 1 April 2013	0	646	513	0	3,822	4,981
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	305	111	0	722	1,138
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2014	0	951	624	0	4,544	6,119
Net book value at 31 March 2014	0	1,039	548	0	3,128	4,715
Net book value at 31 March 2014 comprises:						
Purchased	0	1,039	548	0	3,128	4,715
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2014	0	1,039	548	0	3,128	4,715

For 2013/14 intangible assets includes £7k held within the charity accounts.

16.3 Intangible non-current assets

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

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

The economic lives of intangible fixed assets range from:	**Min life (years)**	**Max life (years)**
Software purchased	3	8
Licences and trademarks	2	8
Development Expenditure	5	8

17 Analysis of impairments and reversals recognised in 2014-15

	2014-15 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	19,297
Total charged to Annually Managed Expenditure	**19,297**

This refers to impairment of the new builds completed in October 2014

18 Investment property

	31 March 2015 £000s	31 March 2014 £000s
At fair value		
Balance at 1 April 2014	**0**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Additions Through Subsequent Expenditure	**0**	0
Other Acquisitions	**0**	0
Disposals	**0**	0
Property Reclassified as Held for Sale	**0**	0
Loss from Fair Value Adjustments - Impairments	**0**	0
Loss from Fair Value Adjustments - Reversal of Impairments	**0**	0
Gain from Fair Value Adjustments	**0**	0
Transfer to other NHS Foundation Trust	**0**	0
Transfers (to) / from Other Public Sector Bodies under absorption accounting	**0**	0
Other Changes	**0**	0
Balance at 31 March 2015	**0**	0

19 Commitments

19.1 Capital commitments

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

	31 March 2015 £000s	31 March 2014 £000s
Property, plant and equipment	**1,110**	20,759
Intangible assets	**0**	0
Total	**1,110**	20,759

The reduction in capital commitments represents the completion of the OCH programme.

19.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession

	31 March 2015 £000s	31 March 2014 £000s
Not later than one year	**0**	0
Later than one year and not later than five year	**0**	0
Later than five years	**0**	0
Total	**0**	**0**

20 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with Other Central Government Bodies	1	0	4,236	0
Balances with Local Authorities	33	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	20	0
Balances with NHS bodies inside the Departmental Group	18,318	0	17,478	53,580
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	22,373	1,352	47,478	15,367
At 31 March 2015	**40,725**	**1,352**	**69,212**	**68,947**
prior period:				
Balances with Other Central Government Bodies	23,717	0	5,292	0
Balances with Local Authorities	154	0	0	0
Balances with NHS bodies outside the Departmental Group	13	0	0	0
Balances with NHS Trusts & FTs	3,937	0	5,191	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	0	0	0	0
At 31 March 2014	**27,821**	**0**	**10,483**	**0**

21 Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2014	**1,626**	**3,047**	**0**	**217**	**0**	**0**	**4,890**	0
Additions	409	0	0	0	0	0	**409**	0
Inventories recognised as an expense in the period	(10)	(583)	0	(53)	0	0	**(646)**	0
Write-down of inventories (including losses)	0	0	0	0	0	0	**0**	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	**0**	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	**0**	0
Balance at 31 March 2015	**2,025**	**2,464**	**0**	**164**	**0**	**0**	**4,653**	**0**

Inventories includes for 2014/15 £409k consolidated ENH Pharma stock.

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS receivables - revenue	**10,221**	16,576	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**7,988**	9,765	**0**	0
Non-NHS receivables - revenue	**7,619**	3,516	**0**	1,699
Non-NHS receivables - capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**8,998**	6,015	**0**	0
PDC Dividend prepaid to DH	**110**	**0**	**0**	0
Provision for the impairment of receivables	**(632)**	(578)	**(267)**	(263)
VAT	**1,781**	1,385	**0**	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**5,562**	3,293	**1,619**	0
Total	**41,647**	39,972	**1,352**	1,436
Total current and non current	**42,999**	41,408		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Group's (CCG's) as commissioners for NHS patient care services. As CCG's are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

The Trade and other receivables note includes other entities within the consolidated accounts in the SOFP and so 2014/15 includes a £296k net reduction from charity receivables, £1218k ENH Pharma receivables. For 2013/14 a £101k net receivable from charity is shown.

