East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2017/18 annual report and accounts

24 May 2018

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Performance report

Introduction

Welcome to the Trust's annual report and accounts for 2017/18, which was a challenging year for us and the wider NHS. This report comprises three sections:

- Performance report, which covers the Trust's performance against a range of standards set both nationally and locally
- Accountability report, which looks at our corporate governance arrangements, as well as remuneration and staff-related data
- The final section has the financial statements and related notes for the financial year

Before setting out these formal reports, however, I would like to thank all our staff for their dedication and hard work over the last 12 months as we embarked upon a recovery programme that would see us managing our finances better, whilst at the same time improving the quality and timeliness of the care provided to patients.

Throughout this annual report, there will be many examples of the work undertaken by our staff in improving our performance across a wide range of clinical, operational and financial indicators. This information, however, only tells part of the Trust's story. The rest is about people and care experienced by our patients.

Day in and day out, we see examples of how our staff go out of their way to help each other and, of course, patients. And no more so than in the face of major challenges, such as the cyber-attack that affected us in May 2017. Then there was the rollout of our new electronic patient record system in September 2017 and finally, the winter pressures that took hold of the whole NHS during the first few weeks of 2018.

Every time the Trust faced such a major challenge, our staff rose to the occasion and made sure that our patients received the care they needed. And whilst our clinical teams were at the heart of that work, often it was the contribution of our support teams – from IT to switchboard, cleaners to porters and admin staff to catering who helped to make a real difference. Once again, I wish to thank everyone working for the Trust for everything that they do – it is very much appreciated.

2017/18 was a hard year for the Trust and while great progress was made on many fronts, as ever there is more to be done. We have a clear sense of direction, however, as we look to work with our health and social care partners across the Hertfordshire and West Essex Sustainability and Transformation Partnership to ensure that local people receive the right care, in the right place and at the right time.

Ellen Schroder
Chair

Performance overview

The purpose of this section of the Trust's performance is to set out in summary terms the Trust's clinical, operational and financial performance for 2017/18, covering:

- Chief executive's statement
- An overview of the Trust, its strategic objectives, organisational structure, services provided and population served
- The Hertfordshire and West Essex Sustainability and Transformation Partnership (STP)
- Strategy overview
- Statement on adopting *Going Concern* basis
- Summary of the Trust's performance (covering clinical, operational, financial and workforce)

The second section of the performance report provides more detailed analysis, along with summaries of how we engage with our local communities, social legal requirements and our sustainability duties.

Chief executive's statement

In 2017/18, the NHS faced one of its most challenging years as many organisations across the health service sought to maintain quality services at the same time as making the efficiency savings needed to bring their finances back in to balance.

This was the position that the Trust faced at the start of the year, as it sought to deliver a £23 million cost improvement programme whilst meeting national operational and clinical performance standards. As you will see from other sections of this annual report, we made real progress in some areas but have more work to do in others.

Clinically, the quality of care provided to patients continues to improve. Our mortality rates, as measured by the Summary Hospital-level Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are now within the *as expected* range or better. Levels of hospital-acquired infections remain low, with good performance achieved in reducing avoidable hospital-associated pressure ulcers and inpatient falls over recent years maintained over the last 12 months. We are proud that 96.2% of our patients received harm free care in 2017/18 (2% more than our peers). Results from the Friends and Family Test also showed how highly patients rate the care they have received in the Trust's hospitals.

From an operational perspective, the Trust performed well for some standards, but faced bigger challenges in other areas. Like most of the NHS, our A&E waiting times did not meet the national standard (95%) during 2017/18. A recovery plan agreed with NHS Improvement saw our performance begin to improve in the second half of the year, although progress slowed as winter pressures mounted from January 2018. Despite this, however, our A&E performance was consistently better than in the corresponding period 12 months earlier. The winter months were a very difficult time for our staff, especially those who cared for emergency patients, but they coped very well in the circumstances and we have continued to make progress since.

A second area where our performance needed improving was around cancer waiting times – especially the 62-day wait referral to treatment standard. An in-year recovery plan was agreed with NHS Improvement, and we are on track to recover the 85% performance standard during 2018/19.

Our new electronic patient record system – called Lorenzo – was rolled out in September 2017, although there have been on-going, significant data reporting challenges as our staff have continued to learn how to use the new systems to optimal effect. Although able to report centrally on most performance indicators, more time will be needed before the Trust can report formally on its 18-week referral to treatment standard. The Trust has agreed a plan to improve the system's performance, with the support of our regulators and NHS Digital.

Financially, the Trust has had a mixed year. At the start of 2017/18, we accepted a control total deficit position of £8.65 million. Given that the previous year we reported an outturn deficit of £29.5 million, clearly a great deal of work was needed to bridge that gap.

The Trust launched its *Transforming our Hospitals* programme, which comprised several different strands – including making our services more effective and efficient, alongside more traditional cost controls. The combined cost improvement programme (CIP) for the year was set at £23.3 million and in delivering this work, our core proposition was that quality of care was always prioritised. Every proposed scheme was reviewed by the Trust's directors of medicine and nursing to give assurance that the quality of patient care was not compromised.

It is a tribute to our staff that £19.5 million pounds of efficiency savings were delivered over the last 12 months, some of which only had a part-year effect and so will deliver their full benefit this year too. Around £2 million of these savings were delivered directly through our ideas generation programme, allowing individual staff members to submit suggestions that were then investigated and put through our approvals process. In total some 400 ideas were submitted – and more continue to come in every week, which sets us in good stead for the coming year.

Where the Trust performed less well from a financial perspective in 2017/18 was in respect to our income. The combined effect of May's cyber-attack, the rollout of the new electronic patient record system in September and the busy winter pressure period, when NHS hospitals were instructed to reduce elective surgery, meant that less activity took place than planned – which totalled £16.2 million less than planned. As a result, the Trust has posted a year-end deficit of £25 million. This compares to a deficit of £29.5 million in the previous year.

The challenge for 2018/19, therefore, is to continue to improve our financial management so that our expenditure position matches income levels much more closely.

Finally, I want to touch on our second major inspection from the Care Quality Commission (CQC), which took place over March and April 2018. When the CQC's inspectors visited the Trust in October 2015, our overall rating was *requires improvement*. We expect our report and new ratings to be published by the CQC this summer.

The performance report that follows has been prepared in adherence to the required reporting framework

Nick Carver
Chief Executive, 24th May 2018

About the Trust

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

Since October 2014, the Lister has been the Trust's main hospital for specialist inpatient and emergency care. The New QEII hospital, which was commissioned by the East and North Hertfordshire Clinical Commissioning Group, opened fully from June 2015 and provides outpatient, diagnostic and antenatal services, along with a 24/7 urgent care centre. Hertford County also provides outpatient and diagnostic services. The cancer centre provides tertiary radiotherapy and local chemotherapy services.

The Trust owns the freehold for each of the Lister and Hertford County; the New QEII is operated on behalf of the NHS by Community Health Partnerships and the Mount Vernon 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 that are 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 parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City. Over the past decade, rates of death from all causes, early deaths from cancer and early deaths from heart disease have all improved and are generally similar to, or better than, the England average.

The birth rate is slightly above the England average, with the Trust's core catchment population forecast to rise by just under 10% over the 10 years to 2026; the most significant growth is 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 (i.e. non-white British) make up approximately 10% 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 urgent care services – including and emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,500 staff are employed by the Trust and its annual turnover is approximately £420 million.

Organisational structure

Currently the Trust has five clinical divisions for medicine, surgery, women and children's services, cancer and clinical support services. Each clinical division has a chair, who is a senior clinician, director who is an operational manager and a head of nursing (or midwifery in case of women's services).

Alongside the five clinical divisions are corporate teams covering: company secretariat; finance and IT; medical practice, education and research; nursing practice and education; operations; strategy (includes estates and facilities); and workforce and organisational development.

The Trust's executive directors meet weekly as the executive committee, which every second week meets as the divisional executive committee when clinical divisional chairs and directors are also in attendance. Both of these committees are chaired by the Trust's chief executive, with the executive committee being a formal board committee.

A full account of the Trust's organisational structure and its associated governance arrangements is set out in the accountability report.

Hertfordshire and West Essex STP

We are an active partner in the Hertfordshire and West Essex Sustainability and Transformation Plan (STP). The vision of our STP is to support the residents of Hertfordshire and West Essex to live as healthily and independently as possible, supported by caring, effective and affordable health and care services.

We have been working on a number of projects to support area-wide improvements including:

- Improving cancer treatment pathways – especially how we ensure earlier diagnosis
- Improving patient flow and the sustainability of urgent and emergency care
- How we join up our IT systems to support service transformation.

As well as our transformation programmes, the STP is in the process of designing a population-based system in which the system(s) will take on collective responsibility for resources and population health, providing integrated, better co-ordinated care.

Further information can be found on the STP's website.

Strategy overview (including objectives)

The Trust's current vision is to strive *to be amongst the best* for:

- Patient safety
- Clinical outcomes
- Patient experience
- Financial sustainability

We are doing this by:

- Keeping our promises on quality and value
- Delivering new services and ways of caring
- Securing a positive future for the Mount Vernon Cancer Centre

Working to our **PIVOT** values – **putting** patients first; striving for excellence and continuous **improvement**; **valuing** everybody; being **open** and honest; and working as a **team**.

The tables below summarise the Trust's performance during 2017/18 against its strategic aims and objectives.

Our strategic aims	Our strategic objectives	Primary measure of success	Achievements to date 17/18

Delivering our promises on value and quality	...by improving patient experience	• *achieve milestones in Patient & Carer Experience Strategy*
		• *achieve milestones in Engagement Strategy*
			Key successes:
			• The Trust continues to maintain a consistently high inpatients' Friends and Family inpatient score throughout 2017/18, with above national-average participation
			  • December 2017 97.87 %
			  • January 2018 97.20%
			  • February 2018 96.88%
			  • March 2018 96.66%
			• We extended visiting hours to support patients and their families and improve the patient experience
			• Purple Stars for supporting people with learning disabilities have been earned by the Trust's diabetic eye screening team at Hertford County and ambulatory care team at the New QEII
			• Our annual general meeting (AGM) in July 2017 attracted over 300 delegates returning a 90% satisfaction rating
			• In collaboration with Health Education East of England we delivered the Trust's second annual work experience week at the Lister hospital for 74 local school pupils
			• The Lister's multiple pregnancy team has been rated as 'exceptional' by the Twins and Multiple Births Association (TAMBA). In recognition of a decrease in the number of women delivering their second twin through caesarean section after giving birth to the first naturally. The rate has fallen from 17% to 3%

	...by improving patient outcomes	• *achieve milestones in the Improving Outcomes Patient Strategy* • *achieve milestones in the Research Strategy*	**Key successes:** • Hospital-acquired pressure ulcers are at an all-time low. In 2017 there were just 35 cases (excluding suspected deep tissue injuries) reported across the whole 12 months • It has been over six years since the Trust recorded the most severe form of pressure ulcer (grade four) • Use of e-observations (Nervecentre) commenced on wards • We are exceeding our target for the number of research participants to studies which are adopted to the national Institute for Health Research Portfolio. For April 2017 to December 2018, we recruited 1,803, 9% ahead of our year to date expectation of 1,655. • The Trust is now in the top 50 research active hospitals in the country (annual National Institute for Health Research activity league table) • SHMI is stable at 103; crude mortality continues to benchmark well when Michael Sobell House (hospice) is excluded from the figures. **On-going challenges:** • Whilst rolled out, there is further work needed to embed e-observations
	...by securing financial recovery – transforming our services	• *deliver 17/18 and 18/19 agreed control totals* • *deliver underpinning CIP* • *implement the Trust Lorenzo PAS system during 2016/17* • *improve financial and operational decision making* • *deliver Phase 2 Our Changing Hospitals Transformation Programme*	**Key successes:** • Delivered 85% of CIP target through Transforming our Hospitals programme • Lorenzo implemented September 2017 • Financial and operational decision-making strengthened by Qlikview • New systems and processes being embedded around business planning **On-going challenges:** • Agreed control total unlikely to be met • Phase two of Our Changing Hospitals delayed due to financial position
	...by developing our organisational culture and ensuring our staff are supported and engaged	• *achieve milestones within the People Strategy* • *achieve milestones within the Culture Change Programme* • *achieve milestones in Leadership and Management Strategy* • *achieve milestones in Health & Wellbeing Strategy*	**Key successes:** • LEND embedded as Trust leadership model via quarterly sessions with staff • Leadership, Management and Coaching Development Pathway in place to update staff skills • Health and Wellbeing programme supporting our staff to be well **On-going challenges:** • Initial feedback from Staff Survey suggests deterioration. Ability to have early review has enabled action plans to be developed
	...by transforming our services to deliver consistent improvements in access to care and quality of the care that our patients receive	• *achieve and sustain delivery of all constitutional standards* • *achieve consistent Good CQC ratings across all services and sites*	**Key successes:** • Commencing work on redesign of non-elective pathway • Changes made at Lister's emergency department mean that, on average, 80% of ambulances are now turned around within the overall national 30-minute standard, compared to around 10% previously **On-going challenges:** • Lorenzo has impacted our reporting ability and measurement of access standards • Continue to struggle to meet four-hour target – not met in over 12 months, with final figure for 2017/18 standing at 83.6% • Working on GP streaming at front door • Still not achieving cancer 62 day target, however started making improvements in final quarter for 2017/18 – latest year-to-date position was 73.7%

Our strategic aims	Our strategic objectives	Primary Measure of Success	Achievements to date 17/18
New ways of caring	...by developing and redesigning our workforce to respond to recruitment challenges and support new models of care	• achieve milestones within People Strategy • finalise and implement Multi-professional Education strategy • achieve University Trust status	**Key successes:** • Electronic rostering rolled out to all staff • Nursing Associate role implemented • University status awaiting sign off from Department of Health **On-going challenges:** • Achievement of staffing levels on wards
	...by transforming our services to support and deliver STP plans	• *work with partners to redesign patient-centred pathways that facilitate keeping patients out of hospital including full participation in the STP work streams harness benefits from developing back office & support services at scale across ENHT and PAH* • *reduce unwarranted variation*	**Key successes:** • The Trust has established an outreach frailty service, supporting local care homes, and daily frailty clinics to help keep patients out of hospital • A new telemedicine service in diabetes and endocrinology allows hospital consultants to engage directly with their GP colleagues, to identify those patients who would benefit most from an early review of their care • Unwarranted variation has been reduced through review of chest pain, community acquired pneumonia and frailty pathways with STP colleagues • Options are being explored to work more closely with Princess Alexandra Hospital on medicines management and pharmacy **On-going challenges:** • Pace of STP delivery
	...by developing and delivering sustainable specialist services across the STP	• *deliver the renal sustainability strategy* • *further develop seven day services and strengthen clinically fragile services by working collaboratively with partners* • *review capacity and demand and transform service models to deliver more efficient and cost effective pathways*	**Key successes:** • Renal project team established and at options appraisal phase • Vascular hub project and clinical teams established and reviewing data for clinical and financial appraisals **On-going challenges:** • Financial constraints continue to impact on ability to deliver at pace
Develop the Mount Vernon Cancer Centre	...by securing a positive future for the Mount Vernon Cancer Centre (MVCC)	• *commence delivery of the clinical service strategy for MVCC* • *secure the Trust's interest in the site to facilitate future development* • *deliver rolling Linac replacement programme aligned with clinical strategy* • *achieve milestones in Research Strategy*	**Key successes:** • Linac replacement on track; proposals for satellite radiotherapy unit being re-costed • Investigated and evaluated finding a suitable clinical and academic partner for Mount Vernon to support long term ambition • Recently signed Memorandum of Understanding with UCLH **On-going challenges:** • Estate at Mount Vernon Cancer Centre is in poor condition • Discussions with The Hillingdon Trust are on-going to secure a long term solution

Looking forward

2018/19 is the final year of the Trust's current strategy, and in the last quarter of 2017/18 we commenced the development of a new five-year strategy for the Trust, the aim of which will be ensure that the Trust is fit for the future and able to provide high quality services for the populations we serve. Through this process, we are seeking the views of our staff, patients and their families and key partners, including the Hertfordshire and West Essex STP. We hope to conclude this work in the latter half of 2018/19, ready for the strategy's launch in April 2019.

In addition, we will also develop a series of service-based clinical strategies that will support the delivery of the Trust's new overall strategy.

Statement on adopting *Going Concern* basis

The Trust has prepared its financial plans and cash flow forecasts on the assumption that support funding will continue to be received through the Department of Health and Social Care. These funds are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the Trust. The Trust incurred a deficit and is forecast to incur a deficit in the forthcoming financial year; furthermore the Trust is reliant on the aforementioned funding for the foreseeable future.

Whilst the directors are certain that the provision of services will continue, there are material uncertainties within the Trust's financial performance that may cast significant doubt over the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business, and around the form of the Trust that delivers those services. This provision will also be dependent on both acceptance and delivery of the financial recovery plans and continuation of support from the Department of Health and Social Care. Notwithstanding the material uncertainty, the directors have not had any communication indicating that necessary support funding will not be made available for the foreseeable future and have therefore prepared these financial statements on a going concern basis. A full statement of the risks and concerns are included in this annual report.

There are thus material uncertainties that may cast significant doubt as to the Trust's ability to continue as a going concern and, therefore, may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would be required if the going concern basis were not appropriate.

