East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2012/13 annual report and accounts

26 June 2013

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Chapter 1: about the Trust

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

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

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

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

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

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including A&E and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,482 staff are employed by the Trust, which represents around 4,730 whole time equivalents.

The Trust's annual budget is approximately £350 million. The Trust receives circa 70% of clinical income from Hertfordshire, with a further 6% from Bedfordshire. The majority of the remainder of the Trust's clinical income relates to the provision of specialised services.

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

The last 12 months have represented a period of major change within the NHS. The Health and Social Care Act 2012 has resulted in significant structural change across the health service in England.

On 1 April 2013, the role of commissioning health services passed from primary care trusts to new clinical commissioning groups (CCGs), which are led by GPs and had been operating in shadow form for the previous year. Strategic overview of commissioning now rests with NHS England, known formerly as the NHS Commissioning Board.

Many of the functions provided by strategic health authorities prior to their abolition on 1 April 2013 have now passed to local area teams that form part of NHS England. Performance management of NHS trusts has passed to the Trust Development Authority. At the same time, public health services have transferred to local authority control.

The Trust Board is supportive of the changes delivered through the Health and Social Care Act 2012, most notably placing GPs at the centre of commissioning of local health services. The Trust enjoys a very positive relationship with its two main clinical commission groups – East and North Hertfordshire CCG and Bedfordshire CCG – and very much looks forward to developing those relationships over the coming months and years.

At the same time as structural changes were introduced in to how the NHS is organised, one of the most fundamental reports into hospital care was published in February 2013 when Robert Francis QC published his findings. More importantly changes that the NHS needs to make to avoid the problems that led to excessive deaths of patients cared for at the Mid Staffordshire NHS Foundation trust between 2005 and 2009.

Although many of Francis' recommendations were aimed at Government and regulators, much of the report focussed on the need to ensure that high quality and compassion for patients is placed at the heart of the health service.

For the Trust, the path being mapped out by Robert Francis for the NHS matched that set by the Board two years ago. Despite significant progress made in transforming the Trust's operational and financial performance since the early 2000s, enough evidence existed suggesting more could be done to improve both the quality of care received by patients and their experience of that care.

Whilst a number of initiatives were set in train back in 2011 to address these important issues, one of the key areas has been organisational culture change. The Trust's own ARC programme – which stands for *A*ccelerate, *R*efocus and *C*onsolidate – is a long term initiative to place patients and their needs at the heart of decision-making across the Trust. The programme's aim is to help deliver the Trust's ambition of becoming *amongst the best* organisations within the NHS, based on increasing research evidence base linking engaged and valued staff with better patient outcomes and experience.

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

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

These values are at the heart of several important issues undertaken by the Trust recently, including:

- Reviewing our systems and processes;
- Benchmarking our staffing levels;
- Our director of nursing, Angela Thompson, has been working with focus groups consisting of nurses, midwives and other staff and patients from across our hospitals to assess in detail the recommendations from the Francis Inquiry and the implications for patient care and service delivery;
- Our top 500 leaders are engaged in a similar process through our ARC organisational development programme;
- The Trust's non-executive and executive directors have been trained in taking patients' stories and are encouraged to spend more time meeting with patients and front line staff on our wards and clinics;
- Seeking to put every single member of our staff through customer care training before the end of the year.

Back in 2009, the Trust developed a set of strategic objectives for the following five years. With those objectives having been reviewed and updated by the Trust Board in March 2013, I would like to reflect briefly on the Trust's progress to date.

Improve the quality of all aspects of the Trust's services
Much of the Trust's focus over the last few years has been to approve the quality of services provided to patients. Perhaps the biggest indicator of improvement is mortality rates. Over the last three years, work undertaken by the Trust's clinical and non-clinical teams has seen its hospital standardised mortality ratio (HSMR) fall consistently so that it is now below what would be expected for a Trust of our size and patient case mix. A similar fall has been seen in the new, relatively experimental, summary hospital-level mortality indicator (SHMI), which when adjusted for palliative care deaths – the Trust is one of a handful of NHS trusts with a hospice – sees the Trust performing broadly as expected. Whichever rating is used, however, the result is the same – more patients being at the Trust have better outcomes as treatments improve over time. Nonetheless, this remains a high priority and focus of the Trust.

Consolidate acute services for complex or serious conditions on to a single site
Three of the four phases of the Trust's *Our changing hospitals* programme were completed in 2011, with work on the final fourth phase – which comprises 11 separate projects – getting underway in 2012, the entire programme is set to be completed before the end of 2014. By this time, some £150 million will have been invested in to transforming the Lister into the main inpatient and emergency hospital for all of east and north Hertfordshire, as well as parts of Bedfordshire. Led now by the East and North Hertfordshire Clinical Commissioning Group, work also began this year on creating the £30 million New QEII Hospital in Welwyn Garden City, which is set to open in the Spring of 2015. At this point, the process of reconfiguring health services agreed in 2007 following the *Delivering quality health care for Hertfordshire* consultation will have been delivered in full.

Work with colleagues in primary care to extend local access to specialist acute services
Compared to a decade ago, and through the support of the Trust's commissioners, today patients access services at the Lister that previously were found only in major teaching and specialist hospitals in London and Cambridgeshire. Examples include the Trust's robotic urological surgery services and with the creation of the new Bedford and Harlow satellite units, one of the country's largest specialist renal dialysis services. Today patients suffering a heart attack have access to the Hertfordshire Cardiology Centre, which is set to become a 24/7 service from this year. The Trust now has dedicated stroke and sleep disorders units, as well as a children's emergency service that is still considered as an exemplar nationally across the NHS. With local commissioning responsibility now passed to GPs, the Trust looks forward to building on this success and developing new models of care for the benefit of local people.

Maintain Mount Vernon's pre-eminence as tertiary cancer centre, and provide more cancer care locally
Investment, totalling £4.5 million, in two new linear accelerators at Mount Vernon, both capable of delivering intensity-modulated radiation therapy (IMRT) routinely for suitable patients continues a period of significant development of the cancer centre's treatment options covering both radiotherapy and chemotherapy. Work is now underway with hospital site landlords, Hillingdon Hospitals NHS Foundation Trust, to secure ownership of the cancer centre so that the inpatient wards can be rebuilt. At the same time, the Trust is working with Macmillan to create a brand new, larger chemotherapy unit at the Lister by 2014. This development reflects the Trust's aim to ensure that local access to high quality cancer remains a high priority going forward.

Following a period of extensive consultation with the Trust's senior clinical and non-clinical staff, as well as representatives from a range of partner organisations, a new set of strategic aims for the next five years have been set by the Board. They are:

1. Improving continuously the quality of services in order to provide the best care and improve health outcomes for each and every individual accessing the Trust's services.

2. Excelling at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.

3. Providing and supporting the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.

4. Consolidating services and enhancing local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services that are sustainable.

5. Supporting the continued development of the Mount Vernon Cancer Centre and provision of leading local and tertiary cancer services.

6. Improving the Trust's staff engagement and organisational culture to be amongst the best nationally.

These new strategic objectives build on the successes achieved to date by the Trust and its staff over the last decade, whilst at the same time recognising the future challenges facing the Trust, Hertfordshire's health system and the NHS as a whole. Delivering these objectives will help ensure that the Trust achieves its aim of becoming amongst the best performing organisations in the English health service – which includes becoming a NHS foundation trust once final consolidation of emergency and inpatient care is completed at the Lister by the end of 2014.

The Trust is also aware of the importance of innovation and research in delivering higher quality care for its patients. Having secured in 2010 an academic partnership between the Mount Vernon Cancer Centre, Royal Marsden NHS Foundation Trust and Institute of Cancer Research, in 2012 the Trust joined the new Academic Health Science Network (AHSN) covering Eastern England. Between them, these important ventures provide the Trust's clinicians with opportunities to build on, and grow, a strong research tradition. As such, the development of the new network in the East of England is very much welcomed and the Trust looks forward to playing a major role in its future development.

As is set out in this report, 2012/13 proved to be a good year for the Trust. Across a range of operational, clinical and financial standards, all were either met in full or saw significant improvements year-on-year. Of particular importance was the progress made in building better patient experience and more engaged staff. The success enjoyed, however, would not have been possible without the dedication and support provided by the Trust's staff, for which I wish to extend the Board's continued gratitude.

Ian Morfett
Chairman

Chief executive's report

This year's annual report shows that despite the economic pressures facing the NHS, 2012/13 was a good year for the Trust. Whilst very pleased with that outcome, which reflects the hard work of our staff, the Trust is not complacent – there are still areas where further improvement is needed if we are to achieve our objective of becoming amongst the best performing organisations in the health service.

The Trust's operational and financial performance has been good for many years now and in 2012/13, we built on that base to ensure that standards set continued to be met. I am pleased to confirm that this is exactly what was achieved last year.

Operationally, we met virtually all waiting times and other standards set for all NHS trusts. This included A&E, where significant pressures were evident right through the winter months – which was an unusually long period, stretching right through to March 2013.

Financially speaking, the Trust also met its main targets – albeit with a surplus of £0.5 million, which was lower than forecast at the start of the year.

In last year's report, I set out the major challenge facing the Trust – improving further the quality of care patients receive and their experience of that care. The importance of this area of work for the Trust was highlighted by the content and recommendations made by Robert Francis QC in February 2013 on the failures experienced at the Mid Staffordshire NHS Foundation Trust.

Two years ago, the Trust recognised the important connection between engaged staff and positive outcomes for patients. Research from across many sectors, and increasingly within the NHS, shows that where staff feel engaged by and with the organisation for whom they work, improvements are made in both the experience of patients and the quality of care they receive.

Whilst all the new facilities being created at the Lister and QEII, as well as more recently at Mount Vernon and Hertford County, bring very real benefits, they alone are not sufficient to deliver the Trust's aim to become amongst the best NHS trusts in the country. Essentially it is people – our staff – that really make the difference.

Back in 2010/11, the Trust developed its ARC programme to help drive an organisational culture that assures that all of us are focussed upon the needs of the people we serve. ARC stands for:

- **A**ccelerate the pace of change and improvement being made within the Trust
- **R**efocus efforts to improve both the quality of care and patient experience
- **C**onsolidate emergency and inpatient services at the Lister, as well as the patient services being undertaken at the Trust's other hospitals

The ARC programme stresses the Trust's core values – called PIVOT:

- We put our ***P****atients* first
- We strive for excellence and continuous ***I****mprovement*
- We ***V****alue* everybody
- We are ***O****pen* and honest
- We work as a ***T****eam*

Over the last two years, each quarter I have met, through a series of meetings, around 500 of our senior doctors, nurses, other healthcare professionals and managers. The focus of each set of meetings is around a specific core value or related subject (such as most recently the recommendations made by the Francis Report); invariably these meetings focus on real patient experience case studies, suitably anonymised and used with the permission of the patients and/or relatives involved.

Our leaders then engage their teams in order to consider what changes can be made locally, as well as across whole directorates and divisions, that will help patients experience better quality care day-in, day-out.

Changing an organisation's culture does not happen overnight, but over the last two years it is clear that the ARC programme is achieving results. Evidence for this comes from a number of different sources, but principally two national annual NHS surveys published in 2012/13:

- Staff survey – the level of engagement reported by the Trust's staff has improved year-on-year and is now better than the average achieved by NHS organisations;
- Inpatient survey – showed improvements across several important indicators.

Information provided by the Dr Foster organisation, as well as the NHS Information Centre, shows that the Trust's mortality rates have been falling steadily since 2010. Today, our HSMR score is below what would be expected given our size and patient case mix. That means increasing numbers of patients are receiving better outcomes following treatment in our hospitals.

Equally the numbers of people experiencing hospital-acquired infections, pressure ulcers and falls have all fallen significantly over the last 12 months.

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

There can be little doubt that the progress made by the Trust over the last few years has been impressive. It would be wrong, however, to assume that there is nothing left to be done. Whilst the evidence listed above demonstrates progress, more still needs to be carried out so that the Trust can be described as performing amongst the best.

Perhaps a good example of what is meant by this challenge is the achievements made by the Trust's maternity service. Back in 2011, the inpatient and birthing teams at the Lister and QEII were brought together in the Trust's new Diamond Jubilee Maternity, which was opened officially by Her Majesty The Queen on 14 June 2012. New ways of working for our staff were adopted that offered mothers improved choices in how and where their babies are born.

Over the last 12 months, it is clear that women's satisfaction with the new service has improved dramatically, with complaints dropping significantly and positive feedback growing at the same rate. Through bringing the service together and recruiting more doctors and midwives, consultant presence on the maternity unit and wards has been increased and the ratio of midwives to women reduced – changes known to improve outcomes for women and their experience of the care and support they receive.

These improvements have been made at the same time that the cost of running the service has reduced by some £1 million annually. Now that the new services have had time to bed in, the Trust's women's team is focussing on the next set of improvements that it can make to help ensure that it is *amongst the best* in the NHS. This shows how bringing services together, can not only improve the quality of care provided, but also reduce the cost to taxpayers.

The experience of maternity service is just one of several projects now underway across the Trust through the *Our changing hospitals* programme. When completed by the end of 2014, this will see all emergency and inpatient care provided at the Lister hospital in Stevenage. Some £150 million is being invested in new services and facilities – including a new emergency department, ward block and theatres block, all of which will be open by the end of next year.

Over a three-year period by 2015, in order to meet the savings challenge facing the NHS, the Trust needs to release 17% of its cost base. Whilst much of this will be achieved through the reconfiguration of services being delivered by the *Our changings hospitals* programme, that will not be enough on its own. This is why each year the Trust devises and delivers a cost improvement programme (CIP), which is set by individual teams, directorates and divisions – with input from doctors and nurses to ensure that they do not affect patient care adversely.

During 2012/13, the Trust had a CIP challenge to save £15 million. This was achieved at the same time as recording real improvements in both the quality of care and patient experience. This shows that as long as such programmes are managed carefully and with clinical input, high quality services can be maintained whilst reducing costs. This is an important factor when recognising that the CIP programme facing the Trust over the next two years is equally challenging.

In my report I have set out a picture of continued improved performance across all areas of activity within the Trust. It is very important that I recognise that at the heart of these improvements is the Trust's staff. Our current positive position reflects their dedication and hard work – for which once again I would like to extend my gratitude.

Nick Carver
Chief Executive

Chapter 3: NHS Constitution

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

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

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

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

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

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

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

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

Legal rights of patients and staff

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

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

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

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

The Trust has undertaken significant work to align its values to the NHS Constitution – work that is set out in more detail in chapter 5 of this annual report. These values have been embedded into the Trust's recruitment and appraisal processes.

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

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

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

Chapter 4: future trends and projections

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site
- Objective 3: work with colleagues in primary care to extend local access to specialist acute services
- Objective 4: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

Strategic change underway

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

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

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

- Enabling the achievement of best clinical practice, whilst at the same time improving outcomes and productivity across the Trust's hospitals;

- Improving the Trust's ability to attract and retain high quality staff in a way that is supportive of a fast-approaching future where more acute care is provided within the community;

- Creating a critical mass of clinical and specialist staff to support the introduction of new technologies, as well as sustain a wider range of high quality acute services than otherwise would be possible;

- Maintaining viable 24/7 medical staffing rotas for all of the Trust's clinical services;

- Facilitating the modernisation of the Trust's facilities, improving their attractiveness to patients and staff alike, as well as enabling them to be fit for purpose;

- Reducing estate and related costs from the reshaping of the QEII site to offset income loss and support the revenue consequences of capital investment in the Lister.

The Trust's *Our changing hospitals* programme being delivered at the Lister currently takes a phased approach to change, testing deliverability and flexibility at each stage. The following progress has been made to the year ending March 2013:

- Phase one – the Lister Surgicentre: financial close was reached in 2009 between the former primary care trust, NHS Hertfordshire, and its independent sector partner Clinicenta Ltd. – a wholly owned subsidiary of Carillion plc – with construction of the new £47 million facility completed in Spring 2011. Following initial delays, NHS Hertfordshire approved finally Clinicenta's operational plan that saw services commence fully from the Surgicentre in October 2011.

- Phase two – maternity expansion: full business case approval for this £16.5 million NHS-funded scheme was achieved in August 2009, with construction completed in December 2010. The new maternity service commenced, on schedule, from October 2011, which is when all of the Trust's inpatient maternity and gynaecology services at the QEII transferred to the Lister. Ante and post natal services at Hertford County and the QEII were not affected directly by this service change.

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

- Phase four – full consolidation of all remaining emergency and planned acute hospital services: in 2010 the Trust refined the outline business case to reflect NHS Hertfordshire's refreshed commissioning strategy. Having been approved by the respective boards of the Trust, NHS Hertfordshire and NHS East of England in September 2010, the outline business was approved formally by the Department of Health and HM Treasury on 4 August 2011. Full business cases for the majority of the 11 phase four projects have now been approved, with final reconfiguration of these services expected to be completed by Autumn 2014 – a few months prior to the New QEII Hospital opening in 2015.

- Phase four – the full business case for the Lister's new £19 million emergency department has been approved by the Trust, NHS Hertfordshire, East and North Hertfordshire Clinical Commissioning Group, NHS East of England, Department of Health and HM Treasury. Construction started in 2012 and the new facility will be completed by Autumn of 2014.

- Phase four – the full business case for the Lister's new £39 million ward and theatres blocks has been approved by the Trust, NHS Hertfordshire, East and North Hertfordshire Clinical Commissioning Group, NHS East of England, Department of Health and HM Treasury. Construction started in early 2013, with the new facilities set to be completed before the of Autumn of 2014.

- Phase four - the £2.0 million expansion of critical care services at the Lister was completed and opened during 2012.

- Phase four – work continued during 2012/13 on creating the Hertfordshire scanning centre, which includes two new CT scanners and a second MRI scanner.

- Phase four – agreement reached with Macmillan to create jointly a new chemotherapy unit at the Lister, work on which is expected to start later in 2013.

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

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

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

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

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

The strategy's financial implications

In implementing its strategy, the Trust will have to raise the necessary funds to allow capital developments set out through the *Our changing hospitals* programme to take place. This borrowing will, in turn, be financed by savings released as services shift to the Lister site in accordance with the defined phases outlined above. The funding source for the fourth and final phase of the *Our changing hospitals* programme was confirmed during 2012/13, in line with the Trust's long term financial model, as being accessed via the Department of Health – i.e. traditional NHS capital funding, involving a mixture of interest bearing debt and public dividend capital.

Bearing in mind the current economic climate, consolidating acute services on to one main hospital site helps to ensure that the Trust has a viable financial future, at the same time as supporting the very real improvements in clinical quality being demanded of the NHS. Between 2011/12 and 2013/14, the Trust will deliver relatively modest net surpluses. Post configuration, the achievable level of surplus grows, albeit slowly.

The Trust's development programme was based upon an indicative timetable that assumed business case approvals were achieved as per the programme milestones. Where these milestones have not been met, the Trust has revised its financial plans and managed the financial position through a combination of increased efficiency savings and the deferral of capital loans. Throughout the Trust's five-year financial plan, a minimum financial risk rating of 3 is forecast.

Achieving NHS foundation trust status

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

During 2013, therefore, a revised foundation trust timeline will be agreed with the new Trust Development Authority, which also enables the Trust to focus on the final stages of its reconfiguration programme – the aim of which is to achieve better clinical outcomes and experience for patients.

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

Governors

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

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

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

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

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

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

During 2012/13, the Trust has continued to develop its foundation trust membership and implement a new engagement strategy to increase involvement of members, with the additional aim of also increasing nominations for prospective governors.

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Current service development plans

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

Emergency department services – improving consultant cover
In response to national best practice recommendations, the Trust has plans to recruit four additional emergency medicine consultants to improve access to senior medical input within the new emergency department at the Lister and QEII's A&E service, as well as improved consultant cover out-of-hours.

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

Cardiology – 24/7 primary angioplasty service
Supported by local commissioners and the regional cardiology network, the Trust's business case to extend the current primary angioplasty service at the Lister to a full 24/7 service awaits the final go-ahead – expected during 2013. Currently the Lister-based service operates during week day times only, with patients outside of these hours being taken to specialist units at Harefield and Papworth hospitals (both of which are outside Hertfordshire).

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

Improving the Trust's information management and technology

A robust and fit for purpose information management and technology (IM&T) infrastructure is indispensable to support the delivery of the Trust's vision, annual plan and key service priorities. This has been recognised by the Trust and has led to a joint strategy being presented by Trust's IT and information department teams.

The 2012/17 IM&T strategy was approved by the Trust Board last year. The vision encapsulated in the strategy was to: *provide secure, fast, and connected information systems to promote high quality clinical care.*

This vision was to be delivered using the following drivers for change:

- Locally within a Hertfordshire-wide health service re-configuration programme
- Nationally through the quality agenda, and through the national informatics agenda

Current status
Since the Trust's last strategy was agreed, major improvements have been made in the use of technology to deliver secure and quality patient care. Some of the schemes implemented include the:

- Delivery of a robust Wi-Fi infrastructure to enable flexible working within clinical and non-clinical areas
- Development of a data warehouse to ensure quality and accurate data capture
- Development of an e-prescribing solution for the Trust's cancer services division

2012/17 strategy
The Trust's IM&T strategy for 2012-17 will be delivered through five key work streams, each with its own goals as set out below

1) Effective delivery
    - Better customer experience through defined IT service management principles
    - Timely and cost-effective project deliveries through defined project management methodologies
    - More efficient and cost-effective operating IT infrastructure

2) Better decision support
    - Improved data quality through informatics training to maximise skills in the general workforce
    - Provision of specialised decision support tools to increase productivity

3) Improved care
    - Greater use of electronic patient records to support patient care
    - Improved patient outcomes by collating more clinical information within a clinical portal

4) Greater transparency
    - Better patient experience and reduced overheads through patient booking initiatives
    - An extended use of social media in order to improve patient experience and care delivery
    - Improved patient outcomes by exploiting the interest and growth in personal health records

5) Controlled access
    - Robust information governance processes that support the efficient and safe operation of the Trust
    - Greater productivity within the wider workforce through consolidated identity-management initiatives

As part of an on-going infrastructure development within the Trust, a virtualisation project – which will see the rationalisation of the Trust's server estate, thereby saving both capital and revenue expenditure in the procurement of hardware for a new solution – will be completed in the second year of the current strategy

The Trust's *single sign-on* project, which will be delivered in the second year of the strategy, will allow staff authenticated access to all their clinical and business systems through using their smart card to manage their credentials. This improvement will allow significant productivity savings for clinical staff who will spend less time logging on to a computer and more time with their patients.

The strategy is also looking to deliver the following by 2017:

- Robust online meeting services that will enable clinicians work more flexibility
- Development of a clinical portal that will provide a fast and effective decision-making tool for clinicians by providing them with one view to various clinical applications to enable them make fast and accurate decisions relating to patient care
- Effective mobile working solutions aimed at revolutionising the way staff and clinicians work within the Trust.
- An electronic document management solution aimed at providing faster operational efficiency and improved regulatory compliance.
- Digital and Voice Transcription aimed at enhancing productivity, flexibility and better hands off.

Delivering commissioning intentions

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

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

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

Meeting the expectations of regulators

The Trust was registered fully with the Care Quality Commission (CQC), without compliance conditions, on 1 April 2010. The CQC has not taken enforcement action against the Trust during 2012/13.

The Trust was inspected once during 2012/13 when the CQC carried out a routine unannounced inspection of the Lister hospital on the 6 and 7 December 2012. The inspection team tested compliance against five outcomes:

- Outcome 4 (care and welfare)
- Outcome 6 (cooperating with other providers)
- Outcome 7 (safeguarding people who use services from abuse)
- Outcome 13 (staffing)
- Outcome 16 (assessing and monitoring the quality of service provision).

The Trust was found to be fully compliant with each of the five essential standards inspected at the Lister.

As in previous years, the Trust continues to monitor compliance against all the essential standards of quality and safety on an on-going basis. During 2013/14, the Trust will seek to improve further upon this performance with regulators such as the Care Quality Commission, NHS Litigation Authority risk management standards and, continue a programme of self-assessment programme against the standards required by Monitor.

Chapter 5: organisational development

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site
- Objective 3: work with colleagues in primary care to extend local access to specialist acute services

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

This chapter of the annual report is new for 2012/13 and has been pulled together to reflect the work that is being undertaken by the Trust around organisational development, but also to provide a more consistent focus on the Trust's workforce and related area. In previous, annual reports workforce matters in particular have been somewhat dispersed, making it difficult to present a coherent picture of the work being undertaken around organisational development – an issue that took on additional performance following the publication of the *Francis Report* in February 2013, which set out a range of recommendations aimed at changing organisational culture within the NHS.