22.2 Receivables past their due date but not impaired

	31 March 2015 £000s	31 March 2014 £000s
By up to three months	**5,653**	11,338
By three to six months	**2,011**	6,036
By more than six months	**3,107**	2,324
Total	**10,771**	19,698

22.3 Provision for impairment of receivables

	2014-15 £000s	2013-14 £000s
Balance at 1 April 2014	**(841)**	(903)
Transfers under Modified Absorption Accounting - PCTs & SHAs	0	0
Transfers under Modified Absorption Accounting - Other Bodies	0	0
Amount written off during the year	**163**	58
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(221)**	4
Transfer to NHS Foundation Trust	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Balance at 31 March 2015	**(899)**	**(841)**

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non NHS debt has been analysed at invoice level and all overseas patient debt not on repayment plan has been provided for. Also within the figures quoted includes a provision relating to the NHS Injury cost recovery scheme to reflect the risk of write offs over a significant period, this has been increased from 12.6% to 16.5% as per Department of Health guidance of total receivables under this catagory this financial year.

23 NHS LIFT investments

The Trust has no Lift investments.

24.1 Other Financial Assets - Current

The trust has no Other financial assets.

24.2 Other Financial Assets - Non Current

	31 March 2015 £000s	31 March 2014 £000s
Opening balance 1 April	**0**	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	**0**	0
Transfers under Modified Absorption Accounting - Other Bodies	**0**	0
Additions	**2,293**	0
Revaluation	**0**	0
Impairments/reversals taken to Revaluation Reserve	**0**	0
Impairment/reversals taken to SoCI	**0**	0
Change in Fair Value through SoCI	**0**	0
Transferred to current financial assets	**0**	0
Disposals	**0**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	**0**	0
Total Other Financial Assets - Non Current	**2,293**	0

Other Financial Assets includes additions of £1m share capital in ENH Pharma and £1.293m equity in tPP referred to in notes 1.32 and 1.33.

25 Other current assets

The trust has no Other current assets.

26 Cash and Cash Equivalents

	31 March 2015 £000s	31 March 2014 £000s
Opening balance	**4,741**	10,318
Net change in year	**(3,158)**	(5,577)
Closing balance	**1,583**	4,741
Made up of		
Cash with Government Banking Service	**579**	4,281
Commercial banks	**530**	0
Cash in hand	**9**	8
Liquid deposits with NLF	**0**	0
Current investments	**465**	452
Cash and cash equivalents as in statement of financial positior	**1,583**	4,741
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**1,583**	4,741

The Cash and Cash Equivalents note includes other entities within the consolidated accounts in the SOFP and so 2014/15 includes £465k charity investments and £518k ENH Pharma cash. For 2013/14 the note includes £452k for charity investments.

27 Non-current assets held for sale

	Land £000s
Balance at 1 April 2014	0
Plus assets classified as held for sale in the year	11,913
Less assets sold in the year	0
Less impairment of assets held for sale	0
Plus reversal of impairment of assets held for sale	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0
Transfers to Foundation Trust	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0
Balance at 31 March 2015	**11,913**
Liabilities associated with assets held for sale at 31 March 2015	**0**
Balance at 1 April 2013	0
Transfers under Modified Absorption Accounting - PCTs & SHAs	0
Transfers under Modified Absorption Accounting - Other Bodies	0
Plus assets classified as held for sale in the year	0
Less assets sold in the year	0
Less impairment of assets held for sale	0
Plus reversal of impairment of assets held for sale	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0
Transfers to Foundation Trust	0
Transfers (to)/from other public sector bodies	0
Balance at 31 March 2014	**0**
Liabilities associated with assets held for sale at 31 March 2014	0

The asset held for sale in the 2014/15 accounts is the land of the former QE11 Hospital situated at Welwyn Garden City.
The reason that this land is being disposed is due to the Trust's Our Changing Hospital's consolidation strategy and the Government Homes initiative.