The following factors could potentially impact the Trust's performance and position:

- Commissioners' ability to pay for increasing demand for services
- Essential capital expenditure exceeds the funding secured for delivery
- Unplanned capital investment required to maintain the Trust's estate and infrastructure
- Lorenzo stabilisation is not completed to timetable

Key performance summary

During 2017/18, the Trust rolled out two important programmes:

- Transforming our Hospitals
- Digital transformation

The *Transforming our Hospitals* programme comprised two elements:

- Financial turnaround – our financial turnaround (sometimes known as *Grip and Control*) work involves challenging what we spend, as well as our processes and procedures. Together with a central team in the programme management office (PMO), project managers worked with each division to identify and develop cost improvement plans (CIPs) and ways to make efficiency savings.

- Model Hospital - this work brings clinical and operational teams together to improve how we use data and make things more efficient. The work included a detailed diagnostic assessment for each work stream to find opportunities to make changes that will increase efficiency and patient experience, whilst reducing costs safely. Between them, eight work streams covered: patient flow and emergency patient; outpatients; cardiac catheterisation laboratories; endoscopy; theatres ; job planning; clinical administration and workforce planning; and demand and capacity planning.

The Trust's *digital transformation* programme covered the rollout of Lorenzo, our new patient administration system and Nervecentre, which enables us to take electronic observations in clinical areas, from September 2018. All staff who use or view patient records were trained in using these new systems, which will support us in becoming more efficient and deliver better patient care.

Work has been on-going since September's launch to help make sure that our staff make the best of Lorenzo and Nervecentre, which required a stabilisation project to be agreed and rolled out towards the end of 2017/18 - work that has continued in to 2018/19.

Set out below are summaries of the Trust's performance during 2017/18, with more detailed accounts provided in the performance analysis section of this annual report.

Clinical/quality performance summary

In 2017/18, the headline performance figures were:

- MRSA bacteraemias (blood infections) – one Trust-allocated case against a target of none
- *Clostridium difficile* infections – 28 reported cases, of which 12 were accepted for exemption by the CCG appeals panel as there were no identifiable gaps in clinical practice. This means that the Trust was five over the target of 11 cases for the year
- Crude mortality rates – 1.54% for the 12 months to February 2018, compared to 1.62% for the last three years
- HSMR – 99.41 for the 12 months to December 2017, which statistically is in the *as expected* range
- SHMI – 102.91 for the 12 months to September 2017, which places the Trust within the *as expected band two* range
- Friends and Family Test – the Trust performs consistently highly when it comes to patients be willing to recommend the Trust as somewhere they would be happy for their friends and family to be treated. The latest set of information can be found on the Trust's website.

Operational performance summary

The key headline figures for 2017/18 were:

- A&E (95% of patients seen, treated and either admitted or discharged within four hours of arrival) – 83.6%
- Cancer two week referrals – the Trust continued to deliver two-week waits for GP referrals to first outpatient appointment and also for those with breast symptoms (97.7% and 94.0% against national standards of 93.0% for both)
- Cancer 62-day referral to treatment – 73.7% against the national 85% standard. A recovery programme saw the Trust deliver 84.4% in February 2018, which was ahead of trajectory and just 0.6% below the national standard
- Cancer 31-day decision to treat to first definitive treatment – 93.0% against a national standard of 96.0%

- 18-weeks referral to treatment (RTT) and radiology diagnostic standards – following the roll-out of the Trust's new electronic patient record system, Lorenzo, in September 2017, the Trust is not reporting RTT data currently

Financial performance

The Trust agreed its financial plan for 2017/18 with NHS Improvement based on a control total of an £7.744 million deficit. In order to deliver this control total, the Trust required support from the national Sustainability and Transformation Fund of £10.2 million. This support was conditional on achieving financial and operational targets, which were only met partially.

The Trust reported a deficit, after technical adjustments of £25.76 million. Whilst the Trust's reported financial performance for 2017/18 has improved compared with 2016/17, it was at variance material from plan expectations.

The key features of financial performance during 2017/18 and explanations for the gap between planned and actual performance were:

- The Trust earned significantly less income from patient activities than it had planned for the year. There were a number of causes for this under performance. The implementation of a new Patient Administration System (PAS) served to exacerbate existing weaknesses in capacity planning and hindered the Trust in its ability to effectively book and schedule patients, thereby significantly restricting it ability to generate revenues.

- Patient activity levels and associated income were also materially impacted upon by both the WannaCry cyberattack during May 2017 and the NHS directive to reduce planned elective services during an extremely challenging winter period for the service both locally and nationally.

- The impact of local health economy schemes to reduce and redirect demand for emergency services proved more significant than the Trust had envisaged and this resulted in significant unplanned reductions in both activity and revenue.

- The Trust changed its approach and framework for identifying and delivery cost efficiency and savings during 2017/18. This resulted in total savings of £19.5 million across the year. This represents a very significant improvement on all historic performance. Unfortunately, this did fall short of the ambitious target (£23.3 million) that the Trust had set for the year.

- The Trust has made considerable progress during 2017/18 in reducing its agency staffing costs. They have reduced by £13.0 million compared with 2016/17, which has helped the Trust to limit the rate of pay bill inflation.

- As a consequence of the significant financial pressures summarised above and the resulting variance from planned control total, the Trust was unable to access the full value of Sustainability and Transformation Funding that it had anticipated within its financial plan.

Workforce performance

Key headline figures for 2017/18 were:

- The Trust ended the year with an expenditure of £12.424 million on agency staff, which was £4.256 million under the agency ceiling target set for the Trust – a positive variance of 26%

- The vacancy rate at the end of March 2018 was 8.4% (469.7 whole time equivalents or WTEs), which represents an improvement from the position in April 2017 (11.9%)
- A detailed sickness absence action plan has been developed that, along with a revised policy that provides a more consistent and robust framework for managing sickness absence was launched in March 2018. This initiative is being supported with training sessions aimed at line managers
- A staff survey action group has been formed to respond to the findings of the 2017 national staff survey and the Trust's subsequent online staff survey workshops. The themes identified by staff are being progressed, each with its own executive director sponsor.

Performance analysis

In this part of the performance report for 2017/18, several areas are covered in more detail:

- Key performance indicators, including how performance against them is monitored and their link to risk and uncertainties
- In-depth review of the Trust's clinical/quality, operational, financial and workforce performance
- An overview of social matters, covering membership, patient experience, partnership working and charitable activities
- Statements relating to social matters (human rights, anti-corruption and anti-bribery matters
- Sustainability summary statement

Key performance indicators

Our ambitions are set high to ensure continuous improvement in the quality and safety of care for patients and ensure longer term financial sustainability. Key strategies are developed that support the delivery of the Trust's annual objectives and strategic aims, including:

- Improving patient outcomes strategy
- Patient and carer experience strategy
- People strategy
- Engagement strategy

The Trust's Board recognised 2017/18 as being a challenging year, with changes in demand leading to both capacity and financial challenges. Other key risks included staff recruitment, delivery of performance targets and financial pressures, as well as the delivery of service pathway changes across organisations.

During quarters three and four in 2017/18, we reviewed and approved a new Risk Management Strategy and associated Board Assurance Framework that identifies 12 principle risks to achieving our strategic objectives, how we are managing these and the key actions we are taking. In addition we have reviewed our Accountability Framework – Divisions to Board and the information that supports this model to monitor and support the delivery of key organisational objectives and targets and support continuous improvement. This is being implemented currently. Further detail on this is provided in the Governance Statement on page 56.

The diagram on the next pages shows the accountability structure and information flows supporting these new arrangements.

Accountability framework structure

Information flow

Board of Directors discussion on Board Assurance Framework (BAF), Integrated Performance Report (IPR), Quality. Non-executive director challenge.

Executive discussion on divisional risk (to inform BAF), performance (to inform IPR) and quality.

Output of this meeting to be taken to the Board of Directors as the BAF and the IPR

Supported by:
- Data set of indicators;
- Terms of reference;
- Set agenda,
- Minutes, action log etc.

Output of this meeting to be taken to Exec Committee and help inform the integrated report and the BAF

Supported by:
- Terms of reference;
- Framework agenda;
- Minutes, action log etc.

Minutes and escalations to be taken to the Divisional Accountability Review Meetings

Delivery against our Trust objectives

Summary information about the delivery against the Trust's 2017/18 objectives can be found on pages 9 to 10.

Care Quality Commission – Essential Standards of Quality and Safety

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is *Requires Improvement*.

The Lister's registration includes the renal satellite units in St Albans and the Luton and Dunstable hospitals; the units at Harlow and Bedford were inspected but not rated in 2015.

The Care Quality Commission has not taken enforcement action against the Trust during 2017/18. The Trust has also not participated in any special reviews or investigations by the CQC during the same period.

As part of CQC's ongoing monitoring and inspection programme, it confirmed a number of the Trust's core services would be re-inspected – this was unannounced and started in March 2018. The core services being inspected are:

- Urgent and emergency care services (Lister and New QEII)
- Surgery (Lister)
- Children and young people (Lister)
- Maternity (Lister)
- Medical care (Lister and MVCC)
- Chemotherapy (MVCC)
- End-of-life care (MVCC)

The inspection sought to check whether the services we provide are safe, caring, effective, responsive to people's needs and well-led. The Trust also received a well-led and use of resources reviews as part of the CQC's new inspection regime; these were both completed in April 2018. The outcome of the overall inspection process are expected to be published in summer 2018.

In-depth performance review

Over the next few pages, the annual report sets out in more detail the Trust's performance in 2017/18 in relation to its clinical, operational, financial and workforce performance. There is also a separate and more detailed workforce report in the accountability section of this document.

Clinical/quality performance

The Trust's clinical performance relates to standards set both nationally and locally, which are reviewed through a combination of:

- Regular performance management meetings between members of the executive team and each clinical division;
- Exception reporting via the Trust's executive committee, which meets weekly;
- Monthly via the Trust Board's risk and quality committee, as well as through the committee's monthly report to the Trust Board.

Externally, the Trust is held to account for its operational performance by NHS Improvement.

Mortality rates

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

Crude mortality is a straightforward analysis of the percentage of patients who died against the number of admissions to hospital. The latest available data for the Trust is set out below:

- Average rate over the last three years (to February 2018) – 1.62%
- Average for the last rolling 12 months (to February 2018) – 1.54%

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

The two main mortality measures used are:

- Hospital standardised mortality ratio (HSMR) – data produced via the Dr Foster organisation, which looks at patients who die in hospital;

- Summary hospital-level mortality indicator (SHMI) – data produced by the NHS Digital (provides an overall rating that includes deaths following patient discharges (up to 30 days) that may be due to other causes. Unlike HSMR it does not make adjustment for palliative care, but includes patients who die in the community within 30 days of their discharge.

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

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

- *HSMR* – the most recently published data, for the rolling annual 12-month period to December 2017, is 99.4. Statistically speaking, this falls within the *as expected* range

- *SHMI* – the most recently published score, for the 12 months to September 2017, is 102.91 and is in the *as expected band 2* range. This is a significant improvement on the Trust's position over the positions recorded two years ago (111.25) and last year (105.61).

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

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

Infection prevention and control

During the 12 months to the end of March 2018, the Trust recorded one Trust-associated blood infections (bacteraemia) caused by Methicillin-resistant *Staphylococcus aureus* (MRSA) bacterial strains. Over the same period, there were 28 cases of Trust-associated infections due to *Clostridium difficile* reported. Of the latter, 12 cases were accepted by the appeals panel for exemption from financial sanctions as there were no identified gaps in clinical practice. The targets for these two significant causes of Trust-associated infections were zero and 11 cases respectively.

In March 2018, two patients on one inpatient ward at the Lister were identified as having acquired an infection from the same strain of C. difficile, indicating that the organism may have been spread between patients whist in hospital. A serious incident was declared and continues to be investigated.

In line with national requirements, infection rates associated with several types of orthopaedic surgery are monitored, with these figures included in the Board papers placed on the Trust's website for each public board meeting held throughout the year. The data is used to identify improvements in surgical orthopaedic pathways to reduce infection rates even further.

There were several outbreaks of suspected or confirmed Norovirus on the Trust's inpatient wards during the year, especially in the first few weeks of 2018. When an outbreak is suspected, the Trust's teams work together closely to contain such outbreaks and prevent spread of the infection.

Reducing pressure ulcers

The Trust is committed to minimising harm caused to patients whilst in hospital, particularly through the prevention of hospital-acquired pressure ulcers of all grades. Not only are pressure ulcers painful and uncomfortable, they are often – although not always – preventable through good clinical practice.

The Trust is committed to reducing this form of harm to its lowest level possible. For 2017/18, the total number of avoidable hospital-acquired pressure ulcers, including SDTIs (suspected deep tissue injuries), was just 69.

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

The Trust's tissue viability nursing team continues to support this improvement through providing a range of resources, including holding study days for clinical staff in pressure ulcer prevention and by being involved in all aspects of pressure ulcer prevention within and outside the Trust.

Preventing inpatient falls

Inpatient falls remain the most commonly recorded patient safety incident in the NHS. Nationally, 30% of people aged between 65 and 79 years of age, as well as 50% of those over the age of 80, will fall every year. It is well researched that people over the age of 65 who are admitted to hospital during an episode of acute illness are at a significantly higher risk of falling.

During May 2017, the Trust participated in the second national audit of inpatient falls; it is anticipated that the Trust will perform within the top 20% of all participating acute trusts. In the previous national audit of inpatient falls undertaken in 2015, it was identified that the Trust had the lowest number of falls per 1,000 bed days in the East of England region.

Currently the Trust is engaged in NHS Improvement's national falls prevention collaboration, which provides further opportunities for our falls prevention team to share and acquire additional best practices in a professional forum which is facilitated by nationally recognised experts. It is anticipated that the Trust will be earlier implementers of innovative practices identified in the collaboration, which will help reduce the risk of inpatient falls in the future.

Tackling the problem of inpatient falls is a significant challenge throughout the NHS. There are no single or easily defined interventions that, when done on their own, are shown to reduce falls. Research has shown that multiple interventions performed by multidisciplinary teams and tailored to the individual patient can reduce falls significantly.

The Trust's current falls prevention strategy utilises a multi-disciplinary team approach towards reducing the risk in individual patients by adopting the latest NICE guidance and through the use of the Royal College of Physician's fall safe care bundle approach.

Adult and children's safeguarding services

Adult safeguarding is an important part of patient care within the Trust, reflecting the statutory framework for adult safeguarding under the Care Act 2014.

The Trust's director of nursing is the executive lead for safeguarding in the Trust, with the day-to-day work of adult safeguarding undertaken by all Trust staff with support from the adult safeguarding nurses and adult safeguarding doctor. All staff receive training and regular updates, guided by the Trust, local and national policies. The Trust is an active partner in the activities of the Hertfordshire Safeguarding Adults Board.

The Trust continues to support the adult safeguarding systems and processes in Hertfordshire by raising concerns, or supporting families to raise concerns, about neglect or abuse and to work with adults *at risk* to provide personalised protection plans. During 2017/18, the Trust has continued to work closely with the IDVA (Independent Domestic Abuse Advisor) service developing the role of the Hospital IDVA.

Providing support to *at risk* adults is an important part of health care and the Trust has developed services to support adults with particular needs. For example, adults with learning disability are supported by the learning disability acute liaison nurses and patients with dementia are supported by the Trust's dementia and enhanced care team.

During 2017/18, the Trust's ambulatory care service at the New QEII hospital was successful in being awarded *Purple Star* accreditation by Hertfordshire County Council in recognition of the work the team has done to develop learning disability-friendly services. This is third of our services that have received such accreditation, following diabetic eye screening at Hertford County and day surgery at the Lister.

The Trust has enhanced care team that provides enhanced support on the Lister's wards for patients who need extra supervision or assistance whilst they are in hospital; this can include patients with confusion, delirium, dementia, learning disability or physical disability. The team works with patients to reduce agitation or distress and help to keep patients safe from harm.

Other initiatives that have enhanced the quality of care for patients have included the introduction of the *Stay with me – John's campaign* to support carers of patients with dementia being able to stay with them whilst they are in hospital; this can help to reduce agitation, disorientation or distress experienced by some patients with dementia if they do not see people who are most familiar to them. More recently, the Trust participated in NHS England's national end PJ paralysis campaign that aims to get more patients dressed in their own clothes to help speed up their recovery and discharged back to where they live.

The Trust has an established team of Butterfly volunteers who are able to stay with patients at the end of their lives, where the person does not have family or friends who can stay with them in hospital.

The work of the adult safeguarding team continues to include awareness training for staff around the statutory duty for Prevent (the Government's anti-radicalisation strategy), as well as increasing knowledge and skills in relation to use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The Trust continues to see a year-on-year increase in the number of urgent authorisations for Deprivation of Liberty Safeguards (DoLS) since the changes made by the Supreme Court in 2014.

Safeguarding children services promotes the welfare of children and prevents them from harm. It is a core part of the Trust's business and recently has had a very positive review to ensure compliance against *Section 11 of* The Children's Act.

The Trust works closely with partner organisations and services; it has executive representation at the Hertfordshire Safeguarding Children's Board through Trust's director of nursing and executive safeguarding lead attending these meetings.