The Trust is going through a period of major change in both where and how its services are provided to patients. Specific examples of changes underway currently include the:

- *Our changing hospitals* programme – the bringing together of the Trust emergency and inpatient services onto the redeveloped Lister hospital by the end of 2014;

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

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

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

- Vision and values
- ARC programme – its aims and progress
- 2012 national NHS staff survey findings
- Response to the Francis Report

Vision and values

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

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

The Trust has satisfied itself that its vision and values are in line with the principles and values set out in the NHS Constitution and during 2012/13 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 his chief executive's report, Nick Carver set out an overview of the Trust's ARC programme, which commenced less than two years ago. Built around the strapline, *It's all about you*, the ARC programme was created in recognition that the Trust's *Our changing hospitals* initiative was delivering much needed new and updated facilities for patients. As a result, the Trust needed to ensure that its staff were ready and able to meet the challenges of changing demands and expectations of commissioners and patients.

At the heart of the Trust's strategic plans is ensuring that it is well equipped for the future. Processes have been put in place that support this aim, including the ARC programme and wider staff enagagment activities (the latter being covered in more detail in chapter 11). The successes acheived to date following the rollout of the ARC programme across the Trust include:

- An improvement in overall staff engagement;
- Staff feeling strongly that they are able to contribute to work improvements;
- Staff recommending the Trust as a place to work and receive treatment;
- Staff motivation being higher than the national average;
- Improvements in effective team working.

ARC stands for:

- **A**ccelerate – our quality
- **R**efocus – on our patients and our values
- **C**onsolidate – our services and teams

The ARC name is underpinned by the strapline *It's all about you* – which is a key message to every member of the Trust's staff, whereby each individual plays a role in making a difference to the quality of services provided to patients.

Developed in-house, ARC is a Trust-wide programme of activities to aid staff in delivering the highest quality of healthcare to patients, whilst recognising that an engaged and effective workforce is essential in achieving this aim. The Trust aspires *to be amongst the best* hospital groups in the NHS. At the heart of this aspiration, as well as being the driving force behind the ARC programme, is the Trust's values.

The Trust's values articulate the belief that the quality of staff experience has a direct impact on the quality of experience patients have when receiving services at the Trust's hospitals. This correlation has been shown through emerging research to be as true in the NHS as it is in other sectors of the UK's economy.

Quarterly ARC briefing sessions with the Trust's clinical and non-clinical leadership, which numbers some 500 people, have taken place to improve staff engagement. They also provide an invaluable forum for on-going, regular face-to-face communication between the Trust's leadership and executive directors. Topics covered by the ARC sessions during 2012/13 included:

- Staff engagement and patient experience;
- Team-working;
- Customer care – how to provide excellent patient experience;
- Health and well-being.

Other key ARC programme activities during the year included: annual and monthly staff recognition schemes (*Aiming High* awards); leadership development (see chapter 10); health and well-being programmes (again see chapter 10); equality and diversity work; and improving team-working.

During 2012/13, a total of 1,452 members of staff attended the four sets of quarterly meeting. 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/or better patient experience.

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. It is expected that by the end of 2013, everyone working for the Trust will have been through this programme. To ensure that the benefits of this investment in staff training are measured, a set of indicators are being produced to evaluate the process. The trainers also provide evaluation on a regular basis.

Where staff development needs are identified during the training programme, these are captured through the annual appraisal process for these individuals.

National 2012 NHS staff survey

As stated previously, the Trust's vision is *to be amongst the best*, i.e. to become one of the top 20% of acute trusts in England. Part of that ambition is to ensure that the Trust's staff view it as being one of the best places to work in the country, with the results of the 2012 NHS staff survey – which was conducted in November 2012 and published by the Care Quality Commission in March 2013 – highlighted key areas where the Trust is realising its vision already, along with areas where further improvement is needed.

From the findings of the 2012 survey, the Trust is already performing amongst the best in the NHS in the following areas – namely where staff:

- Feel satisfied with the quality of work and patient care they are able to deliver;
- Have had well-structured appraisals during the previous 12 months to the survey being conducted;
- Have had equality and diversity training over the same time period.

In addition, improvements were seen in the following areas since the 2011 survey was published, moving the Trust above the national average for acute trusts and making progress to be amongst the best in the following areas:

- Engagement score with staff has improved (now 70%, up from 61% in the previous year);
- Staff feeling able to contribute towards improvements at work;
- Those reporting positive job satisfaction and being satisfied with the quality of work and patient care they are able to deliver;
- Staff saying they are motivated in their work and experience effective team-working.

The work undertaken at all levels of the Trust to engage staff and ensure that regular appraisals are taking place is now reaping benefits. Staff ratings have improved since 2011 and are now amongst the top 20% of acute trusts in the country

Whilst the 2012 survey reported some important and clear improvements, there were other areas where more work needs to be done. Of particular importance was reporting around the area of violence and harassment from patients, relatives, public and staff. There was also an increase in the percentage of staff reporting work-related stress in the 12 months to November 2012, which was when the survey was conducted.

Results from the 2012 national survey, along with the Trust's own internal quarterly surveys, are communicated to staff through a variety of methods. The Trust is working in partnership with its management and staff side representatives to address issues of concern and develop action plans to make improvements where necessary during 2013/14. Part of this work included the April/May 2013 set of ARC meetings, which were used to consider what actions need to be taken to address the poorer performing aspects of the 2012 staff survey

Trust's response to the Francis report

On the 6 February 2013, Robert Francis QC published the recommendations of the inquiry he chaired that looked at the failings of care within the Mid Staffordshire NHS Foundation Trust between 2005 and 2009.

Data shows that there were between 400 and 1,200 more deaths at the Mid Staffordshire NHS Foundation Trust than would have been expected. The Francis report describes clearly the *"….appalling and unnecessary suffering of hundreds of people….*", who were *"….failed by a system which ignored the warning signs and put corporate self-interest and cost control ahead of patients and their safety.*".

Key recommendations

The report made 290 recommendations aimed at ensuring patients are put first. In particular, it recommended:

- The merger of the regulation of care into one body – two are involved currently;
- Senior managers to be given a code of conduct and the ability to disqualify them if they are not fit to hold such positions;
- Hiding information about poor care to become a criminal offence;
- A statutory obligation on doctors and nurses for a duty of candour so they are open with patients about mistakes;
- An increased focus on compassion in the recruitment, training and education of nurses, including an aptitude test for new recruits and regular checks of competence as is being rolled out for doctors.

Implications for the Trust, its hospitals, staff and patients

As a Trust – like all hospital groups across the NHS – it is committed to learning from the failings that took place at Mid Staffordshire. Robert Francis made it clear that his recommendations represent:

> *"….not the end but the beginning of a journey towards a healthier culture in the NHS in which good practice in one place is not considered to be a reason for ignoring poor practice somewhere else; where personal responsibility is not thought to be satisfied by a belief that someone else is taking care of it; where protecting and serving patients is the conscious purpose of everything everyone thinks about day in day out."*

Importantly, he added that:

> *"…..patients are entitled to be the first and foremost consideration of the system and all those who work in it."*

In the light of the events at Mid Staffordshire, the Trust has reviewed its systems and processes, including benchmark its staffing levels. As a result, the Trust is confident that it provides best practice levels of care, which it will continue to assess.

The Trust monitors carefully what others say about its services and actively encourages and involves its patients, staff, commissioners, the local Healthwatch and other representatives in helping the Trust to identify ways it can keep improving.

It is acknowledged, however, that there is more the Trust can and should do. Patient care is not just the responsibility of those who work directly with patients on a day-to-day basis. It is also the responsibility of the Trust Board's members, its partner organisations and all staff who work in the Trust's hospitals.

The Board reviewed the Francis Report and its recommendations in February 2013, and as a consequence asked its staff to consider what improvements they could make in their own areas. The key lessons from the Francis report, is that individually and collectively, whatever their role within the Trust, every staff member must redouble their efforts in striving to become amongst the best in providing the best possible care for patients.

The Trust's focus will remain, therefore, on placing the needs of its patients at the heart of everything it does, as well as ensuring that all staff operate in accordance with the Trust's values. The review process began at the Board February 2013 meeting, following which a number of steps have been taken to consider the impact of the recommendations for the Trust and how these may further improve patient care, including:

- The Trust's director of nursing, Angela Thompson, worked with focus groups consisting of frontline nursing, midwifery and other staff and patients to assess, in detail, the recommendations from the Francis report, along with their implications for patient care and service delivery ;

- Through the Trust's ARC programme, the Trust's 500 clinical and non-clinical leaders have been engaged in a similar process, bringing to a total some 1,000 members of staff who have reviewed the Francis recommendations with the executive directors;

- The Trust is seeking to put every single member of its staff through customer care training before the end of 2013.

The findings of the Trust's review will be implemented in ways that will help ensure patients and local people, as well as staff and volunteers, have confidence in the way that the Trust works. It will also help restore public faith in the NHS, some of which may have been lost as a result of Mid Staffordshire.

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. This issue is dealt with in greater detail in chapter 10, it is important to note that the Trust's chief executive has reiterated to all staff their absolute duty to ensure patients receive the very best care and to take responsibility for dealing with, and addressing, any concerns they may have about the care provided. Fundamentally, they must not ignore such concerns or think they are for someone else to deal with – a core message is that the Trust's staff must never become *bystanders*.

Chapter 6: 2012/13 overview

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site
- Objective 3: work with colleagues in primary care to extend local access to specialist acute services
- Objective 4: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally

Further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13 is covered in this chapter.

The areas covered in this chapter are:

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

Delivery of the Trust's corporate objectives for 2012/13

During 2012/13, the Trust worked to four strategic objectives, namely to:

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

Significant progress has been made in year, including:

- Securing Department of Health and HM Treasury approval for two full business cases (emergency department and new ward/theatres blocks) that between them represent major acute consolidation schemes for the Trust;
- Developing a new clinical strategy for Mount Vernon's cancer services;
- Progressing delivery of the Trust's Our changing hospitals programme for acute consolidation within overall budgets and spending limits approved by the Trust Board;
- Bidding successfully for, and winning, contracts to provide two new renal dialysis satellite units in Bedford and Harlow;
- Delivering the Trust's new combined heat and power plant on plan and budget, realising revenue savings and carbon emission reductions in line with the Trust's sustainability strategy.

In terms of annual objectives, the Trust met 21 out of 34 in full. In addition, three are on track to be delivered (awaiting national data to confirm) and four have been met partly. This leaves six annual objectives that were not achieved by year-end – with the exception of one, these are being reviewed currently to be taken forward during 2013/14.

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

Objective 1: improve the quality of all aspects of the Trust's services		
1.1	To maintain a governance risk rating of *amber/green*, or better, demonstrating performance improvement from the previous year	**Achieved**
1.2	To improve the financial efficiency of the Trust and achieve a minimum finance risk rating of *3* and deliver the cost improvement plans across the Trust for 2012/13	**Achieved**
1.3	Following the implementation of the Trust's patient-level costing system in 2010/11, ensure that it is used to inform decision making at all levels within the organisation demonstrating service improvement contribution	**Not achieved***
1.4	To deliver on the Trust agreements within the Tripartite Agreement and achieve authorisation as a NHS foundation trust	**Not achieved***
1.5	*To demonstrate improvement from the end of year achievements of the 2012/13 indicators on patients safety, outcomes, quality, patient experience, clinical effectiveness, workforce, and specifically:*	
	i) Further improve the HSMR to ensure within the as expected *range (in rebased data) at year end, demonstrating five points improvement from the Trust's 2011/12 performance*	**Achieved****
	ii) Implement an improved patient experience strategy, utilising new and appropriate techniques for engaging with patients and users of Trust services, ensuring that all divisions act on their patient experience outcome data and implement appropriate changes to improve the experience thus maintaining a Department of Health green *rating (performing)*	**Achieved****
	iii) Further reduction of avoidable *health care-acquired infections (HCAIs) in line with agreed targets*	**Achieved**
	iv) Reduction of serious harm falls by 25% and zero tolerance approach to hospital-acquired avoidable grade two to four pressure ulcers	**Achieved**
	v) Ensure robust monitoring and achievement of Commissioning for Quality and Innovation *(CQUIN) payment targets*	**Achieved****
	vi) To implement and deliver against the key milestones within the Trust's Our changing hospitals *programme to ensure further improvements made during 2012/13 and the delivery of clearly measureable cultural indicators to support on-going organisational development and staff engagement*	**Achieved**
1.6	To ensure the delivery of safe services at the QEII during the final phase of the Trust's consolidation programme for inpatient and emergency service, ensuring the effective management of patient safety and clinical risks associated with delays to the phase four projects within the *Our changing hospitals* programme	**Achieved**
1.7	To deliver on the key priorities for 2012/13 agreed within the Trust's *Quality Account*. Priorities include: improving safety in elderly care; improving clinical outcomes; staff development; improving experiences in maternity and children's services; improving outcomes in cancer care	**Partly achieved*****
1.8	To deliver the 2012/13 elements of the Trust's *learning disability improvement plan*	**Achieved**
1.9	To review and develop the Trust's longer term strategic objectives in the context of: NHS changes to structures and environment; demographics and the local health economy; science and technology; workforce; patient and societal expectations; and productivity and efficiency	**Achieved**
1.10	To develop a series of strategies that consider the risks and opportunities that the six issues listed above (i.e. *NHS changes to structures and environment; demographics and the local health economy; science and technology; workforce; patient and societal expectations; and productivity and efficiency)* pose to the Trust	**Achieved**

Notes to annual objectives 1.1 to 1.10

*1.3: Not achieved – revised strategy approved through the Trust's finance and performance committee to implement service line reporting during 2013/14.

*1.4: Not achieved – Trust now in discussion with the new Trust Development Authority regarding a revised timeline for its NHS foundation trust application submission, which follow final reconfiguration of services in 2014.

**1.5i: The 2011/12 HSMR was calculated at 98.2. The current assessment of HSMR for 2012/13 is 92.5, which is a reduction of 5.7 points. The figure for 2012/13 is calculated on 2011/12 benchmarks and is based on 99% of available data. The first full revision for this year will be available in July 2013.

**1.5ii: Anticipate being achieved – Trust's patient experience has improved from 64.8 to 66.3 on the composite five questions, but the national comparisons are not yet known. Improvements delivered are in line with those set in year one of the Trust's patient experience strategy

**1.5v: Forecast to have achieved expected level

***1.7: See Trust's 2012/13 *Quality Account* for full details why this annual objective was delivered in part

Objective 2: consolidate acute services for complex or serious conditions on to a single site		
2.1	Phase 0: Deliver combined heat and power plant (CHP), on plan and on budget, realising revenue savings and carbon emission reductions	**Achieved**
2.2	Phase 3, part 2: Develop an outline business case (OBC) to deliver the outstanding car park capacity to support acute consolidation	**Not achieved***
2.3	Phase 4: Improve the patient and service quality through phase four schemes at the Lister and obtain approval specifically of:	
	i) Theatres and new ward block full business case (FBC)	**Achieved**
	ii) Critical care FBC and implement	**Achieved**
	iii) Mortuary FBC and implement	**Achieved**
	iv) Health records FBC and implement	**Achieved**
	v) Ward 7 FBC and implement	**Achieved**
	vi) Pathology FBC and implement as per programme	**Not achieved***
2.4	Support the development of the New QEII Hospital, which is led by NHS Hertfordshire (replaced as of 1 April 2013 by the East and North Hertfordshire CCG):	
	i) Develop the QEII site disposal plan, ensuring land and associated enabling works are made available	**Partly achieved****
	ii) Develop staffing plan, pathways and mobilisation plan for QEII	**Partly achieved****
2.5	Workforce: In collaboration with key executives and divisional directors, develop the detailed workforce strategy and delivery plan required to manage and deliver the phase four workforce skill-mix changes and planned workforce reductions in line with phase four, Trust's foundation trust application and Hertfordshire's QIPP plan	**Not achieved***
2.6	Develop and approve a business case in response to the NHS Midlands and East procurement of community pathology services that ensures the transformation of hospital pathology services will deliver high quality, value for money services, with a workforce that meets the future needs of the Trust	**Partly achieved****

Notes to annual objectives 2.1 to 2.6

*2.2: Not achieved – currently the Trust is exploring options to deliver the required capacity upon consolidation

*2.3vi: Not achieved – the regional timetable, managed until 1 April 2012 by the former NHS Midlands and East, has delayed implementation across the region

**2.4i: Partly achieved – work has commenced but will not complete until 2014

**2.4ii: Partly achieved – work has commenced but will not complete until 2014

*2.5: Not achieved – the Trust's workforce strategy is under review; details behind the workforce plans relating to the Trust's *Our changing hospitals* programme is now a focus for the first six months of 2013/14

**2.6: Partly achieved – contingency plans are being developed to ensure that continuity of acute pathology services and maintenance of the phase four critical path within the Trust's *Our changing hospitals* programme in the event of significant further delays to the region-wide procurement process and service transformation during 2013/14.

Objective 3: work with colleagues in primary care to extend local access to specialist acute services		
3.1	To develop a robust bid and be awarded one of the proposed renal satellite service contracts, which will enable delivery of care closer to home.	**Achieved****
3.2	To ensure delivery of the year two Trust elements of the jointly-agreed, Hertfordshire-wide QIPP programme in 2012/13 (strategic change programme, demand management and CIPs)	**Achieved**
3.3	To build upon existing relationships and structures and strengthen associations with new emerging commissioner organisations (e.g. clinical commissioning groups, local authorities and health and wellbeing boards) to maintain Trust market share within agreed tolerances	**Achieved**
3.4	To develop a robust bid and achieve becoming the provider of specialist vascular services across Hertfordshire	**Not achieved***
3.5	To develop a robust business case with the outcome of achieving 24/7 heart attack status	**Achieved**

Notes to annual objectives 3.1 to 3.4

**3.1: The Trust was awarded contracts to run both of the new satellite dialysis services for which it bed (Bedford and Harlow) with its partner Diaverum

*3.4: Not achieved – the Midlands and East Specialist Commissioning Group is proposing to consolidate vascular services at Watford General Hospital and the Trust remains represented at relevant working groups

Objective 4: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally		
4.1	In collaboration with key executives and divisional directors, and within the constraints of a listed building, ensure the delivery of the Mount Vernon Cancer Centre (MVCC) project plan to improve the current ward areas and environment, ensuring standards are compliant with CQC standards and other national guidance on infection control	**Achieved**
4.2	To develop the commercial and clinical strategy for the cancer service, which has the support of the commissioners and includes improved access and productivity; MVCC site development and a cancer satellite service, which will lead to improvements in patient experience	**Achieved**

Further information

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

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Operational, clinical and financial performance summary

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

Activity	2012/13 planned	2012/13 actual	% variance
A&E activity (attendances)	124,094	119,716	-3.5%
Outpatient activity (first appointments)	89,277	88,552	-0.8%
Elective activity (number of planned episodes of surgery/treatment	28,678	28,327	-1.2%
Non-elective activity (number of emergency admissions)	36,236	37,587	+3.7%
Number of births	5,600	5,303	-5.3%

Patient access

In terms of existing nationals and local standards set for the Trust to achieve during 2012/13, a summary of the main patient access and clinical indicators is set out in the table below.

Standard	Target	2012/13 outturn
18 weeks standard – admitted	≥90.0%	92.2%
18 weeks standard – non-admitted	≥95.0%	97.1%
18 weeks standard – open pathways	≥92.0%	94.9%
A&E four-hour wait	≥95.0%	95.8%
Two-week rapid access chest pain clinic wait	≥98.0%	100%
PPCI heart attack service – 150 min call to balloon time	≥80.0%	100%
Patients spending 90% hospital stay on specialist stroke unit	≥80.0%	79.8%
Patients with high-risk TIA seen and scanned/treated within 24 hours	≥60.0%	51.2%
Two-week maximum wait, referral to outpatient appt (all cancers)	≥93.0%	98.5%*
Two-week wait – breast symptoms	≥93.0%	96.3%*
31-day diagnosis to treatment (all cancers)	≥96.0%	97.8%*
31-day second or subsequent treatment (anti-cancer drug)	≥98.0%	99.8%*
31-day second or subsequent treatment (surgery)	≥94.0%	97.6%*
31-day second or subsequent treatment (radiotherapy)	≥94.0%	98.8%*
62-day urgent referral to treatment (all cancers)	≥85.0%	86.0%*
62-day referral to treatment (from screening)	≥90.0%	93.2%*
Choose and Book slot issues	≤5.0%	11.02%
DNA (did not attend) rate – outpatients	≤7.2%	7.1%
New to follow-up outpatient appointment ratio	≤1.75	2.25
Pre-operative bed days	≤6.0%	7.3%
Delayed transfers of care (inpatients)	≤3.50%	2.8%
Cancelled operations	≤0.8%	0.58%
Cancelled operations rebooked within 28 days	100%	99.0%

*Data only confirmed six weeks after month end – year-end outturn not confirmed until May 2013

Overall the Trust's performance against standards set for it to be achieved during 2012/13 saw improvements on the previous year, although some areas saw performance slip slightly in comparison. Once again, a wide range of standards including those covering A&E waiting times, cancer care and cardiology were met. The Trust's team also maintained standards around cancelled operations and delayed transfers of care, even in the traditionally challenging winter months.

Areas of specific focus for 2012/13 include:

- Maintaining the Trust's A&E waiting times standard, with at least 95% of those attending the Trust's service being seen, treated and either admitted or discharged within four hours of arrival;

- Continuing to work with commissioners to reduce the level of issues with outpatient appointment slots coming through the *Choose and Book* system operated in those GP practices using this service on behalf of their patients;

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

- Work to reduce the ratio of new to follow-up outpatient appointments and the average number of pre-operative days to below standard sets, as well as ensuring that 100% of those whose operation is cancelled on the day are readmitted within 28 days – all three were standards achieved in 2011/12.

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 2012/13 – a summary of which are set out in the table below.

Healthcare quality indicator	2012/13 Standard	2012/13 Outturn	2011/12 Outturn
MRSA blood infections (post 48 hours)	≤3	2	3
Clostridium difficile infections	≤14	13	12
Emergency MRSA screening compliance	100%	90.8%	n/a
Adult inpatients undergoing VTE risk assessment	≥98%	99.2%	92.8%
Net promoter score (*Friends and Family Test*)	≥71.0	71.1	n/a
Patients stating involved in decisions	≥71.0	68.1	68.6
Patients stating worries and fears addressed	≥58.0	64.8	64.8
Patients stating had privacy to discuss conditions/treatment	≥80.0	87.6	87.5
Patients stating told about medication side-effects	≥50.0	45.1	44.9
Patients stating knew who to contact if worried on leaving hospital	≥79.0	76.0	74.1
Falls resulting in serious harm	≤24	14	n/a
Pressure ulcers – grades two to four	≤120	113	323
Never Events	0	2	1
Serious dispensing drug errors	≤3	1	n/a
Prescribing drug errors	≤186	125	n/a
Administering drug errors	≤145	177	n/a
NPSA safety alerts outstanding	0	0	0
Hospital standardised mortality ratio (100 = expected NHS average)	≤89	92.5[1]	98.2
Summary hospital-level mortality rate (100 = expected NHS average)	≤95	111.4[2]	114.1
Summary hospital-level mortality rate – adjusted for palliative care	≤90	102.0[2]	103.7

[1]Rolling 12-month score, provided three months in arrears – means final 2012/13 position not known until at least July 2013
[2]Rolling 12-month score, provided six months in arrears – means final 2012/13 position not known until at least October 2013

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

Trust's financial performance
By the end of March 2013, the Trust reported a year-end surplus of £0.532 million. This was marginally better than the £0.5 million revised year-end forecast, although significantly less than the £3.6 million forecast at the start of the year. The final surplus was delivered on a budget of some £350 million, representing just over 0.14% of turnover.

Looking back across the year, elective income was almost exactly in line with plan in total with shortfalls on inpatient admissions (mainly in orthopaedics) being offset by positive variances in outpatients. Non-elective income was also on target, however maternity services have seen a reduction in the number of births as the year has progressed and had particularly quiet months in February and March 2013 (a total financial shortfall for the year of over £1.0 million). Other areas of note are GP direct access diagnostics, which continued to grow as they have been in recent years (total of £0.8 million over plan) and Mount Vernon, which made up some of the ground lost earlier in the year.

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

- The Trust's external financing limit (cash target) of £10.02 million was achieved;

- The Trust's capital programme for the year totalled £17.7 million, which was £6.6 million behind the revised plan (caused by delays in approval of the Trust's full business cases for its new emergency department, along with new ward and theatres blocks at the Lister) and £1.4 million below the forecast outturn position of 2012/13. Slippage on capital schemes for last year will represent the first call on the 2013/14 capital programme;

- The Trust had another successful year when it came to delivering its annual cost improvement programme (CIPs), with 100% delivery against a plan of £15.020 million for 2012/13.