28 Trade and other payables

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
NHS payables - revenue	**963**	2,356	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**8,047**	8,127	**0**	0
Non-NHS payables - revenue	**20,538**	12,031	**0**	0
Non-NHS payables - capital	**1,058**	4,820	**0**	0
Non-NHS accruals and deferred income	**22,517**	15,143	**0**	0
Social security costs	**1,876**	2,048	**0**	**0**
PDC Dividend payable to DH	**0**	0	**0**	**0**
VAT	**0**	0	**0**	0
Tax	**2,360**	2,403	**0**	**0**
Payments received on account	**0**	0	**0**	0
Other	**4,134**	2,872	**0**	0
Total	**61,493**	49,800	**0**	0
Total payables (current and non-current)	**61,493**	**49,800**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved (number)	**0**	0		
outstanding Pension Contributions at the year end	**2,776**	2,827		

The Trade and other payables note includes other entities within the consolidated accounts in the SOFP and so 2014/15 includes £63k net charity payables and £1361k ENH Pharma payables. For 2013/14 the note includes £18k charity payables.

29 Other liabilities

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
PFI/LIFT deferred credit	**0**	0	**0**	0
Lease incentives	**0**	0	**0**	0
Other	**203**	203	**5,218**	5,420
Total	**203**	203	**5,218**	5,420
Total other liabilities (current and non-current)	**5,421**	**5,623**		

The "Other" liabilities relates to the inclusion of the Lister Hospital multi storey car park in the assets of the Trust.
The car park has been funded through a private/public partnership arrangement. The liabilites relating to the car park asset will be amortised over a 30 year period at the end of which ownership will transfer to the Trust.

The liability relating to the car park is split between other financial liabilities (Note 31) and deferred income (Note 32).

30 Borrowings

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Bank overdraft - Government Banking Service	**0**	0	**0**	**0**
Bank overdraft - commercial banks	**0**	0	**0**	**0**
Loans from Department of Health	**8,488**	2,510	**53,580**	54,352
Loans from other entities	**0**	0	**0**	0
PFI liabilities:				
Main liability	**307**	275	**7,404**	7,711
Lifecycle replacement received in advance	**0**	0	**0**	0
LIFT liabilities:				
Main liability	**0**	0	**0**	0
Lifecycle replacement received in advance	**0**	0	**0**	0
Finance lease liabilities	**0**	0	**0**	0
Other (describe)	**0**	0	**0**	0
Total	**8,795**	**2,785**	**60,984**	**62,063**
Total other liabilities (current and non-current)	**69,779**	**64,848**		

Loans have been received from the Department of Health in order to pay for the new build at Lister Hospital as per Our Changing Hospitals.

Borrowings / Loans - repayment of principal falling due in:

	31 March 2015		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	8,488	307	**8,795**
1 - 2 Years	2,588	289	**2,877**
2 - 5 Years	7,764	902	**8,666**
Over 5 Years	43,228	6,213	**49,441**
TOTAL	**62,068**	**7,711**	**69,779**

31 Other financial liabilities

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Embedded derivatives at fair value through SoCI	**0**	0	**0**	0
Financial liabilities carried at fair value through profit and loss	**145**	140	**2745**	2891
Amortised cost	**0**	0	**0**	0
Total	**145**	140	**2,745**	2,891
Total other financial liabilities (current and non-current)	**2,890**	3,031		

32 Deferred revenue

	Current		Non-current	
	31 March 2015 £000s	31 March 2014 £000s	**31 March 2015 £000s**	31 March 2014 £000s
Opening balance at 1 April 2014	**5,353**	2,904	**5,420**	5,623
Deferred revenue addition	**1,489**	2,449	**0**	0
Transfer of deferred revenue	**0**	0	(202)	(203)
Current deferred Income at 31 March 2015	**6,842**	5,353	**5,218**	5,420
Total deferred income (current and non-current)	**12,060**	10,773		