2017/18 CQUIN performance

The CQUIN indicators agreed with the East and North Hertfordshire Clinical Commissioning Group for 2017 to 2019 focus on:

- Improvement of health and well-being
- Improving healthy food by reducing sugary food and drinks
- Improving 'flu vaccination uptake
- Timely identification and treatment of sepsis
- Review and reduction of antibiotic prescriptions
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance to GPs from agreed list of consultant-led services
- Providers to publish all services make all first outpatient appointment slots available on NHS e-Referral Service (e-RS) and move to full electronic referrals from October 2018.
- Supporting proactive and safe discharges
- Roll-out and implementation of emergency care dataset
- Preventing ill-health by risky behaviours - alcohol and tobacco (2018/19 indicator only)
- Engagement with STPs
- CQUIN risk reserve

The CCG has also agreed to the roll-over of a local CQUIN indicator from 2016/17 for renal telemedicine.

In addition, the Trust has several national CQUIN indicators from NHS England that focus on:

- SACT dose banding
- Hospital medicines optimisation
- Enhanced supportive care
- Optimising palliative chemotherapy decision-making
- Shared decision-making

There was one CQUIN Indicator for NHS England Dental for 2017/18 that related to attendance at the hub and spoke dental meetings on a quarterly basis.

The Trust is forecasting that compliance against these CQUIN schemes will be 75% for the CCG, 94% for NHS England and 100% for NHS England Dental.

Going forward, the Trust has reviewed its governance arrangements around the delivery of CQUIN performance in order to ensure that we meet the expectations set for us by commissioners in delivering innovative care for patients.

Operational performance

The Trust's operational performance relates to standards set both nationally and locally, which are reviewed through a combination of:

- Regular performance management meetings between members of the executive team and each clinical division;
- Exception reporting via the Trust's *executive committee*, which meets weekly;
- Monthly via the Trust Board's *finance and performance committee*, as well as through the committee's monthly report to the Trust Board.

Externally, the Trust is held to account for its operational performance by NHS Improvement.

The 2017/18 year represented a challenging period for the Trust, characterised by changes in patient activity compared to previous years. The launch of our new electronic patient record (Lorenzo) and patient e-obserbvation (Nervecentre) systems in September 2017 affected the ability to report reliable data nationally. Whilst we returned to reporting on most waiting time standards relatively quickly, including for A&E, we do not expect to start reporting formally on our 18-week referral to treatment and radiology diagnostic standards until later in 2018.

Despite meeting many of the standards set nationally and locally for the Trust, there were two areas where additional work was required in line with trajectory recovery programmes agreed with NHS Improvement:

- A&E four-hour waiting time standard
- 62-day urgent GP cancer referral to treatment standard

A&E four-hour waiting time standard

Building on the work that started in 2016/17, which has since been superseded through the Trust's the *emergency care pathway* project, we have sought throughout 2017/18 to deliver a trajectory of continuing improvement on the A&E waiting time standard. There has been a lot of attention on improving hospital flow this year, with a keen focus on discharge management. The Trust also relaunched the roll-out of the *Red/Green* initiative, which identifies the status of each patient, with respect to their ongoing care plan and discharge.

During 2017/18, the Trust did not achieve the A&E standard, delivering a year-end position of 83.6%. The NHS as a whole, however, has not met the 95% target. Following publication of national technical guidance, the Trust will be required to achieve a minimum of 90% by September 2018 and 95% by March 2019.

Key areas of focus going forward include:

- Improving minors and non-admitted breach performance in the Lister's emergency department
- Earlier senior clinical decision-making
- Improvements to Nervecentre and its use

62-day urgent GP cancer referral to treatment standard

For the second year running, 2017/18 saw under-performance against this target, a trend that started in 2015/16 across the NHS. Our latest year-to-date performance for 2017/18 – against the 85% target – was 73.7%.

A revised action plan agreed with the commissioners and regulators, was implemented during the year to address the underlying issues mitigating against the Trust's abilities to achieve the national standard. Evidence has developed during the year of a clear against the Trust's agreed trajectory recovery plan. For example, by February 2018 the Trust reported a post-breaching sharing performance of 84.4% against the national standard of 85%.

Electronic patient record system and digital stabilisation programme

Our new electronic patient record system – called Lorenzo – was rolled out in September 2017. The implementation highlighted several areas of concern relating to poor quality data passed from legacy systems and the requirement for additional training and support to staff using the systems.

Although we are able to report centrally on most performance indicators, more time will be needed before the Trust can report formally on its 18-week referral to treatment standard. We have agreed a stabilisation and optimisation plan to improve the system's performance, which is supported by our regulators and NHS Digital. A Lorenzo Stabilisation Board has been established to monitor progress. This includes representation from NHS Improvement and NHS Digital, with reports being taken to the Trust's finance and performance committee.

We have an established governance framework to manage data quality and clinical risks to make sure that the impact on clinical quality and patient safety is mitigated and no patients are *missed* on the patient tracking list. This was considered and endorsed by the Board in March 2018.

Where patients have waited over 52 weeks for the 18-week referral to treatment standard or over 100 days against the cancer 62-day pathway, a harm review will be undertaken. The harm review process has been agreed with our commissioners and the progress and outcomes is reported to the risk and quality committee and Board at each meeting.

For financial impact, please see finance performance summary on pages 13 and 14.

Activity planning

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

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

Although the Trust has developed longer-term activity plans through its integrated business plan, for the purposes of this annual report, the information available on activity plans is limited to the year ahead (i.e. 2018/19). This information, along with comparisons against the previous year's performance, is set out in the table overleaf.

Activity	2017/18 actual	2018/19 planned
A&E attendances (includes urgent eye clinic service)	158,346	156,497
Outpatients – first appointments (includes non face-to-face and procedures)	155,084	161,273
Outpatients – follow-up appointments (includes non face-to-face and procedures)	313,871	323,914
Elective inpatients (i.e. planned admissions)	8,086	8,483
Elective day cases	35,357	35,712
Non-elective inpatients (i.e. emergency admissions)	45,261	44,404
Births*	5,461	5,468

*Please note that births are counted as the mother giving birth, not the number of babies.

Emergency preparedness

Over the past twelve months the work programme has focused strengthening its compliance with standards to ensure the Trust meets it's legal and statutory obligations as a category one responder under the Civil Contingencies Act 2004.

During 2017/18, the Trust started a process to review and improve its emergency preparedness and business continuity plans and policies. This follows experience gained following internal major incidents that were declared in May 2017 following a cyber-attack and as part of the planned roll-out of the Trust's electronic patient record system in September 2017. This work is on-going and will complete in 2018.

The Trust also made its annual core standards submission to NHS England during the year, clarifying its levels of competency. This identified a number of areas where improvements need to be made, work that is being addressed currently via the processes referred to above.

Governance for emergency preparedness within the Trust is controlled through the emergency planning committee, risk and quality committee and the Trust board. This duty is discharged by the director of strategy as the accountable officer, with the support of the emergency planning lead.

For further information, please contact:

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

Financial performance

The Trust's pre-audited reported financial performance was an adjusted retained deficit of £25.8 million. The Trust is required to meet a number of statutory and administrative duties in its financial performance, these are outlined below. As with other NHS trusts and foundation trusts, the Trust is held to account by its external oversight body, NHS Improvement, for both financial and operational performance.

Breakeven duty

The Trust has a duty to *breakeven* i.e. to ensure that any cumulative deficits between income and expenditure do not exceed 0.5% of turnover over a period to be agreed with its oversight body, NHSI. In 2017/18, the Trust agreed that its financial performance, its *control total*, would be a deficit of £7.744 million.

The Trust's pre-audited reported financial performance was an adjusted retained deficit of £25.8 million, which includes the consolidated profits of the Trust's wholly owned subsidiary, ENH Pharma of £0.6 million. There is a technical adjustment of £1.4m to be applied to this, which results in *breakeven duty financial performance* of £24.4m. The breakeven position was -5.80% in year, which contributed to the cumulative position of -14.71%. *Therefore, the Trust has not met its financial duty in this respect*.

External Financing Limit

The Trust is given an External Financing Limit (EFL) each year, which it is permitted to undershoot. In 2017/18, the Trust's EFL was £34.3 million, of which it utilised £31.1million, leading to an undershoot of £3.2 million (*financial duty achieved*). Included in this *undershoot* is £0.6 million cash balance relating to ENH Pharma.

Incorporated within the EFL cash flow financing, was £29.0 million of Working Capital Support Loans, necessitated by the Trust's increased deficit position, together with £2.6 million of Capital Support Loans. In addition, the Trust received allocations of Public Dividend Capital totalling £3.4 million, towards capital expenditure for a new linear accelerator at Mount Vernon, improvement to the emergency department and cyber security. The Trust has repaid £3.3 million of its borrowings in-year.

Capital Resource Limit

The Trust is required to keep its investment in capital assets within its internally generated resources, together with approved sources of financing from the Department of Health. The Trust's Capital Resource Limit for 2017/18 was £13.2 million, against which it expended £12.9 million – an undershoot of £0.3 million (*financial duty achieved*).

Better Payment Practice Code

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

The Trust's detailed performance against this target for non-NHS creditors is set out in note 36 in the annual accounts section of this annual report. Despite the challenging financial environment and liquidity issues the Trust has experienced, the Trust has benefited from the receipt of cash support from the Department of Health. As a consequence, the Trust's overall performance in relation to the code has been 67.6% (2016/17 – 39.1%) of non-NHS trade invoices paid within target during 2017/18.

As the Trust works to deliver its cost improvement programme it aims to improve on this position.

Financial outlook

The Trust Board is committed to ensuring that the Trust has a secure and sustainable financial future, to enable the Trust to deliver safe and effective care to patients.

Through improved financial control, the Trust will aim to deliver service improvements and cost improvement programmes in 2017/18 that will lead to the better use of resources, including the Trust's estate. 2018/19 is likely to be another challenging year but the Trust will be looking to improve its financial performance through the delivery of its financial recovery plan, which is being delivered through the ongoing dedication and commitment of the Trust's staff, as a key step to returning to financial balance.

Workforce performance

The Trust's workforce performance relates to standards set both nationally and locally, which are reviewed through a combination of:

- Regular performance management meetings between members of the executive team and each clinical division
- Exception reporting via the Trust's executive committee, which meets weekly
- Monthly via the Trust Board's finance and performance committee, as well as through the committee's monthly report to the Trust Board
- Quarterly via the Trust Board's risk and quality committee

Trust's culture

To support the delivery of the *people strategy* that runs from 2014 to 2019, we introduced ARC –a programme of work to deliver large-scale and long-term cultural change within the organisation. This evolved into the LEND programme, which is an agreed, declared and aspirational set of leadership behaviours.

At the same time, we have moved to a more coaching approach to leadership aimed at improving staff engagement, better patient and staff experience and the embedding of a continuous improvement culture that will improve our overall performance.

LEND (Listen, Empower, Nurture, Develop) – leadership behaviours were developed in consultation with staff and launched in the organisation in summer 2016, followed by the leadership, management and coaching development pathway (LMCDP) – the Trust's first comprehensive leadership education and training programme. Take up of leadership and management training has almost tripled since and impact evaluation has demonstrated the positive impact of the programme.

Our *leadership development and talent management* strategy provides a framework for developing the Trust's leadership capacity and capability, whilst at the same time recognising and nurturing talent. We have made a commitment to embedding a coaching and facilitative leadership culture and a programme of work is well underway and involves leaders throughout the Trust, from the Board to frontline leaders and managers.

Staff health and well-being

The three-year (2016 to 2019) health and well-being CQUIN aims to improve the support available to our staff to help promote health and well-being in order for them to remain healthy and well at work.

Some of the initiatives implemented within the Trust during the year were:

- Early assessment and advice for staff unable to work due to stress-related or mental health issues, or a musculoskeletal issue. Advisors from our Health at Work service are telephoning staff on day one of their sickness absence (or the next working day if at a weekend) to: undertake an early assessment; offer advice; support and, where appropriate, refer to fast track physiotherapy; signpost staff to appropriate sources on on-going support; and, again where appropriate, refer to counselling and/or online CBT
- Fast-track physiotherapy service to prevent and reduce sickness absence for musculoskeletal issues
- Health at Work advice line
- Referrals for 12 weeks free at Weight Watchers and Slimming World
- Promotion of and referrals to stop smoking service
- Mental Health first aid training for managers
- Exercise classes, walking groups and activity challenges
- Weekly mindfulness drop-in sessions delivered by hospital chaplains
- Employee assistance programme, providing staff free access, 24 hours-a-day to advice, support and counselling
- Well-being events held every month to encourage staff to make healthy lifestyle choices, including mental health awareness, healthy eating (included cholesterol testing), exercise promotion including on-site exercise classes

NHS national staff survey 2017

While this year's survey results were disappointing, they should be seen in the national context that showed that across the acute NHS trust sector there was a decline in nearly two-thirds of the key findings and over three-fifths of the individual questions when compared to the 2016 survey results.

The Trust maintained or improved its position in some areas of the 2017 national staff survey, although there were also a number of themes that showed a decline on the 2015 and 2016 results. The Trust score is in the best-performing 20% for the Key Finding *Staff experiencing physical violence,* meaning that the rates of violence are amongst the lowest of English acute trusts, maintaining our track record of improvement in this area (where we have been above average or in the top 20% of acute Trusts since 2011).

The Trust is above average in the Key Finding *Quality of appraisal,* again an area where we have traditionally performed well. Progress has been made in the Key Finding *Reporting most recent experience of bullying and harassment,* which is also now above average, demonstrating a significant improvement on our 2015 and 2016 scores.

However, the results in some other areas show a need for improvement. These include elements of themes related to *Health and Wellbeing, Job Satisfaction, Managers, Support for Development* and *Violence, Harassment and Bullying* as well as the themes relating specifically to how staff perceive the care provided by the Trust: *Patient Care and Experience* and *Errors and Incidents.* The *Overall Staff Engagement* indicator also showed a decline on the 2016 result.

In response to the decline in this year's results, the Trust has adopted an innovative, more open and inclusive approach to addressing the concerns and issues raised by the survey results. Following early indicators on the areas showing the most significant decline, an online workshop ran for three weeks in the New Year. This enabled staff to contribute ideas, comments and suggestions in the following three areas:

- Improving the health and wellbeing of all our staff
- Improving communication between senior managers and staff
- Making it easier for staff to contribute to improvements

The workshop had a high level of participation, with over 700 individual members of staff contributing over 330 ideas as well as over 600 comments and nearly 7,300 votes.

Distinct themes have emerged from the workshop content, and these have been prioritised based on their importance to staff. The top themes have been assigned an executive sponsor to take forward the action planning, with work commencing in April 2018. Once the implementation of the action plans has begun, a one-off pulse check will run to gain an insight into the extent of their impact on the organisation.

To further support this work a series of staff experience groups has now been launched, which aims to provide a forum for staff to continue to raise areas of concern and to contribute ideas and suggestions on how their experience of working at the Trust can be improved further. Feedback from these groups will be incorporated into the action planning and implementation.

People performance

Recruitment and retention

The Trust has continued to work to reduce vacancy rates and improve the time to hire during 2017/18, with a particular focus on recruitment to band two clinical support worker (CSW) and band five staff nurse vacancies. The aim of this work has been to achieve a CSW vacancy rate and a qualified nursing vacancy rate of 6% by the end of 2017.

A blended approach to this work has been taken during the year, using UK nursing recruitment to hold staffing levels against turnover, with wider international recruitment from mainly the Philippines and India to address vacant posts and those that arise from the approval of any new business cases.

Local recruitment increased in 2017/18, based on advertising in local media, developing a streamlined recruitment process for student nurses who have had their placements at the Trust by guaranteeing them a post and also streamlining the process for bank and agency staff to transfer to permanent posts within the Trust. The cohort recruitment days for band five nurses and band two clinical support workers was also continued, with additional dates added to increase the recruitment pipeline during the year.

The time to hire has decreased from 9.3 weeks in March 2017 to 8.6 weeks in March 2018.

The Trust has put actions in place during 2017/18 to address staff turnover, which continues to be a concern - although the rate remains amongst the lowest locally. A more structured process of exit interviews was implemented to gain more insight into why staff leave the Trust and views have also been sought from staff who are employed currently to understand the main challenges to their work. This approach is tied into the overall *retention* strategy the Trust launched at the end of 2017, looking at decreasing attrition with a specific focus on nurses and care support workers.

As well as initiatives outlined elsewhere in this report that will have a positive impact on retention rates, other actions taken include: centralised flexible working requests and a Trust-wide flexible working review; increased opportunities for training and development, as well as the introduction of a clinical director's mentorship and development programme. Each of the Trust's five clinical divisions has also developed specific recruitment and retention plans.

Current work includes band five nurse rotations, a lead role within the STP recruitment and attraction work stream, along with enhanced work with the Ministry of Defence to support Armed Forces leavers into the workplace.

Temporary staffing

We have continued to make significant strides to reduce reliance on bank and agency staff, along with the associated costs, during 2017/18. By the end of the year, we saw a positive variance of 26% versus the agency ceiling target set for us by NHS Improvement; a year-on-year comparison shows a reduction of 21% in temporary staffing expenditure.

Agency costs have reduced by 53% (for all staff-groups). On-going work includes leading the regional hub across Hertfordshire and Bedfordshire to ensure maximum efficiencies around agency rates, as well as being the first *bankshare* go live nationally with two other Hertfordshire trusts in July 2017. Its successful implementation has resulted in the consortium being approved as one of the trusts for a Department of Health and Social Care-funded pilot to develop our *bankshare* and social engagement offering further in 2018/19.

Tighter centralised controls and a revised process have been embedded across the Trust, with executive director sign-off required for all agency shifts. The usage of temporary staffing across the Trust is reviewed on a weekly basis for all clinical divisions.