Regulation and assessment-related information

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

Locations	Location Code	Regulated Activity
Queen Elizabeth II Hospital Queen Elizabeth II Hospital Welwyn Garden City AL7 4HQ	RWH20	Assessment or medical treatment for persons detained under the Mental Health Act 1983
		Diagnostic and screening procedures
		Family planning
		Maternity and midwifery services
		Surgical procedures
		Termination of pregnancies
		Treatment of disease, disorder or injury
Mount Vernon Cancer Centre Rickmansworth Road Northwood HA6 2RN	RWH04	Assessment or medical treatment for persons detained under the Mental Health Act 1983
		Diagnostic and screening procedures
		Surgical procedures
		Treatment of disease, disorder or injury
Lister Hospital Coreys Mill Lane Stevenage SG1 4AB	RWH01	Assessment or medical treatment for persons detained under the Mental Health Act 1983
		Diagnostic and screening procedures
		Family planning
		Maternity and midwifery services
		Surgical procedures
		Termination of pregnancies
		Treatment of disease, disorder or injury
Hertford County Hospital North Road Hertford SG14 1LP	RWH23	Diagnostic and screening procedures
		Family planning
		Maternity and midwifery services
		Treatment of disease, disorder or injury

During March 2013, an application was submitted to CQC to register the Trust's new renal dialysis unit in Bedford as an additional location to those mentioned above. Following an assessment, the Trust received approval of the application for registration; the unit opened to receive patients on 8 April 2013.

Inspections and reviews

The Trust has been inspected once during 2012/13. The CQC carried out a routine unannounced inspection of the Lister hospital on 6 and 7 December 2012, with inspection team testing compliance against five outcomes:

- Outcome 4 (care and welfare)
- Outcome 6 (cooperating with other providers)
- Outcome 7 (safeguarding people who use services from abuse)
- Outcome 13 (staffing)
- Outcome 16 (assessing and monitoring the quality of service provision).

During the two-day inspection, the team interviewed key members of staff, visited several wards where they spoke to clinical staff, patients and their families and also reviewed health records. Detailed evidence to support outcome 16 was requested and provided to the inspection team for review.

The team found that that people spoken to by its inspectors had experienced care and treatment that met their needs at the Lister hospital and had been involved, where possible, in decisions about their care.

The inspectors reported that people's health, safety and welfare had been protected when more than one provider was involved in their care and treatment, or when they moved between different services. People were also protected from the risk of abuse because the Trust had taken reasonable steps to identify the possibility of abuse and prevent it from happening.

Those who spoke with the CQC inspection team said that there was adequate staff in place to meet people's needs on a day-to-day basis. The Trust provided CQC with evidence that demonstrated that staff at the Trust worked to improve continuously the quality of all aspects of their services through the review of progress against organisational performance priorities and strategies.

In summary, the Trust was found to be fully compliant with each of the five essential standards inspected at the Lister.

Listening to patients' concerns

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

The Trust's PALS teams, who work closely with their complaints colleagues, aim to resolve issues locally, without the need for these concerns to be escalated to a more formal level. The teams also try to make initial contact with complainants who have written to the Trust to establish if their concerns can be addressed more effectively at a local level. During 2012/13, a total of 1,728 separate contacts were made with the Trust's PALS services – this includes those seeking direct help from the teams themselves, as well as via comment cards. The numbers using the Trust's PALS service during the year was broadly similar to that recorded in 2011/12 (1,733 separate contacts).

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

During the year, the Trust's PALS service has seen a reduction in the number of hours the service is staffed, however the use of volunteers has increased and it is hoped that this will continue to be the case over coming months.

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 2012/13, the Trust received 969 formal complaints – a 9% reduction on the number received the previous year. Given the continuing reconfiguration of services that has taken place during 2012, along with the Trust's open encouragement of complaints being received, this is a pleasing outcome for the year. It is also important to note that in areas such as maternity services, where reconfiguration has been completed and new service models become established, complaint levels have reduced considerably. Overall, the majority of complaints reported to the Trust were of a low or moderate severity.

Everyone who makes a formal complaint is offered an opportunity to meet with relevant staff if they remain dissatisfied after receiving the Trust's investigation response. In 2012/13 there were 30 such meetings – two more than the previous year. These meetings form part of what is known as the *local resolution* process.

In the 12 months to March 2013, a total of 23 people asked the Ombudsman to consider an investigation of their complaint. Following discussion with the Ombudsman's office, however, it became clear that many of these requests had not concluded the *local resolution* stage of the complaints handling process, so were passed back to the Trust for further action. As a result, the Ombudsman accepted only three of the 23 applications for further investigation. An additional five complaints that had been referred to the Ombudsman in the previous year (i.e. 2011/12), were also accepted for investigation.

In addition to these complaints, during 2012/13 the Trust formally received 144 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 Department of Health, which also now appear on the independent *Patient Opinion* online service.

The total comments being made in this way is growing year-on-year, with 2012/13 seeing at least 100 being made across the Trust's four hospitals. Such means of online commentary are an increasing trend within healthcare, building on the success of such services as TripAdvisor in the holiday sector.

The vast majority of comments received through NHS Choices are highly positive of the care and treatment received at the Trust's hospitals. Using a new five star rating system introduced in 2012/13, ratings for the Trust's hospitals are as follows:

- Lister – overall four stars based on a total of 151 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, the Lister has had 331 reviews.

- QEII – overall four stars based on 76 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, the QEII has had 241 reviews.

- Hertford County – overall four stars based on 16 ratings (cleanliness – four stars; staff co-operation – four and a half stars; dignity and respect – five stars; involvement in decisions – four and a half stars; and same sex accommodation five stars). Since the NHS Choices service started, Hertford County has had 40 reviews.

- Mount Vernon Cancer Centre – overall five stars based on four ratings (cleanliness – four stars; staff co-operation – five stars; dignity and respect – five stars; involvement in decisions – five stars; and same sex accommodation five stars). Since the NHS Choices service started, Mount Vernon has had 13 reviews.

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

The level of commentary on the Trust's hospital services through NHS Choices compares very favourably with that of nearby NHS hospitals. Based on those involved in star grading system introduced in 2012, the only hospital bordering the Trust that received a greater number of ratings than the QEII was for Watford General Hospital (80 ratings). None received greater than 100 ratings, with the exception of the Lister (151 ratings posted). The hospital with the lowest level of ratings surprisingly was the biggest – Addenbrooke's with 33 ratings over the same time period.

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.

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 1,300 followers of the Trust's Twitter feed and nearly 1,800 people who receive the Trust's postings on its Facebook channels.

The role of the Trust's hospital volunteers

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

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

Education and training summary

The Trust has always recognised the importance of staff training and education. During 2012/13, it continued to focus on a wide range of internal training for both clinical and non-clinical staff, including:

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

Throughout the year, the Trust has continued to evolve and clarify its statutory and mandatory training programmes, taking into account changing national legislation – for example Care Quality Commission requirements for safeguarding adults – and the need to ensure that high levels of compliance with training are met.

E-learning programmes continue to be developed with the aim of building on the current portfolio of courses that are available to junior doctors in advance of their starting their employment with the Trust, as well as to all other staff on an on-going basis.

During 2012/13, the Trust continued to support national management graduate training schemes, along with regional senior leadership programmes.

Research and development summary

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

During 2012/13, the Trust had some 250 active research studies covering around 2,000 participants. Over 90% of these studies were funded externally. Over the last three calendar years, i.e. 2010 to 2012, researchers at the Trust contributed to circa 500 publications in peer-reviewed journals.

According to the latest figures available, patient recruitment into the United Kingdom Clinical Research Network portfolio studies has risen and been maintained over recent years, with 1,476 Trust patients participating in these studies during 2012/13. This number is likely to rise as recruitment reporting is completed for the year. The national ambition is to double the number of patients taking part in clinical trials and other well-designed research studies within the next five years.

Systems are in place to ensure that the principles and requirements of the national research governance framework are applied consistently. The management and administrative arrangements for research activity are governed by a full set of policies and standard operating procedures, which have been ratified by the Trust. A record of all research being conducted is maintained by the Trust's research and development team, which works for both the East and North Hertfordshire and West Hertfordshire Hospitals NHS trusts.

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

In the past year, the Trust has established an R&D Board overseeing research activity at all its hospital sites. A Trust-wide R&D strategy, along with key performance indicators, has been implemented. This important work has resulted in a number of new grant applications from researchers in the Trust addressing issues that are of importance to patients.

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

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

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

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

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

Impact of Trust research activity – cancer

The cancer centre was a major recruiter to the ICON 7 trial, which has led to the licensing of bevacizumab for the treatment of advanced ovarian cancer. This drug is the first to demonstrate a survival advantage in therapy of first line ovarian cancer for many years.

Professor Rustin has also won grants totalling in excess of £2 million from Cancer Research UK, GlaxoSmithKline, Oxigene and the Cancer Treatment Research Trust CTRT for a clinical trial of the vascular disrupting agent fosbretabulin combined with the anti-angiogenic agent pazopanib. Once a safe dose of the combination has been established, further patients with recurrent advanced ovarian cancer will be randomised to receive fosbretabulin alone, pazopanib alone or the combination during the first week before then continue with the combination therapy. The research team is hopeful that the use of serial dynamic MRI scans and measurement of several biomarkers will indicate whether combining the drugs has a synergistic effect.

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

Dr Makris is a co-chief investigator of the OPTIMA trial, which commenced in 2012. The pilot part of OPTIMA is funded by a £2 million grant from the Human Tissue Authority and its main objective is to determine whether multi-parameter assays can be used to spare some women with high-risk hormone receptor positive disease undergoing chemotherapy.

Professor Hoskin continues to make significant impacts internationally in radiotherapy. The FORT trial, which was presented at the American Society for Radiation Oncology, explored the role of very low dose radiotherapy (4Gy) in follicular lymphoma, showing that this was inferior to standard dose (24Gy) – thus establishing the latter as the international standard radiation dose for follicular lymphoma. Based on this and the previous radiotherapy dose trial in lymphoma, Professor Hoskin has co-authored both national (British Society of Haematology) and international (ESMO) guidelines on the management of follicular lymphoma.

Professor Hoskin's collaborative work as co-investigator and co-author enabled the results of the RAPID trial to be presented at the American society of Haematology meeting, which has shown the value of PET scanning in the management of early Hodgkins disease.

Updated analyses of Professor Hoskin's randomised trial of HDR brachytherapy continues to show an advantage for this approach in the radiotherapy for prostate cancer, as a result of which an increasing number of UK centres are adopting this approach – often with mentorship from the Mount Vernon team.

The radiotherapy QA team at Mount Vernon leads the way in the UK for radiotherapy QA work, which supports at any time over 20 national portfolio studies and has completed a national intensity-modulated radiation therapy (IMRT) credentialing exercise, facilitating the introduction of IMRT across England in line with national targets set by the Department of Health.

Impact of Trust research activity – cardiology

Professor Gorog has led a pilot research project about a novel blood test that identifies patients at increased risk of heart attack. Cardiovascular disease is the leading cause of death in the UK, as well as the rest of the developed world. The predominant cause of morbidity and mortality from cardiovascular disease is due to a blood clot blocking an artery in the heart, resulting in a heart attack.

It is not understood fully yet why some people develop such a blood clot in their heart arteries, whilst others do not. Furthermore, whilst blood-thinning medications to treat such conditions are effective in preventing recurrent heart attack in many patients, some patients continue to have recurrent heart attacks and stroke, despite optimal treatment.

Treating everyone with very strong blood-thinning agents is risky, because these agents increase the risk of major bleeding. Thus, there is a real need to identify those patients who are at greatest risk of arterial thrombosis (blood clot in an artery), targeting them with strong blood thinning medications to reduce their risk of heart attack and stroke.

The research team led by Professor Gorog has used a novel blood test to assess how quickly a patient's blood can form a clot and how easily it could dissolve such a clot. The global thrombosis test (GTT), a near-patient blood test, was used to assess 300 patients with a recent acute coronary syndrome (ACS; heart attack) who were receiving optimal medical treatment with blood thinners. The team showed that despite such medication, 23% of ACS patients were shown by the new blood test still to be prone to clot formation and such clots were resistant to dissolution. Such an abnormal blood test result with the GTT was a significant and independent predictor of cardiovascular death and recurrent heart attack.

Patients with end-stage renal failure on dialysis are at very high risk of heart attack and stroke. They tested 200 patients with renal failure who were on dialysis; blood was tested using the GTT. It was shown that patients with abnormal GTT results who developed clots resistant to dissolution (thrombolysis) were 14 times more likely to suffer a heart attack or stroke in the next 12 months, than those with normal GTT results. They were also 10 times more likely to block their dialysis fistula – the forearm arterio-venous connection that allows patients to dialyse.

Thus Professor Gorog's team has identified a novel risk factor that predisposes patients to heart attack. It can be tested using a simple bedside blood test. The team's findings have been published in the Journal of the American College of Cardiology and the European Heart Journal. It is hoped that further research will follow as finding new ways to identify patients at risk of thrombosis and reducing thrombotic risk could be valuable tools to reduce the occurrence of heart attack, stroke and cardiovascular death.

Impact of Trust research activity – renal medicine

Research in the Trust's renal medicine service has impacted in a number of areas. There is a work stream related to technical aspects of renal dialysis. One focus of this research has been to establish the importance of residual renal function to many aspects of well-being in haemodialysis patients and thus underpinning the renal team's incremental haemodialysis programme.

Work carried out by the Trust's researchers on residual renal function is now quoted widely and embodied in national guidelines. The team also has an on-going interest in the measurement of dialysis adequacy and, in particular, the importance of adjusting dialysis dose to metabolic rate and physical activity. This work has been supported by grants from Kidney Research UK and the British Renal Society.

The team's work on long term outcomes of hemodiafiltration has contributed to the increased uptake of this modality in the UK and the benefits reported in a published retrospective study have been confirmed in the recent Catalonian random controlled trial.

The renal team has also developed a major interest in self-management in haemodialysis patients over recent years, with work continuing supported by a research for patient benefit (RfPB) grant made by the National Institute for Health Research.

There is also on-going work on psychosocial aspects of advanced kidney disease. Support by grants from the British Renal Society and Kidney Research UK, this research has established the prevalence of depression in dialysis patients, along with its effects on outcomes. Currently the team is running a multi-centre random control trial to determine the benefits of depression treatment in this population. This research is also supported by an RfPB grant from the National Institute for Health Research. Another British Renal Society grant is supporting work to determine the constructs of depression in the South Asian population on dialysis.

Adherence to treatment schedules in dialysis is a major problem. Grants from the British Renal Society are supporting studies to improve adherence in the management of phosphate and inter-dialytic fluid gains in this setting.

The renal team also has a major interest in the conservative management of patients with advance kidney disease. This work, some of which has been supported by a grant from the British Renal Society, has been a major influence in increasing the number of conservative management programmes throughout the UK. It has also contributed to national policy documents, including *End of life care in advanced kidney disease: a framework for implementation* and to Renal Association guidelines. The team has also had a long interest in end-of-life care for patient on dialysis and recently finished a project support by a National Institute for Health Research grant in this area. This work has also contributed to the policy documents and guidelines mentioned above.

Finally the team also carried out work on depression in renal transplant recipients. This work has resulted in the setting up of a service locally to support these patients using cognitive behavioural therapy.

Clinical service developments during the year

During 2012/13, much of the Trust's attention continued to be placed on two major projects at the Lister – gaining Department of Health and HM Treasury approval of its full business cases for the Lister's new £19 million emergency department and the combined £39 million project that will see new ward and theatres/endoscopy blocks created at the hospital. Important clinical and service developments taking place during the year included:

- **September 2012** – building of the Lister's new emergency department started. When ready to treat its first patients in the Autumn of 2014, the new facility will have specialist emergency and urgent care services for both adults and children, as well as improved access to radiology services (including both MRI and CT scanning).

- **December 2012** – ward 7A at the Lister reopened, following a £0.96 million refurbishment programme, as the Trust's single inpatient gynaecology service. The new ward also houses the Trust's early pregnancy and emergency gynaecology units

- **January 2013** – The Trust's new £2.0 million critical care service opened at the Lister, encompassing the existing intensive care and high dependency units at the hospital. The new unit has up to 20 beds, which will be used flexibly in caring for patients. At the same time, the QEII's high dependency service transferred to the new Lister unit, leaving the QEII with up to five critical care beds to support patients following surgery and/or those who may deteriorate whilst on a hospital ward. This service will remain in place until all inpatient and emergency services are brought together finally at the Lister towards the end of 2014.

- **January 2013** – the Trust's maternity service was awarded £0.19 million from a Department of Health fund to upgrade its two inpatient wards. The funding was used to refurbish bathrooms, as well as provide new toilet facilities and reclining chairs for partners. It was also used to helping women with higher risk pregnancies to have a normal birth through the use of new birthing stools and other equipment to encourage active birth positions. Finally the funding was used to purchase baby cots that were adjustable in height in order to support early bonding, and promote continued skin-to-skin contact between mother and child, which also aids breast feeding.

- **March 2013** – two of the Mount Vernon Cancer Centre's eight linear accelerators were replaced with £3.7 million state-of-the-art intensity-modulated radiation therapy (IMRT) machines, supported by upgraded software and hardware systems across the cancer centre's radiotherapy service (made possible through £0.75 million investment provided from national innovation radiotherapy fund). IMRT, which is a more accurate treatment compared to conventional radiotherapy, is suitable for use on a range of cancers – especially those occurring in the head and neck, lung and pelvis. The machines are also able to provide treatments using RapidArc™, which is a fast and efficient way to deliver IMRT.

- **March/April 2013** – the first of the Trust's two new £1.5 million satellite renal dialysis units opened in Bedford in early April 2013. The new unit is capable of supporting the dialysis needs of around 60 patients at any given time; it also has sufficient capacity in the longer term to dialyse some 90 people. The Bedford unit also offers local people much shorter travel times compared to existing units in hospitals elsewhere – which for those who dialyse several times a week can become a very important factor in choice of their renal unit. The Trust's second new satellite unit in Harlow is set to open the Summer of 2013.

Foundation trust membership report

Membership profile

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

Public constituency

The Trust has set itself an ongoing target to secure and retain a public membership of 10,000 people. The composition of this membership is monitored against a range of criteria including age, gender and ethnicity to make sure that it is representative of the local communities served by the Trust.

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

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

Public constituency	
Total public members at 31 March 2013	10,414

The Trust has made significant progress in both recruiting and involving public members in 2012/13. By the end of the year, it had 10,414 public members in total – including 219 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, ranging from just receiving the regular member magazine through to getting notification of all opportunities.

Member satisfaction with involvement events, including the 2011/12 AGM attended by some 50 public members, has been consistently strong throughout the year, averaging out at over 80%.

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 ranging from way-finding within hospitals, patient and societal expectations to elderly care services – the latter delivered jointly with the Hertfordshire Partnership NHS Foundation Trust.

The Trust has been particularly successful in recruiting and involving young people, developing an innovative approach that is fun and interactive and geared towards showing them what the NHS can do for them. The Trust's membership team has worked with these new recruits to help redesign the offer being made to young people to ensure the Trust stays relevant and continues to attract new young members. This work was showcased as best practice at a national Foundation Trust Network (FTN) event held in London during February 2013.

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

In the coming year 2013/14, the membership team aims to further develop 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.

Staff constituency	
Total staff members at 31 March 2013	5,482

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 feed back 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 nine of the 12 organisations selected to hold an appointed governor position on the Council of Governors. These individuals, who represent key partner organisations, have been invited to, and in several cases participated in, events, meetings and workshops held by the Trust. Some of these individuals have also attended development events for shadow appointed governors, run by the Foundation Trust Network, to better understand the appointed governor role.

The Trust is also seeking to recruit 20 public governors, to be elected by the public membership, and is delighted that to date it has over 370 public members who are considering the role of governor. An additional six governors will be elected by Trust staff. Elections will take place for both public and staff members, to the new Council of Governors once the Trust's foundation trust application is moved forward to Monitor.

Contacting the Trust

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

- Tel: 01438 781846;
- Email: ftmembership.enh-tr@nhs.net.

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

Chapter 7: operational performance for 2012/13

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

In the previous chapter, the Trust's overall operational performance for 2012/13 was reviewed. Here the report seeks to provide further information on the Trust's operational management and performance.

Performance overview

The 2012/13 year represented one of significant success for the Trust's operational teams – which comprise doctors, nurses, other healthcare professionals, managers and support staff. As highlighted in the previous chapter, excellent progress was made against delivering the vast majority of patient access standards expected of the NHS, whilst also managing an effective efficiency savings programme.

Particularly pleasing was the Trust's continued success around achieving the standards for delayed transfers of care and cancelled operations. Historically, these have been areas that have been extremely challenging for the Trust. More importantly, they caused disruption to the care that patients received and were often at the heart of many complaints. For the fourth year running, despite sustained winter pressures that lasted right through to March 2013, the Trust delivered on both these important standards.

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

The Trust's good operational performance during 2012/13 was delivered at the same time as many services underwent significant reconfiguration, with many being consolidated at the Lister. Examples of include the:

- Trust's new gynaecology inpatient service moving from ward 11A to the newly refurbished ward 7A at the Lister;
- From January 2013, the majority of the Trust's critical care and all of its high dependency patients being cared for in the new critical care unit created at the Lister.

Like similar service changes made in 2010/11 as part of the Trust's *Our changing hospitals* programme, these newly combined services are already showing real improvements in terms of both patient experience and clinical outcomes. As outlined elsewhere in this report, however, much still needs to be done to achieve full reconfiguration of the Trust's inpatient and emergency services at the Lister by the end of 2014 – which sets the backdrop for the operational challenge facing the Trust over the next two years.

Whilst this work continues, opportunities are also being taken to focus on making improvements to existing services. Examples include the Trust's specialist stroke unit; although now based on a single site for the past two years and improvements having been made in its performance during 2012/13, more work needs to be done – in conjunction with the local heart and stroke network – to ensure the Trust's performance meets national standards consistently – something that was just missed during 2012/13.

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

- Commencing on the creation of the Lister's new £emergency department, ward and theatres blocks due to open by the end of 2014;
- Supporting the East and North Hertfordshire Clinical Commissioning Group in building the New QEII Hospital, with its local A&E service, which is scheduled to open by the Spring of 2015.

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

Management arrangements

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

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

Clinical division	Specialties
Cancer services Dr Catherine Lemon, divisional chair David Govan, divisional director	Clinical haematology Mount Vernon Cancer Centre Oncology Palliative care
Medicine Dr Jon Baker, divisional chair* Aisling Bowman, 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 Isobel Day, divisional director	Child health, include acute and community services Gynaecology Maternity/obstetrics Neonatal intensive care, including special care baby units
Clinical support services Dr Tim Walker, divisional chair Joanna Carter, divisional director	Health records Outpatients Pathology Pharmacy Private patients Radiological imaging

Activity planning

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

- Commissioning plans of clinical commissioning groups (CCGs) locally and specialised commissioning groups (SCGs) regionally;
- 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. 2013/14). This information, along with comparisons against the previous year's performance, is set out below.

Activity	2012/13 actual	2013/14 planned
A&E attendances	119,716	121,932
Outpatients – first appointments	88,552	84,829
Outpatients – follow-up appointments	217,478	223,969
Elective inpatients (i.e. planned admissions)	9,308	8,799
Elective day cases	19,019	19,786
Average length of stay for elective patients (days)	2.4	2.4
Non-elective inpatients (i.e. emergency admissions)	37,587	38,854
Average length of stay for non-elective patients (days)	5.0	4.8
Births	5,303	5,250

Emergency preparedness – major incident plan

The Trust has a comprehensive major incident and mass casualties plan, which covers its two hospitals with accident and emergency departments – the Lister in Stevenage and QEII in Welwyn Garden City. The plan complies with Department of Health guidelines and relevant legislation (Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2012).

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

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

Over the last 12 months the Trust has reviewed its major incident policy and hospital evacuation plan and developed a new training strategy to ensure that senior staff have access to and undertake major incident role specific training. The key priorities identified for the forthcoming year include to:

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

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

For further information, please contact:

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Chapter 8: clinical performance for 2012/13

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

- Objective 1: improve the quality of all aspects of the Trust's services

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

This chapter considers in more detail the Trust's performance during 2012/13. 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 2012/13 Quality Account, available via the Trust's website.

Reducing hospital-acquired infections

During the 12 months to the end of March 2013, the Trust recorded just two hospital-acquired blood infections (bacteraemias) caused by Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteria strains, along with 13 cases of infections due to the bacteria *Clostridium difficile*. The targets for these two important causes of hospital-acquired infections were three and 14 cases respectively.

This impressive performance sets the Trust amongst the best performing NHS trusts in the country and represent significant falls in hospital-acquired infections compared to five years ago. Achieved through a series of proven infection prevention measures, today patients being treated at the Trust's hospitals have a very low chance of acquiring an infection that risks their recovery and discharge home.

More problematic for the Trust, however, has been the increase in numbers of Norovirus outbreaks – the so-called winter vomiting bug. Although self-limiting and rarely a threat to patients' lives, last year saw particularly high levels of this contagious virus that is spread easily. The principal cause of outbreaks within the Trust's hospitals is often well-intentioned but infected visitors coming on to wards and spreading the infection.

Once a Norovirus infection becomes established, it can spread between patients and staff very quickly, leading to wards being closed to new admissions. Given the disruption that such closures can have on a hospital's ability to admit new patients – especially those presenting as emergencies, the Trust has adopted a robust and aggressive approach to containing the virus.