33 Finance lease obligations as lessee

The Trust has no Finance lease obligations as lessee

34 Finance lease receivables as lessor

The Trust has no Finance lease receivable as lessor

35 Provisions

	Total	Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**1,262**	1,003	79	0	0	0	180	0
Arising during the year	**87**	3	0	0	0	0	84	0
Utilised during the year	**(216)**	(87)	(14)	0	0	0	(115)	0
Reversed unused	**(36)**	0	0	0	0	0	(36)	0
Unwinding of discount	**18**	18	0	0	0	0	0	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2015	**1,115**	**937**	**65**	**0**	**0**	**0**	**113**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**284**	106	65	0	0	0	113	0
Later than One Year and not later than Five Years	**427**	427	0	0	0	0	0	0
Later than Five Years	**404**	404	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2015	100,885
As at 31 March 2014	74,461

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

The real discount rate applicable on 31 March 2015 is 1.30% (the previous year's rate was 1.80%) as per the Department of Health manual.

36 Contingencies

	31 March 2015 £000s	31 March 2014 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**0**	0
Employment Tribunal and other employee related litigation	**0**	0
Redundancy	**0**	0
Other *(give details)*	**(34)**	(57)
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**(34)**	(57)
Contingent assets		
Contingent assets *[give details]*	**0**	0
Net value of contingent assets	**0**	0

The net contingent liability relates to Litigation Authority Third Parties Scheme. The value is calculated by NHS Litigation Authority on a claim by claim basis and communicated to the Trust via an annual report.

37 PFI and LIFT - additional information

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

The contract is paid in the form of an annual unitary charge that covers repayment of capital, cost of financing and service costs. The future commitment of the elements of the charge at 31st March 2014 are as follows:

	£000
Capital	7,711
Lifecycle replacement cost	4,094
Interest	6,403
Contingent rental	9,292
Service	2,263

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

The contingent rental costs relate to the effect of inflation on the finance charge over the period of the contract. The cost is charged annually to the Statement of Comprehensive Net Income under finance costs.

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

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

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	**2014-15 £000s**	2013-14 £000s
Total charge to operating expenses in year - Off SoFP PFI	**0**	0
Service element of on SOFP PFI charged to operating expenses in year	**98**	101
Total	**98**	101
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**100**	98
Later than One Year, No Later than Five Years	**427**	416
Later than Five Years	**1,736**	1,847
Total	**2,263**	2,361

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**876**	866
Later than One Year, No Later than Five Years	**3,236**	3,397
Later than Five Years	**10,002**	10,717
Subtotal	**14,114**	14,980
Less: Interest Element	**(6,403)**	(6,994)
Total	**7,711**	7,986

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2014-15 £000s**	2013-14 £000s
No Later than One Year	**307**	275
Later than One Year, No Later than Five Years	**1,191**	1,259
Later than Five Years	**6,213**	6,452
Total	**7,711**	7,986
Number of on SOFP PFI Contracts		
Total Number of on PFI contracts	**1**	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**	0

Number of off SOFP PFI Contracts
The trust has no off SOFP PFI Contracts.

Charges to operating expenditure and future commitments in respect of on and off SOFP LIFT
The Trust has no Lift schemes.

38 Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes

	2014-15 £000s	2013-14 £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)		
Depreciation charges	**87**	86
Interest Expense	**848**	906
Impairment charge - AME	**0**	0
Impairment charge - DEL	**0**	0
Other Expenditure	**98**	101
Revenue Receivable from subleasing	**0**	0
Impact on PDC dividend payable	**0**	0
Total IFRS Expenditure (IFRIC12)	**1,033**	**1,093**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	**(1,370)**	(1,334)
Net IFRS change (IFRIC12)	**(337)**	**(241)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12		
Capital expenditure 2014-15	**0**	0
UK GAAP capital expenditure 2014-15 (Reversionary Interest)	**0**	0

39 Financial Instruments

39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's 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 2015 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

East and North Herts NHS Trust operating costs are incurred under contracts with primary care organisations, which are financed from resources voted annually by Parliament . East and North Herts NHS Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. East and North Herts NHS Trust is not, therefore, exposed to significant liquidity risks. The Trust received temporary borrowing in 2014/15 which minimised the liquidity risk.