The temporary staffing office for doctors (TCOD) function was moved in-house from NHS Professionals in May 2017, which has allowed us to enhance further protocols around booking bank and agency staffing, as well as recent engagement with East of England trusts to align agency rates. The Trust is also set to launch a plan to deliver greater savings through direct engagement compliance of any agency locums used in 2018/19. In its first year, a review of the TSOD suggests that agency expenditure for medical locums has reduced by over £3 million through efficiencies, recruitment into substantive posts and a lower reliance on agency medical locums.

Employee relations advisory service (ERAS)

The ERAS team deals with all calls and correspondence from both staff and managers who have queries or require support in relation to employee relations matters, in relation to the application of Trust workforce policies and in respect of Agenda for Change terms and conditions of employment.

The team's general approach is to identify concerns and provide early intervention before a situation escalates. Within the team there are a number of trained mediators; offering timely and informal intervention for workplace issues through mediation and facilitated conversations.

As well as providing advice and support, the ERAS team also provides employee training for managers, working in conjunction with the organisational development team on the development and delivery of the Trust's core management skills programme. The team also continues to deliver a number of *bitesize* training sessions; focused on improving policy understanding and to support managers in improving their HR and management capabilities.

A high level of positive feedback has been received from managers or supervisors who have attended our bitesize sessions during 2017/18. There have been 301 supervisors or managers who have attended our bespoke policy training sessions, in addition to those attending the core management programmes.

Appraisals

A key factor in supporting and enabling good staff performance is through appraisal. Since November 2015, incremental pay awards have been dependent on the completion of an annual appraisal, along with statutory and mandatory training compliance. This has had a demonstrable effect on both, with appraisal rates improving from 81.75% in March 2017 to 82.97% in March 2018, and full statutory and mandatory compliance rates increasing from 62.50% in March 2017 to 68.50% in March 2018.

The quality of appraisals continues to improve and this was demonstrated again in the 2017 staff survey where appraisals were one of the areas in which the trust performance remained strong.

Statutory training

The Trust monitors compliance for nine statutory competencies and is 66.91% compliant for overall coverage and 88.40% for staff compliant with all nine.

Medical education

The medical education team has demonstrated continuous improvements in developing a supportive environment for education and training in the Trust. Good governance systems and processes for trainer and trainee engagement have helped in achieving quality targets for delivery of medical education and training. A robust education infrastructure underpins educational governance in the Trust.

Over the course of the year there has been progress in trainee engagement and the Trust's trainee survey 2017/18 has shown trainee satisfaction with the quality of training in the Trust. The GMC Trainee Survey for 2017 showed improvement across clinical specialities in the Trust. Robust processes for student and trainee feedback are in place, which strengthen trainee engagement with the education faculty.

There have been several visits to the Trust by speciality and undergraduate schools. The visiting teams acknowledged the outstanding quality of medical education and supportive environment for training in the Trust.

For undergraduate education, the Trust has links with Cambridge Medical School and University College London. The number of students from UCL has increased and there is substantial increase in the number of Cambridge students coming to the Trust since September 2017.

The Hertfordshire and Bedfordshire Physician Associate Expansion Programme, which is run by the University of Hertfordshire, is a Masters-level initiative funded by Health Education England; the Trust is one of the key NHS trusts supporting the clinical elements of this programme. The programme commenced in September 2017, with 20 students in the first year. The programme will provide the Trust with an opportunity to train physician associates in Hertfordshire and Bedfordshire. Once trained, these individuals are more likely to support local healthcare initiatives. Trained physician associates employed by the Trust will help support services where national shortages of doctors have led to gaps in services.

The phased implementation of the new Junior Doctors Contract 2016 is progressing well. The first changeover point was October 2016 and other changeover points were February and April 2017. The contract was implemented fully by November 2017. To date very few exception reports have been submitted to the Trust's director of medical education relating to education and training. The *Guardian of Safe Working Hours* has been receiving exception reports relating to trainees working over and above their contractual hours; formal reports by the Guardian are submitted to the Trust Board.

Medical education faces several challenges. Rota gaps continue to be an issue in many specialities. With substantial increase in undergraduate numbers and the establishment of the physician associate programme with the University of Hertfordshire, the pressure on educational space has increased. More training space is required – particularly for expansion of skills and simulation facilities.

Despite these challenges, there has been significant improvement in most aspects of teaching and training. The medical education team is providing an outstanding learning environment in the Trust.

Non-medical education

The Trust's non-medical education team has been committed to supporting wards at the Lister and Mount Vernon Cancer Centre, along with other clinical areas, to achieve high quality outcomes for patients. The team has supported international recruitment, pre-registration students, delivered statutory and mandatory training for all staff; and learning and development for all non-medical staff. Many new initiatives and projects have been developed over the year, some of which are detailed below.

International recruitment

A two-week bespoke programme has been developed and implemented to support international nurses who already have their NMC PIN and who obtain their NMC PIN following a successful objective structured clinical exam (OSCE). The programme of assessment, co-designed with the University of Hertfordshire to prepare overseas nurses for their OSCE, was delivered successfully throughout the year to support and prepare overseas nurses.

Since March 2017, 118 nurses have been recruited successfully since following this route. There has been a 93.5% pass rate with NMC OSCE, compared to the 56% national average pass rate.

Nursing and midwifery revalidation

On-going support has been provided for registrants in the form of workshops on the revalidation process and reflective writing. The Trust has been successful in supporting all staff to achieve revalidation.

Social matters

The Trust has developed a reputation for engaging and involving local communities and partners as well as its public members and staff. We are accredited national good practice on the NHS England Involvement Hub. We are also committed to putting our hospitals at the heart of our local communities and this work continued to feature strongly in our activities throughout 2017/18.

Working with local charities

The Trust is very grateful for the support of more than £200,000 in 2017/18 from local charities – including the Cancer Treatment and Research Trust, the Marie Curie Research Wing at the Mount Vernon Cancer Centre, local fundraising for the Trust Charity and support to the Lee Haynes Research Institute at the Lister hospital. It would be very hard for the Trust to continue supporting research at its current level without significant and on-going local charitable support. The Trust is very grateful to the many patients and relatives who continue to donate to support research.

Public membership

Our work with members shifted in focus in 2017/18. We have not sought actively to recruit new members, rather we have been trying to improve the ways we involve the large number of public members we have already. Despite this shift in focus we had 12,687 members as at 31 March 2018 – a net increase of 64 from the previous year.

We have prioritised the involvement of members and patient representatives in our governance and accountability. We get the benefit of fantastic support and insight from members at:

- Care environment committee
- Patient experience committee
- Patient Led Assessment of the Care Environment (PLACE)
- 15 Steps Challenge
- Voluntary service steering group

Engagement with public and partners

Much of our wider community engagement work is developed from our annual general meeting (AGM). In July 2017 our AGM returned to the University of Hertfordshire's de Havilland campus in Hatfield. Around 300 public members, staff and partners came together to discuss the Trust's performance in 2016/17, as well as learn about cutting-edge clinical practice such as our urology robotic surgery service. In addition we premiered a new film commissioned to showcase all that is good about the Trust and our care for patients.

The Trust contributes to a range of health and well-being partnerships across Hertfordshire and beyond. Our chief executive sits on the Health and Wellbeing Board for Hertfordshire, ensuring that the interests of provider organisations are represented in strategy development and commissioning. In addition, the Trust's head of engagement sits on local council-led health and well-being partnerships driving health improvement for local areas, as well as Hertfordshire's Public Health Board designed to join-up public health interventions across the NHS and local government.

Not all busy acute healthcare providers make the time to contribute proactively to local partnership working – we continue to do so because our partners and local communities tell us they value our contributions to efforts in helping to make Hertfordshire a better place in which to live, work and visit.

The Trust is committed to working with local health scrutiny committees and Healthwatch organisations. Our Board has a transparent approach when it comes to accounting for performance with our auditors, inspectors, regulators, commissioners and scrutineers, as well as patient groups and champions. We are delighted to report that all our stakeholders continue to be happy with the diligence and candour with which we report our activities.

Work with GPs

We run a dedicated helpdesk for GP queries about our care of their patients. This facility was set up five years ago as good practice and continues to deliver a timely and robust response to primary care colleagues. This helps all healthcare professionals ensure that the administration and communication of care is improved for patients.

A growing number of primary care colleagues are coming to recognise the helpdesk service as the most effective route to resolving queries about patient care. We also work closely and very well with the local clinical commissioning group to support GPs and their patients.

In the coming year, the Trust is looking to spend more time out and about in GP surgeries and patient participation groups to continue to improve the links with our hospitals' doctors and nurses and so enhance patient experience further.

Our volunteers

Based at the Lister, our team of 2.5 wte voluntary services staff promote, recruit, check people's DBS, train and match volunteers at the Lister, New QEII and Hertford County. Currently we have 334 volunteers, working over 1,000 hours per week in such roles as:

- Patient companions – ward-based volunteers whose activity is directed by the ward manager to improve patient experience. They will help serve meals and refreshments but are able to spend time sitting with patients and talking to them
- Butterfly volunteers – providing companionship at the end of life
- Patient visitors – volunteers will make pastoral visits to patients of faith and no faith;
- Hospital guides - helping patients find their way round the hospital
- Activity volunteers – ward-based activities, encouraging patients to get up, get dressed, get moving

In addition, we have our *Boredom Busters* – a small team of volunteers who work with our patient experience co-ordinator to come up with suggestions and support ward-based activities as follows:

- PAT dogs – we now have nine PAT dogs, most of whom come in once a week to visit specific wards, spending a couple of hours in the hospital. We get really good feedback from the wards they visit; patients, visitors and staff love to see them.
- Musicians/singers – we have an increasing band of musicians and singers who come along to entertain patients for a short while. Individuals and small groups will perform on the wards and larger groups and choirs will perform on the main concourse, close to outpatients.
- Beauticians and hairdressers – we work with local colleges to bring in students to give a hand massage or style hair. It's a very popular event on the wards for both male and female patients.

We also support several community groups, including *Knit'n'Knatter* and *Sew Dementia* – the work that these volunteers do benefits a large number of patients. The items they produce mean that staff can always offer patients a soft shawl or knee blanket, a teddy bear or perhaps a sensory blanket or twiddle muff for those with dementia.

Mount Vernon Cancer Centre

We oversee a number of volunteer-led services at Mount Vernon, supported by a team of 1.9 wte who manage around 300 volunteers.

Lynda Jackson Macmillan Centre

- Drop-in volunteers
- Welfare advice
- Counselling
- Pre-chemotherapy and pre-radiotherapy consultation sessions
- Fundraising
- Patient support (meet and greet)

Michael Sobell Hospice

- Ward support (mealtimes)
- Day centre (patient support, art therapy, hairdressers)
- Receptionists
- Gardeners
- Aviary

The cancer centre itself

- Evening radiotherapy patient support volunteers
- Staff health and well-being support volunteers
- Ward support (mealtimes)
- Administration
- Gardeners
- Charity ambassadors
- Volunteer buddies to provide 1:1 support for patients with additional needs

Improving patient experience

The Trust's vision is to be amongst the best performing NHS trusts in the country, with excellent patient experience and improved clinical outcomes and patient safety at the heart of this ambition. The aim is to provide patients and their carers with the best possible experience whilst they are using the Trust's services.

The Trust's *patient and carer experience strategy 2015/19* was developed with patients, carers and staff and sets out three clear ambitions for improving patient experience:

- ***Ambition 1:*** *we want to improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care.*
- ***Ambition 2:*** *we want to improve the information we provide to enhance communication between our staff, patients and carers.*
- ***Ambition 3:*** *we want to meet our patients' physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique.*

The Trust encourages feedback actively from patients and carers as this enables good practice to be shared and changes made to improve services. The Trust has a patient and carer experience committee, which includes patient and carer representatives who discuss and review actions to improve patient experience. Each of the Trust's five clinical divisions has a patient experience action plan that is presented regularly to the committee.

A quarterly patient experience report is produced combining patient experience feedback in one document, covering Friends and Family Test (FFT) surveys, local and national surveys, social media, complaints and concerns). We also ensure that all feedback from patients and/or their families/carers is shared with the relevant ward/department. The patient and carer experience committee produces an annual report on progress towards the milestones set out within the patient and carer experience strategy.

In 2017/18 across all services in the Trust, over 57,500 patients responded to our Friends and Family Test survey telling us how likely they would be to recommend our services to their friends and family if they required similar care or treatment. Consistently the Trust's FFT responses for inpatient and day cases are higher than the national average for both response rate and the proportion of patients who would recommend the Trust to their friends and family.

Initiatives to improve patient and carer experience include:

- Development of ward information leaflets – a one page leaflet providing information about visiting times, mealtimes, nutrition, how to ask questions, complaints/concerns, chaplaincy, preventing infection, carers etc.
- Increased the number of patient information leaflets available on the Trust website to 361.
- Introduced renal tele-clinic patient survey, maternity bereavement survey and experience of end of life care survey.
- Developed an accessible information policy and process for patients to contact the Trust to share their communication needs.
- Suite of ward posters developed in conjunction with staff and patients to share key information - staff update posters monthly with latest ward scores.
- Launched 'get up, get dressed, keep moving' campaign to encourage patients to wear their own clothes and get out of bed. Developed patient information leaflet and posters to support this.
- Introduced open visiting hours on wards (Johns Campaign).
- Ambulatory care unit at the New QEII received purple star accreditation for patients with a learning disability – the third such service at the Trust to achieve such recognition
- Introduction of new menus in wards and a new children's menu developed with patients, public and children.

Complaints and concerns also provide valuable information to enable the Trust to learn and make changes based on the experiences of patients, carers and relatives. In 2017/18 across all services within the Trust, 1,101 formal complaints and 4,132 informal concerns were received. Examples of learning outcomes following a formal investigation include:

- Additional training for the neutropenic sepsis policy in the Lister's emergency department, where nursing staff are now trained to give antibiotics on arrival to the department
- A review of the pathway for the management of women who are under 20-weeks pregnant when the early pregnancy unit is closed
- Further training on the management of diabetes in pregnancy
- Communication skills training undertaken by reception staff
- Recruitment drive in pathology to increase the number of phlebotomists
- Recruitment drive in ophthalmology to support the increase in appointments made by telephone

Statements relating to social matters

The Trust takes very seriously its legal requirements in relation to human rights, as well as anti-corruption and anti-bribery activities.

Respect for human rights and anti-corruption/bribery matters

We are committed to taking all necessary steps to counter fraud, bribery and corruption within the NHS, through continuing to develop an open and honest culture. A clear anti-fraud and bribery policy is in place at the Trust, which was reviewed and updated in 2017 before being approved by the Trust's audit committee.

To meet our objectives, the Trust complies with the four-stage approach developed by NHS Counter Fraud Authority:

- Strategic governance (rated as green)
- Inform and involve (green)
- Prevent and deter (green)
- Hold to account (amber)

The Trust reported an overall outcome of *green* for the 2017/18 self-assessment against the NHS Counter Fraud Authority Standards. One standard under *involve and inform* and two standards under *hold to account* were assessed as *amber*; actions are in place to improve these areas during 2018/19.

RSM are contracted as the Trust's local counter fraud specialist and are responsible for taking forward all anti-fraud work locally in accordance with national NHS Counter Fraud Authority standards; they reports directly to the director of finance.

Sustainability summary statement

Accountability

The Trust made significant progress in delivering its sustainability agenda within the organisation, meeting reduction targets set for 2015 four years early. By 2014, the Trust had reduced its carbon emissions by 17.4% against a target of a 10% reduction. The next target for reducing our carbon emissions by 34% by 2020 is, by contrast, more challenging. From extensive stakeholder engagement with the community, however, it is clear they expect the Trust to continue to be a leader on the sustainability agenda.

The development and publication of the Trust's sustainability strategy for 2015 to 2020 focusses the work undertaken by the Trust, with consistent leadership and accountability at director level from the director of strategy.

Progress is managed, monitored and reported through the Trust's *sustainable development committee*, along with the annual implementation of a sustainable development management plan and bi-annual adaptation plan. The Sustainable Development Unit introduced a new sustainable development assessment tool in November 2017 which is currently in final stages of completion, this new tool will be used to track progress and compare performance to other similar organisations around the country.

Context

Following on from the Trust's sustainability development strategy for 2009 to 2014, a new strategy was developed in 2014/15. Part of the process involved extensive discussions with stakeholders both within and without the Trust – including patient representatives, local school students (who are also young members) and leads on sustainability from around the organisation.

The focus of sustainability by the Trust has developed not only to encompass the reduction in utility and energy consumption, but now includes social sustainability – supporting local communities to develop and sustain from a health and social care perspective.

The Trust's current sustainability strategy sets out in full the objectives and plans for achievement of the 2020 target reduction in carbon footprint.

Foundations

The Trust has mature systems in place for driving the sustainability agenda. The planning for achievement of targets set for the Trust is monitored through the sustainable development management plan, which is updated on an annual basis.

The Trust adaptation plan is also reviewed bi-annually to incorporate plans for events such as heatwave, extreme cold spells, etc. and is planned for update in the forthcoming year alongside emergency planning procedures.

The promotion of sustainable activity continues to be promoted across all areas, which has resulted in a decrease in the use of consumables and increasing awareness around the sustainability of health and well-being. This work is enhanced by the Trust's participation in the annual NHS sustainability day, a comprehensive communications campaign and by implementing specific initiatives throughout the year. As part of the day for action, the Trust has taken part in tree planting, healthy eating promotions, energy awareness and health and wellbeing initiatives over recent years.