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

Over the last six months of 2012/13, when many hospitals across the country had multiple wards – often at the same time – closed due to Norovirus outbreaks, the Trust managed similar outbreak levels with the least disruption to operational performance that was possible under such circumstances. The result was that wards or ward areas were closed to new admissions more quickly, but also returned in to use more effectively. Throughout all of this work, patients and their relatives on affected wards were kept aware of what was happening, the minimal risk to their health and the progress being made to contain the outbreak.

Falling mortality rates

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

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

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

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

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

HSMR

Since January 2011, the Trust's rolling annual HSMR score has fallen consistently from a high of 103 to 92.7 for the most recently published figures, which are for April 2012-March 2013. This is statistically better than the national average and represents a considerable improvement from the position of two to three years ago.

In terms of areas where specific improvements were made over this time period, three stand out:

- Patients with fractured hips – known more correctly as fractured neck of femur – now receive their surgery in a dedicated unit at the QEII (which will transfer to the Lister along with all of the QEII's remaining emergency and inpatient services by the end of 2014). This service now has a HSMR relative risk rate of 82.6 for the period from April 2012 to March 2013.

- The Trust's emergency general surgery service was brought together at the Lister in October 2011. Since that time there has been a dramatic improvement. In the year following centralisation, HSMR was 73.8 between April 2012 and March 2013, whereas between April 2010 and March 2011 it had been 110.6.

- Several care pathways have been improved for common emergency medical conditions such as kidney failure, heart failure, pneumonia and certain infections. Whilst almost all pathways have seen clear improvements, the most dramatic has been for septicaemia patients where HSMR has improved from 122 in 2011/2 to 89 in 2012/3.

Work has also continued on improving both the accuracy of the Trust's primary coding of patients' illnesses and conditions, as well as the depth of coding achieved. More accurate coding leads to better information being fed to those who analyse such data to create HSMR ratings.

SHMI

Still described as a relatively new and experimental mortality indicator, SHMI is now provided as an overall rating. The Trust is one of a handful of hospital groups in the country that has an NHS hospice (Michael Sobell House at the Mount Vernon Cancer Centre), the effect of which can be to cause SHMI scores to be higher than otherwise might be the case.

The Trust's most current SHMI score, which is for the 12 months to September 2012, was 111.4. When adjusted for palliative care by Dr Foster, the score for the same period reduced to 102.0 – pretty much at the *as expected* level. It is also important to note that the Trust's quarterly rolling average SHMI (unadjusted for palliative care) has fallen from a high of 120 just 15 months ago to 111 for the period of June to September 2012.

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 in hospital.

During 2012/13, the Trust set itself a target of having fewer than 120 grade two to four preventable pressure ulcers. By the end of March 2013, 114 pressure ulcers had been recorded in the Trust's hospitals – with none of the most serious grade four ulcers happening at all. This performance compares very favourably to the previous year when 323 grade two to four ulcers were recorded, which included some at grade four.

This improvement in preventing pressure ulcers developing followed the adoption of the regional *Stop the pressure* campaign, which was led by the Trust's tissue viability nursing team. As a result, the Trust has enjoyed one of the better performances in reducing such ulcers to be found in hospitals across Eastern England.

Preventing patient falls

When in hospital, patients can trip and fall. Often little or no injury results, but occasionally the consequences can be more serious – and in some cases even life-threatening. In response to unacceptably high patient fall rates, in 2012/13 the Trust embarked on a programme that sought to reduce the number of falls patients had in hospital, especially the more serious. The target set for the latter was to see such falls reduced to just 24; in fact the Trust recorded 14 over this 12-month period. Since March 2011, overall the Trust has reduced patient falls by 41% and this area remains one of continued focus over the coming months and years.

Improving patient experience

The Trust has as its vision to be amongst the best performing NHS trusts in the country, with high quality care and excellent patient experience at the heart of all it does. The Trust aims to provide patients and their carers with the best possible experience whilst they are using its services. Some of the key initiatives that are in place to drive improvements in patient experience are outlined on the next two pages.

Patient and carer experience strategy

Launched in July 2012, the Trust's patient and carer experience strategy for 2012-15 sets out seven key ambitions for improving patient experience:

- Ambition 1: Improve patient experience from start to finish of their journey;
- Ambition 2: Improve patient experience of accessing hospital services;
- Ambition 3: Improve communication with patients;
- Ambition 4: Meet patients' physical comfort needs;
- Ambition 5: Provide patients with emotional support needed whilst using Trust services;
- Ambition 6: Respect needs of patients and recognise their individuality;
- Ambition 7: Improve involvement of patients and carers.

Patient experience surveys

The annual inpatient experience survey is undertaken in all NHS acute hospitals, with results published by the Care Quality Commission. Those for the survey undertaken in July 2011 were received in April 2012; they reflected the views of 425 people who were inpatients at the Trust's hospitals. This is, of course, only a small percentage of the number of inpatients who are cared for in the Trust each year.

The Trust monitors feedback from patients continually and uses this information 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 using a simple electronic device whilst they are in the hospital; these surveys can also be accessed via the Trust's website for completion by patients at home.

During 2012/13, 7,440 inpatients, 2,111 maternity patients, 5,313 outpatients and 1,128 A&E patients completed these surveys. Ward and departmental staff are able to access the results of these surveys in real-time, thus enabling prompt actions to be taken to address any problems areas identified. The highest performing areas of the electronic surveys are patients feeling they have been treated with respect and dignity and patients having a choice of food.

The Trust also surveys inpatients following their discharge home using questions that mirror the national inpatient survey conducted annually. The quarterly survey is undertaken for one month each quarter and an average of 2,100 patients are surveyed. The average response rate during 2012/13 was 32.6%.

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

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

Friends and Family Test
The Trust implemented the *Friends and Family Test* question in April 2012, where patients are asked: *how likely is it that you would recommend this service to friends and family*. The question must be asked at, or within 48 hours of, a patient's discharge from hospital. NHS Midlands and East set the upper quartile net promoter score at 71 in April 2012. The Trust remained above the upper quartile level for nine months and consistently was a high responder throughout the year.

Carers survey
The Trust is working to improve the experience of carers and has hosted quarterly carers focus groups throughout 2012/13. A dedicated survey was established, with key input from carers in its design, to help the Trust ensure that the systems and support available to carers meets their needs. The survey is sent out monthly to patients who have a carer identified on the Trust's system and is also available for carers to complete via the Trust's electronic surveys and via its website.

CQUIN – responsiveness to personal needs of the patients
The Trust has made significant progress with the five questions in the inpatient survey that make up the *responsiveness to personal needs* target. The overall score has improved from 64.6 in 2010 to 66.3 in 2012. The five questions are:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Patient stories
Staff have been trained in taking patient stories and these commenced in January 2013. Staff meet with patients from an area in which they do not usually work to listen to people talk about their experience in hospital. The discussions are led by the patient and they are able to discuss any aspect of their experience. The key themes from these patient stories are shared within the Trust and to the Board. Patients have been invited to attend Board meetings to talk in person about their experiences.

Kissing it Better
The Trust is pleased to be working with *Kissing it Better*, a charity that harnesses the contributions of volunteers and the local community and co-ordinates activities in hospital, which can make a big difference for patients.

The Trust now has well-established links with North Herts College, with student beauticians visiting weekly as part of their timetable to give hand and arm massages and manicures to patients. Singers, choirs and drama students have performed for patients; a group of Brownies undertook their dignity badge on the elderly care ward, with other regular visitors including Pets as Therapy (PAT) dogs. These visits are welcomed by patients, visitors and staff alike and have received many favourable comments.

Trust's 2012/13 CQUIN performance
A proportion of the Trust's income from its commissioners in 2012/13 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 2012/13 amounted to approximately £6.7 million of which £6.4 million was received from the Trust's commissioners. The Trust CQUINs for 2012/13 are set out in the table below, together with their full monetary value and details of whether or not these quality improvements were met.

	CQUIN scheme	Percentage value with 100% scheme achievement	Actual scheme achievement	Percentage value awarded with actual achievement	Approximate value (£000s)
1	Venous-thromboembolism (VTE) prevention	5%	100%	5%	336
2	Improving responsiveness to personal needs of patients	5%	60%	3%	202
3	Diagnosis of dementia in acute trusts	5%	100%	5%	336
4	NHS safety thermometer	5%	100%	5%	336
5	Improving outcomes for patients with COPD	10%	100%	10%	672
6	Patient experience – net promoter	10%	75%	7.5%	504
7	Reducing hospital mortality	15%	95%	14.25%	958
8	Improving carers experience	15%	100%	15%	1,008
9	Assessing and improving outcomes for patients following a stroke	10%	100%	10%	672
10	Making Every Contact Count (MECC)	10%	100%	10%	672
11	Improving cancer and palliative care/end-of-life services	10%	100%	10%	672
	Totals	**100%**	**n/a**	**94.75%**	**6,370**

Chapter 9: financial performance for 2012/13

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site
- Objective 3: work with colleagues in primary care to extend local access to specialist acute services
- Objective 4: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

Review of 2012/13

During 2012/13, the Trust continued to maintain its strong financial position, delivering a surplus of £0.532 million (note 34.1). This is the sixth consecutive year of surplus dating back to 2006/07, although this year the original planned surplus of £3.6 million was reforecast part way through to 2012/13 to reflect a number of external factors outside of the Trust's direct control.

Looking back across the year, the Trust's elective income was almost exactly in line with plan. Shortfalls on inpatient admissions (mainly in orthopaedics) were offset by positive variances in outpatient attendances. Non-elective income was also on target, although maternity services saw a reduction in the number of births as the year progressed – with unusually quiet months in February and March. This represented a financial shortfall for the year of over £1.0 million.

Other areas of note during 2012/13 were: GP direct access diagnostics, which continued to grow as has been the case in recent years (total of £0.8 million over plan); and Mount Vernon's performance, which made up some of the ground lost earlier in 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 pressure for the Trust, as do penalties for readmissions.

The Trust had another successful year when it came to delivering its annual cost improvement programme (CIPs), with 100% delivery against a plan of £15.020 million for 2012/13.

During 2012/13, the Trust drew down long-term capital investment loans of £13.074 million from the Department of Health to support its strategic investments in the *Our changing hospitals* programme. Delays in progressing the programme's largest phase 4 projects – the new emergency department, ward and theatres blocks at the Lister – resulted in capital expenditure being considerably below initial plans set at the start of the year.

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

Capital spending

The Trust's total capital expenditure during 2012/13 was £18.410 million, with projects including:

- **Phase four of the *Our changing hospital* project – £9.6 million**. Phase four will complete the Trust's programme to bring all inpatient and emergency services on to a redeveloped Lister hospital site. The most significant items in 2012/13 related to works on the: new emergency department (£4.9 million – work on-going); expanded critical care capacity, enabling greater flexibility between ITU and HDU (£1.8 million – work complete); refurbishment of ward 7A to create a dedicated inpatient and outpatient gynaecology facility (£0.9 million – work complete); additional theatre capacity (£0.5 million – work on-going); and improved chemotherapy facilities (£0.4 million – project on-going, in collaboration with Macmillan).

- **Combined heat and power plant – £2.0 million**. A combined heat and power plant (CHP) project, financed and built by the Trust's commercial partner, Dalkia, provides a unit that burns gas to generate electricity (providing savings to the Trust from the differential in gas and electricity costs), as well as recycling the waste heat generated. The new plant replaced two old boilers at the Lister. This work will provides the required power supply to service the site on the completion of the Trust's *Our changing hospitals* capital investment programme in 2014.

- **Endoscopy decontamination - £0.8 million.** The endoscopy decontamination function was relocated to a larger facility to accommodate washers and drying cabinets.

- **Mount Vernon Radiotherapy Innovation Fund – £0.7 million**. The Trust bid successfully for funding from the Cancer Radiotherapy Innovation Fund. This investment will allow the Trust to utilise intensity modulated radiotherapy (IMRT) and image-guided radiotherapy (IGRT).

The Trust invested a further £1.5 million during 2012/13 on new information technology, £1.3 million on medical equipment and £2.5 million on estates maintenance.

Financial implications of *Our changing hospitals* programme

The Trust began planning and implementing its *Our changing hospitals* programme in 2009/10, which represents continued major capital investment until 2014/15. The programme's outcome will result in a consolidation of acute inpatient and emergency services from the QEII on to the Lister site.

The total Trust investment involved in this work is estimated to be £88 million, which will be financed through a combination of Department of Health loans (£63.588 million), Public Dividend Capital (£10.386 million) and operational capital funding. Other projects in the programme, including the creation of the Lister Surgicentre and multi-storey car parks, were funded by private sector partner organisations.

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

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

Looking to the future

Overall, 2012/13 was another important year in terms of consolidating the Trust's continued good financial performance. It supported the progress being made towards achieving NHS foundation trust status and is key to future plans to invest and modernise the Trust's hospital facilities, particularly at the Lister.

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

Going concern

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

Better payment practice code

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

The Trust has adopted the national *NHS Better payment practice code*. The target set is that at least 95% of all trade creditors should be paid within 30 days of a valid invoice being received or the goods being delivered, whichever is the later – unless other terms have been agreed previously.

The Trust's detailed performance against this target for non-NHS creditors is set out in note 10 in the annual accounts shown below. Its overall performance in relation to the code improved significantly during 2012/13 – 77% of non-NHS trade invoices were paid within target compared to 63% in 2011/12. It is anticipated that this improvement will continue into the new financial year.

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 the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

Workforce statistics

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

Activity	31 March 2013	31 March 2012	31 March 2011
Staff employed (full time equivalents)	4703.04	4,730.31	4,739.01
Vacancy rate	8.6%	8.0%	8.0%
Turnover rate	10.3%	10.0%	10.0%

During 2012/13, the Trust maintained a steady vacancy rate that by year-end stood at 8.63% against a target of no more than 10%. This apparently good performance, however, masks differences between staffing group, with the number of clinical vacancies, including nursing, driving bank and agency overspends. Recruitment campaigns are underway to recruit to qualified nursing staff. For 2013/14, the vacancy target for the Trust has been set at 6.5%, which will need continual monitoring to ensure that this position is being achieved and thus reduce further to the Trust's use of agency staff in particular.

Turnover rate for the Trust remained at around 10% for 2012/13, which currently is in line with the existing workforce modelling undertaken to support the Trust's *Our changing hospitals* programme – although this will be reviewed as the Trust prepares to deliver the programme's final phases by the end of 2014.

Reducing sickness absence remains a key indicator for the Trust and performance during 2012/13 has been very good. The average for the year was 3.7%, which compares favourably with the 3.8% average achieved by large acute NHS trusts across the country, 3.9% recorded for Hertfordshire's health economy and the 4.2% average recorded by the NHS across the East of England. The aim for 2013/14, is to reduce sickness absence to 3.5%; if achieved, this would place the Trust in the top 10% performing NHS organisations in the English health service.

Recruiting and retaining staff

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

The Trust enjoys a generally positive reputation as being a good employer, both locally and nationally. Within Hertfordshire, it continues to work in partnership with the education sector in promoting careers within the NHS. The Trust also works in partnership with the local community to develop pathways into employment for disadvantaged groups. Additional work commenced in March 2013 to review a number of workforce schemes associated with recruitment including streamlining the total recruitment process so reducing the gap between a member of staff leaving and their replacement starting in post, along with smarter use of bank staff.

The Trust has just embarked on an immediate recruitment campaign to recruit approximately 160 new nursing staff. Nurses will be recruited from the EU targeting Ireland, Scotland and Portugal, with clinical support workers being recruited locally. The priority will be recruitment for Trust's emergency department, renal and inpatient ward services.

In July 2012, the Trust outsourced the contract of the supply of bank, agency and locum staff to NHS Professionals. The Trust is performance managing the service to deliver contract savings of £1.0 million in terms of the full-year effect. The plan is to increase the use of bank staff, whilst at the same time reducing use of staff supplied by commercial agencies.

A highly skilled workforce

Developing a highly skilled workforce is key to excellent patient care. The current provision of staff development opportunities available within the Trust are amongst the best available from NHS organisations, consisting of high quality programme provision ranging from excellence in supervision, through to excellence in leadership and Trust Board development initiatives. 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;
- Time management skills development;
- Stress management skills development;
- Assertiveness skills development.

Additional management and leadership development initiatives available to staff include:

- Sisters fora and nurses days that run periodically throughout the year;
- Preceptorship programmes, incorporating leadership development;
- New line managers induction programme;
- NHS graduate trainee scheme;
- Bespoke leadership and management courses developed in partnership with the University of Hertfordshire.

During 2012/13, the following development opportunities were provided to the Trust's staff:

- Excellence in supervision (typically bands 3 to 5): 36 places offered, of which 28 completed
- Excellence in management (typically bands 6-7): 12 places offered, of which 11 completed
- Excellence in leadership (typically bands 7-8): 14 places offered, of which 13 completed

Developments delivered during 2012/13

A number of key leadership and management development initiatives were piloted during 2012/13 in response to feedback from the Trust's results from the 2011 national staff survey. These included:

- Introduction of the *Aston Team Inventory Tool* as a means of improving team effectiveness;
- Team coaching;
- *Strive for Excellence Development Centre* project;
- Leadership coaching and 360 degree feedback.

Results published in the 2012 staff survey showed an improvement in effective team working, suggesting that these new courses had the desired impact.

Programme reviews and evaluations have now been completed, with the findings demonstrating positive outcomes in terms of:

- Leadership and management needs analysis and competency framework and skills development;
- Improved team effectiveness;
- Improvements to the quality of patient care – for example, a service improvement project improving the quality of blood sampling in the Trust's emergency department service, resulting in reduced need for repeated samples being taken from patients;
- Service improvements projects – for example, the introduction of a nurse-led pre-assessment process in endoscopy, supporting the achievement of a £1.2 million service development investment.

Developments planned for 2013/14

During 2013/14, the Trust's personal effectiveness, leadership and management development focus will be on:

1. Developing a leadership and management development strategy aimed at increasing the organisation's leadership and management capability further whilst maintaining quality of provision;

2. Incorporating the Trust's leadership competency framework into key human resources processes, such as:
    - recruitment and selection processes
    - appraisals and performance reviews
    - talent management

3. Developing further the skills of leaders and managers to carry out effective appraisals where staff are recognised and rewarded for good performance;

4. Supporting leaders and managers to improve the performance and potential of others, as well as effective talent management;

5. Evaluating the impact that the learning and development initiatives provided by the Trust have on the achievement of organisational objectives.

Appraisals and professional revalidation

Staff appraisals
The Trust's ambition, as stated regularly throughout this annual report, is to become amongst the best performing NHS organisations in the English health service. The Trust's results from the 2012 staff survey published earlier this year highlighted key areas where the Trust is achieving that ambition already – in particular the percentage of staff taking part in effective appraisals over the past 12 months.

Work undertaken over the last two years to ensure that the Trust's staff take part in regular appraisals with their line managers has really paid off. The Trust's performance improved considerably since 2011/12, placing it amongst the top 20% performing acute trusts in the country.

Despite being amongst the better performing NHS organisations for appraisals, however, the Trust's end of year rate was 70% - which is below the Trust's own target of 90% set for appraisal completion during 2012/13.

Whilst a major improvement, there is still some way to go before the Trust delivers the demanding standards that it has set for itself. Going forward, there is a need to build on the work being undertaken currently across the organisation to achieve the ambition of a 90% overall staff appraisal rate. As a result, the year ahead will see fundamental changes in the way that the Trust appraises the performance of its staff, using an appraisal framework whereby staff performance and commitment is recognised and rewarded.

Appraisal developments planned for 2013/14
The development and implementation of a new appraisal framework, process and policy is a key workforce initiative for 2013/14. The new approach will:

- Be aligned to our organisational objectives and values;
- Meet staff performance and development needs to achieve organisational objectives;
- Be developed in partnership, as well as be fair, open and transparent;
- Meet nationally agreed changes to *Agenda for Change* in relation to performance-related pay progression;
- Explore the use of 360 degree feedback.

Consideration will also be given to linking the new approach to statutory and mandatory training compliance.

Appraisal rates within the Trust are recorded currently on a monthly basis, using a combination of paper and electronic processes. Any new appraisal process will require an easily accessible electronic system for recording and reporting on appraisal activity. This system will also need to be linked to the Trust's payroll system.

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 process of revalidation requires all practising medical staff, on a five-yearly cycle, to demonstrate actively to the General Medical Council (GMC) that their licence to practise should be renewed. This requires medical staff to participate in annual appraisal, clinical audit and to undertake 360 degree multi-source feedback.

To support the revalidation process locally, the Trust's medical director's team was strengthened by the appointment to the new post of associate medical director for professional standards, along with the introduction of a new electronic system to collate appraisal and associated data (Premier IT). The whole system is also supported by a new administrative post – called a revalidation officer – to support the medical director's team in revalidation and the management of performance cases.

Medical education and training

The Trust's directorate of medical education has fostered an ethos of excellence in medical education and provides an outstanding learning environment in the Trust. The programme is governed by a robust governance structure, with a multi-professional education board (see table below) as the *nerve centre* co-ordinating educational activities across the Trust.

Multi-professional education board members
Chairman and director of medical education
Clinical tutors (Lister, QEII and Mount Vernon)
Foundation training programme directors
Non-medical education Lead
Nurse education continuing professional development (CPD) lead
Non-medical clinical tutor
Dental tutor
Undergraduate tutor

The directorate shows innovative ways of ensuring quality in medical education. The appointment of a simulation tutor and the development of a multi-professional skills laboratory is a positive step towards establishing a strong simulation faculty that is invaluable in improving patient safety.

The appointment of non-medical clinical and surgical clinical skills tutors, along with an educational resources officer, are some of the recent developments to support education and improve quality of training in the Trust. Development of the library outreach service is another facility that will promote multi-disciplinary education.

To comply with General Medical Council (GMC) standards, the directorate has planned a series of workshops in collaboration with the University of Hertfordshire. This novel programme of accrediting the Trust's consultant workforce will ensure that high standards of medical supervision are maintained in the Trust.

A recent quality assurance visit by the East of England Multi-Professional Deanery, which took place in January 2013, commended the Trust on many aspects of training and areas of good educational governance. It was acknowledged that trainees and students are valued and there is commitment to education and active involvement at every level of the organisation.

The directorate has strong links with several Universities for medical education and working with the new East of England Academic Health Sciences Network (AHSN) is now a priority going forward. Strong links have also been established with the Cambridge Medical School and student numbers visiting the Trust as a result have increased. The Trust's historic links with University College London continue, with regular medical student intake.

The medical education directorate provides excellent facilities and a dynamic educational environment with extensive educational opportunities for all medical staff. With relocation of all remaining emergency and inpatient clinical services to the Lister due to be completed by the end of 2014, it is proposed that all education services will also be consolidated by 2015.

Nursing and midwifery education and training

Clinical skills training is offered to the Trust as part of the internal training programme. These courses include intravenous drug administration, venepuncture and cannulation skills, patient safety, safeguarding adults and a dementia champion's programme. Newly registered nurses continue to be offered preceptorship workshops to support the preceptorship pathway.

Quality clinical leadership remains a high priority within the Trust's nurse education programme. During 2011/12, a total of 28 junior *Agenda for Change* band 3 to 5 nursing and midwifery staff completed the Trust's excellence in supervision, effective supervisor programme. Twenty two clinical managers completed the Trust's *excellence in management effective manager* programme and a further 13 clinical leaders completed the *excellence in leadership* programme.

Continuing professional development (CPD) focused on the Trust's quality, innovation, productivity and prevention (QIPP) agenda and associated initiatives. This included dementia awareness, nutritional assessment tool training, critical care skills, falls awareness education and non-medical prescribing

Apprenticeships

Apprenticeships have become integral to the recruitment process of band two clinical support workers since 2009 at the Trust. The programme provides knowledge and skills, along with development of staff within bands two to four, in line with the Trust's skills pledge and striving towards having a workforce within that group who are fit for practice.

Band two clinical support workers are recruited, on a fixed term contract, into vacancies on a level two health and social care apprenticeship. Subject to completion of the apprenticeship and a vacancy existing, a substantive post is offered. These individuals can also undergo further development by progressing onto a level three apprenticeship.

In 2012/13, 91 people were employed into band two clinical support worker vacancies on an apprenticeship contract. Thirty one people also commenced a level three apprenticeship.

Equality and diversity

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

The Trust's equality and diversity annual report, which was produced in June 2012 and presented to the Trust's risk and quality committee, contains the most recent data and summary of the Trust's workforce profile in terms of equality and diversity; it can also be located on the Trust's website.

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

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

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

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

An annual review of progress on the equality delivery system has been drafted and an event to involve stakeholders is expected to take place in June 2013. This will be a collaborative approach from NHS organisations from across Hertfordshire and will showcase the regions progress since the equality delivery system's initial implementation.