39.2 Financial Assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0	0	0	**0**
Receivables - NHS	0	17,662	0	**17,662**
Receivables - non-NHS	0	8,791	0	**8,791**
Cash at bank and in hand	0	600	0	**600**
Other financial assets	0	0	0	**0**
Total at 31 March 2015	**0**	**27,053**	**0**	**27,053**
Embedded derivatives	0	0	0	0
Receivables - NHS	0	26,320	0	26,320
Receivables - non-NHS	0	4,055	0	4,055
Cash at bank and in hand	0	4,289	0	4,289
Other financial assets	0	0	0	0
Total at 31 March 2014	0	34,664	0	34,664

39.3 Financial Liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0	0	**0**
NHS payables	0	5,756	**5,756**
Non-NHS payables	0	39,305	**39,305**
Other borrowings	0	62,068	**62,068**
PFI & finance lease obligations	0	7,711	**7,711**
Other financial liabilities	0	8,311	**8,311**
Total at 31 March 2015	**0**	**123,151**	**123,151**
Embedded derivatives	0	0	0
NHS payables	0	7,883	7,883
Non-NHS payables	0	29,445	29,445
Other borrowings	0	56,860	56,860
PFI & finance lease obligations	0	7,986	7,986
Other financial liabilities	0	8,654	8,654
Total at 31 March 2014	0	110,828	110,828

40 Events after the end of the reporting period

There are no non-adjusting events after that the reporting period that require disclosure

41 Related party transactions

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

The Department of Health is regarded as a related party. During the year the East and North Hertfordshire NHS Trust has had a significant number of material transactions of at least £200k with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Related party organisation	Income £000's	Expenditure £000's	Debtors £000's	Creditors £000's
Clinical Commissioning Groups				
Barnet CCG	387	0	318	0
Bedfordshire CCG	20,894	0	1,500	0
Brent CCG	368	0	118	0
Cambridgeshire and Peterborough CCG	1,956	0	235	0
Chiltern CCG	273	0	32	0
Ealing CCG	222	0	70	0
East and North Hertfordshire CCG	203,597	0	4,596	2,600
Enfield CCG	222	0	153	0
Harrow CCG	781	0	23	150
Herts Valleys CCG	14,950	0	356	1
Hillingdon CCG	2,005	0	64	0
Luton CCG	3,012	0	689	0
West Essex CCG	634	0	271	0
NHS Trusts				
Hertfordshire Community NHS Trust	1,897	3,070	821	1,538
London Ambulance Service NHS Trust	0	319	0	21
The Princess Alexandra Hospital NHS Trust	38	1,305	112	1,100
West Hertfordshire Hospitals NHS Trust	574	1,427	409	209
NHS Foundation Trusts				
Cambridge Univ Hosp NHS Foundation Trust	98	778	55	594
Hertfordshire Partnership NHS Foundation Trust	2,004	13	87	3
Luton and Dunstable University Hospital NHS Foundation Trust	456	810	665	480
Norfolk And Norwich University Hospitals NHS Foundation Trust	2,816	45	352	4
Royal Free London NHS Foundation Trust	14	101	205	15
The Hillingdon Hospital NHS Foundation Trust	274	11,790	16	1,036
University College London NHS Foundation Trust	0	259	120	253
Other Health Bodies				
East Anglia Area Team	70,232	0	123	0
Hertfordshire and the South Midlands Area Team	4,461	0	226	0
Leicestershire and Lincolnshire Area Team	10,871	0	2,033	4
NHS Blood and Transplant	0	1,685	0	20
NHS Business Services Authority	0	1,337	0	193
NHS Litigation Authority	0	7,512	0	0
Health Education England	13,202	4	1,547	105
Department of Health (incl. core trading and NHS Supply Chain Maidstone, not incl. Parliamentary funding or grant-in-aid)	763	3	470	0
Public Health England	773	40	469	3
Intra Group				
ENH Pharma Ltd	470	1,729	113	283