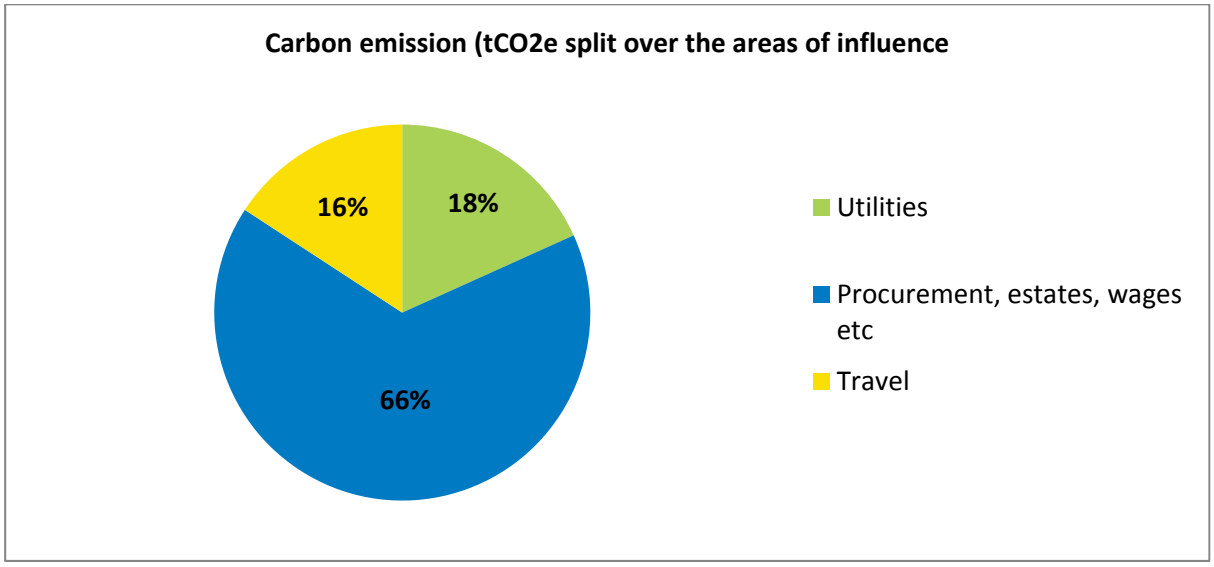
The goals and target for achieving the 2020 reduction of carbon emissions by 34% is expected to be challenging, albeit one that the Trust expects to achieve. The Trust is committed to meeting the target, which will be delivered through a combination of specific carbon reduction schemes, behavioural change, engagement and promotion not only within the Trust itself, but also within the wider NHS and local communities.

Measurements

In accordance with NHS requirements, the Trust commissioned independent energy consultants (M&C Energy Group – now Schnieder Limited) to establish the organisation's carbon footprint baseline in 2007/08. The carbon emission data shown in the table below highlights improvements made within the organisation from the 2007 baseline information.

tCO2e	2007 baseline	2014/15	*2015 target*	2015/16	2016/17	*2017/18*	*2020 target*
Procurement, estates, catering, wages, etc.	58,231	44,819	*52,407*	44,814	44,882	44,257	*38,432*
Utilities	16,382	15,498	*14,743*	12,765	12,079	*12,249*	*10,812*
Travel	8,309	8,174	*7,479*	7,966	7,875	*10,599*	*5,484*
Total footprint	82,922	68,491	*74,629*	65,545	64,836	67,105	*54,728*

The chart below presents the same 2017/18 carbon footprint information by percentage.



Overall in 2017/18 our carbon emissions are 23.7% reduction on the 2007 baseline but remain 18.4% above the overall 2020 expected position. With the increased patient activity there has been a marginal increase in utilities and travel.

The Trust's inter-site bus service now includes a "dial a ride" type service to improve accessibility and convenience of inter-site travel. Travel is an area targeted for improvement in 2018/19.

Overall waste production has increased as a direct result of the increase in patient numbers across the organisation. However, within the total waste produced we have as a Trust recycled less and this is an area targeted for improvement in 2018/19 .

The Trust is currently finalising the new sustainable development assessment tool (SDAT) which will enable the Trust to benchmark and monitor progress internally, as well as comparing progress against other similar organisations.

In 2017/18 a number of initiatives have been implemented aimed at improving the general health and wellbeing of all staff members across the organisation. This includes increasing the number of staff members receiving flu jabs across the winter period, a refresh of all food and drink items offered in all catering outlets across all trust sites, and availability of activity classes such as walking groups, mindfulness sessions and discounts at local gyms to improve overall general health.

The Trust was successful and was awarded the bronze level Food for Life Scheme. Food for Life Served Here is a widely respected scheme, recognised by the Department of Health, Department for Education, and the Government's Plan for Public Procurement, that is raising the standards of food quality, provenance, and environmental sustainability in public and private sector catering.

The Trust implemented and continues to support the application of Lorenzo. This enables easier access to patient information, reduction in paper as more processes within the patient pathway are now electronic, and reduction in time on patient administration enabling more time to be spent with patients. Also helps improve patient care through enforcing process standards, improving patient outcomes. This is a further step towards creating an electronic patient record.

The Trust completed an energy awareness campaign across all of our sites. Distribution of energy awareness posters and stickers were distributed to help encourage our staff to save energy and raise awareness of energy saving in the workplace.

Accountability report

The accountability report is made up from three sections:

- Corporate governance report
- Remuneration report
- Parliamentary accountability report

I can confirm that these have been prepared in adherence with the reporting framework.

Nick Carver, Chief Executive
24th May 2018

Corporate governance report

This part of the annual report looks at the following areas:

- Directors' report
- Statement of accountable officer's responsibilities
- Governance statement
- Modern slavery act statement

Directors' report

The Trust Board

The Trust Board has a key role in shaping the strategy, vision and purpose of an organisation. It holds the organisation to account for the delivery of strategy and ensure value for money and is also responsible for assuring that risks to the organisation and the public are managed and mitigated effectively. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the Board has a collective responsibility for the performance of the organisation.

The purpose of NHS Boards is to govern effectively, and in so doing build patient, public and stakeholder confidence that their health and healthcare is in safe hands. This fundamental accountability to the public and stakeholders is delivered by building confidence:

- In the quality and safety of health services
- That resources are invested in a way that delivers optimal health outcomes
- In the accessibility and responsiveness of health services
- That patients and the public can help to shape health services to meet their needs
- That public money is spent in a way that is fair, efficient, effective and economic

The Board has resolved that certain powers and decisions may only be exercised by the Board at its formal meetings. These powers and decisions are set out in the Trust's standing financial orders and instructions, which includes a scheme of delegation on the decisions that can be undertaken by the Board committees and specific individuals. These are reviewed on an annual basis.

The Board met in formal session on seven occasions during 2017/18, six of which were held in public followed by a private session to consider matters of a confidential nature. The Board met on a further five occasions for a board development session.

The Board is of sufficient size and the balance of skills and experience is appropriate for the requirements of the business and the future direction of the Trust. Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust.

The Board consists of a non-executive chair, 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 strategy and chief people officer – participate in board meetings, but do not have voting rights. The executive and non-executive members function as a team, working closely together, although with different responsibilities.

During 2017/18, two non-executive directors, including the vice chair, left the Board. Following a recruitment process with NHS Improvement, Mr Nick Swift joined the Board in November 2017 and Mr Jonathan Silver in October 2017. Mr Silver's post initially was a non- executive director designate post and part of succession planning for Ms Alison Bexfield, who ended her maximum 10-year term in January 2018. The chair continues to review the skills and experience required for the challenges ahead.

During 2017/18 there have been three changes to the executive team. The chief operating officer left the Trust in September 2017. Ms Bernie Bluhm joined the Trust as interim chief operating officer and will remain with the Trust until the new chief operating officer joins the Trust in June 2018.

Ms Liz Lees had acted as the Trust's director of nursing from November 2016 until the new director of nursing, Ms Rachael Corser joined the Trust in January 2018.

Ms Jane McCue, retired as medical director in December 2017 and following a recruitment process, Dr Mike Chilvers took up this position upon her retirement.

The chair and non-executive directors are appointed by NHS Improvement Appointments, on behalf of the Secretary of State for Health and Social Care. The normal term of office served by the chair and non-executive directors is either two or four years, renewable for a further four-year period. The maximum term is 10 years.

The chair and non-executive directors appoint the Trust's chief executive. Together with the chief executive, the chair and non-executive directors appoint all other executive directors and determine their remuneration. Specialist recruitment consultants have been used to support the recruitment processes for executive and non-executive director posts during 2017/18.

The executive directors are appointed by the Board on permanent contracts. All executive and non-executive directors undergo an annual performance evaluation and appraisal. The chair conducts the annual performance evaluation and appraisal of the chief executive and non-executive directors.

The chief executive, in turn, conducts the annual performance evaluation and appraisal of the Trust's executive directors. The chair is appraised by NHS Improvement.

The outcomes of the appraisals of executive directors and chief executive are discussed by the non-executive directors at the Board's *remuneration committee*. The chief executive is not present when their appraisal is being considered by the *remuneration committee*.

Each Board member is required to meet the *Fit and Proper Persons test*. This is undertaken on appointment and reviewed annually through a self-declaration process.

Board performance is evaluated further through focussed discussions at Board development days, meetings, observation, annual evaluation of the Board committees and ongoing in-year review of the board assurance framework and delivery of the Trust's strategic objectives.

The role of the NHS trust chair

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

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

The role of non-executive directors

Non-executive directors work alongside other non-executives and executive directors as an equal member of the Board. They share responsibility with the other directors for the decisions made by the Board and for success of the organisation in leading the local improvement of healthcare services for patients. Non-executives use their skills and personal experience as a member of their community to:

- Formulate plans and strategy – bringing independence, external perspectives, skills, and challenge to strategy development
- Ensure accountability – holding the executive to account for the delivery of strategy; providing purposeful, constructive scrutiny and challenge; chairing or participating as a member of key committees that support accountability; being accountable individually and collectively for the effectiveness of the Board
- Shape culture and capability – actively supporting and promoting a healthy culture for the organisation; providing visible leadership in developing a healthy culture so that staff believe non-executive directors provide a safe point of access to the Board for raising concerns; champion an open, honest and transparent culture within the organisation
- Context – mentoring less experienced non-executive directors where relevant
- Process, structures and intelligence – satisfying themselves of the integrity of reporting mechanisms, and financial and quality intelligence including getting out and about, observing and talking to patients and staff; providing analysis and constructive challenge to information on organisational and operational performance

- Engagement – ensuring that the Board acts in best interests of patients and the public; being available to staff if there are unresolved concerns; showing commitment to working with key partners

The time commitment required of non-executive directors is two to three 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 their 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. To support engagement with the organisation each non – executive director has been linked with a division.

The Trust Board 2017/18

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

Key to principal committee membership

AC – audit committee
EC – executive committee
FPC – finance and performance committee
RAQC – risk and quality committee
RC – remuneration committee
CTC – charity trustee committee
IC – involvement 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 Trust chair attends the *finance and performance* and *risk and quality committees* although she is not a designated member and the new Chair of the *finance and performance committee* frequently attends *the risk and quality committee*. The committee attendance figures listed below do not take into account these additional attendances; rather they reflect attendances that are *expected*.

Ellen Schroder, chair

Ellen became the Trust's chair on 1 April 2016, prior to which she was vice-chair and audit chair for the Camden Clinical Commissioning Group since its inception in 2012. Her responsibilities included developing the CCG's strategy as well as setting up an effective governance and risk management structure. From 2003 to 2012, Ellen was a non-executive director at Imperial College Healthcare NHS Trust and its predecessor St Mary's NHS Trust, where she chaired both the audit and finance committees. Ellen holds a number of other NHS-related non-executive positions, including chairing the clinical ethics committee at Great Ormond Street Hospital for Children NHS Foundation Trust and the organ donation committee at Imperial College Healthcare NHS Trust. She also chairs the PFI companies which built Amersham Hospital and part of High Wycombe Hospital and is a Trustee of the Radcliffe Trust charity. Between 1979 and 2003, Ellen pursued a career in corporate finance working for the investment banks, Dresdner Kleinwort Benson and Wood Gundy Inc. Ellen, who lives with her family in North London, has been appointed the Trust's chair for four years until 31 March 2020.

Committee membership: RC

Attendance: Trust Board 6 out of 7; FPC 9 out of 10; RAQC 8 out of 10; RC 1 out of 1, Board Development 4 out of 5

Nick Carver, chief executive

After initially working as a hospital porter, Nick qualified as a Registered Nurse before developing his interest in health service management. In addition to his registered general nurse qualification, he holds a BA (Hons) in political theory and government, as well as an MSc in health care management. Nick was appointed as Chief Executive in November 2002, having previously been Chief Executive of the George Eliot Hospital NHS Trust in Warwickshire, prior to which he held senior roles in the West Country and South Wales. He has led the East and North Hertfordshire NHS Trust through major service change and delivered public and political support for a major reconfiguration of hospital services that delivered substantial quality and financial benefit to the local health economy.

In 2013, Nick was presented with the *Inspirational Leader of the Year* award by Health Education, East of England. Nick is passionately committed to leadership development and is the Chief Executive lead for the widely praised Bedfordshire and Hertfordshire Aspiring Directors Development Scheme and also chairs the Midlands and East Regional Talent Board.
Committee membership: EC, FPC (core attendee), RAQC (core attendee), AC (attendee), RC (attendee)
Attendance: Trust Board 6 out of 7; FPC 8 out of 10; RAQC 7 out of 10 (due to required attendance at system wide STP meetings); AC 2 out of 6; RC 1 out of 1, Board Development 4 out of 5

Alison Bexfield, vice-chair (until January 2018)

Alison, who lives in Letchworth, started her career as a chartered accountant in public practice. She spent several years with KPMG, where she provided audit services across a number of healthcare organisations. She held a variety of senior finance and governance roles at the BBC, most recently as head of internal audit, and currently is director of internal audit at HMRC. Alison has also served as an independent audit committee member on a number of audit committees across the public sector. Alison was appointed a non-executive director on 1 February 2008. She was re-appointed in 2012 and again in 2016; she will serve on the Trust Board until 31 January 2018. Alison is vice-chair of the Trust Board. She chaired the *audit* and *remuneration committees*.
Committee membership: AC, FPC, RC,
Attendance: Trust Board 4 out of 6; AC 4 out of 4; FPC 6 out of 8; RC 1 out of 1, Board development 2 out of 4

Julian Nicholls, non-executive director (until July 2017)

Julian has spent 20 years successfully managing substantial business to business services companies in the UK and Europe. Currently he is chairman of Whitehill Pelham Ltd and advisor to a number of private equity-owned companies. During his early career he had senior roles in sales, marketing and business development in the computer industry. He spent parts of his early career working in Africa, the Middle East and South East Asia. Julian was appointed as a non-executive director in July 2010 and chairs the Board's *finance and performance committee*.
Committee membership: AC, FPC, RC
Attendance: Trust Board 1 out of 2; AC 2 out of 2; FPC 3 out of 3; RC 1 out of 2 , Board development 2 out of 2

Bob Niven, non-executive director

Mr Niven, who lives in Hatfield, is a retired senior civil servant. He joined the civil service in 1974, having graduated from Oxford University with a BA in politics, philosophy and economics, followed by an MA in Political Science from Michigan State University and a B. Phil in Management Studies from Oxford University. His final post on retirement in 1999 was director of equal opportunities legislation policy at the then Department for Education and Employment. Following his departure from the civil service, Mr Niven became the chief executive of the Disability Rights Commission until September 2007. After a number of board appointments, including as chair of the Mental Health

Helplines Partnership and at the Office of the Public Guardian, Mr Niven served as the resident independent adviser to the Israeli Equal Employment Opportunities Commission under a two-year, EU-supported capacity-building project until February 2012. Bob was appointed a designate non-executive director on 1 September 2013 and a full non-executive director from 6 January 2014 and chairs the *charity trustee committee*.
Committee membership: RAQC, RC, AC, CTC, RC
Attendance: Trust Board 7 out of 7; RAQC 9 out of 10; AC 5 out of 5; CTC 3 out of 3; RC 1 out of 1; Board Development 4 out of 5

John Gilham, non-executive director

John joined the Trust on 1 December 2014 as a designate non-executive director and became a full non-executive director on 1 June 2015. John took over chairing the risk and quality committee in January 2016. He lives in Brentwood and has previously held chief executive roles at Southend University Hospital and the Princess Alexandra Hospital in Harlow. John started his NHS career as a medical laboratory scientific officer and has since held a range of managerial roles. In total, John has worked for the NHS for over 30 years. John holds a master's degree in business administration and has particular interests in patient safety and the quality of care patients receive. John is passionate about the NHS – one of his three sons also works for the NHS. John recognises the importance of staff engagement and the role it plays in providing high quality of services for patients. John chairs the *risk and quality committee*.
Committee membership: RAQC, RC
Attendance: Trust Board 6 out of 7; RAQC 8 out of 10; RC 0 out of 1; Board Development 4 out of 5