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

- Trust policies are ratified at various groups, for example through Trust Partnership;
- The Trust has a guide to assist managers in completing the equality impact assessment process that is available on the Trust's *Knowledge Centre*;
- The requirement to complete an equality impact assessment is reiterated by the Trust's divisional human resource managers with their respective divisional teams. Reminders are also sent periodically via several routes, including the weekly electronic *Trust Bulletin* and e-mails;
- Clinical governance ensures all clinical policies have an equality impact assessment attached.

Occupational health policy

During 2012/13, the Trust's occupational health service – which covers all of the Trust's sites with the exception of Mount Vernon, where the service is provided by the Hillingdon Hospitals NHS Foundation Trust – has provided interventions for workplace advice and recommendations to over 3,000 staff.

Occupational health is a fundamental part of the effective management of the health of people at work. By understanding the relationship between health and the workplace our approach to staff well-being has contributed effectively to organisational strategic and business planning needs by giving advice and guidance on:

- Employment issues relating to health;
- Managing sickness absence effectively;
- Complying with Health and Safety legislation;

- Working with managers and staff to produce timely, meaningful reports following occupational health intervention.

Through supporting staff and managers, the occupational health service team has contributed to the Trust's well-being strategy, improving staff morale and supporting a healthier workforce that in turn will lead to better patient care, increased staff productivity, quality and efficiency, in line with the national QIPP agenda.

This work, in turn, supports the Trust in fulfilling its obligations under the NHS Constitution (Section 3a) and the required standards from the Care Quality Commission in regard to suitability of staff and relevant NHS Litigation Authority standards.

In December 2012, the Trust's occupational health service re-accredited to SEQOHS – stands for safe, effective, quality occupational health service). This ensures that the services provided by the team meet national standards laid down by the Royal College of Physicians and Faculty of Occupational Medicine, in collaboration with a multi-agency, multi-disciplinary stakeholder group. This accreditation ensures that its occupational health service continues to contribute to the Trust's vision to become amongst the best performing NHS organisations.

During April 2013, the occupational health service moved locations, with all administrative tasks – both clinical and non-clinical – now carried out from a central administration hub based in Anritsu House. Working from one administration base enables task allocation to be managed more appropriately. The hub is then supported by appointment-only, face-to-face clinics held at the Lister and QEII hospitals.

Health and safety

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

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

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

Raising issues of concerns policy and procedure

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

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

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 the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site

For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

Engaging with the Trust's staff

Informing and consulting staff

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

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

- **Focus groups/briefings** – where the views and input of staff is required on specific projects and changes, the Trust seeks to take issues out to them – either in full open-house sessions that anyone can attend, or to individual departmental and/or team meetings. This process was used during 2012/13 to develop the Trust's health and well-being strategy, with a further series of focus groups being run in the Spring/Summer of 2013 to inform specific actions that staff wish to see.

- **Workshops** – dedicated time where invited staff can debate specific issues relating to aspects of major strategic projects being worked on by the Trust. The ARC programme is a good example of this approach and forms part of the Trust's organisational development strategy. Each quarter, executives – including the chief executive – meet with around 500 of the Trust's clinical and non-clinical leadership in open discussion on various topics of importance to the Trust and its staff – see chapter five of this annual report.

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

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

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

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

- **Grapevine** – now published for the Trust's staff, volunteers and public members, the Trust's quarterly newsletter has been an unqualified success since its launch in 2003. Grapevine provides staff with a unique platform through which their contributions can be recognised by their colleagues.

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

Trust Partnership

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

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

The Trust's chief executive and other directors also meet with staff side representatives regularly to brief them in more detail on strategic issues, as well as on the organisation's clinical, operational and financial performance. The workforce and organisational development directorate funds two full time posts to enable strategic partnership working within the Trust.

Public and patient engagement

Health scrutiny committee

The Trust values the county's health scrutiny committee and has continued to support and inform the committee's work programme during 2012/13, including providing reports on finance, patient experience, performance and quality accounts. The Trust always ensures that Board-level directors present the Trust's contributions to the committee's debates.

Hertfordshire Local Involvement Network (LINk)

The Hertfordshire LINk was established in early 2008, since when the Trust has sought to work closely with the organisation. LINks were introduced to help communities influence the health and social care they receive; they have statutory powers to monitor services on behalf of the local population.

Over the last year, the Trust has continued to work positively with Hertfordshire LINk in supporting its visits designed to review the Trust's services from a local user perspective. During 2012/13, LINk has conducted *enter and view* visits to review elderly care wards and A&E services – the latter with a focus on patients with disabilities.

Hertfordshire LINk representatives met with members of the Trust's senior management team on a number of occasions throughout the year, as well as attending Trust Board meetings when they can. Its deputy chairman is also a member of the Trust's involvement committee.

During 2012/13, the Trust was proactive in supporting Hertfordshire county council develop arrangements for Hertfordshire LINk's successor organisation – Healthwatch Hertfordshire. The Trust was pleased to involve the new chair and chief executive of Healthwatch Hertfordshire in Board discussions designed to inform the development of the Trust's new strategic aims. Regular meetings have already been scheduled involving the Trust's chairman and chief executive meeting with their opposite numbers in Healthwatch Hertfordshire.

The Trust worked in partnership with Hertfordshire LINk in 2012/13 in continuing to support local community groups such as the Stevenage Health Involvement Partnership.

Involvement committee

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

The committee's membership consists of managers from across the Trust, including clinical, nursing, strategic, engagement, governance and voluntary services, as well as representatives from Hertfordshire LINk, disability organisations, patient groups and our shadow appointed governors, ensuring representation from local authorities, county council, university, black and minority ethnic (BME) groups and local commissioners.

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

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

Local strategic partnerships

Local strategic partnerships (LSPs) are responsible for developing sustainable community strategies, which are strategic plans for those involved in providing services within a local government area to help improve the lives of people living in that area. Despite revocation of the statutory guidance underpinning LSPs, local authorities across Hertfordshire are choosing to continue to work in partnership to deliver outcomes for local people. The Trust is contributing to this work enthusiastically, focussing on areas that the Trust and its members can support the health and well-being agenda in partnership with public health colleagues and other partners.

The new Health and Wellbeing Board for Hertfordshire, with its strategy identifying nine priorities for health and well-being across the county, has provided a new impetus for a partnership approach to delivering improved health and well-being for the county's population. The Trust is represented on the Board, as well as contributing actively to all five district health and wellbeing sub-groups of LSPs across east and north Hertfordshire. The Trust was pleased to involve the chair and lead officer of the Hertfordshire Health and Wellbeing Board in Board discussions designed to inform the development of the Trust's new strategic aims.

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

Patient experience feedback

The Trust actively seeks patient experience feedback. All patient experience data are incorporated into performance management processes and are monitored by the patient experience committee. This group oversees delivery of the Trust's patient experience strategy, which is used to drive continuous improvements in the quality of services being delivered – progress against which is measured by the risk and quality committee which reports to the Trust board.

A great deal of emphasis is placed on patient feedback through real-time (patient experience trackers) and postal surveys, as well as complaints and comments received through the Trust's patient advice and liaison service (PALS), NHS Choices and other channels that are directed to the appropriate teams for investigation, follow-up and resolution. Further information about this important work is set out in chapter eight of this document.

Clinical commissioning group, GP and Local Medical Committee engagement

Clinical commissioning groups and GPs

In recognition of the need to provide a seamless service between primary and secondary care, the Trust has worked hard to strengthen relationships with its local clinical commissioning groups (CCGs) and GPs. Good progress has been made in developing relationships with two of the three new CCGs in the area.

Clinical engagement with CCG leads is supported through regular clinical liaison meetings, which are attended by the Trust's medical director, director of operations and director of business development and partnerships along with CCG GP leads from East and North Hertfordshire and Bedfordshire.

Regular contact has also been established between the Trust's primary care customer relations manager and the local GP community, with visits to practices and localities to meet with GPs and practice staff taking place regularly. 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.

A *GP Update* e-newsletter was launched before the end of 2012/13 to provide necessary information to help GPs access the Trust's services more easily. A GP helpline service is also provided by the Trust for resolution of mainly operational issues – with those raised through this service being analysed and fed back to the Trust's clinical divisions for improvement planning in order to help prevent similar incidents from occurring.

The Trust has contributed to a number of locality and CCG meetings, some of which have included the chief executive; these meetings have provided a useful opportunity for GPs to ask questions and for the chief executive to hear directly from them. A number of Trust clinicians have also contributed directly to clinical items and teaching at locality sessions. These are all designed to help the Trust improve the quality of the services provided and, hence, patient experience.

Local Medical Council

The Trust's relationship with the Bedfordshire and Hertfordshire Local Medical Committee has also been supported over the last year, including regular liaison with the LMC's chief executive to identify areas of mutual interest to work together and support GPs.

Chapter 12: sustainability

This chapter's contents relate to part or all of the following Trust strategic objectives:
• Objective 1: improve the quality of all aspects of the Trust's services • Objective 2: consolidate acute services for complex or serious conditions on to a single site
For further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13, please go to chapter six.

Environmental impact – context

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

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

This represents 25% of total public sector emissions in England and 3.2% of total carbon emissions overall. The Trust, along with the NHS in general, is subject to a number of national and international carbon reduction schemes and targets including:

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

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 2012/13 will not be available for some months yet due to way these figures are calculated.

Scope	2007 baseline	2010/11	2011/12	2015 target
Procurement, estates, catering, wages, etc.	58,231	46,155	45,776	52,407
Utilities	16,382	17,128	16,222	14,743
Travel	8,309	8,695	8,189	7,479
Total footprint	**82,922**	**71,978**	**70,187**	**74,629**

The Trust continued to sustain its carbon reduction achievements in to 2011/12 exceeding again the target set to be achieved by 2015. This progress is anticipated to continue in to the reporting year for 2102/13, following the successful installation of the Trust's new combined heat and power plant (CHP) in October 2012. The business case for this scheme estimates that the Trust would reduce its carbon emissions by 14%.

There is a lag period between the end of the financial year and final reporting of the utility figures for the carbon reduction commitment scheme, but early indications demonstrate that the CO_2 emissions associated with utilities for 2012/13 will be 15,852 tonnes – demonstrating the continued achievement of reductions in the Trust's CO_2 emissions.

Some of the schemes that have contributed to the reductions in 2011/12 and again in 2012/13 included the continued roll out of waste recycling (now up to 60%), further reductions in staff business mileage and changes to examination glove packaging.

The Trust remains confident that it can continue to deliver further reductions and thus achieve the 2015 targets.

On-going initiatives

Work also continues on the implementation of the Trust's green travel plan, which focuses on cutting business mileage, reducing the number of single occupancy vehicles accessing the Trust sites and increasing the number of staff cycling, car sharing and using public transport to get to and from their place of work.

The Trust, with its new waste disposal partner, has introduced a scheme to recycle all food waste from the catering service, which is then used for the production of bio fuel.

Working with the Trust's procurement partner Hertfordshire Supply Management Confederation, a number of initiatives have been introduced that seek to reduce the Trust's impact in the environment. These include:

- The NHS Supply Chain having upgraded 96% of its transport fleet from EUR3 to EUR5, equating to a 3% average fuel efficiency increase, as well as undertaking driver efficiency training and route efficiency planning;
- Switching to *Fair Trade* tea bags on wards, which also released a small revenue saving;
- A supplier sustainability pack was issued for sign-up to the top 100 NHS trust suppliers, resulting in a 40% acceptance rate thus far;
- Introduction of a recycling and returns policy to re-allocate, return or recycle unused stock.

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

In addition, it is anticipated that up to a further 37% reduction in CO_2 emissions will be achieved once all of the Trust's remaining inpatient and emergency services at the QEII transfer up to the redeveloped Lister site by the end of 2014.

Carbon reduction commitment energy efficiency scheme

Like all other 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 each year. For 2012/13, the Trust pays the carbon tax for the preceding year's (2011/12) emissions at cost of £12.00 per tonne. Based on the tonnes of carbon produced in 2011/12, the Trust's costs under the scheme were £194,664.

These costs will rise to £16.00 per tonne in 2012/13, with a further £2.00 per tonne being levied for each successive year – yet another incentive for the Trust to continue to reduce its carbon emissions.

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

Sustainable development management

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

The Trust registered for the *Good Corporate Citizen* scheme in 2010, which represents a valuable tool used to identify how the organisation contributes to sustainable development and ensuring that day-to-day activities support, rather than hinder, progress with sustainable development. In January 2013, the criteria for the tool changed with more emphasis being placed on stakeholder engagement, adaptation and consideration of clinical models of care and sustainability.

The Trust's initial baseline assessment against the scheme's new criteria shows that it is at the *Getting Started* stage; work will be carried out during 2013/14 with the aim that Trust reaches the *Getting There* stage across all elements. The action plans to achieve this outcome will complement the annual sustainable development management plan and will be monitored and reported upon regularly through the Trust's sustainable development committee.

The Trust's return for the NHS Sustainability Report Framework for 2012/13 can be found in the appendix included at the end of this year's annual report and accounts (see page 154 onwards).

Chapter 13: governance and the trust board

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

- Objective 1: improve the quality of all aspects of the Trust's services
- Objective 2: consolidate acute services for complex or serious conditions on to a single site
- Objective 3: work with colleagues in primary care to extend local access to specialist acute services
- Objective 4: maintain the pre-eminence of Mount Vernon as a tertiary cancer centre, and to provide more cancer care locally

Further details on the Trust's performance on each of these strategic objectives, along with their related annual objectives, during 2012/13 is covered in this chapter.

This section of the 2012/13 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 workforce and organisational development, and strategic development – and a non-executive director designate participate in board meetings but do not have voting rights.

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

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

The role of the NHS trust board

The Board's role includes:

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

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

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

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

The role of the NHS trust chairman

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

- Providing leadership to the Board, ensuring its effectiveness in all aspects of its role, and taking responsibility for setting its agenda;
- Ensuring the provision of accurate, timely and clear information to directors and other stakeholders;
- 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 2012/13

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

Key to principal committee membership

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

Notes to committee attendance

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

Ian Morfett, chairman

Ian was appointed chairman from 1 April 2012, having previously been a non-executive director of the Trust from 1 August 2005 (reappointed in 2009) and vice chairman from 1 January 2011. He teaches at University College London, developing programmes in leadership and management. Until 2006, he was the deputy director of the *Better Regulation Executive* within the Cabinet Office, where he worked with stakeholders to identify and reduce the negative impact of regulation on business. Prior to that, Ian worked for BT for 30 years, most recently as managing director of strategy and business development for BT Wholesale – the network and carrier services arm of BT. He has also been group director of regulatory affairs for BT and has held a number of senior roles covering finance, commerce and customer service. Ian lives in Letchworth.

Committee membership: FTC, RAQC (part year), RC, CTC
Attendance: Trust Board 11 out of 11; FTC 3 out of 3; RAQC 3 out of 4; RC 4 out of 4; CTC 3 out of 6

Nick Carver, chief executive

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

Committee membership: EC, FTC, FPC (core attendee), RAQC (core attendee), AC part year (core attendee)
Attendance: Trust Board 10 out of 11; FTC 2 out of 3; FPC 9 out of 12; RAQC 8 out of 11; AC 2 out of 2

Alison Bexfield, vice chairman

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

Committee membership: AC, FPC, RC

Attendance: Trust Board 6 out of 11; AC 6 out of 6; FPC 11 out of 12; RC 3 out of 4

Dyan Crowther, non-executive director

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

Committee membership: FTC, RAQC, RC

Attendance: Trust Board 8 out of 11; FTC 1 out of 3; RAQC 11 out of 11; RC 4 out of 4

Julian Nicholls, non-executive director

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

Committee membership: AC, FPC, RC

Attendance: Trust Board 7 out of 11; AC 6 out of 6; FPC 11 out of 12; RC 2 out of 4

Karen Pettit, non-executive director

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

Committee membership: RAQC, CTC, RC

Attendance: Trust Board 4 out of 6; RAQC 4 out of 6; CTC 0 out of 2; RC 1 out of 1

Douglas Smallwood, non-executive director (to 31 March 2013)
Between 2004 and 2010, Douglas was the chief executive of the national medical charity, Diabetes UK. Before that, he worked in corporate banking for 17 years and social housing for 10 years. Douglas has been a member of the GP commissioning support team at NHS East of England, with responsibility for public and patient involvement. He lives in Hertford, where he is also secretary of the local RSPB group. In addition, he has chaired the British Pain Society's patient liaison committee. Douglas was appointed as a non-executive director from 13 January 2011 and chaired the Board's *charity trustee committee.* He resigned as non-executive director on 31 March 2013, having been appointed chairman of the Princess Alexandra Hospital NHS Trust from 1 April 2013.
Committee membership: AC, RAQC, FTC, CTC, RC
Attendance: Trust Board 10 out of 11; AC 5 out of 6; RAQC 7 out of 11; FTC 3 out of 3; CTC 6 out of 6; RC 3 out of 4

Neil Dardis, director of operations (to 1 February 2013)
Neil was appointed as the Trust's director of operations in June 2008, following a period as deputy director of operations. Previously, he held several senior general management roles within the Trust, including leading its surgical services. He also held several senior management roles in other acute teaching hospitals. As director of operations, Neil was responsible for the effective delivery of high quality and accessible services for patients across all four of the Trust's hospitals, and for ensuring that these services met national and local performance and quality standards. On 1 February 2013, Neil left to become deputy chief executive and chief operating officer at the Buckinghamshire Healthcare NHS Trust.
Committee membership: EC, FTC, FPC (core attendee), RAQC (core attendee)
Attendance: Trust Board 9 out of 9; FTC 3 out of 3; FPC 10 out of 10; RAQC 6 out of 9

John Watson, director of operations (from 4 February 2013)
John joined the Trust in February 2013 from Ipswich Hospital NHS Trust, where he was director of operations for three years. Prior to this, he held acting director of operations and divisional manager posts at Kings College Hospital in central London. John has also completed the Public Service Leaders scheme, which included a two-day a week secondment to the Department of Health. Having started his NHS career in 1990, John has a BSc in social policy and economics and an MSc in health policy, planning and finance – both from the London School of Economics. He has management responsibility for over 3,000 front line staff through the leadership of the Trust's five clinical divisions and their senior managerial and clinical teams.
Committee membership: EC, FTC, FPC (core attendee), RAQC (core attendee)
Attendance: Trust Board 2 out of 2; FTC 0 out of 0; FPC 2 out of 2; RAQC 2 out of 2

Jane McCue, medical director
Jane has over 30 years' experience working in the NHS in twelve 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 has also been medical director for the Mount Vernon Cancer Network since February 2011. Jane led three major strategic reviews of surgery and planned care for the East of England Strategic Health Authority between 2007 and 2011 and currently is adviser to NHS London for its emergency surgery review. She is a member of the University of Hertfordshire Governing Board and is a past council/committee member for the Association of Coloproctology, the Royal Society of Medicine Section of Coloproctology, the St Mark's Association and Women in Surgery, Royal College of Surgeons.
Committee membership: EC, FTC, RAQC (core attendee)
Attendance: Trust Board 6 out of 11; FTC 2 out of 3; RAQC 9 out of 11

Angela Thompson, director of nursing

Angela took up the post of director of nursing, patient experience, and infection prevention and control at the Trust in 2011. Previously, she was assistant and then deputy chief nurse at Cambridge University Hospitals NHS Foundation Trust from 2007 to 2011, and lead for infection prevention and control from 2006 to 2010. She was also an advisor to Waikato District Health Board, Hamilton, New Zealand between 2006 and 2010. Angela is a registered general nurse (adult) and a registered sick children's nurse specialising in neonatal intensive care and care of the newborn. Her previous experience includes multi-disciplinary education, research, governance, patient safety and patient experience.
Committee membership: EC, FTC, RAQC (core attendee), FPC (attendee)
Attendance: Trust Board 11 out of 11; FTC 3 out of 3; RAQC 10 out of 11 ; FPC 8 out of 12

Paul Traynor, director of finance

Paul was appointed as the Trust's finance director in May 2009. He joined from Dartford and Gravesham NHS Trust, where he had been finance director since mid-2005. Previously, Paul held a similar role at Kent Ambulance NHS Trust, and prior to that he held a number of senior finance positions in both acute hospitals and primary care trusts. He joined the NHS in 1990 and completed his accountancy qualification in 1995.
Committee membership: EC, FTC, CTC, FPC (core attendee), AC (core attendee)
Attendance: Trust Board 10 out of 11; FTC 2 out of 3; CTC 5 out of 6; FPC 11 out of 12; AC 5 out of 6

Stuart Gavurin, non-executive director designate

Stuart spent over 20 years in private practice as a qualified accountant, but more recently as a commercial director with particular experience in finance, property development, investment, management and contract negotiation in the commercial, health and residential sectors. He has specialist knowledge of commercial legal affairs, with responsibility for setting up legal partnership arrangements between NHS bodies and the private sector. Stuart has been a Board member for a number of public and private organisations, including several NHS partnership companies, in both executive and non-executive capacities. He is an experienced executive and non-executive company chair and director. He lives in Bushey Heath and was appointed a non-executive director designate in August 2012.
Committee membership: FPC, RAQC, RC
Attendance: Trust Board 6 out of 7; FPC 5 out of 7; RAQC 5 out of 7; RC 1 out of 2

Stephen Posey, director of strategic development

Stephen joined the Trust in January 2008 from the East of England Strategic Health Authority (SHA), where he had been its provider development and foundation trust lead. Prior to his time at the SHA, he had undertaken a number of senior management roles within acute trusts, the Department of Health, strategic health authorities and primary care trusts across the East of England. Stephen has lead director responsibility for business development, partnerships, involvement, sustainability, facilities and, from February 2013, workforce, as well as strategic development. He is responsible for delivery of the Trust's *Our changing hospitals* programme to consolidate acute services at the Lister hospital. This forms part of the Hertfordshire-wide *Delivering quality health care for Hertfordshire* (DQHH) programme.
Committee membership: EC, FTC, CTC, FPC (core attendee)
Attendance: Trust Board 11 out of 11; FTC 3 out of 3; CTC 6 out of 6; FPC 9 out of 12

Greg Allen, director of workforce and organisational development (to 31 January 2013)

Greg took up the post of director of workforce and organisation development in 2011, joining the Trust from NHS Devon where he was director of human resources and workforce development, having held a number of senior posts in human resources in the south west. From February to October 2011 he was seconded as special advisor to the director of NHS Employers and to the Department of Health/national HR transition team. Greg left the Trust in January 2013 to take up the post of chief operating officer at the Centre for Workforce Intelligence.
Committee membership: EC, FTC, RAQC (core attendee); FPC (attendee)
Attendance: Trust Board 8 out of 9; FTC 2 out of 3; RAQC 7 out of 9; FPC 8 out of 10

	Title	Appointment date	Term(s) of office	Term of office ends
Ian Morfett	Chairman	1 April 2012	Four years	31 March 2016
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chairman	1 February 2008	Four years plus four years	31 January 2016
Dyan Crowther	Non-executive director	1 July 2010	Four years	30 June 2014
Julian Nicholls	Non-executive director	1 July 2010	Four years	30 June 2014
Karen Pettit	Non-executive director	12 July 2012	Four years	11 July 2016
Douglas Smallwood	Non-executive director	13 January 2011	Four years	31 March 2013 (resigned)
Neil Dardis	Director of operations	6 June 2008	n/a	1 February 2013
John Watson	Director of operations	4 February 2013	n/a	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	n/a	n/a
Stuart Gavurin*	Non-executive director designate	15 August 2012	Four years	n/a
Greg Allen*	Director of workforce	3 October 2011	n/a	31 January 2013
Stephen Posey*	Director of strategic development	21 January 2008	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:

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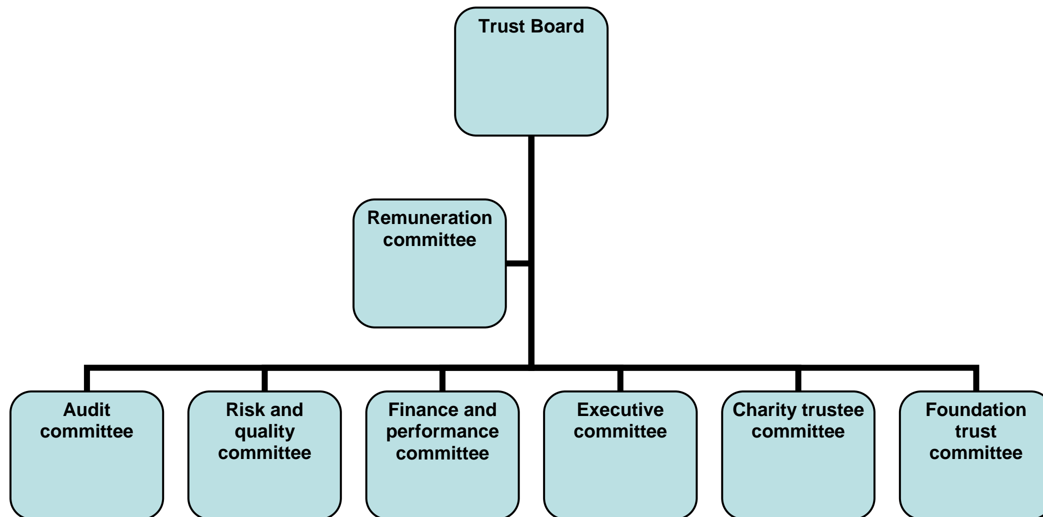
Governance structure

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



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

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

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

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

The *finance and performance committee* meets monthly and as part of the review in 2012, in order to meet the requirements under Monitor's code of governance, it revised its membership to three non-executive directors, thus ensuring it was constituted as an assurance committee to the Board. Its main role is to hold the executive to account for effective progress in managing financial, performance, strategic development, data quality and marketing strategy.