42 Losses and special payments

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	217,435	162
Special payments	11,027	36
Total losses and special payments	228,462	198

The total number of losses cases in 2013-14 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	53,457	208
Special payments	1,307,460	21
Total losses and special payments	1,360,917	229

43. Financial performance targets

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

43.1 Breakeven performance	**2005-06 £000s**	**2006-07 £000s**	**2007-08 £000s**	**2008-09 £000s**	**2009-10 £000s**	**2010-11 £000s**	**2011-12 £000s**	**2012-13 £000s**	**2013-14 £000s**	**2014-15 £000s**
Turnover	246,307	270,257	286,332	309,074	331,312	340,309	346,402	350,543	365,313	**376,050**
Retained surplus/(deficit) for the year	(22,379)	(1,527)	2,003	2,070	(19,220)	1,459	3,193	(12,416)	22,153	**(22,656)**
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	**0**
2006/07 PPA (relating to 1997/98 to 2005/06)	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0	0	0	0	0	0	0	0	0
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	21,758	1,906	88	12,658	781	**19,297**
Adjustments for impact of policy change re donated/government grants assets	0	0	0	0	0	0	287	290	(414)	**(254)**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	0	0	0	0	(38)	(37)	0	0	0	**0**
Absorption accounting adjustment	0	0	0	0	0	0	0	0	(22,411)	**0**
Other agreed adjustments	8,557	22,379	0	0	0	0	0	**0**	0	**0**
Break-even in-year position	**(13,822)**	**20,852**	**2,003**	**2,070**	**2,500**	**3,328**	**3,568**	**532**	**109**	**(3,613)**
Break-even cumulative position	**(23,100)**	**(2,248)**	**(245)**	**1,825**	**4,325**	**7,653**	**11,221**	**11,753**	**11,862**	**8,249**

*

Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	**2006-07 %**	**2007-08 %**	**2008-09 %**	**2009-10 %**	**2010-11 %**	**2011-12 %**	**2012-13 %**	**2013-14 %**	**2014-15 %**
Materiality test (I.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-5.61	7.72	0.70	0.67	0.75	0.98	1.03	0.15	0.03	-0.96
Break-even cumulative position as a percentage of turnover	-9.38	-0.83	-0.09	0.59	1.31	2.25	3.24	3.35	3.25	2.19

The amounts in the above tables in respect of financial years prior to 2009/10 have not been restated to IFRS and remain on a UK GAAP basis.

43.2 Capital cost absorption rate

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

43.3 External financing

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

	2014-15 £000s	2013-14 £000s
External financing limit (EFL)	**16,585**	37,974
Cash flow financing	**16,556**	37,678
Unwinding of Discount Adjustment	**0**	19
Finance leases taken out in the year	**0**	0
Other capital receipts	**0**	0
External financing requirement	**16,556**	37,697
Under/(over) spend against EFL	**29**	277

The trust undershot the external financing limit.

43.4 Capital resource limit

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

	2014-15 £000s	2013-14 £000s
Gross capital expenditure	**28,648**	39,025
Less: book value of assets disposed of	**0**	0
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(549)**	(967)
Charge against the capital resource limit	**28,099**	38,058
Capital resource limit	**28,100**	40,132
(Over)/underspend against the capital resource limit	**1**	2,074

The trust undershot on the capital resource limit, thereby not breaching an administrative duty.