Val Moore, non-executive director

Val Moore, who lives near Cambridge, has worked in several roles for the National Institute for Health and Care Excellence (NICE) between 2006 and 2015 – most recently as its implementation programme director. Originally trained in psychology and as a science and physical education teacher, Val moved in to the NHS in 1990 working in health promotion prior to taking up roles including as executive director in the former Cambridgeshire Health Authority and then regional director for the Health Development Agency (1999 to 2006). Val, who is also the chair of Healthwatch Cambridgeshire, will serve on the Trust's Board for a four-year period from 1 September 2016 to 31 August 2020. Val chairs the *patient experience committee*.
Committee membership: RAQC, RC, CTC
Attendance: Trust Board 6 out of 7; RAQC 9 out of 10; RC 2 out of 2; Board Development 5 out of 5

Jonathan Silver, non-executive director (from October 2018)

Jonathan, who lives in Aldenham, studied operational research and accountancy at Strathclyde University, graduating in 1978. On qualifying as a chartered accountant with Grant Thornton in 1981, he moved to Fisons plc. After five years, Jonathan joined Laird plc – now a global technology company providing systems, components and solutions that protect electronics from electromagnetic interference and heat, and that enable connectivity in wireless applications and

antennae systems. Following 29 years with Laird, the last 21 of which had been as its chief financial officer and main board director, Jonathan retired in 2015. He is a non-executive director and audit committee chairman of Invesco Income Growth Trust plc and of Spirent Communications plc.
Jonathan chairs the Audit Committee.
Committee membership: FPC, RC, AC
Attendance: Trust Board 3 out of 3; FPC 5 out of 6; RC 0 out of 0; AC 4 out of 4; Board Development 2 out of 2

Nick Swift, non-executive director (from November 2017)

After studying engineering at Exeter University, Nick qualified as a chartered accountant with Touche Ross in 1988 and then spent five years in New Zealand in both practice and commerce before starting a family and returning to the UK. Nick brings over 20 years of board experience in a variety of international finance roles, most recently as chief financial officer for British Airways until 2016. Nick is now studying part-time for an MSc in Health and Medical Science at University College London, is a trustee at the girls education charity Camfed and is a member of the audit committee at Exeter University. Nick lives in Hatfield with his wife Jude and their two daughters. Nick chairs the Finance and Performance Committee.
Committee membership: FPC (Chair), RC
Attendance: Trust Board 2 out of 2; FPC 5 out of 5; Board Development 1 out of 2, RC 0 out of 0

Jane McCue, medical director (until December 2017)

Jane has had extensive NHS experience working in almost twenty hospitals. She trained in surgery in London and Toronto and has been a consultant colorectal surgeon since 1996. She was medical director for the Trust from 2003 to 2007 and was appointed as its medical director again from April 2012. She was also the medical director for the Mount Vernon Cancer Network from February 2011 until March 2013. Jane led three major strategic reviews of surgery and planned care for the East of England Strategic Health Authority between 2007 and 2011 and was adviser to NHS London for its emergency surgery review. She is a member of the University of Hertfordshire Governing Board and women in surgery committee at the Royal College of Surgeons. She is a past council/committee member for the Association of Coloproctology, the Royal Society of Medicine Section of Coloproctology and the St Mark's Association.
Committee membership: EC, RAQC (core attendee)
Attendance: Trust Board 5 out of 5; RAQC 8 out of 11, Board Development 1 out of 3

Tom Simons, chief people officer

Thomas joined the Trust in February 2013, and has been a full board member since January 2014. He is responsible for staff recruitment, medical staffing, managing organisational and cultural change and leadership and management development. He also oversees the development and governance of the Trust's workforce. Before joining the Trust, Thomas had extensive experience of leading large-scale organisational mergers including the recent merger of three acute hospital Trusts in London to create Barts Health NHS Trust. Before that, Thomas held senior change management roles in the health sector. Thomas holds a master's degree in human resource management and is a full member of the Chartered Institute of Personnel and Development. He is also vice-president of the healthcare people management association (HPMA) for the East of England.
Committee membership: EC, FPC (attendee), RAQC (core attendee), RC (attendee)
Attendance: Trust Board 5 out of 7; FPC 7 out of 10; RAQC 2 out of 10; RC 1 out of 1; Board Development 4 out of 5

Martin Armstrong, director of finance

Martin started his NHS career as a national financial management trainee in 1994 at the South Tees Community and Mental Health NHS Trust. Since that time, he has worked in several financial management roles in the North-east, London and the South-east – including at the Princess Alexandra hospital as its deputy director of finance from 2003 to 2007, followed by becoming its director of performance from 2007 to 2009. Martin's most recent role before joining the Trust in October 2016 was director of finance, information and performance at the North Middlesex University Hospital Trust.

Committee membership: EC, FPC (core attendee)

Attendance: Trust Board 6 out of 7; FPC 10 out of 10 , Board Development 5 out of 5

Nigel Kee, chief operating officer (until September 2017)

Nigel joined the Trust in January 2017, with over 12 years NHS board level experience – at chief operating officer and chief nurse level. Nigel is responsible for the running of the Trust hospitals on a day-to-day basis and leads the five clinical divisions, as well as the estates and facilities services. He is also the executive lead for emergency planning, business continuity and security. Born in New Zealand, Nigel has a nursing background and before joining the Trust he had extensive experience in a variety of roles at regional, national and international level – in both nursing and health management.

Nigel has formal qualifications in both nursing and management, and was awarded fellowship to the Royal College of Nursing. He is also a member of the Institute of Directors and is a Justice of the Peace.

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

Attendance: Trust Board 4 out of 4; FPC 2 out of 3; RAQC 2 out of 3; Board Development 2 out of 2

Kate Lancaster, director of strategy

Kate joined the Trust as director of strategy in February 2017. Previously she was a board director at Cambridge University Hospitals NHS Foundation Trust, where she held a corporate portfolio that included corporate governance, communications, legal and support services, and contributed to policy and strategy. Over her career, Kate has worked in several NHS roles in England and Scotland.

Committee membership: EC, FPC (attendee), CTC

Attendance: Trust Board 5 out of 7; FPC 8 out of 10; CTC 3 out of 3; Board Development 3 out of 5

Liz Lees , acting director of nursing (from 7 November 2016)

Liz took up the post of interim director of nursing and patient experience in December 2016. She joined the Trust in 1993 and had been the Trust's deputy director of nursing since 2014. Previously, Liz was general manager in the emergency department and nursing services manager for cancer and palliative care. Liz is a registered general nurse (adult), specialising in oncology. Liz has a BSc (Hons) in oncology nursing and is currently studying for an MSc in Leadership and Management in Public Services at the University of Hertfordshire. In the 2016 New Year's honours list, Liz was awarded an MBE for her services to nursing.

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

Attendance: Trust Board 4 out of 5; FPC 2 out of 7; RAQC 6 out of 7; Board Development 2 out of 4

Bernie Bluhm – Interim Chief Operating Officer (from September 2018)

A highly-experienced and respected chief operations officer, Bernie has held a number of interim director-level roles within the NHS since 2013, including at St George's Healthcare NHS Trust and Bradford Teaching Hospitals NHS Foundation Trust.

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

Attendance: Trust Board 3 out of 3; FPC 5 out of 6; RAQC 5 out of 6; Board Development 2 out of 3

Michael Chilvers, medical director (from December 2017)

Michael has been a consultant in the Trust since 1999, in the specialty of anaesthesia and critical care. He has trained in Nottingham, Brisbane and London – including The Royal Free, University College London Hospitals, Great Ormond Street and Harefield hospital. Michael was appointed as medical director in December 2017 and prior to this was divisional chair of surgery for five years.

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

Attendance: Trust Board 2 out of 2; FPC 2 out of 4; RAQC 2 out of 4; Board Development 1 out of 1

Rachael Corser, director of nursing (from January 2018)

Rachael joined the trust in January 2018 from West Hertfordshire Hospitals NHS Trust, where she was the deputy director of nursing and governance for just over two years. She has had previous experience of working in acute, community, integrated care and independent sector healthcare settings, at board and sub-board level. With an extensive and varied clinical background, including working as an advanced clinical practitioner, Rachael has published her own research and evaluation of developing integrated healthcare services. Rachael has an MSc in nursing research and practice innovation and is a Florence Nightingale Scholar.

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

Attendance: Trust Board 2 out of 2; FPC 1 out of 3; RAQC 3 out of 3; Board Development 1 out of 1

	Title	Appointment date	Term(s) of office	Term of office ends
Ellen Schroder	Chair	1 April 2016	Four years	31 March 2020
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chairman	1 February 2008	Four years plus four years plus further two years	31 January 2018 – maximum term completed
Julian Nicholls	Non-executive director	1 July 2010	Four years plus two years plus further two years	30 June 2018 - resigned – left 31 July 2017
Robert Niven	Non-executive director designate*	1 September 2013	n/a	Ended 5 January 2014
	Non-executive director	6 January 2014	Four years plus further two years	5 January 2020
John Gilham	Non-executive director designate*	1 December 2014	n/a	Ended 31 May 2015
	Non-executive director	1 June 2015	Two years plus further two years	31 May 2019
Val Moore	Non-executive director	1 September 2016	Four Years	31 August 2020
Nick Swift	Non-executive director	20 November 2017	Four Years	19 November 2021
Jonathan Silver	Non-executive director designate*	16 October 2017	n/a	31 January 2018
	Non-executive director	1 February 2018	Two Years	31 January 2020
Jane McCue	Medical director	1 April 2012	n/a	Left the Trust 15 December 2017
Tom Simons*	Chief people officer	January 2014	n/a	n/a
Martin Armstrong	Director of finance	31 October 2016	n/a	n/a
Liz Lees	Acting director of nursing	7 November 2016	n/a	1 January 2018
Nigel Kee	Chief operating officer	9 January 2017	n/a	Left the Trust 1 September 2018
Kate Lancaster*	Director of Strategy	1 February 2017	n/a	n/a
Bernie Bluhm	Interim chief operating officer	11 September 2017	n/a	n/a
Michael Chilvers	Medical director	18 December 2018	n/a	n/a
Rachael Corser	Director of nursing	2 January 2018	n/a	n/a

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

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken *"…all the steps that he or she ought to have taken…"* to make himself/herself aware of any such information and to establish that the auditors are aware of such information.

Declarations of Interests of the Board of Directors

The Board of Directors undertakes an annual review of it Register of Declared interests. At each meeting of the Board and at the sub committees of the Board a standing item also requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda, and any changes to their declared interest.

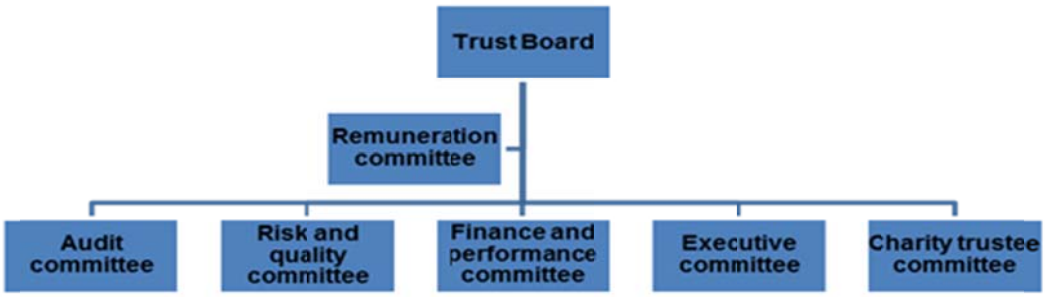
The Register of Declared Interests is made available to the public via the Board meeting minutes, and within the Declarations of Interests Register which is published on the Trust's website. Members of the public can also gain access by contacting the Trust's Company Secretary:

Jude Archer
Company Secretary
Trust Management Offices
Corey Mill Lane
Stevenage
SG1 4AT

Email: jude.archer@nhs.net

Governance structure

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



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

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

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

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

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

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

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

- *Division of surgery* (divisional chair, Dr Mark Hearn and divisional director, Jason Willis)
- *Division of medicine* (divisional chair, Dr Suresh Mathavakkannan and divisional director Bridget Sanders)
- *Division of clinical support services* (divisional chair, Dr Tim Walker and divisional director, Claire Moore)
- *Division of cancer services* (divisional chair, Jagdeep Kudhail and divisional director, Sarah James)
- *Division of women's and children's services* (divisional chairs, Mr Douglas Salvesen /Dr Linda Struthers and divisional director, Palmer Winstanley)

The divisional structure is being reviewed currently to ensure it continues to meet the needs of the organisation for 2018/19.

Information governance

The Trust's assurance framework and risk register include the risks associated with the management and control of information. In this respect, the Trust also has an information governance statement of compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage.

For 2017/18, the Trust achieved 76%, which is a *satisfactory* rating. The Trust is preparing for the new assessment framework and towards compliance with the requirements of the new General Data Protection Regulations (GDPR) that come in to effect from May 2018.

The Trust has reported two information governance serious incidents due to *disclosed in error* during the year to the Information Commissioner's Office (ICO) and one cyber security incident.

On 12 May 2017, the Trust experienced a cyber-attack resulting in complete loss of IT and some telephony systems. The major incident plans were initiated and recovery processes to reintroduce them systems undertaken over a number of days, with normal activity resuming on 19 May 2017. No patient data was compromised and there was not been any patient harm reported as a consequence of the major incident.

A full serious incident review was undertaken to ensure lessons are learnt and actions taken to mitigate a reoccurrence. The actions have included investment to enable the Trust to meet the requirements of *cyber essentials*.

The two reportable serious incidents, which took place in November 2017 and February 2018, both related to disclosure of staff personal identfiable data. The two routine internal management reports [Medical staffing list (819 individuals) and flu vacciniation report (6,800 records)] had not been customised to remove the unpinning data before the report was distributed to the usual circulation lists – senior managers, via NHS email addresses.

Immediate actions were taken to recall the lists or confirm deletion of the report and email. The two incidents were investigated fully and the root cause was identified as human error. Actions have been taken to mitigate the risk of reoccurrence, including additional training for staff undertaking the report, checking process and implementing a standard operating procedure.

Information governance training remains a priority for the Trust; the e-learning package is supported by an increased number of face-to-face training sessions delivered on the Trust's statutory and mandatory training day, as well as a number of other training and awareness activities across the organisation.

External auditor

In line with the *Local Audit and Accountability Act 2014* (the 2014 Act) and following a tender process BDO LLP were appointed as the Trust's external auditors by the Trust Auditor Panel and Board commencing 1 April 2017; the contract award is for two years, with an option to extend for one further year. BDO LLP does not provide non-audit services to the Trust.

BDO LLP has previously been the Trust's external auditor for 2015/16 and 2016/17 as appointed by the Audit Commission.

The external auditors attend the Trust's audit committee and have regular dialogue and meetings to discuss audit and other issues promptly.

Internal auditors

RSM, the Trust's internal auditors, is responsible for undertaking the internal audit functions on behalf of the Trust. The head of internal audit reports to each meeting of the Trust's *audit committee* on the audit activity undertaken. 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; therefore, it can 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 trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The summary of the internal audit work is included in the annual governance statement.

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

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* 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 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  **Nick Carver, chief executive**

Date: 24 May 2018

Governance statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East and North Hertfordshire NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East and North Hertfordshire NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The board of directors leads the management of risk across the organisation and is committed to the active management of risk, providing better care and a safer environment for patients, staff and other stakeholders. The executive team lead on the areas of risk with in their portfolios (as defined in the Corporate Assurance Map) and are nominated as the lead for specific risks on our new Board Assurance Framework.

During 2017/18 we have reviewed our Risk Management Strategy, Board Assurance Framework and Accountability Framework structure to ensure these provide clear and comprehensive risk management and fully support the corporate governance systems.

The Board Assurance Framework and Risk Management Strategy 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 appropriate to their authority and duties.

The Board 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.

The Company Secretary ensures the Board receive support and training on risk management and in December 2017 the Board had a risk management workshop, facilitated by an external specialist and reviewed the key areas of strategic significance and potential risks facing the Trust in the future. The Audit Committee and Board reviewed and approved the principle strategic risks and a new Board Assurance Framework in March 2018.

This is reviewed each month by the Executive Director Lead for each risk and jointly by Executive Committee/Divisional Executive Committee. The BAF is now considered by the relevant Board Assurance Committee at each public meeting of the Board. This is supported by the Directors detailed reports to the Board and its committees, which include workforce, finance, operational performance and quality and safety.

The operational responsibility for risk management is managed by the relevant division. Each of the Trust's clinical divisions has a Divisional (clinical) Chair, a Divisional Director and Head of Nursing who are accountable for risk and governance. A process of review and challenge of Divisional risks, as contained in the Risk Register, is conducted through the Divisional Accountability 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. In addition the Clinical Governance Strategy Committee will review and scrutinise the clinical risks and escalate to the Risk and Quality Committee.

The Quality and Patient Safety Team provides support and training to staff on risk management and the risk register. The Health, Safety and Security Team provide mandatory training on health, safety and security and fire to all staff across the organisation.

We seek to learn from good practice in a number of ways including from internal and external reviews, clinical audit programme, incidents, feedback from complaints and patient and carer experiences. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff though governance half days, monthly patient safety newsletter, trust daily bulletin, staff forums and the organisational development programme (LEND). Divisions use local methods including newsletters, posters, staff meetings, message of the week and safety huddles. In addition, to support identifying learning from serious incidents as soon as possible, bi weekly SI panels have been established and risk clinics have commenced to support the management and scrutiny of organisational risk.

A number of maternity staff have received training in and commenced using *human factors*. We are will be extending the use of human factors across the organisation through the train the trainer model.