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

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

- **Division of surgery** (divisional chair, Dr Michael Chilvers and divisional director, John Fitzmaurice)
- **Division of medicine** (divisional chair, Dr Jon Baker and divisional director, Aisling Bowman)
- **Division of clinical support services** (divisional chair, Dr Tim Walker and divisional director, Joanna Carter)
- **Division of cancer services** (divisional chair, Dr Catherine Lemon and divisional director, David Govan)
- **Division of women's and children's services** (divisional chairs, Mr Rob Sattin/Dr Linda Struthers and divisional director, Isobel Day)

External auditor

Owing to the special accountabilities attached to public money and the conduct of public business, the Audit Commission – independently of the Trust – appoints external auditors. The *Audit Commission Act 1998* sets out the role of the Audit Commission in the appointment of external auditors for NHS bodies. It appoints auditors from its own staff, as well as from private firms of auditors. For 2012/13, 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 29 of the accounts section. During the 2011/12 financial year, the Trust entered into a Public Private Partnership with Vinci Park to finance a new multi-storey car park on the Lister site. The capital investment associated with the Trust's plans to reconfigure its acute hospital services will be funded through Trust borrowing.

Fixed assets

As set out in note 1 of the 2012/13 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 2012/13 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 1.5 and valuation details under note 9.6 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 2012/13.

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 2012/13, 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 improved from the previous year.

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

The Trust reported no incidents of level three or above to the NHS Hertfordshire or the Information Commissioner during 2012/13.

Summary of other personal data-related incidents in 2012/13		
Category	**Nature of incident**	**Total**
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secure NHS premises	1
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	0

Remuneration report

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

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

The *Remuneration committee* is a committee of the Trust Board, consisting of the chairman and all the non-executive directors. It is chaired by the vice chairman. The committee is supported by the chief executive, director of workforce and organisational development and the company secretary. The *Remuneration committee* aims to meet quarterly to fulfil its duties and it met four times during 2012/13. Details of directors' remuneration are given in the annual accounts.

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

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

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate. During 2012/13 the Trust recruited a new director of operations. Non-executive directors were involved in the recruitment of this post.

All the Trust's executive directors hold permanent contracts. The notice period for executive directors is generally three months, although it is six months in the case of the director of finance. There are no arrangements for termination payments or compensation for early termination of contract. The Trust is also not liable for any compensation payments to former senior managers or amounts payable to third parties for the services of a senior manager.

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

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

Salary and pension entitlements of senior managers

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

Nick Carver
Chief Executive

Remuneration tables

Name and title	2012/13				2011/12			
	Salary	Other remuneration	Bonus payments	Benefits in kind	Salary	Other remuneration	Bonus payments	Benefits in kind
	(bands of £5000)	(bands of £5000)	(bands of £5000)	Rounded to the nearest	(bands of £5000)	(bands of £5000)	(bands of £5000)	Rounded to the nearest
	£000	£000	£000	£000	£000	£000	£000	£000
Executive directors								
Nick Carver	170-175	0	0	1.7	160-165	0	0	2.7
Chief executive								
Paul Traynor	135-140	0	0	4.0	135-140	0	0	0.2
Director of finance								
Angela Thompson (from 30/08/11)	100-105	0	0	0.5	55-60	0	0	0.4
Director of nursing								
Neil Dardis (to 03/02/13)	100-105	0	0	0.5	110-115	0	0	0.3
Director of operations								
John Watson (from 04/02/13)	15-20	0	0	0	n/a	n/a	n/a	n/a
Director of operations								
Jane McCue (from 01/04/12)*	85-90	0	0	0	n/a	n/a	n/a	n/a
Medical director								
James Quinn (to 31/01/12)*	n/a	n/a	n/a	n/a	50-55	0	0	0.3
Medical director								
Stephen Posey	100-105	0	0	4.6	95-100	0	0	3.5
Director of strategic development								
Gregory Allen (from 03/10/11 to 24/02/13)	90-95	0	0	5.4	50-55	0	0	7.7
Director of workforce and organisation development								
Alex O'Grady (to 02/10/12)	n/a	n/a	n/a	n/a	50-55	0	0	0
Interim director of human resources								

*The role of medical director was covered by John Saetta and Michael Chilvers between 01/02/12 and 31/03/13, for which no remuneration was received.

Name and title	2012/13				2011/12			
	Salary	Other remuneration	Bonus payments	Benefits in kind	Salary	Other remuneration	Bonus payments	Benefits in kind
	(bands of £5000)	(bands of £5000)	(bands of £5000)	Rounded to the nearest	(bands of £5000)	(bands of £5000)	(bands of £5000)	Rounded to the nearest
	£000	£000	£000	£000	£000	£000	£000	£000
Non-executive directors								
Ian Morfett	20-25	0	0	0	6-10	0	0	0
Chair 2012/13 and vice-chair 2011/12								
Richard Beazley	n/a	n/a	n/a	n/a	20-25	0	0	0
Chairman 2011/12								
Alison Bexfield	6-10	0	0	0	6-10	0	0	0
Dyan Crowther	0	0	0	0	0	0	0	0
Julian Nicholls	6-10	0	0	0	6-10	0	0	0
Douglas Smallwood	6-10	0	0	0	6-10	0	0	0
Karen Pettit (from 12/07/12)	0-5	0	0	0	n/a	n/a	n/a	n/a
Stuart Gavurin (from 15/08/12)	0-5	0	0	0	n/a	n/a	n/a	n/a

Notes to remuneration tables

Benefits in kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. The medical director's remuneration quoted in the table above relates to senior manager duties only. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, having the effect of reducing the salary paid during 2011/12 and 2012/13. Dyan Crowther does not draw a salary from the Trust.

Pay multiples

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

The banded remuneration of the highest paid director in the Trust in 2012/13 was £172,500 (2011/12 – £162,500). This was 5.9 times (2011/12 – 5.6) the median remuneration of the workforce, which was £29,006 (2011/12 – £29,006). The lack of variance between the two years is consistent with the 2012/13 pay freeze.

In 2012/13, 21 employees (2011/12 – 35 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £14,153 to £226,983 (2011/12 – £13,903 to £226,983).

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 2013	Lump sum at aged 60 related to accrued pension at 31 March 2013	Cash equivalent transfer value at 31 March 2013	Cash equivalent transfer value at 31 March 2012	Real Increase in cash equivalent transfer value	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver	5-7.5	15-17.5	55-60	165-170	1,050	916	86	0
Chief executive								
Paul Traynor	2.5-5	7.5-10	35-40	110-115	566	510	29	0
Director of finance								
Neil Dardis	0-2.5	2.5-5	20-25	65-70	289	269	6	0
Director of operations to 03/02/13								
John Watson	5-7.5	15-17.5	30-35	95-100	521	418	82	0
Director of operations from 04/02/13								
Stephen Posey	0-2.5	5-7.5	15-20	55-60	241	206	24	0
Director of strategic development								
Gregory Allen	0-2.5	2.5-5	10-15	30-35	175	155	12	0
Director of workforce and organisation development to 24/02/13								
Angela Thompson	5-7.5	20-22.5	35-40	115-120	707	567	110	0
Director of nursing								

Notes to pensions table

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

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

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

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

Off-payroll engagements

In line with national guidance, the two tables below set out off-payroll engagements with the Trust.

Off-payroll engagements at a cost of over £58,200 per annum in place as of 31 January 2012:

	Main department
Number in place on 31 January 2012	12
Of which:	
Number that have since come onto the organisation's payroll	0
Of which:	
Number that have since been re-negotiated/re-engaged to include contractual clauses allowing the (department) to seek assurances as to their tax obligations	0
Number that have not been successfully re-negotiated and therefore continue without contractual clauses allowing the (department) to seek assurance as to their tax obligations	2
Number that have come to an end	10
Total	12

All new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months:

	Main department
Number of new engagements	3
Of which:	
Number of new engagements that include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance obligations.	1
Of which:	
Number for whom assurance has been accepted and received	1
Number for whom assurance has been accepted and not received	0
Number that have been terminated as a result of assurance not being received	0
Total	1

Chapter 14: annual accounts for 2012/13

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

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

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

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

Signed Chief Executive

Date: 23 May 2013

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

By order of the Board

Date: 23 May 2013 Chief Executive

Date: 23 May 2013 Finance Director

Annual governance statement 2012/13

Insert name of organisation: East and North Hertfordshire NHS Trust

Organisation Code: RWH

Governance statement

1. Scope of responsibility

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

In undertaking this role I, and my team, have developed strong links with the strategic health authority, local primary care trusts, emerging clinical commissioning groups, Trust Development Authority and partner organisations.

2. The governance framework of the organisation

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

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

The system of internal control has been in place in the East and North Hertfordshire NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

2.2 Capacity to handle risk
The Trust has established clear leadership and accountability arrangements and from 1 April 2012 to 31 March 2013, the responsibility for ensuring that there is a comprehensive risk management and corporate governance systems in place has been delegated to the company secretary. In addition, I have delegated: clinical governance and health and safety to the director of nursing; clinical governance and the co-ordination of the management of all clinical risks to the medical director; financial and IM&T risks to the director of finance; emergency planning to the director of operations; estates, security management and sustainability management to the director of strategic development; and workforce and organisational development to the director of workforce and organisational development.

Further detail on individual director accountabilities are set out in:

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

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

- Leadership is given to the risk management process
- The principle risks to achieving the strategic and annual objectives are 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 appropriately managed throughout the organisation.

Each of the Trust's clinical divisions has a divisional (clinical) chair and divisional director, who are accountable jointly for risk and governance. A process of review and challenge of divisional risks, as contained in the risk register, is conducted through divisional performance review meetings. Areas of high risk are escalated to the *risk and quality committee* (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; during 2012, the Board had a development programme to review the key strategic issues facing the Trust in the next 10 years and approved a new quality governance and risk Management strategy. 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 Trust 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 2012/13 and how these have been mitigated and reviewed is discussed at Trust Board each quarter in the public session. These risks include:

- The risks of delay to consolidation programme resulting from on-going HM Treasury review and approvals process, subsequent impact on programme and Trust reputation and, the delay in the delivery programme to reconfiguration services due to the volume, pace, interdependence and complexity of the major change programme. These were mitigated throughout the year and are now both ***green***. The first risk has now been closed.

- The financial risk of access to capital funding in line with programme assumptions for the consolidation programme and with business case approvals required from Department of Health and HM Treasury programme is now ***green*** as approval was granted.

- The main financial risk to non-delivery of the £3.6 million surplus in 2012/13. This risk was increased to ***red*** following the reforecast of the surplus to £0.5 million. However, the Trust has maintained a strong performance on a number of the financial indicators, including delivery of the cost improvement programme (CIP) – see section five (review of economy, efficiency and effectiveness of use of resources) for details.

- Patient experience risks remain but the Trust has a new patient and carer experience strategy and has delivered improvements that are evidenced through the net promoter score performance in the upper decile for 9 out of 12 months, along with an improved position from 64.8 to 66.3 on the composite five inpatient survey questions.

Other operational key risks, including mortality and performance, that have been managed during 2012/13 are discussed in section five.

3.2 Risks escalated to the Board assurance framework (BAF) during 2012/13:
During 2012, two new risks were added to the BAF. These were:

1) Risk that the Trust breaches the terms of the Tripartite Formal Agreement (TFA) and does not achieve NHS foundation trust Status. This risk was captured previously within risks relating to other objectives. Performance against the TFA was monitored monthly though the Board and its committees. The Trust FT application was submitted in 2012 for consideration but this risk was increased to ***red*** following the reforecasting of the Trust's financial surplus (see later section). Currently the Trust is in the process of agreeing a revised timeline to become a foundation trust with the Trust Development Authority.

2) Risk to reputation of the Trust if Clinicenta performance is poor. The risk reflects that the service is located on the Lister hospital site and that delivery of the service is outside the control of the Trust. The Trust has maintained relationships with Clinicenta and NHS Hertfordshire (replaced by the East and North Hertfordshire Clinical Commissioning Group as of 1 April 2013) and continued to support a whole systems approach to the pathway of care and the delivery of the actions resulting from a risk summit. This risk remains as ***amber***.

Assurance framework ratings explained:
Red: *A significant failure to mitigate a risk either through lack of controls identified (or poorly framed controls), with a high likelihood of the risk being realised in the short term.*
Amber: *On course to be mitigated, given the controls identified, but further work required in delivering the agreed actions.*
Green: *The risk has been mitigated as defined by the controls and actions identified. These risks will continue to be displayed on the framework so that assurances received can be kept up to date.*

4. The risk and control framework

Quality governance and risk management is central to the effective running of the organisation and the Trust's ambition to *be amongst the best*. The objectives of this strategy are to:

- Achieve the Trust's strategic and operational objectives as defined in the integrated business plan and annual plan;
- 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* by end of 2014/15 *(*rated currently as *medium risk*);
- Achieve NHS Litigation Authority level two *(*or its equivalent*)* in 2014 and level three within two years of reconfiguration;
- Achieve CNST (maternity) level two by the end of quarter two 2013.

The aims of this strategy are to:

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

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

Board assurance and reporting

The Trust Board has established three committees to discharge its responsibilities on Board assurance. These are the *audit*, *risk and quality* and *finance and performance committees*. They 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, along with oversight of the capital programme;
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The FPC also oversees aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T strategy for the Trust. It will ensure the Trust is prepared for the forthcoming major changes including from the *Our changing hospitals* programme and achieving NHS foundation trust status.

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 the corporate risk register, ensuring appropriate action is taken to mitigate risks where possible and advising the Board where acceptance of risk may need to be considered;

- Monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS Litigation Authority (NHSLA), Clinical Negligence Scheme for Trusts (CNST), Health and Safety Executive (HSE), Strategic Health Authority (SHA), the risk elements of the Auditors Local Evaluation (ALE), and ensure action is taken for compliance;
- Monitor and advise the Board on compliance with the *Hygiene Code*;
- Endorse, monitor and receive reports on the implementation of the Trust's key quality, clinical outcome, patient safety and patient experience strategies and indicators;
- Provide regular risk management reports to the Trust Board;
- Liaise with the *audit committee* and the *finance and performance committee*;
- Receive, annually, divisional presentations on progress with divisional objectives, governance structures, quality, safety and risk;
- Review the quality risk assessment of the cost improvement programme (CIP);
- To work with the *audit committee* when appropriate, and specifically in agreeing the annual Internal audit plan and providing a review of effectiveness on clinical audit.

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

- Clinical governance strategy committee
- Patient safety committee
- Patient experience committee
- Health and safety committee
- Emergency planning committee
- Information governance steering group
- 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 2012/13 has not highlighted any issues. These are reported in full in the Trust's annual report (see chapter 13).

Board development

During 2012/13 the Board had a series of development sessions to consider six identified areas of strategic significance. These were research and development, demographics change and public health, patient and societal expectations, the Health Act and changing commissioning landscape, workforce and efficiency and innovation. Following consultation with key stakeholders the Board approved revised strategic aims for 2013 to 2018 at its meeting in March 2013.

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

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

The Board has also reviewed its compliance against the Board governance assurance framework and quality governance framework. The self-assessments were evidence-based and no areas of significant risk were identified. An action plan is in place and monitored to ensure that the Trust continues to develop its systems in line with all the areas of good practice.

Assurance framework and risk register

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

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

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

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

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

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

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

Care Quality Commission
The Trust was registered fully with the Care Quality Commission (CQC), without compliance conditions, on 1 April 2010. The CQC has not taken enforcement action against the Trust during 2012/13.

The Trust has been inspected once during 2012/13. The CQC carried out a routine unannounced inspection of the Lister hospital on the 6 and 7 December 2012. The inspection team tested compliance against five outcomes:

- Outcome 4 (care and welfare)
- Outcome 6 (cooperating with other providers)
- Outcome 7 (safeguarding people who use services from abuse)
- Outcome 13 (staffing)
- Outcome 16 (assessing and monitoring the quality of service provision)

The Trust was found to be fully compliant with each of the five essential standards inspected at the Lister site.

During 2012/13, the Trust has maintained a positive CQC quality risk profile (QRP). The QRP is reviewed after each publication to ensure actions are in place to address any data sources rated as negative or *red*. The Trust continues to monitor compliance against all the essential standards of quality and safety on an on-going basis. Through the Trust's quality governance and risk management strategy, the Trust seeks to maintain a positive QPR and ensure on-going compliance with the CQC's essential standards of quality and safety.

Clinical audit
The *risk and assurance committee* considered the assurances on clinical audit following an evidence-based self-assessment against the criteria stated in the Audit Committee Handbook 2010. The self-assessment demonstrates that the Trust's clinical audit processes are compliant, and that there are plans in place to continue to strengthen these. It is clear that processes and monitoring have led to a significant improvement in clinical audit activity across the Trust. Approximately 88% of the clinical audit programme (660 clinical audits) have been completed or are in progress for 2012/13.

Information governance
The assurance framework and risk register includes the risks associated with the management and control of information. In this respect the Trust also has an information governance statement of compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage. For 2012/13, the Trust achieved the minimum level two compliance for all requirements in the information governance toolkit and achieved a *satisfactory* rating. Overall, the Trust's score improved from the previous year. Information governance training remains a priority for the Trust and the e-learning package is supported by a number of other training and awareness activities across the organisation.

Performance
The Trust has maintained consistent strong performance against a number of key indicators and delivered a quarterly risk rating of *amber/green*. This rating was triggered by the A&E indicator and *Clostridium difficile*. Whilst challenging, both of these indicators have achieved the year end position within the target.

The pressures on the A&E standard have been due to multiple factors, including an increase in admissions in March creating significant bed flow problems impacting on the emergency department, increased levels of acuity amongst patients (77% majors, compared to 50% in previous years), lack of assessment space due to bed capacity, sustained period of cold weather, delays in specialities reviewing patients and staffing shortfalls. A clear action plan is in place which is reported and monitored monthly by the Board with exception reports and clear trajectories.

Mortality

The Trust's HSMR position in the year-to-date for 2012/13 was eighth out of the 17 acute trusts in the East of England and still alerting *green* (better than expected) after ten months of 2012/3 at 94.4.

The latest SHMI for the period July 2011 to June 2012 is 110.8. This places the Trust in 128th position nationally out of 142 Trusts. Although higher than average, this shows an improving position with a five-point improvement over 15 months. This figure now lies within the expected range.

Mortality monitoring includes reviewing *alerts* that show higher than expected mortality with certain diagnoses. This has been seen in five areas: respiratory infection; urinary infection; acute renal failure; septicaemia; and congestive heart failure. The care and treatment of patients with these conditions have been reviewed during the year and updated processes put in place. However, it will be some time before improvements are shown in the SHMI data as there is a significant time lag of approximately 8 to 20 months before the reporting month (i.e. data from July 2011 to June 2012 was reported in January 2013).

Reducing mortality remains an improvement priority for the Trust in 2013/14 and the Trust's operating plan and clinical outcomes strategy set out the priorities for and actions.

Pensions

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are 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 mitigates and manages effectively the risks to deliver the Trust's strategic and annual objectives.

The Trust delivered a surplus in 2012/13, maintained its financial risk rating of *three* and delivered 100% of its CIP programme. However, the planned surplus of £3.6 million was reduced to £0.5 million as a result of a legal claim against the organisation, a number of contractual risks with commissioners and a significant reduction in the level of cancer income against plan in 2012/13.

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 2012/13 has been led by the 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 four priorities chosen for 2012/13 were developed with input from staff, key external stakeholders and foundation trust members through the Trust's annual general meeting and involvement committee. The priorities for improvement were identified for a range of reasons, including feedback on survey data and a review of clinical outcomes. The highest priorities chosen by stakeholders were agreed as the quality improvement priorities for the 2012/13 report. These were:

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

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

An overview of 2012/13 shows that the Trust has:

- Reduced the number of falls and harm from falls
- Reduced the number of pressure ulcers
- Improved ways to keep patients nourished and hydrated
- Maintained outcomes for surgery and continued to reduce mortality
- Ensured patient choice for patients being cared for on the Liverpool Care Pathway
- Maintained sickness levels
- Received encouraging feedback from patients and carers about their experience but
- Recognised there is more to be achieved

Also shown is that the Trust needs to work closely with its community partners to improve the care offered to people who have had a stroke and the need to improve the appraisal process at divisional level.

The Trust recognises that the four improvement priorities for 2012/13 remain important and these will remain the same for 2013/14, although priority one has now been extended to all patient groups.

Throughout the year the Trust intends to ensure on-going engagement with the county's new Health and Wellbeing Board and Health Scrutiny Committee. The Trust will continue to monitor performance against priorities, including by the use of floodlight scorecards at ward, divisional and Trust level.

Francis Inquiry

On the 6 February 2013, Robert Francis QC published the recommendations of the inquiry he chaired that looked at the failings of care within the Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations aimed at ensuring patients are put first. The Trust is committed to learning from the failings that took place at Mid Staffordshire.

The Trust Board has reviewed the Francis report and its recommendations. As a result, the Trust's focus will remain on placing the needs of its patients at the heart of everything it does and ensuring that each member of its staff operates in accordance with the Trust's values.

The review began at the Trust Board meeting held in February 2013. Steps have been taken already to consider the impact of the recommendations for the Trust and how it may improve patient care further, including:

- Reviewing the Trust's systems and processes;
- Benchmarked staffing levels;
- The Trust's director of nursing, Angela Thompson, has been working with focus groups consisting of nurses, midwives and other staff and patients from across the Trust's hospitals to assess, in detail, the recommendations from the Francis report and the implications for patient care and service delivery;
- The Trust's top 500 leaders are engaged in a similar process through the ARC organisational development programme;
- Seeking to put every single member of Trust staff through customer care training before the end of 2013.

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

6. Significant Issues

There no significant control issues to report.

Review of effectiveness

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

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of 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 2012 to 31 March 2013, overall opinion is that:

- There is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and / or inconsistent application of controls, puts the achievement of particular objectives at risk.

- Using the terminology set out in the Department of Health guidance to heads of internal audit (gateway approval 15460), this opinion would equate to *significant assurance*.

- The opinion is based solely on our assessment of whether the controls in place support the achievement of management's objectives as set out in our annual internal audit risk assessment and plan and in individual assignment reports.

The basis for forming the opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

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. These are summarised below:

- Electronic staff records (ESR) project review – The review highlighted a number of issues relating to the project governance. Changes have been implemented and the revised project plan is monitored though the Trust's *executive* and *finance and performance committees*.

- Health and safety – The review identified some gaps in the departmental health and safety records (red files) tested, some were either missing one or more risk assessments or one or more risk assessment was out of date; a full audit has been completed and actions have been taken to address this issue. This is monitored through divisional performance reviews.

- Access policy – The Trust has updated its access policy, which outlines the Trust's processes for managing the access to services for patients who are not emergencies in the context of achieving the national 18-week referral-to-treatment pathway and ensuring a high quality and fair service to all patients. The review established that some outcome forms were not fully completed by clinicians for all patients and data from these forms is transcribed incorrectly to patient administration system; actions have been implemented to address this area of risk including training and review of the forms. An action plan to address the other recommendations I are in progress and will be monitored through the operations group and *audit committee* until closure.

- Patient experience – The review identified that despite clear escalation procedures being in place, there has been consistent poor performance in replying to patient complaints within the Trust's target timescale of 25 working days. At the time of audit 52.5% of responses were made within 25 working days whereas the target is to meet this for 75%; actions have been taken to address this and performance has improved to 62%. Restructuring of the team in 2013 is expected to support further improvements.

- Risk management – The review highlighted that the: risk register database is not being completed fully; review dates are not always updated and re-assessed; action plan updates are not always completed; and risks have gone past their review. Steps are in place to address this with the individual areas identified and will be monitored through the key performance indicators.

- Information governance – The review showed that 16% of staff have never attended information governance (IG) training. The Trust will target these staff for training and continue to raise IG awareness and emphasise the importance of all staff completing the mandatory IG training modules; this is monitored by Trust's *risk and quality committee* in the floodlight scorecard.

- Key financial controls – The audit found that in payroll, appropriate signatures are not always obtained retrospectively when verbal clarification is gained from the human resources team and managers so as not to delay payments to staff. There is a clear action plan to address and monitor this issue.

- Patient-level costing – The report highlighted a number of process and operational controls that require addressing prior to being able to use the PLiCs as an effective decision-making tool across the organisation. The Board had recognised this and had reflected this on the *board assurance framework*. This objective has been carried forward to 2013/14, with a broader scope and revised project plan which will address the recommendations.