44 Third party assets

East and North Herts NHS Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2015	31 March 2014
	£000s	£000s
Third party assets held by the trust	**4**	4

National Reporting Framework
Sustainability Report

Introduction

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, East & North Hertfordshire NHS Trust has developed an annual sustainable development management plan and is committed to the reduction of carbon levels as a Trust.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. As a Trust we have superseded the original target by reducing our carbon emissions by 15.35% in 2011/12 using 2007/08 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). The board approved our SDMP in June 2014, and will be updated again this year, therefore our plans for a sustainable future are well known within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) tool. The last time we used the GCC self-assessment was in March 2015, scoring 62%. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve this goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved Adaptation Plan addresses the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

We have not currently established any strategic partnerships. For commissioned services here is the sustainability comparator for our CCGs:

Organisation Name	SDMP	GCC	Board Lead	Adaptation	SD Reporting Score
NHS East and North Hertfordshire CCG	No	No	Yes	Not answered	Minimum
NHS Bedfordshire CCG	Yes	Yes	Yes	Yes	Excellent
NHS Herts Valleys CCG	No	No	Yes	Yes	Minimum
NHS Cambridgeshire and Peterborough CCG	No	No	Yes	No	Minimum

More information on these measures is available here:
http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

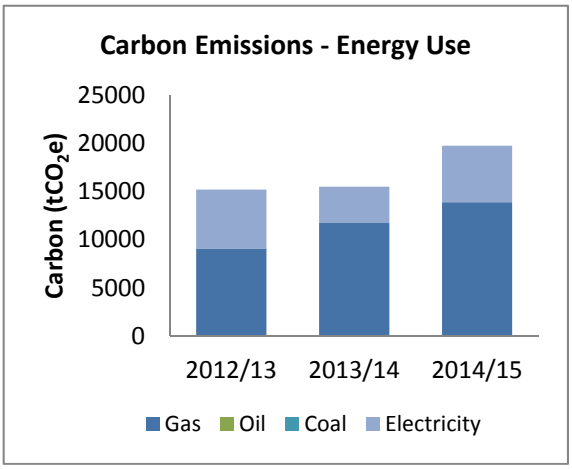
Context info	2007/08	2012/13	2013/14	2014/15
Floor Space (m^2)	107,025	118,003	128,240	130035
Number of Staff	4256	4732	4802	4582

In 2009 the Carbon Reduction Strategy outlined an ambition to reduce the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. We have supported this ambition as follows:

Energy

East & North Hertfordshire NHS Trust has spent £2,809,525 on energy in 2013/14, which is a 1.2% increase on energy spend from last year.

Resource		2012/13	2013/14	2014/15
Gas	Use (kWh)	44,443,522	55,229,788	66,175,796
	tCO_2e	9,082.03	11,716.44	13,883.88
Oil	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Coal	Use (kWh)	0	0	0
	tCO_2e	0	0	0
Electricity	Use (kWh)	15,271,169	17,555,348	19,428,088
	tCO_2e	6,106.58	3,784.65	5,870.25
Total Energy CO_2e		**15,188.61**	**15,501.09**	**19,754.14**
Total Energy Spend		**£ 2,768,225**	**£ 2,776,613**	**£ 2,809,525**