During 2017/8 the Board had a series of development sessions to consider key areas of strategic significance and risk, including our strategic plan, accountable care organisations, reducing unwarranted variation, strategic risks, CQC and the well led framework and staff survey outcomes. Board members have also sought to increase the amount of time they spend with front line services in the Trust.

The expectation is that these sessions provide strategic focus to the organisation, enabling it to proactively respond to and support the achievement of strategic priorities for the local health economy in ways which are commercially and clinically effective for the Trust and support visibility and engagement across the Trust. There have been a number of changes within the Board over the last year and a Board Development programme has been commissioned for 2018/19.

The risk and control framework

We recognise that the provision of healthcare and the activities associated with the treatment and care of patients, employment of staff, maintenance of Trust sites and managing finances incur risks and the need to ensure there are proactive systems in place to effectively identify and manage its risks with the aim of protecting patients, staff and members of the public as well as its assets.

Our risk management strategy aims to provide the framework and outline the processes needed to support the Trust in delivering its strategic and other objectives by identifying and managing risks.

Our aim is to ensure that the effective management of risk is an integral part of everyday management by having comprehensive risk management systems in place with clear responsibility and accountability arrangements throughout the Trust.

The approach to risk management includes clinical and non-clinical risk and aims to ensure that risk management is clearly and consistently integrated and not managed in silos. By achieving this we can:

- Keep our patients, staff and visitors safe and ensure high standards of patient care.
- Protect the reputation, assets and finances of the Trust.
- Anticipate changing internal and external circumstances and respond by adapting and remaining resilient.
- Remain compliant (as a minimum) with health and safety regulations, insurance, accreditation and legal requirements.

We will do this by:

- Demonstrating the application of risk management principles in all activities of the Trust.
- Clearly defining the roles, responsibilities and reporting lines within the Trust for risk management.
- Making sure all staff understand the importance of effective risk management.
- Maintaining a comprehensive register of both clinical and non-clinical risks and reviewing the same on a periodical basis.
- Ensuring effective controls are in place to mitigate the risk and rectify gaps in control.
- Ensuring effective and documented procedures exist for the control of risk and provision of suitable information, training and supervision.
- Ensuring the Trust has appropriate Business Continuity arrangements in place.

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 Resolution, H&SE notices, will be placed on the Risk Register.
- **External guidance/alerts** – NICE, Quality Strategies, etc. that are not yet implemented.
- **Results of feedback** – Learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices etc.

Where appropriate, through consultation and direct involvement with the Trust, public stakeholders are involved in managing risks which impact on them. For example we have patient representation on our Care Environment Committee and Patient and Carer Experience Committee.

We have 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.

Taking into account the recommendations from internal auditors, external reviews including on corporate governance and the requirements of the Risk and Quality Committee (RAQC) a risk register improvement plan is being developed to embed proactive risk management across the organisation, provide greater scrutiny and level of oversight. New risk clinics for each division and a review of the corporate risk register commenced in March 2018.

We will review our appetite for and attitude to risk during 2018/19, updating these where appropriate. This includes the setting of risk tolerances at the different levels of the organisation, thresholds for escalation and authority to act, and evaluating the organisational capacity to handle risk. This will lead to the generation of a new risk appetite statement which defines the Board's appetite for risk in relation to each of the strategic objectives and risks throughout the organisation will be managed within the Trust's stated risk appetite. The previous statement will remain in place until the review has concluded.

Board Assurance and Reporting

Our Trust Board has three established committees to discharge its responsibilities on Board assurance. These are the Audit Committee, Risk and Quality Committee and the Finance and Performance Committee. These are constituted as key assurance mechanisms 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 and requirements of the provider licence. They are each chaired by an Non-Executive Director. In addition, the Board has established the Charity Trustee Committee to provide assurance and support for its responsibility as a Corporate Trustee. Directors' attendance at the Board and its Committees is recorded and monitored. A review of attendance during 2017/18 has not highlighted any issues. These are reported in full in the Trust's Annual Report.

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 and to oversee the development of the Trust Strategy.

This includes:

- Overseeing the development and maintenance of the Trust's medium and long term financial strategy.
- Reviewing and monitoring financial plans and their link to operational performance.

- Overseeing financial risk management.
- Scrutiny and approval of business cases and oversight of the capital programme.
- Maintaining oversight of the finance function, key financial policies and other financial issues that may arise.

The FPC will also oversee aspects of the underpinning activity performance of the Trust, along with responsibility for the enabling IM&T strategy for the Trust.

The Risk and Quality Committee, a formal committee of the Board, the Committee ensures that the Trust has an effective management and clinical governance framework that includes the management of risk, quality governance, patient outcomes, patient and carer experience, clinical audit and effectiveness programme and compliance with regulation (including CQC).

Each Executive Director is accountable to the Finance and Performance Committee and 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 the RAQC include:

- Clinical Governance Strategy Committee.
- Patient Safety Committee.
- Patient Experience Committee.
- Health & Safety Committee.
- Emergency Planning Committee.
- Infection Prevention and Control Committee.

Key Committees supporting FPC include:

- Programme Board with key supporting structures on finance and workforce
- Strategy Board
- Lorenzo Stabilisation Board
- Information Assurance Group

This is supported by the Directors detailed reports and local and national data to the Board and its committees, which include workforce, finance, operational performance and quality, safety, experience and outcomes. The implementation of the new Accountability Framework will support information flow and reporting from ward to Board.

A review of the clinical governance structures is currently being undertaken by the Medical and Nursing Directors to ensure they remain fit for purpose and support the new Quality Transformation Programme. The QTP has five key workstreams: valuing the basics; quality governance and risk; keeping our patients safe; patient experience; quality strategy. Progress against the QTP will be monitored by the RAQC.

Principle Risks

As stated above the Trust has 12 principle risks defined on the Board Assurance Framework each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified.

As at the 31 March 2018, the Board sees its major risks as:

- **001/18:** There is a risk that within the context of the Healthcare Economy the Trust has insufficient capacity to sustain timely and effective patient flow through the system which impacts the delivery of the 62day cancer, RTT and the A&E 4-hour standards.
- **003/18:** There is a risk that the Trust is unable to achieve financial performance in 17/18 as a result of not securing the required efficiency improvement within its cost improvement plan and its income.
- **004/18:** There is a risk that the Trust is unable to deliver target levels of patient activity and achieve reimbursement from commissioners for activity in 17/18.
- **005/18:** There is a risk that the Trust's IT systems are not sufficiently embedded/stabilised to ensure the hospital is run in a safe and effective way.
- **006/18:** There is a risk that there is insufficient capital funding to address all estates backlog maintenance, including fire estates work, and funding for medical equipment
- **011/18:** There is a risk that the Trust is not always able to consistently embed a safety culture and evidence of continuous quality improvement and patient experience.

The Board and its committees receive regular reports on the above to assure itself that the mitigations are operating where this is within the trusts ability to do so and that those mitigations are effective or further actions identified.

Care Quality Commission, Well Led and Provider Licence

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is 'Requires Improvement'.

The Care Quality Commission has not taken enforcement action against ENHT during 2017/18.

The Trust has not participated in any special reviews or investigations by the CQC during 2017/18.
As part of CQC's ongoing monitoring and inspection programme, the CQC confirmed a number of the Trust's core services would be re inspected – this was unannounced and commenced in March 2018. The Core Services that were inspected are:

- Urgent and Emergency Care Services (Lister Hospital and the New QEII).
- Surgery (Lister Hospital).
- Children and Young people (Lister Hospital).
- Maternity (Lister Hospital).
- Medical Care (Lister Hospital and MVCC).
- Chemotherapy (MVCC).
- End of Life (MVCC).

The inspection is to check that the services that we are providing are safe, caring, effective, responsive to people's needs and well-led. The Trust also received a well-led review and use of resources review as part of CQC new inspection regime. These were both completed in April 2018. The outcome of the inspections will be published when received in July 2018. Actions based on the initial feedback that we have received to ensure our services continue to improve have commenced.

To support ongoing compliance with the essential standards of quality and safety we have a programme of activities to test this, including 15 steps challenge (first impressions), mini focused inspections on targeted topics, internal mock inspections and unannounced quality and safety visits by our CCG.

We use the new CQC Insight report and internal quality and safety information to enable a risk based approach to our inspections. We are reviewing and formalising this programme for 2018/19.

We undertake an annual review to ensure the requirements of the fit and proper persons are met.

In September 2017 we had an external review of our corporate governance structures taking into account the NHSI guidance on the well-led framework and during quarter four we have undertaken an internal review against our compliance with the well-led framework. Where areas for improvement have been identified actions are in place.
We undertake an annual review against the requirements of the provider license.

Data security

Data security risks are identified through a variety of mechanisms including information from local and national networks regarding cyber security, internal and external audit reviews, data flow mapping, incidents and incident reporting and penetration testing. During 2017/18 we have taken a number of actions to improve our data security and resilience including cyber security. Action plans are in place and monitored through the Board, its committees and the Information Governance (IG) steering group. In readiness for GDPR we asked all areas to review their data flows and these will enable any new or potential risks to be identified and mitigated. For cyber security, see sections on *information governance* and *review of the economy, efficiency and effectiveness of the use of resources*.

Operational performance

A&E: The pressures on the Emergency Department have continued in 2017/18 and we failed to deliver the 95% target to be seen within 4 hours, achieving 83.6%. Please note that we were not able to report A&E data during September and October 2018 due to the rollout of Lorenzo.

The teams, with external expertise have reviewed pathways and a recovery plan agreed with NHS Improvement saw our performance begin to improve in the second half of the year, although progress slowed as winter pressures mounted from January 2018. We are committed to improving this during 2018/19.

Cancer waits: We have continued to deliver on the two-week wait target; however, there is a need to focus on the improvement on the 31 day and 62 days targets. An in-year recovery plan was agreed with NHS Improvement, and we are on track to recover the 85% performance standard during 2018/19.

18 weeks: Referral to treatment time and radiology diagnostic standards – following the rollout of the Trust's new electronic patient record system, Lorenzo, in September 2017, we are not reporting RTT data currently. We are addressing the data quality issues and continue to work towards returning to national reporting in November 2018.

Electronic patient record system and digital stabilisation programme

Our new electronic patient record system – called Lorenzo – was rolled out in September 2017. The implementation highlighted several areas of concern relating to data of a poor quality passed from legacy systems and the requirement for additional training and support to staff using the systems.

Although we are able to report centrally on most performance indicators, more time will be needed before the Trust can report formally on its 18-week referral to treatment standard. We have agreed a stabilisation and optimisation plan to improve the system's performance, which is supported by our regulators and NHS Digital. We have established a Lorenzo Stabilisation Board to monitor progress. This includes representation from NHSI and NHS Digital and the Stabilization Board reports into the Finance and Performance Committee.

We have an established governance framework to manage the data quality and clinical risks and make sure that the impact on clinical quality and patient safety is mitigated and no patients are 'missed' on the patient tracking list. This was considered and endorsed by the Board in March 2018 and is routinely monitored. Where patients have waited over 52 weeks for the 18-week referral to treatment standard or over 100 days against the cancer 62 day pathway, a harm review will be undertaken. The harm review process has been agreed with our commissioners and the progress and outcomes is reported to RAQC and Board at each meeting. For the financial impact see section on *Review of economy, efficiency and effectiveness of the use of resources*.

Learning from deaths

We have an established mortality review process to enable learning and this is reported through our governance structures to RAQC and Board. We continue to perform well and our HSMR position for the twelve months to December 2017 is rated statistically "as expected" and is slightly better than the national average (99.41). The SHMI for the twelve months to September 2017 is 102.9 and remains within the 'as expected' range. To support reducing this further we have improvement plans for pneumonia, heart failure, lung disease and septicaemia.

Never events

We reported six never events in 2017/18:

- A needle was retained after suturing following childbirth. The needle and thread separated during the procedure and whilst it was believed that the needle had been disposed of safely, in fact it had been retained.
- An operation was undertaken on the wrong finger. The operation site marking was on the back of the hand rather than a circumferential mark (like a ring) around the finger.
- A patient was fed fluids via a feeding tube that was placed in the lung rather than in the stomach.
- A gallstone retrieval bag was left in place following surgery. The operation had been started laparoscopically (using instruments though three small cuts in the skin) but due to complications the procedure extended to fully opening the abdomen. During this transition the retrieval bag was accidentally left inside the body and was not visible during the open procedure.
- A small quantity of the wrong blood was given to a patient.
- A guidewire was accidentally left in place after inserting a central line (tube into a large vein to allow fluids and medication to be given). The wire is used to help insert the line and should be removed after insertion.

Each of these incidents is investigated fully to understand how they happened and to apply methods to prevent a re-occurrence. As a result of these incidents the following changes have been made / are underway:

- Amendments to the surgery checklist to include additional products in the count of items used.

- Review of training and competency assessments for doctors as they progress from junior to middle grade.
- Update to training programmes.
- Review of products available for central line insertion to prevent lines being left in place.

We aim to reduce significantly the number of never events during 2018/19 and improve and embed our learning from these incidents as part of our new quality improvement plan.

Infection control

During 2017/18 we reported 1 hospital acquired MRSA bacteraemia against a target of zero and 28 cases of clostridium difficile against a planned maximum of 11. Each of the cases is subject to an investigation to identify causes and apply future preventative measures. In thirteen of these cases all appropriate care was given and these were deemed as unavoidable. To reduce the incidence of infection further actions are required relating to handwashing, optimum antibiotic usage and timely diagnosis. In addition there are some wards where the space between beds is less than national guidance but can only be addressed by removing beds (further reducing capacity) and some investment is required within the environment. In May 2018 we were able to reduce the relevant areas from six to five beds. We have agreed an improvement plan with NHSI to support our compliance with the hygiene code and reduce the number of incidences.

Safer staffing

Ensuring safe staffing levels remains a priority and we have continued to invest in recruiting permanent staff and reduce the use of agency. This supports patient safety and quality. We undertake a formal review of the nursing establishment twice a year and report this to RAQC and Board. In addition safer staffing is reported each month to RAQC and Board.

Data quality

We have continued to review our data quality both internally and with the support of external experts and our 2017/18 Internal Audit programme undertaken included a focus on data quality. The external auditors have audited our A&E four hour target and 62 day cancer waits as part of the data quality audit for our Quality Account 2017/18. Data quality continues to be a priority for 2018/19 as part of the Data Quality Improvement Plan and Digital Stabilisation Plan. We have invested in the team to support data validation and training for our staff. With regards clinical coding the audit confirmed a level 3 achievement of the measure within the Information Governance Toolkit.

Fire, medical equipment and backlog maintenance

We have undertaken a review of our compliance with fire safety and the associated risk assessments. This included a six facet survey to review our estate in line with Department of Health recommendations and guidance and, a detailed fire compartmentation survey and risk assessments of the highest buildings (Tower Block and Strathmore). The latter forms part of our backlog maintenance strategy and was commissioned prior to the fire in London and conducted in July 2017. The results of these surveys have identified deficiencies and we have prioritised capital investment for 2018/19 to address the identified compartmentation and upgrades fire door risks. This is monitored through RAQC and Board.

Capital allocation available to the Trust is extremely limited, owing to our financial position. We are only able to fund replacement of the equipment/schemes with the highest risk register scores. We have a clear process in place to support the assessment of all requests for capital investment and decision making which is supported by the Capital Review Group (CRG). The CRG meets monthly and includes Executive Directors, Senior Operational Managers, a Clinical representative as well as

finance, IT and estates specialists. The group reports its activities and recommendations to the Divisional and Executive Committee for ratification. The Medical Director and Nursing Director are core members of the Executive Committee and Divisional Executive Committee. As the levels of risk may change during the year, or new risks may emerge, the CRG is tasked with reviewing the capital position on a monthly basis and with assessing any in year requests for use of the contingency funds.

Pension

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

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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's operating plan for 2017/18 was approved by the Board. The Trust agreed its financial plan for 2017/18 with NHS Improvement based on a control total of an £7.744 million deficit. In order to deliver this control total, the Trust required support from the Sustainability and Transformation Funds of £10.2 million. This support was conditional on achieving financial and operational targets, which were only met partially.

Progress against the delivery of the plan is monitored by the Finance and Performance Committee (FPC). In 2017/18 the trust established a PMO office to support the delivery and weekly monitoring of the cost improvement plans. All processes were reviewed with the support of PwC to ensure they were fit for purpose. A weekly Programme Board monitored the delivery of the financial recovery plan and reported to FPC and Trust board.

The Trust has reported a deficit, after technical adjustments of £25.76 million. Whilst the Trusts reported financial performance for 2017/18 has improved compared with 2016/17, it was materially at variance from plan expectations.

The key features of financial performance during 2017/18 and explanations for the gap between planned and actual performance were:

- The Trust earned significantly less income from patient activities than it had planned for the year. There were a number of causes for this under performance. The implementation of a new Patient Administration System (PAS) served to exacerbate existing weaknesses in capacity planning and hindered the Trust in its ability to effectively book and schedule patients, thereby significantly restricting its ability to generate revenues.

- Patient activity levels and associated income were also materially impacted upon by both the WannaCry cyberattack during May 2017 and the NHS directive to reduce planned elective services during an extremely challenging winter period for the service both locally and nationally.

- The impact of local health economy schemes to reduce and redirect demand for emergency services proved more significant than the Trust had envisaged and this resulted in significant unplanned reductions in both activity and revenue.