- Employment check standards – The report highlighted some inconsistencies in the recording of information and policies and procedures. An action plan is in the process of being agreed to address the issues identified.

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, the self-assessment against the CQC essential standards of quality and safety and NHS Litigation Authority and Clinical Negligence Scheme for Trusts assessments.

Further evidence is provided by a range of audit reports including clinical audit, internal audit and external audit. In addition, the process undertaken by the Trust Board and management to assess the organisation's position against Monitor's 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 information governance statement of compliance;
- 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 successful NHS Litigation Authority level two assessment in January 2011 and recent internal audit reports;
- The evidence based self-assessment review against the Department of Health Board Governance Assurance Framework and Monitor's Quality Governance Framework.

Conclusion

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

My review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2013/14.

Accountable Officer : Nick Carver

Organisation: East and North Hertfordshire NHS Trust

Signature:

Date: 23 May 2013

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

We have audited the financial statements of the East and North Hertfordshire NHS Trust for the year ended 31 March 2013 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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 87 and 88;
- the table of pension benefits of senior managers and related narrative notes on pages 89 and 90; and
- the table of pay multiples and related narrative notes on page 89.

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

Respective responsibilities of directors and auditor

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

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the East and North Hertfordshire NHS Trust as at 31 March 2013 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 Department of Health's guidance;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; and/or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

Respective responsibilities of the Trust and 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.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in November 2012, as to whether the Trust has proper arrangements for:

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2013.

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

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in November 2012, we are satisfied that in all significant respects the East and North Hertfordshire NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2013.

Delay in certification of completion of the audit

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

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

Grant Thornton House
Melton Street
Euston Square
LONDON
NW1 2EP

23 May 2013

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Gross employee benefits	9.1	**(222,544)**	(219,674)
Other costs	7	**(135,344)**	(117,933)
Revenue from patient care activities	4	**285,862**	297,259
Other Operating revenue	5	**64,681**	49,143
Operating surplus/(deficit)		**(7,345)**	8,795
Investment revenue	11	**31**	35
Other gains and (losses)	12	**0**	(99)
Finance costs	13	**(1,865)**	(1,739)
Surplus/(deficit) for the financial year		**(9,179)**	6,992
Public dividend capital dividends payable		**(3,237)**	(3,799)
Retained surplus/(deficit) for the year		**(12,416)**	3,193

Other Comprehensive Income	2012-13 £000	2011-12 £000
Impairments and reversals	**(34,541)**	(1,683)
Net gain/(loss) on revaluation of property, plant & equipment	**13,992**	10,338
Public Dividend Capital (repaid)/received	**(395)**	6,500
Total comprehensive income for the year	**(33,360)**	18,348

Financial performance for the year

	2012-13	2011-12
Retained surplus/(deficit) for the year	**(12,416)**	3,193
Impairments	**12,658**	88
Adjustments in respect of donated asset receipts and depreciation	**290**	287
Adjusted retained surplus/(deficit)	**532**	3,568

PDC dividend: balance receivable/(payable) at 31 March 2013	**113**
PDC dividend: balance receivable/(payable) at 1 April 2012	**109**

The notes on pages 114 to 135 form part of this account.

Statement of Financial Position as at 31 March 2013

	NOTE	**31 March 2013**	1 April 2012 (restated)	31 March 2012 (restated)	31 March 2011 (restated)
		£000s	£000s	£000s	£000s
Non-current assets:					
Property, plant and equipment	14	**140,280**	166,633	166,633	140,243
Intangible assets	15	**4,388**	3,845	3,845	3,739
Trade and other receivables	20.1	**1,485**	1,325	1,325	2,047
Total non-current assets		**146,153**	171,803	171,803	146,029
Current assets:					
Inventories	19	**4,864**	4,738	4,738	4,636
Trade and other receivables	20.1	**23,277**	20,504	20,504	12,795
Cash and cash equivalents	21	**10,099**	9,602	9,602	7,226
Total current assets		**38,240**	34,844	34,844	24,657
Total assets		**184,393**	206,647	206,647	170,686
Current liabilities					
Trade and other payables	22	**(39,283)**	(41,221)	(41,221)	(26,046)
Other liabilities	23	**(203)**	(203)	(203)	0
Provisions	27	**(194)**	(456)	(456)	(163)
Borrowings	24	**(241)**	(169)	(169)	(205)
Other financial liabilities	25	**(135)**	(40)	(40)	0
Working capital loan from Department		**0**	0	0	(1,560)
Capital loan from Department	24	**(1,561)**	(1,038)	(1,038)	(862)
Total current liabilities		**(41,617)**	(43,127)	(43,127)	(28,836)
Non-current assets plus/less net current assets/liabilities		**142,776**	163,520	163,520	141,850
Non-current liabilities					
Other Liabilities	23	**(5,623)**	(5,826)	(5,826)	0
Provisions	27	**(961)**	(1,079)	(1,079)	(1,182)
Borrowings	24	**(7,875)**	(8,173)	(8,173)	(8,386)
Other financial liabilities	25	**(3,030)**	(1,167)	(1,167)	0
Capital loan from Department	24	**(34,271)**	(22,899)	(22,899)	(19,590)
Total non-current liabilities		**(51,760)**	(39,144)	(39,144)	(29,158)
Total Assets Employed:		**91,016**	124,376	124,376	112,692
FINANCED BY:					
TAXPAYERS' EQUITY					
Public Dividend Capital		**151,139**	151,534	151,534	145,034
Retained earnings		**(105,787)**	(95,329)	(95,329)	(91,131)
Revaluation reserve		**45,664**	68,171	68,171	58,789
Total Taxpayers' Equity:		**91,016**	124,376	124,376	112,692

The notes on pages 136 to 153 form part of this account.

The financial statements on pages *110 to 113* were approved by the Board on *22 May 2013* and signed on its behalf by

Chief Executive: Date: 23 May 2013

Prior year adjustment

The prior year adjustment is in relation to overstating the new and existing maternity unit. The prior year adjustment of £6,664,000 reduces the property, plant and equipment and restates the Statement of Financial Position for 31 March 2011 and 1 April 2012.

Statement of Changes in Taxpayers' Equity
For the year ended 31 March 2013

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Total reserves £000s
Balance at 1 April 2012	**151,534**	**(95,329)**	**68,171**	**124,376**
Changes in taxpayers' equity for 2012-13				
Retained surplus/(deficit) for the year	0	(12,416)	0	**(12,416)**
Net gain / (loss) on revaluation of property, plant, equipment	0	0	13,992	**13,992**
Impairments and reversals	0	0	(34,541)	**(34,541)**
Transfers between reserves	0	1,958	(1,958)	**0**
Reclassification Adjustments				
PDC Repaid In Year	(395)	0	0	**(395)**
Net recognised revenue/(expense) for the year	**(395)**	**(10,458)**	**(22,507)**	**(33,360)**
Balance at 31 March 2013	**151,139**	**(105,787)**	**45,664**	**91,016**
Balance at 1 April 2011	**145,034**	**(91,131)**	**58,789**	**112,692**
Changes in taxpayers' equity for the year ended 31 March 2012				
Retained surplus/(deficit) for the year	0	3,193	0	3,193
Net gain / (loss) on revaluation of property, plant, equipment	0	0	10,338	10,338
Impairments and reversals	0	0	(1,683)	(1,683)
Reclassification Adjustments				
New PDC Received	6,500	0	0	6,500
Prior year adjustments	0	(7,391)	727	(6,664)
Net recognised revenue/(expense) for the year	6,500	(4,198)	9,382	11,684
Balance at 31 March 2012	**151,534**	**(95,329)**	**68,171**	**124,376**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2013

	2012-13	2011-12
	£000s	£000s
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**(7,345)**	8,795
Depreciation and Amortisation	**7,919**	6,552
Impairments and Reversals	**12,658**	88
Donated Assets received credited to revenue but non-cash	**(269)**	(262)
Interest Paid	**(970)**	(901)
Dividend (Paid) / Refunded	**(3,241)**	(3,902)
Release of PFI/deferred credit	**243**	61
(Increase)/Decrease in Inventories	**(126)**	(102)
(Increase)/Decrease in Trade and Other Receivables	**(233)**	(6,987)
Increase/(Decrease) in Trade and Other Payables	**6,839**	12,425
(Increase)/Decrease in Other Current Liabilities	**(203)**	6,029
Provisions Utilised	**(414)**	(168)
Increase/(Decrease) in Provisions	**8**	326
Net Cash Inflow/(Outflow) from Operating Activities	**14,866**	21,954
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**31**	35
(Payments) for Property, Plant and Equipment	**(24,678)**	(27,076)
(Payments) for Intangible Assets	**(1,616)**	(983)
Proceeds of disposal of assets held for sale (PPE)	**394**	21
Net Cash Inflow/(Outflow) from Investing Activities	**(25,869)**	(28,003)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(11,003)**	(6,049)
CASH FLOWS FROM FINANCING ACTIVITIES		
Public Dividend Capital Received	**0**	6,500
Public Dividend Capital Repaid	**(394)**	0
Loans received from DH - New Capital Investment Loans	**18,093**	4,394
Loans repaid to DH - Capital Investment Loans Repayment of Principal	**(6,199)**	(909)
Loans repaid to DH -Revenue Support Loans	**0**	(1,560)
Net Cash Inflow/(Outflow) from Financing Activities	**11,500**	8,425
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**497**	2,376
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	**9,602**	7,226
Cash and Cash Equivalents (and Bank Overdraft) at year end	**10,099**	9,602

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

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

1.3 Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

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

1.3.2 Key sources of estimation uncertainty

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

Estimation techniques in the following areas are explained in more detail under the relevant note:
The estimation of partly completed spells - note 1.4
Provision for impairment of receivables - note 20.3
The valuation of property, plant and equipment - note 1.7
The calculation of provisions - note 1.17

1.4 Revenue

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

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

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

1.5 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, 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 were not permitted to carry forward annual leave at the end of 2012-13 or 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 NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.6 Other expenses

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

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

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

Valuation

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

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

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

Revaluations are performed every year to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
● Land and non-specialised buildings – market value for existing use
● Specialised buildings – depreciated replacement cost

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

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

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

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

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

1.8 Intangible assets

Recognition

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

1.9 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. 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) from 2011-12. 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.

1.10 Donated assets
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. 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.

1.11 Government grants
Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. 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)

1.12 Non-current assets held for sale

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

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

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

1.13 Leases

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

The Trust as lessee

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

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The trust as lessor

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

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

1.14 Private Finance Initiative (PFI) transactions

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

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)

1.15 Inventories

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

1.16 Cash and cash equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.35% for employee early departure obligations).

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

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

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

1.18 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 27.

1.19 Non-clinical risk pooling

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

1.20 Contingencies

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

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

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

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

1.21 Financial assets

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

Financial assets are initially recognised at fair value.

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

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

1.22 Financial liabilities

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

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

Financial guarantee contract liabilities

The Trust currently has no financial guarantee contract liabilities

Financial liabilities at fair value through profit and loss

The Trust currently has no contracts containing embedded derivatives

Other financial liabilities

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

1.23 Value Added Tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions.

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 35 to the accounts.

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

1.26 Public Dividend Capital (PDC) and PDC dividend

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

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.27 Losses and Special Payments

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

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

1.28 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

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

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

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

1.29 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.
Under this heading, the Trust is involved in a Transforming Pathology Partnership with a number of other NHS parties.

1.30 Research and Development

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

1.31 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 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

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

2. Operating segments

The East and North Hertfordshire NHS Trust provides healthcare services only. The services are managed and resourced as one business unit. Divisions in reporting are for management purposes only. Capital resource allocations are distributed based on the operational and strategic need of the whole organisation. Services are provided largely for Primary Care Trusts and as such provide the same level of risk for each area. Therefore the Trust considers single segment reporting to be the most appropriate reporting format. Details of revenue from the single segment are disclosed in notes 3 and 4.

In 2012/13 income from transactions with Primary Care Trusts amounted to £307 million (2011/12 £305 million) which accounted for 88% of total income (2011/12 88%)

3. 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.

4. Revenue from patient care activities	**2012-13 £000s**	2011-12 £000s
Primary Care Trusts - tariff	**142,288**	151,642
Primary Care Trusts - non-tariff	**118,095**	118,063
Primary Care Trusts - market forces factor	**19,986**	21,300
Local Authorities	**132**	0
Non-NHS:		
Private patients	**3,340**	3,823
Overseas patients (non-reciprocal)	**382**	336
Injury costs recovery	**975**	1,498
Other	**664**	597
Total Revenue from patient care activities	**285,862**	297,259

Patient care activities income has gone down from previous year due to activity transfer to ISTC and 12/13 being first year with full year effect on income.

5. Other operating revenue	**2012-13 £000s**	2011-12 £000s
Recoveries in respect of employee benefits	**4,020**	3,673
Education, training and research	**16,936**	16,780
Receipt of donations for capital acquisitions - NHS Charity	**269**	262
Non-patient care services to other bodies	**34,734**	23,712
Income generation	**2,222**	2,514
Other revenue	**6,500**	2,202
Total Other Operating Revenue	**64,681**	49,143
Total operating revenue	**350,543**	346,402

Other operating revenue has gone up due to transformation and transitional relief funding received in 12/13.

6. Revenue

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

7. Operating expenses (excluding employee benefits)

	2012-13 £000s	2011-12 £000s
Services from other NHS trusts	**4,945**	5,099
Services from other NHS bodies	**121**	108
Services from foundation trusts	**1,860**	6,120
Purchase of healthcare from non NHS bodies	**3,195**	3,612
Trust Chair and Non-executive Directors	**52**	50
Supplies and services - clinical	**58,320**	55,672
Supplies and services - general	**20,006**	15,264
Consultancy services	**534**	430
Establishment	**3,493**	3,413
Transport	**897**	916
Premises	**12,151**	10,942
Impairments and Reversals of Receivables	**275**	304
Depreciation	**6,856**	5,675
Amortisation	**1,063**	877
Impairments and reversals of property, plant and equipment	**12,648**	88
Impairments and reversals of intangible assets	**10**	0
Audit fees	**131**	176
Other auditor's remuneration	**1**	0
Clinical negligence	**6,939**	7,076
Education and Training	**943**	857
Other	**904**	1,254
Total Operating expenses (excluding employee benefits)	**135,344**	117,933

Employee benefits		
Employee benefits excluding Board members	**221,803**	220,384
Board members	**741**	778
Total employee benefits	**222,544**	221,162
Total operating expenses	**357,888**	339,095

8 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.

8.1 Trust as lessee

	2012-13		
	Other	**Total**	2011-12
	£000s	**£000s**	£000s
Payments recognised as an expense			
Minimum lease payments		**4,131**	3,690
Total		**4,131**	3,690
Payable:			
No later than one year	3,853	**3,853**	4,331
Between one and five years	8,302	**8,302**	7,507
After five years	4,228	**4,228**	3,831
Total	**16,383**	**16,383**	15,669

8.2 Trust as lessor

The Trust does not act as a lessor.

9 Employee benefits and staff numbers

9.1 Employee benefits

	2012-13 Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	**190,755**	170,613	20,142
Social security costs	**14,445**	14,289	156
Employer Contributions to NHS BSA - Pensions Division	**19,029**	18,917	112
Total employee benefits	**224,229**	**203,819**	**20,410**
Less recoveries in respect of employee benefits (table below)	**(4,020)**	(4,020)	0
Total - Net Employee Benefits including capitalised costs	**220,209**	**199,799**	**20,410**
Employee costs capitalised	**1,685**	1,606	79
Net Employee Benefits excluding capitalised costs	**222,544**	**202,213**	**20,331**
Employee Benefits 2012-13 - income			
Salaries and wages	**4,020**	4,020	0
TOTAL excluding capitalised costs	**4,020**	**4,020**	**0**

	Total £000s	Permanently employed £000s	Other £000s
Gross Employee Benefits & Net expenditure 2011-12			
Salaries and wages	**188,334**	167,442	20,892
Social security costs	**14,539**	14,221	318
Employer Contributions to NHS BSA - Pensions Division	**18,779**	18,554	225
Other pension costs	**10**	10	0
TOTAL - including capitalised costs	**221,662**	**200,227**	**21,435**
Less recoveries in respect of employee benefits	**(3,673)**	0	(3,673)
Total - Net Employee Benefits including capitalised costs	**217,989**	**200,227**	**17,762**
Recognised as			
Employee costs capitalised	**500**	465	35
Net Employee Benefits excluding capitalised costs	**221,162**	199,762	21,400

9.2 Staff Numbers

	2012-13 Total Number	Permanently employed Number	Other Number	2011-12 Total Number
Average Staff Numbers				
Medical and dental	**700**	653	47	763
Administration and estates	**1,003**	933	70	1,053
Healthcare assistants and other support staff	**330**	290	41	1,000
Nursing, midwifery and health visiting staff	**2,279**	1,989	290	1,786
Scientific, therapeutic and technical staff	**717**	696	21	590
Other	**18**	18	0	7
TOTAL	**5,047**	**4,578**	**469**	5,199
Of the above - staff engaged on capital projects	**37**	33	4	14

9.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	40,544	38,919
Total Staff Years	4,730	4,760
Average working Days Lost	8.6	8.2

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	**5**	6
	£000s	£000s
Total additional pensions liabilities accrued in the year	**374**	414

9.4 Management costs

	2012-13 Number	2011-12 Number
Management costs	15,024	15,027
Income	350,543	346,402
Management costs percentage	4.29%	4.34%

9.5 Exit Packages agreed in 2012-13 and 2011-12

		2012-13			2011-12	
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	0	0	0	0	…	…
£10,001-£25,000	0	0	0	0	…	…
£25,001-£50,000	0	0	0	…	…	…
£50,001-£100,000	0	0	0	0	…	…
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost	**0**	**0**	**0**	…	…	…
Total resource cost (£000s)	**0**	**0**	**0**	40	134	174

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 "...".

9.6 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.

10 Better Payment Practice Code

10.1 Measure of compliance

	2012-13 Number	**2012-13 £000s**	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**71,842**	**111,726**	74,281	104,252
Total Non-NHS Trade Invoices Paid Within Target	**55,056**	**77,690**	46,968	63,974
Percentage of NHS Trade Invoices Paid Within Target	**76.63%**	**69.54%**	63.23%	61.36%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,070**	**36,234**	2,926	**33,129**
Total NHS Trade Invoices Paid Within Target	**1,681**	**19,288**	1,590	**12,705**
Percentage of NHS Trade Invoices Paid Within Target	**54.76%**	**53.23%**	54.34%	38.35%

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.

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

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

11 Investment Income

	2012-13 £000s	2011-12 £000s
Interest Income		
Bank interest	**31**	35
Total investment income	**31**	35

12 Other Gains and Losses

	2012-13 £000s	2011-12 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	(99)
Total	**0**	(99)

13 Finance Costs

	2012-13 £000s	2011-12 £000s
Interest		
Interest on loans and overdrafts	**970**	901
Interest on obligations under PFI contracts:		
- main finance cost	**617**	636
- contingent finance cost	**199**	182
Other interest expense	**53**	0
Total interest expense	**1,839**	1,719
Other finance costs	**0**	0
Provisions - unwinding of discount	**26**	20
Total	**1,865**	1,739

14.1 Property, plant and equipment

2012-13	Land	Buildings excluding 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
Cost or valuation:								
At 1 April 2012	**37,571**	**136,946**	**12,196**	**47,516**	**113**	**10,486**	**3,197**	**248,025**
Additions of Assets Under Construction	**0**	**0**	**5,512**	**0**	**0**	**0**	**0**	**5,512**
Additions Purchased	92	9,101		1,259	0	484	77	**11,013**
Additions Donated	0	15	21	0	0	193	40	**269**
Reclassifications	0	6,017	(4,425)	(1,592)	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	**0**
Disposals other than for sale	(2,700)	0	0	(394)	0	0	0	**(3,094)**
Upward revaluation/positive indexation	0	13,992	0	0	0	0	0	**13,992**
Impairments/negative indexation	0	(34,791)	0	0	0	0	0	**(34,791)**
Reversal of accumulated depreciation b/fwd	0	(42,123)	0	0	0	0	0	**(42,123)**
Reversal of Impairments	0	250	0	0	0	0	0	**250**
At 31 March 2013	**34,963**	**89,407**	**13,304**	**46,789**	**113**	**11,163**	**3,314**	**199,053**
Depreciation								
At 1 April 2012	**0**	**0**	**0**	**29,410**	**113**	**7,491**	**2,255**	**39,269**
Reclassifications	0	0		0	0	0	0	**0**
Reclassifications as Held for Sale and reversals	0	0		0	0	0	0	**0**
Disposals other than for sale	0	0		0	0	0	0	**0**
Upward revaluation/positive indexation	0	0		0	0	0	0	**0**
Impairments	0	12,584	0	281	0	101	19	**12,985**
Reversal of Impairments	0	(63)	0	(190)	0	(71)	(13)	**(337)**
Charged During the Year	0	2,269		3,459	0	911	217	**6,856**
At 31 March 2013	**0**	**14,790**	**0**	**32,960**	**113**	**8,432**	**2,478**	**58,773**
Net Book Value at 31 March 2013	**34,963**	**74,617**	**13,304**	**13,829**	**0**	**2,731**	**836**	**140,280**
Purchased	34,963	74,432	13,283	10,916	0	2,523	726	**136,843**
Donated	0	185	21	2,913	0	208	110	**3,437**
Government Granted	0	0	0	0	0	0	0	**0**
Total at 31 March 2013	**34,963**	**74,617**	**13,304**	**13,829**	**0**	**2,731**	**836**	**140,280**
Asset financing:								
Owned	34,963	67,643	13,304	13,829	0	2,731	836	**133,306**
Held on finance lease	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	**0**
PFI residual: interests	0	6,974	0	0	0	0	0	**6,974**
Total at 31 March 2013	**34,963**	**74,617**	**13,304**	**13,829**	**0**	**2,731**	**836**	**140,280**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	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
At 1 April 2012	13,303	54,222	0	480	143	0	23	**68,171**
Movements	0	(22,507)	0	0	0	0	0	**(22,507)**
At 31 March 2013	**13,303**	**31,715**	**0**	**480**	**143**	**0**	**23**	**45,664**

Additions to Assets Under Construction in 2012-13

	£000's
Buildings excluding Dwellings	5,512
Balance as at YTD	**5,512**

14.2 Property, plant and equipment prior-year

2011-12	Land £000s	Restated Buildings excluding dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Restated Total £000s
Cost or valuation:								
At 1 April 2011	37,082	130,260	8,747	42,332	113	11,139	3,025	232,698
Additions - purchased	0	5,350	17,909	5,935	0	642	184	30,020
Additions - donated	0	42	0	204	0	11	5	262
Reclassifications	0	14,460	(14,460)	0	0	0	0	0
Disposals other than by sale	0	0	0	(1,089)	0	(1,306)	(17)	(2,412)
Revaluation & indexation gains	489	9,706	0	143	0	0	0	10,338
Impairments	0	(1,683)	0	0	0	0	0	(1,683)
Cumulative dep netted off cost following revaluation	0	(14,525)	0	(9)	0	0	0	(14,534)
Prior year adjustment	0	(6,664)	0	0	0	0	0	(6,664)
At 31 March 2012	37,571	136,946	12,196	47,516	113	10,486	3,197	248,025
Depreciation								
At 1 April 2011	0	54,893		27,562	113	7,844	2,043	92,455
Disposals other than for sale	0	0		(1,065)	0	(1,213)	(14)	(2,292)
Impairments	0	0	0	88	0	0	0	88
Charged During the Year	0	1,755	0	2,834	0	860	226	5,675
Cumulative dep netted off cost following revaluation	0	(14,525)	0	(9)	0	0	0	(14,534)
At 31 March 2012	0	42,123	0	29,410	113	7,491	2,255	81,392
Net book value at 31 March 2012	37,571	94,823	12,196	18,106	0	2,995	942	166,633
Purchased	37,571	90,931	12,196	14,368	0	2,981	840	158,887
Donated	0	3,892	0	3,738	0	14	102	7,746
Government Granted	0	0	0	0	0	0	0	0
Total at 31 March 2012	37,571	94,823	12,196	18,106	0	2,995	942	166,633
Asset financing:								
Owned	37,571	87,158	12,196	18,106	0	2,995	942	158,968
Held on finance lease	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	7,296	0	0	0	0	0	7,296
PFI residual: interests	0	7,033	0	0	0	0	0	7,033
Total at 31 March 2012	37,571	101,487	12,196	18,106	0	2,995	942	173,297

14.3 (cont). Property, plant and equipment

In 2012/13 the Trust received donated assets from Comfort Fund Mount Vernon (£49k) and East and North Hertfordshire NHS Trust Charitable Fund (£220k).

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 2012.