Performance

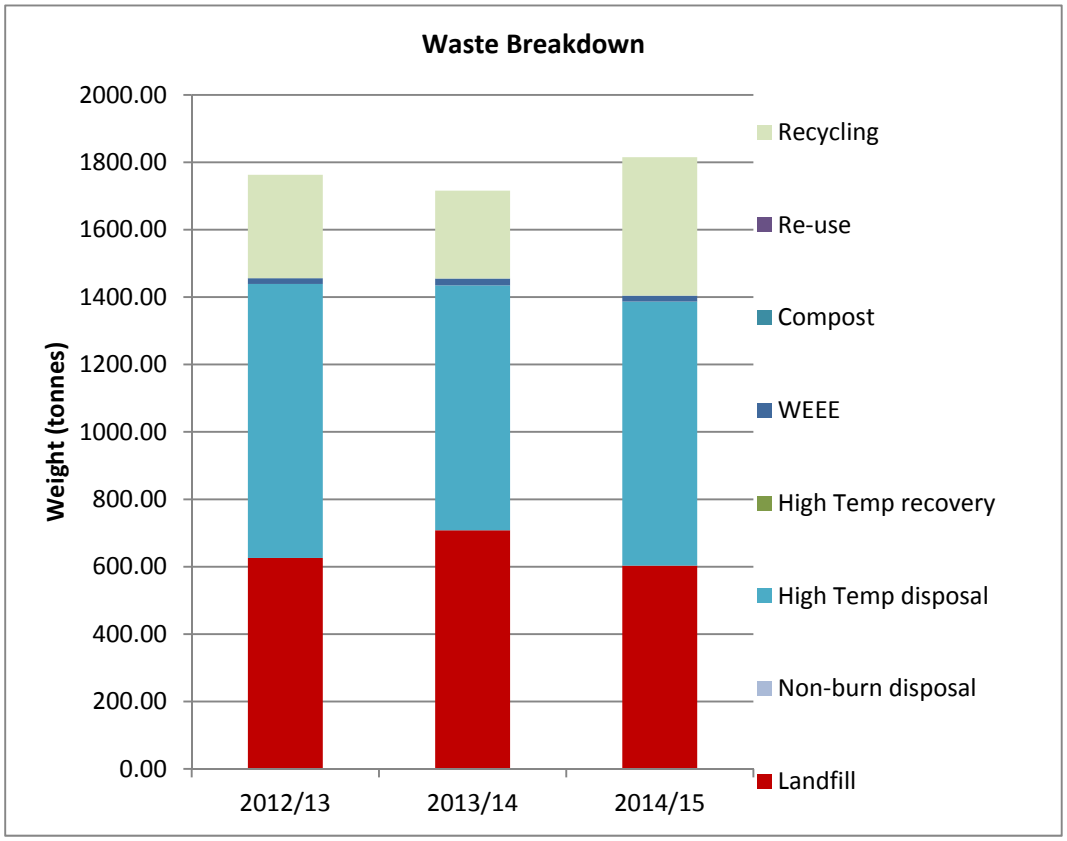
None of our electricity use comes from renewable sources.

Commentary

As anticipated, energy spend has increased for the year 2013/14 and 2014/15 due to the double running of both the Lister and QEII site whilst the redevelopment of Lister and QEII has taken place. Our carbon emissions for 2015/16 will reduce with the closure of the QEII site.

Waste

Waste		2012/13	2013/14	2014/15
Recycling	(tonnes)	307.00	261.00	411.00
	tCO_2e	6.45	5.48	8.63
Re-use	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Compost	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
WEEE	(tonnes)	17.00	20.00	17.40
	tCO_2e	0.36	0.42	0.37
High Temp recovery	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
High Temp disposal	(tonnes)	813.00	727.00	784.00
	tCO_2e	178.86	159.94	172.48
Non-burn disposal	(tonnes)	0.00	0.00	0.00
	tCO_2e	0.00	0.00	0.00
Landfill	(tonnes)	626.00	708.00	603.00
	tCO_2e	153.01	173.05	147.38
Total Waste (tonnes)		1763.00	1716.00	1815.40
% Recycled or Re-used		17%	15%	23%
Total Waste tCO_2e		338.67	338.89	328.86



Performance

An increase in recycling on previous year's figures of from 15% to 23% of total waste tonnage. Landfill also reduced by 15%, compared to the previous year's levels. High temperature waste saw an in increase of 7%, however this could be attributed to the increase in patient contact number seen within the same year's figures.

Commentary

The past twelve months saw the Trust consolidate on to one site at the Lister, with a currently ongoing period of double running of sites. An increase in patient numbers throughout the Trust has also placed additional pressure on all utilities required for clinical care.

In spite of the additional activity level, the Trust has only seen an increase in the levels of high temperature waste (clinical waste which requires specialist disposal) across all sites. These figures also accommodate for the disposal of waste created by the move from the QEII to the Lister site, which was anticipated to increase levels significantly.

Finite Resource Use – Water

Water		2012/13	2013/14	2014/15
Mains	m^3	191594	196511	207927
	tCO_2e	175	179	216
Water & Sewage Spend		£ 328,494	£ 356,547	£ 391,070

Performance

Water usage increased for the Trust by 8% during the year 2014/15.

Commentary

As anticipated, the Trust increased water usage over the past year, due to double running of sites, and an increase in patient numbers. Again, this is anticipated to significantly reduce on the closure of the QEII site.