Basis for Valuation
The Trust has revalued its land and building assets during 2012, as at a valuation date of 1st April 2012, in line with HM Treasury adopted standard approach to valuation based on modern equivalent assets. The trust will record the new values in the annual accounts for the year ending 31st March 2013.

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 exisitng use value and is not materially different from its open market value.

15.1 Intangible non-current assets

2012-13	Software purchased	Licences & trademarks	Development expenditure	Total
	£000's	£000's	£000's	£000's
At 1 April 2012	**961**	**733**	**6,059**	**7,753**
Additions - purchased	919	125	0	**1,044**
Additions - internally generated	0	0	572	**572**
At 31 March 2013	**1,880**	**858**	**6,631**	**9,369**
Amortisation				
At 1 April 2012	**496**	**419**	**2,993**	**3,908**
Impairments charged to operating expenses	3	1	29	**33**
Reversal of impairments charged to operating expenses	(1)	0	(22)	**(23)**
Charged during the year	148	93	822	**1,063**
At 31 March 2013	**646**	**513**	**3,822**	**4,981**
Net Book Value at 31 March 2013	**1,234**	**345**	**2,809**	**4,388**
Net book value at 31 March 2013 comprises:				
Purchased	1,226	339	2,809	**4,374**
Donated	8	6	0	**14**
Government Granted	0	0	0	**0**
Total at 31 March 2013	**1,234**	**345**	**2,809**	**4,388**

Revaluation reserve balance for intangible non-current assets

	£000's	£000's	£000's	£000's
At 31 March 2012	0	0	0	**0**
At 31 March 2013	**0**	**0**	**0**	**0**

Development expenditure relates to development work performed by the Trust's IT Department.

15.2 Intangible non-current assets prior year

2011-12	Software purchased	Licences & trademarks	Development expenditure	Total
	£000s	£000s	£000s	£000s
Cost or valuation:				
At 1 April 2011	859	562	5,367	6,788
Additions - purchased	120	171	0	291
Additions - internally generated	0	0	692	692
Disposals other than by sale	(18)	0	0	(18)
At 31 March 2012	961	733	6,059	7,753
Amortisation				
At 1 April 2011	415	375	2,259	3,049
Disposals other than by sale	(18)	0	0	(18)
Charged during the year	99	44	734	877
At 31 March 2012	496	419	2,993	3,908
Net book value at 31 March 2012	465	314	3,066	3,845
Net book value at 31 March 2012 comprises:				
Purchased	441	306	3,066	3,813
Donated	24	8	0	32
Government Granted	0	0	0	0
Total at 31 March 2012	465	314	3,066	3,845

Development expenditure relates to development work performed by the Trust's IT Department.

15.3 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

16 Analysis of impairments and reversals recognised in 2012-13

	2012-13 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Other	12,648
Total charged to Annually Managed Expenditure	12,648
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Other	34,541
Total impairments for PPE charged to reserves	34,541
Total Impairments of Property, Plant and Equipment	**47,189**
Intangible assets impairments and reversals charged to SoCI	
Other	10
Total charged to Annually Managed Expenditure	10
Total Impairments of Intangibles	**10**
Total Impairments charged to Revaluation Reserve	34,541
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	12,658
Overall Total Impairments	**47,199**
Of which:	
Impairment on revaluation to "modern equivalent asset" basis	20,995

The QE2 site held for sale and the impairment recognised is £26,194

17 Commitments

17.1 Capital commitments

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

	31 March 2013	31 March 2012
	£000s	£000s
Property, plant and equipment	**39,126**	3,596
Total	**39,126**	3,596

17.2 Other financial commitments

The trust has no non-cancellable contracts which are not leases or PFI contracts or other service concession arrangements (2011/12 nil).

18 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	7,691	0	168	0
Balances with Local Authorities	90	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	15	0
Balances with NHS Trusts and Foundation Trusts	1,779	0	5,838	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	6,518	1,485	15,850	0
At 31 March 2013	**16,078**	**1,485**	**21,871**	**0**
prior period:				
Balances with other Central Government Bodies	5,213	0	805	0
Balances with Local Authorities	68	0	0	0
Balances with NHS Trusts and Foundation Trusts	1,249	0	2,569	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	13,974	1,325	37,847	0
At 31 March 2012	**20,504**	**1,325**	**41,221**	**0**

19 Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Total £000s
Balance at 1 April 2012	1,519	3,085	134	**4,738**
Additions	137	0	123	**260**
Inventories recognised as an expense in the period	0	(134)	0	**(134)**
Balance at 31 March 2013	1,656	2,951	257	**4,864**

20.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
NHS receivables - revenue	**8,713**	6,462	**0**	0
Non-NHS receivables - revenue	**3,170**	3,732	**1,699**	1,608
Non-NHS receivables - capital	**2,700**	0	**0**	0
Non-NHS prepayments and accrued income	**6,518**	7,927	**0**	0
Provision for the impairment of receivables	**(689)**	(396)	**(214)**	(283)
VAT	**163**	0	**0**	0
Other receivables	**2,702**	2,779	**0**	0
Total	**23,277**	20,504	**1,485**	1,325
Total current and non current	**24,762**	21,829		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

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

20.2 Receivables past their due date but not impaired

	31 March 2013 £000s	31 March 2012 £000s
By up to three months	**6,666**	1,917
By three to six months	**642**	557
By more than six months	**470**	419
Total	**7,778**	2,893

20.3 Provision for impairment of receivables

	2012-13 £000s	2011-12 £000s
Balance at 1 April 2012	**(679)**	(470)
Amount written off during the year	**51**	95
Amount recovered during the year	**0**	4
(Increase)/decrease in receivables impaired	**(275)**	(308)
Balance at 31 March 2013	**(903)**	**(679)**

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non NHS debt over 180 days and all overseas patient debt over 60 days reflecting the risk in the recovery of this category of debt. Also within the figures quoted includes a provision relating to the NHS Injury cost recovery scheme to reflect the risk of write offs over a significant period, this has been increased from 10.5% to 12.6% of total receivables under this catagory this financial year.

21 Cash and Cash Equivalents

	31 March 2013	31 March 2012
	£000s	£000s
Opening balance	**9,602**	7,226
Net change in year	**497**	2,376
Closing balance	**10,099**	9,602
Made up of		
Cash with Government Banking Service	**10,005**	9,030
Commercial banks	**83**	560
Cash in hand	**11**	12
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**10,099**	9,602
Cash and cash equivalents as in statement of cash flows	**10,099**	9,602
Patients' money held by the Trust, not included above	**1**	3

22 Trade and other payables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
NHS payables - revenue	**2,285**	917	**0**	0
NHS accruals and deferred income	**3,736**	2,457	**0**	0
Non-NHS payables - revenue	**6,404**	11,693	**0**	0
Non-NHS payables - capital	**60**	8,837	**0**	0
Non-NHS accruals and deferred income	**13,520**	8,907	**0**	0
Social security costs	**2,641**	2,302	**0**	0
VAT	**0**	253	**0**	0
Tax	**2,446**	2,657	**0**	0
Payments received on account	**0**	25	**0**	0
Other	**8,191**	3,173	**0**	0
Total	**39,283**	41,221	**0**	0
Total payables (current and non-current)	**39,283**	**41,221**		
Included above:				
outstanding Pension Contributions at the year end	2,533	2,389		

23 Other liabilities

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Other	**203**	203	**5,623**	5,826
Total	**203**	203	**5,623**	5,826
Total other liabilities (current and non-current)	**5,826**	**6,029**		

The "Other" total liabilities relates to the inclusion of the Lister Hospital multi storey car park in the assets of the Trust.
The car park has been funded through a private/public partnership arrangement. The 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 25) and deferred income (Note 26).

24 Borrowings

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Loans from Department of Health	**1,561**	1,038	**34,271**	22,899
PFI liabilities:				
Main liability	**241**	169	**7,875**	8,173
Total	**1,802**	**1,207**	**42,146**	**31,072**
Total other liabilities (current and non-current)	**43,948**	**32,279**		

Loans - repayment of principal falling due in:

	31 March 2013		
	DH £000s	**Other £000s**	**Total £000s**
0-1 years	1,561	241	**1,802**
1 - 2 Years	1,561	284	**1,845**
2 - 5 Years	4,684	982	**5,666**
Over 5 Years	28,026	6,609	**34,635**
TOTAL	**35,832**	**8,116**	**43,948**

25 Other financial liabilities

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Financial liabilities carried at fair value through profit and loss	**135**	40	**3030**	1167
Total	**135**	40	**3,030**	1,167
Total other liabilities (current and non-current)	**3,165**	**1,207**		

26 Deferred income

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	**31 March 2013 £000s**	31 March 2012 £000s
Opening balance at 1 April 2012	203	0	5,826	0
Deferred income addition	2,701	203	0	5,876
Transfer of deferred income	0	0	**-203**	(50)
Current deferred Income at 31 March 2013	**2,904**	203	**5,623**	5,826
Total deferred income (current and non-current)	**8,527**	**6,029**		

27 Provisions

	Total	Comprising: Pensions Relating to Other Staff	Legal Claims
	£000s	£000s	£000s
Balance at 1 April 2012	**1,535**	1,112	423
Arising During the Year	**26**	26	0
Utilised During the Year	**(414)**	(103)	(311)
Reversed Unused	**(18)**	0	(18)
Unwinding of Discount	**26**	26	0
Balance at 31 March 2013	**1,155**	**1,061**	**94**
Expected Timing of Cash Flows:			
No Later than One Year	**194**	100	94
Later than One Year and not later than Five Years	**262**	262	0
Later than Five Years	**699**	699	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2013	75,437
As at 31 March 2012	73,229

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

The Treasury discount rate of 2.35% was used to calculate the amount of unwinding of the provision for pensions relating to staff that have retired early. In the previous year the Treasury rate had been 2.8%.

28 Contingencies

	31 March 2013	31 March 2012
	£000s	£000s
Contingent liabilities		
Other	**(70)**	(67)
Net Value of Contingent Liabilities	**(70)**	(67)

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.

29 PFI - additional information

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

The contract is paid in the form of an annual unitary charge that covers repayment of capital, cost of financing and service costs. The future commitment of the elements of the charge at 31st March 2013 are as follows:

	£000
Capital	8,116
Lifecycle replacement cost	4,251
Interest	7,706
Contingent rental	9,775
Service	2,456

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	**2012-13 £000s**	2011-12 £000s
Service element of on SOFP PFI charged to operating expenses in year	**93**	91
Total	**93**	91
Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI		
No Later than One Year	**95**	93
Later than One Year, No Later than Five Years	**406**	396
Later than Five Years	**1,955**	2,060
Total	**2,456**	2,549

Imputed "finance lease" obligations for on SOFP PFI contracts due	**2012-13 £000s**	2011-12 £000s
No Later than One Year	**842**	788
Later than One Year, No Later than Five Years	**3,457**	3,419
Later than Five Years	**11,523**	12,402
Subtotal	**15,822**	16,609
Less: Interest Element	**(7,706)**	(8,267)
Total	**8,116**	8,342

30 Financial Instruments

30.1 Financial risk management

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

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

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

Interest rate risk

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

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

30.2 Financial Assets	Loans and receivables £000s	Total £000s
Receivables - NHS	8,713	**8,713**
Receivables - non-NHS	12,060	**12,060**
Cash at bank and in hand	10,099	**10,099**
Total at 31 March 2013	**30,872**	**30,872**
Receivables - NHS	6,462	6,462
Receivables - non-NHS	14,042	14,042
Cash at bank and in hand	9,602	9,602
Total at 31 March 2012	30,106	30,106

30.3 Financial Liabilities	Other £000s	Total £000s
NHS payables	6,021	6,021
Non-NHS payables	26,355	26,355
Other borrowings	35,832	35,832
PFI & finance lease obligations	8,116	8,116
Other financial liabilities	8,991	8,991
Total at 31 March 2013	**85,315**	**85,315**
NHS payables	3,374	3,374
Non-NHS payables	29,437	29,437
Other borrowings	23,937	23,937
PFI & finance lease obligations	8,220	8,220
Other financial liabilities	1,207	1,207
Total at 31 March 2012	66,175	66,175

31 Events after the end of the reporting period

There are no non-adjusting events after that the reporting period that require disclosure

32 Related party transactions

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

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

Related party organisation	Code	Income £000's	Expenditure £000's	Debtors £000's	Creditors £000's
Strategic health authorities					
East of England Strategic Health Authority	Q35	15,898	0	132	0
Primary care trusts					
Barnet PCT	5A9	2,006	0	0	40
Bedfordshire PCT	5P2	19,313	0	1,330	0
Berkshire East PCT	5QG	1,145	0	74	0
Brent Teaching PCT	5K5	1,265	0	0	125
Buckinghamshire PCT	5QD	2,204	0	159	0
Harrow PCT	5K6	4,113	0	123	0
Hertfordshire PCT	5QV	218,747	0	2,646	0
Hillingdon PCT	5AT	7,617	0	16	0
Luton Teaching PCT	5GC	2,957	0	182	0
North East Essex PCT	5PW	2,161	0	56	0
South East Essex PCT	5P1	40,482	1	1,476	0
NHS trusts					
Hertfordshire Community NHS Trust	RY4	359	4,143	307	497
West Hertfordshire Hospitals NHS Trust	RWG	510	1,214	132	377
NHS foundation trusts					
Hertfordshire Partnership NHS Foundation Trust	RWR	2,276	53	44	0
Luton and Dunstable Hospital NHS Foundation Trust	RC9	293	1,094	128	535
The Hillingdon Hospital NHS Foundation Trust	RAS	893	6,462	624	3,610
Other NHS bodies					
NHS Blood and Transplant	NBA033	0	1,784	0	15
NHS Business Services Authority	ST1450	0	2,241	0	0
NHS Litigation Authority	ST1150	0	6,939	0	0
Other non-NHS organisations		11,374		209	
Clinicenta Ltd					

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. The Pensions Agency is the largest other central government body the Trust has had transactions with, and this entirely invloves the payment of employees and employers pension contributions. Transactions with local authorities although not material in the context of the above disclosures,

There are transactions between the East and North Hertfordshire NHS Trust and the East and North Hertfordshire NHS Trust Charitable Fund (RN 1053338). The latter organisation is a registered charity of which the Trust is the Trustee.

33 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	53,457	208
Special payments	1,307,460	21
Total losses and special payments	1,360,917	229

The special payments includes a significant payment the Trust was required to make to an ex-employee.

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	Total Value of Cases £s	Total Number of Cases
Losses	95,014	321
Special payments	16,815	38
Total losses and special payments	111,829	359

34. 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.

34.1 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**
Turnover	246,307	270,257	286,332	309,074	331,312	340,309	346,402	**350,543**
Retained surplus/(deficit) for the year	(22,379)	(1,527)	2,003	2,070	(19,220)	1,459	3,193	**(12,416)**
Adjustment for:								
Timing/non-cash impacting distortions:								
Adjustments for Impairments				0	21,758	1,906	88	**12,658**
Adjustments for impact of policy change re donated/government grants assets							287	**290**
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					(38)	(37)	0	**0**
Adsorption Accounting Adjustment								**0**
Other agreed adjustments	8,557	22,379	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**
Break-even cumulative position	**(23,100)**	**(2,248)**	**(245)**	**1,825**	**4,325**	**7,653**	**11,221**	**11,753**

* 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 %**
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**
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**

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

34.2 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%.

34.3 External financing

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

		2012-13	2011-12
	£000s	**£000s**	£000s
External financing limit		**11,961**	12,660
Cash flow financing	**11,003**		6,049
External financing requirement		**11,003**	6,049
Undershoot/(overshoot)		**958**	6,611

The Trust undershot the external financing limit

34.4 Capital resource limit

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

	2012-13	2011-12
	£000s	£000s
Gross capital expenditure	**18,410**	31,265
Less: book value of assets disposed of	**(3,094)**	(120)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**(269)**	(262)
Charge against the capital resource limit	**15,047**	30,883
Capital resource limit	**24,675**	30,884
(Over)/underspend against the capital resource limit	**9,628**	1

The Trust undershot on the capital resource limit, thereby not breaching an administrative duty.

35 Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2013	31 March 2012
	£000s	£000s
Patients monies	**1**	3

Department of Health

NHS Sustainable Development Unit

NHS Reporting on Sustainability Completion Guidance

This sheet contains the completion guidance for the Sustainability Reporting Data Template. When completed correctly this document should populate the Sustainability Reporting Output, with no need for intervention on the part of the user.

The Sustainability Reporting Data Template is designed for inclusion in the annual reports of all Trust types. The Output sheet is to be included in the annual report of the organisation. Although there is a substantial volume of sustainability information to be collated, which often exists in the Estates function of a Trust, the template is designed to be completed with substantial input or leadership from the finance team as part of the annual financial reporting process.

Each question on the Input sheet has a note below giving data source information, and any other completion instructions which we have foreseen to be useful.

Responses to the questions should be entered into the orange frames.
The yellow shaded boxes are calculation cells and do not need adjusting

Formatting note - where your declared changes have been of an order less than 1,000 and additional values are included, remove the "text" function in the Outputs sheet to clear the automatic formatting

Q1 What was your total expenditure on energy in each of the last five financial years?

To respond to this question, please draw the data from your ERIC returns.
- this question is intended to include the cost of electricity purchased, plus the cost of any fossil fuels purchased for generation of electricity or heat, net of the income generated from any energy sold. It is not intended to cover fuel purchased for the purposes of transportation.

Q2 What is the NPV of the savings expected as as a result of your plans to change your organisation to make it more sustainable. What length of time does this assessment cover?

In the first frame please enter the sum of the NPVs of any projects which have been approved for implementation which are intended to make your organisation more sustainable. Examples of such projects include changes to heating or lighting systems, new patient travel arrangements etc.

In the second frame please enter the longest relevant time period. For example, if you have 2 relevant projects, one of which with a lifespan of 3 years, and one of 5 years, please enter 5 into the frame. If you have no such plans, please enter 5 into this frame.

When completing this form, this cell is an opportunity to demonstrate the extent to which your Trust is adapting to the challenge that sustainability issues pose.
We anticipate that this data will be most readily available for Estates projects, where benefits are typically driven by reductions in the consumption of direct energy.
In the event that this is the only area where you have accessible NPV data, then there is no expectation for you to generate additional information.
There is an opportunity, however, for you to highlight the medium and long term financial benefits of sustainability actions. For example, if you are instituting a bus service to bring patients and staff to your site, which might have high initial outlays, NPV is a good way of indicating what savings you expect to be generated.
Likewise, in certain clinical contexts outpatient follow ups by telephone might be an option which has positive financial and sustainability impacts, and could be included here.

Department of Health

NHS Sustainable Development Unit

Q3 What weight of the waste you generate is recycled, and what does this represent as a proportion of total waste?

To respond to this question, please draw the data from your ERIC returns.

Q4 What was your total consumption of energy in each of the last five years (MWh), what was your floor area (in order to calculate energy intensity), what proportion of your energy comes form renewable sources and how much of your energy is generated on site?

To respond to this question, please draw the data from your ERIC returns - 3.6GJ = 1MWh
Energy consumption here includes all energy, as with Q1. Therefore please include all electricity used, as well as fossil fuel and other energy sources.
Use occupied floor area

This question seeks to produce an output which demonstrates side by side the amount of non electrical energy used, and electrical energy used, on a year by year basis by the reporting organisation, whilst simultaneously showing the mix of fuel sources which have provided that energy

If you have CHP or generate your own power, please include the fuel you purchase for generation purposes in the appropriate box (so if your CHP is fuelled by natural gas, include the gas in the gas box for this question)

Q5 Is the tariff which you pay for electricity a "green" or "renewable" tariff?

This question seeks to understand if the organisation is paying their electricity supplier additional amounts in order to secure greener electricity
The NHS has a leadership role in purchasing energy, but of course this must be balanced by the necessary financial considerations.

Q6 What was your Operating Expenditure (per the financial statements) in the last 2 financial years?

Please draw this figure from the I&E page of your annual financial statements

Q7 What were your gross scope 1-3 carbon emissions over the last 5 years, and how were they constituted?

At the request of Trusts, and to develop consistency in reporting, there has been a change made to the spreadsheet. Rather than asking you to calculate your emissions, the sheet now does this automatically, base on consumption. The relevant unit to enter is included in the INPUT sheet. These are:

For electricity - kWh
For natural gas - kWh
For air travel - miles
For road travel - miles
For rail travel - miles

If you do not monitor your emissions for travel & other, please adjust the graph data source in graph outputs in order that only those emissions monitored are covered.
Using your business management data might allow you to complete this on a partial basis.
In the long term, including visitor mileage, generated from patient surveys, would allow a full picture of the impact of NHS related travel emissions to be drawn.

Department of Health

NHS Sustainable Development Unit

For air travel it is assumed that all flights are domestic. If data on long haul to short haul ratio has been collated, please use DEFRA conversion factors found at http://www.defra.gov.uk/publications/2012/05/30/pb13773-2012-ghg-conversion/ to make appropriate adjustments

For road travel the conversion rate for medium car, unknown fuel has been used. Organisations with more detailed business information may chose to adjust this calculation using the conversion factors

Rail journeys are assumed to be national rail (not international or london underground).

A nil return in this field will generate an appropriate comment in the reporting output box.

There is a frame for you to enter which activities you have measured/assessed as part of your "Other" component of your footprint.
Please consider completing this. Around 80% of the total carbon footprint associated with the NHS is generated from this area, and so including it in your assessment would be a powerful statement that you are both considering the way in which to change this, and would announce to peripheral entities that they need to start addressing their carbon generation.

Please consider the impact changing the amount of emissions you monitor as "Other" might have on the disclosure of your carbon footprint
The broader your definition and understanding of your emissions, the better placed you will be to effect a positive change on the environmental sustainability of your organisation. However, by including an area of activity in this category without retrospectively adjusting your previous disclosure values could lead to the impression that your performance is regressing, when this may not be the case.

Q8 What was your water consumption in m3 in the last 3 financial years?

To respond to this question, please draw the data from your ERIC returns.

Q9 What was your total expenditure on water in the last financial year?

Q10 What was your gross expenditure on the CRC Energy Efficiency Scheme in 2012/13?

Q11 What was your expenditure on official business travel in 2012/13?

Q12 What was your expenditure on waste disposal in the following categories:

Total Waste arising
Waste sent to landfill
Waste recycled/reused
Waste incinerated/energy from waste

We understand that this information may have to be completed on an extrapolated or accrued basis - it is important to ensure that this is consistent with your financial statements
The disclosure should include waste disposal contracts, specialist waste arising and the purchase of licenses for waste

Q13 If you have consumed finite resources, and in in doing so incurred material expenditure, then please complete the following boxes

In the event that you have consumed two or more different types of resource/material, enter them into the second box in the following format (without quotation marks) "resource A, resource B & resource C"
A non renewable resource is a natural resource which cannot be replaced, grown, generated or used on a scale which can sustain its consumption rate. Metal ores are a prime example of this.
For the purposes of this spreadsheet fossil fuels are excluded from this analysis, as they are addressed elsewhere.

We'd recommend considering the scale and cost of your use of radioactive materials and anaesthetic gases, as these are likely to be the critical contributors to any positive response to this question.

DH Department of Health

NHS Sustainable Development Unit

Q14 Has your Board approved a Sustainable Development Management Plan in the last 12 months?

If you have a SDMP which covers multiple years, an agreement in the previous 12 months that it still applies is sufficient to be able to answer yes here.
Please do not answer yes to this question if you have not followed NHS SDU's guidance when formulating your SDMP.

Q15 Has your board approved plans which address the potential need to adapt the organisation's activities (models of care) as a result of climate change?

Q16 Has your board approved plans which address the potential need to adapt the organisation's buildings or estates as a result of climate change?

An overarching plan, or projects which specifically alter the buildings or estate are both acceptable here, although the question specifically aims to highlight where you have ADAPTATION plans.

Q17 Does your board consider sustainability issues as part of its risk management process?
Q18 Does your board consider the social and environmental impacts of your organisation's procurement decisions?
Q19 Is there a Board Level lead for Sustainability on your Board?
If Yes - What is their name?
Q20 Are sustainability issues, such as carbon reduction, included in the job descriptions of all staff?
Q21 When was your last staff energy awareness campaign?

Enter the date in the format DD MM YYYY from the drop down boxes, unless one of the two sub questions on the input sheet apply

If it is an ongoing process please enter yes into the orange box on this line
If you have not conducted an energy awareness campaign, please enter No into the box on this line
Q22 Do you have a Sustainable Transport Plan?

Please only enter yes if it meets the ERIC definition.

Q23 If you have used estimation, please indicate what quarters this estimation applies to:

We understand that ERIC data has been collected later than financial data in the past in order that accuracy could be improved. Unfortunately, with financial statements sometimes complete accuracy is sometimes sacrificed for timeliness. Therefore, there may need to be an element of estimation in this report. This might be the result of forecasting, on site meter reading (as opposed to official/supplier feedback) or past experience. In order that the Department of Health can maintain an idea of how much estimation underpins the figures for the whole NHS, it would be helpful if you answered yes or no to this question for each quarter.