- The Trust changed its approach and framework for identifying and delivery cost efficiency and savings during 2017/18. This resulted in total savings of £19.5m across the year. This represents a very significant improvement on all historic performance. Unfortunately, this did fall short of the ambitious target (£23.3m) that the Trust had set for the year.

- The Trust has made considerable progress during 2017/18 in reducing its agency staffing costs. They have reduced by £13.0m compared with 2016/17. This has helped the Trust to limit the rate of pay bill inflation.

- As a consequence of the significant financial pressures summarised above and the resulting variance from planned control total, the Trust was unable to access the full value of Sustainability and Transformation Funding that it had anticipated within its financial plan.

Information governance

The Trust's assurance framework and risk register include the risks associated with the management and control of information. In this respect, the Trust also has an information governance statement of compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage.

For 2017/18, the Trust achieved 76%, which is a *satisfactory* rating. The Trust is preparing for the new assessment framework and towards compliance with the requirements of the new General Data Protection Regulations (GDPR) that come in to effect from May 2018.

The Trust has reported two information governance serious incidents due to *disclosed in error* during the year to the Information Commissioner's Office (ICO) and one cyber security incident.

On 12 May 2017, the Trust experienced a cyber-attack resulting in complete loss of IT and some telephony systems. The major incident plans were initiated and recovery processes to reintroduce the systems undertaken over a number of days, with normal activity resuming on 19 May 2017. No patient data was compromised and there has not been any patient harm reported as a consequence of the major incident. A full serious incident review was undertaken to ensure lessons are learnt and actions taken to mitigate a reoccurrence. The actions have included investment to enable the Trust to meet the requirements of *cyber essentials*.

The two reportable serious incidents, which took place in November 2017 and February 2018, both related to disclosure of staff personal identfiable data. The two routine internal management reports [Medical staffing list (819 individuals) and flu vacciniation report (6,800 records)] had not been customised to remove the unpinning data before the report was distributed to the usual circulation lists – senior managers, via NHS email addresses. Immediate actions were taken to recall the lists or confirm deletion of the report and email. The two incidents were investigated fully and

the root cause was identified as human error. Actions have been taken to mitigate the risk of reoccurrence, including additional training for staff undertaking the report, checking process and implementing a standard operating procedure.

Information governance training remains a priority for the Trust; the e-learning package is supported by an increased number of face-to-face training sessions delivered on the Trust's statutory and mandatory training day, as well as a number of other training and awareness activities across the organisation.

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 2017/18 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 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 review of the priorities for 2017/18 concluded: Significant progress has been made against the majority of the quality account priorities, less progress in others. The Trust recognises that this is likely given the high level of ambition set or where funding was not accessible. Scrutiny of the Quality Account to ensure a balanced view is reflected is provided through scrutiny by the Patient Experience and Carer Committee (includes representatives from Carers and Patients), Risk and Quality Committee, Audit Committee and stakeholder review and comment (Healthwatch, CCG and Health Scrutiny Committee – Hertfordshire and Bedfordshire). External Audit has provided scrutiny of the data accuracy for two of the indicators – ED four-hour target and 62 day cancer target.

In order to identify priorities for 2018/19 the following actions have been undertaken:

- Existing priorities and indicators from 2017/18 were reviewed to consider their ongoing relevance and progress made.
- Current performance was considered to identify emerging concerns e.g. complaints and survey results.
- Cross-referencing with the Trusts operating plan.
- Consideration of the Trusts highest risks.

In addition the opinions of staff and service users were sought from the following committees:

- Patient Experience Committee.
- Patient Safety Committee.
- Clinical Governance Strategy Committee.
- The final decision on priorities was determined by the Executive Committee.

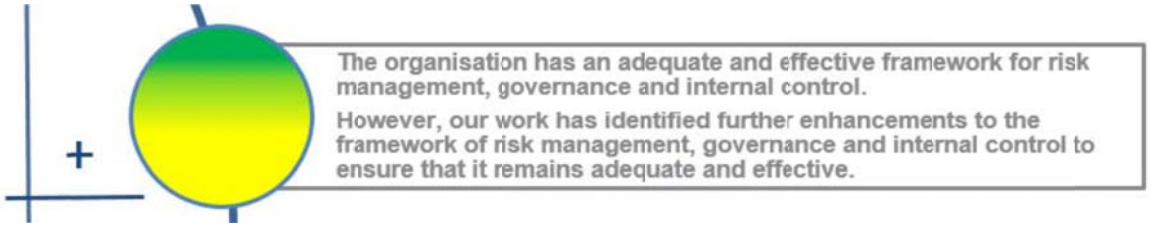
Throughout the year we ensure ongoing engagement with the Health & Well Being Board, Health Scrutiny Committee and our Commissioners. We will continue to monitor performance against priorities, including by the use of floodlight scorecards at ward, divisional and Trust level.

Review of effectiveness

As Accountable 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 NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in 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 Risk and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit (HoIA) provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work.

For the 12 months ended 31 March 2018, the head of internal audit opinion for East and North Hertfordshire NHS Trust is as follows:



No 'no assurance' (red) opinions have been issued to the Trust during the year, although medicines Management, Resilience Planning, Procurement and Fixed assets audits resulted in a partial (amber red) assurance opinion. For these areas, the Board can take partial assurance that the controls to manage these risks are suitably designed and consistently applied.

The Trust's internal audit programme is directed to areas of perceived high risk and where individual weaknesses have been identified the Executive Director lead has ensured comprehensive action plans are in place to address these and evidence is collated to support implementation.

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

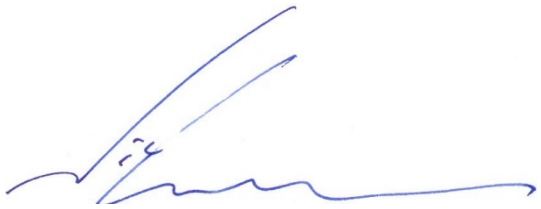
- The Board regularly reviews the Trust's objectives and receives reports on key matters of concern.
- The Audit Committee provides an independent and objective review of the Trust's system of internal control and comments where appropriate on the overall risk management process.
- The Risk and Quality Committee provides assurance on the progress of all areas of risk management.
- The Finance and Performance Committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the Risk and Quality Committee for further scrutiny, while providing proactive risk management within the areas of activity covered by its own remit.

- Clinical Audit – the annual clinical audit programme is reviewed and approved through the Clinical Governance Committee and progress is monitored through the Divisions and RAQC. The Audit Committee receives the annual self-assessment against the assurance framework.
- 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 IG toolkit submission and IGSoC.
- The Board ensures that all senior staff, clinical and other, through various meetings and review processes, including attending the Board Committees as required are held to account in all areas for delivery against finance, performance, quality, governance and risk issues. In quarter 4 2017/18 a new Accountability Framework Structure was approved.
- During 2017/18 we have commissioned various external reviews and expertise to review our financial governance, board governance which takes into account the well led review and preparedness for our new patient administration system. This has provided assurance and additional recommendations, which have been progressed.
- I am confident that Executive Directors, Senior Managers of the Trust and identified risk leads are fully engaged in maintaining and reviewing the effectiveness of the system of internal control. This is supported by the positive CQC engagement and recent Internal Audit reports.

Conclusion

No significant internal control issues. I am satisfied that all internal control issues raised have been, or are being, addressed by action plans and that these will be monitored through the governance structures and these are reflected in the statement above.

Signed:



Chief Executive **Date: 24 May 2018**

Modern Slavery Act 2015 statement

The Modern Slavery Act 2015 establishes a duty for commercial organisations with a turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of steps taken to ensure that slavery or human trafficking is not taking place in its business or its supply claims.

The Trust's income from government sources, including CCGs and local authorities, is publicly funded and outside the scope of these requirements. The Trust does not receive income from non-governmental sources e.g. private patients, in excess of £36 million and hence does not qualify as a commercial organisation for the purpose of the requirements of making this statement under the Modern Slavery Act 2015. However, clearly the Trust is opposed to any actions that could be construed as slavery or human trafficking.

Remuneration and staff report

This part of the annual report looks at the following areas:

- Remuneration report
- Staff report

Where the information in these reports has been audited by the Trust's auditors, BDO LLP, then this is stated as part of the information. If there is no statement made, the disclosure is not required to be audited.

Remuneration report

This section covers:

- Remuneration policy for directors and senior managers, along with the relationship between the numeration report and exit packages, severance payments and off-payroll engagement disclosures
- Remuneration table
- Pensions benefits table

Remuneration policy

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 chair and all the non-executive directors; it is chaired by the vice chair. The committee is supported by the chief executive, chief people officer and the company secretary. The remuneration committee will meet at least annually to fulfil its duties and in 2017/18, it met once. 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 Trust's functions. This is carried out in parallel with a detailed review at approximately every two years of remuneration for individual posts within regional and national markets; this was last undertaken in April 2015 and refreshed in 2016.

In March 2017, the committee considered a benchmarking report prepared by an external body alongside information produced by NHS Improvement - a consolidated foundation and non-foundation Trust executive salary data set. Executive director and chief executive pay is then set based on the following principles:

- What they bring to the role – their experience and capability

- Their marketability and importance to the organisation – their previous salary history, how in demand are they by other organisations and how important are they to the Trust
- The *going rate* for the job and what it means for the person the Trust wishes to appoint or retain
- Performance against objectives and delivery in year
- Taking into account inflation – an underlying rate of inflation at 1.2% (national office of statistics CPI) in the last quarter of the calendar year (November 2017 to January 2018)

This information is also set against an outline pay framework, which is as follows:

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

The committee also pays due consideration to what is happening in the financial environment and with its other employees when determining executive director's remuneration; for example, maintaining a differential between Board and the senior managers at agenda for change band nine. 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 and involvement of a non-executive director. All the Trust's executive directors hold permanent contracts. The notice period for executive directors is six months. There are no arrangements for termination payments or compensation for early termination of contract. The Trust is also not liable for any compensation payments to former senior managers or amounts payable to third parties for the services of a senior manager.

The remuneration and terms of office of non-executive directors are those set out by the NHS Improvement. 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 Trust's chair. 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.

Pay multiples (fair pay disclosure) for 2017/18

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. This information has been subject to audit by the Trust's auditors BDO LLP.

The mid-point of the banded remuneration of the highest paid director in the Trust in 2017/18 was £187,500 (2016/17 – £187,500). This was 6.3 times (2016/17 – 6.2 times) the median remuneration of the workforce, which was £29,860 (2016/17 – £30,357). Median pay has reduced due to the reduction in the number and average pay of contractors, who had been providing support to strategic capital projects. On a like-for-like basis for temporary staff, median salary has increased by 1%, which is the value of the pay rise awarded in 2017/18. As the pay of the highest paid director has remained static and the median salary reduced, the multiple has increased slightly.

In 2017/18, there were 15 employees who received remuneration more than the highest paid director (in 2016/17, the figure reported was 21 employees). The remuneration received by Trust staff in 2017/18 ranged from £15,404 to £288,822 per annum (for 2016/17 – the reported range was £15,251 to £264,925).

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.

Remuneration tables

Name and title	2017/18						2016/17					
	Salary (bands of £5000)	Expense payments (taxable) total Rounded to nearest £100	Performance pay and bonuses (bands of £5000)	Long term performance pay and bonuses (bands of £5000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)	Salary (bands of £5000)	Expense payments (taxable) total Rounded to nearest £100	Performance pay and bonuses (bands of £5000)	Long term performance pay and bonuses (bands of £5000)	All pension related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Executive directors												
Nick Carver	185-190	6	0	0	0	185-190	185-190	8	0	0	0	185-190
Chief executive												
Anthony Ollis (to 30/06/16)	n/a	n/a	n/a	n/a	n/a	n/a	40-45	0	0	0	0	40-45
Director of finance												
Brian Steven (20/06/16-30/10/16)	n/a	n/a	n/a	n/a	n/a	n/a	115-120	0	0	0	0	115.120
Director of finance (interim)												
Martin Armstrong (from 31/10/16)	135-140	0	0	0	0	135-140	55-60	0	0	0	42.5-45	95-100
Director of finance												
Angela Thompson (to 06/11/16)	n/a	n/a	n/a	n/a	n/a	n/a	70-75	0	0	0	30-32.5	105-110
Director of nursing												
Liz Lees (from 07/11/16 to 01/01/18)	70-75	36	0	0	105-107.5	180-185	40-45	21	0	0	45-47.5	85-90
Acting director of nursing												
Rachael Corser (from 02/01/18)	25-30	0	0	0	12.5-15	40-45	n/a	n/a	n/a	n/a	n/a	n/a
Director of nursing												
Brian Owens (01/04/16-01/08/16)	n/a	n/a	n/a	n/a	n/a	n/a	35-40	0	0	0	12.5-15	50-55
Acting director of operations												

Name and title	2017/18						2016/17					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Executive directors (contd.)												
Bernie Bluhm (02/08/16 to 08/01/17 and from 11/09/17))	135-140	0	0	0	0	135-140	140-145	0	0	0	0	140-145
Chief operating officer												
Nigel Kee (from 09/01/17 to 01/09/17))	55-60	0	0	0	40-42.5	95-100	30-35	0	0	0	7.5	35-40
Chief operating officer												
Jane McCue (to 15/12/17)	115-120	1	0	0	0	115-120	160-165	2	0	0	27.5-30	190-95
Medical director												
Michael Chilvers (from 18/12/17)	50-55	0	0	0	30-32.5	80-85	n/a	n/a	n/a	n/a	n/a	n/a
Medical director												
Stephen Posey (to 31/10/16)	n/a	n/a	n/a	n/a	n/a	n/a	80-85	1	0	0	40-42.5	120-125
Deputy CEO/director of strategic development												
Sarah Brierley (01/11/16-31/01/17)	n/a	n/a	n/a	n/a	n/a	n/a	20-25	6	0	0	47.5-50	70-75
Acting director of strategy												
Kate Lancaster (from 01/02/17)	125-130	20	0	0	35-37.5	160-165	20-25	0	0	0	7.5-10	30-35
Director of strategy												
Tom Simons	115-120	65	0	0	27.5-30	150-155	115-120	59	0	0	57.5-60	180-185
Chief people officer												

Name and title	2017/18						2016/17					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ellen Schroder (from 01/01/17)	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Chair												
Alison Bexfield (to 31/01/18)	5-10	0	0	0	0	5.-10	5-10	0	0	0	0	5-10
Vice-chair												
Julian Nicholls (to 31/07/18)	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Bob Niven	5-10	0	0	0	0	5.-10	5-10	0	0	0	0	5-10
John Gilham	5-10	1	0	0	0	5.-10	5-10	0	0	0	0	5-10
Vijay Patel (from 01/11/15 to 31/01/17)	n/a	n/a	n/a	n/a	n/a	n/a	5-10	0	0	0	0	5-10
Val Moore (from 01/09/16)	5-10	1	0	0	0	5.-10	0-5	0	0	0	0	0-5
Jonathan Silver (from 16/10/17)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Nick Swift (from 20/11/17)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a

Notes to the remuneration table for executive and non-executive directors

- The table on the previous two pages includes an amount in respect of the increase in pension entitlements of each executive director. It compares the projected pension and lump sum at the end of the financial year with the equivalent figures at the start of the year, adjusted for inflation and deducting employees' pension contributions. The pension element of the calculation is based on the assumption that the individual will receive a pension for a twenty-year period. The figures for all pension-related benefits do not constitute a charge to the Trust's statement of comprehensive income or a taxable benefit for the directors. The Trust's contribution to directors' pensions was 14.3% of salary for 2017/187 (14.3% in 2016/17). In summary, the figures calculated in the *All pension related benefits* column take in to account several factors, the principal one being the total maximum income that the person would receive covering the following 20-year period if they retired at the end of the financial year in question.
- Benefits-in-kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, which has the effect of reducing the salary paid during 2016/17 and 2017/18.
- The information in the tables above has been subject to audit by the Trust's auditors BDO LLP

Pension benefits

Name and title*	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2018	Lump sum at pension age related to accrued pension at 31 March 2018	Cash equivalent transfer value at 1 April 2017	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2018	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Chief executive								
Martin Armstrong	0	0	30-35	85-90	488	8	496	0
Director of finance								
Nigel Kee (to 01/09/17)	5-7.5	15-17.5	35-40	105-110	583	140	723	0
Chief operating officer								
Kate Lancaster	2.5-5	0-2.5	30-35	80-85	468	58	526	0
Director of strategic development								
Liz Lees (to 01/01/18)	5-7.5	17.5-20	35-40	110-115	519	155	674	0
Acting director of nursing								
Rachael Corser (from 02/01/18) **	2.5-5	2.5-5	20-25	50-55	262	44	306	0
Director of nursing								
Jane McCue (to 15/12/17)***	0	0	65-70	215-220	1,656	n/a	n/a	0
Medical director								
Michael Chilvers (from 18/12/17)	7.5-10	17.5-20	50-55	140-145	820	169	989	0
Medical director								
Tom Simons	2-2.5	n/a	15-20	n/a	150	30	180	0
Chief people officer								

Notes to pensions table

*Nick Carver left the pension scheme with effect from 31st March 2016, so the full range of disclosures is not possible.

**Rachael Corser joined the Trust on 2 January 2018, which means some of her pension benefits arose from her service with her previous NHS employer prior to this point

***Jane McCue retired during the year so no cash equivalent transfer value was applicable at 31 March 2018

As non-executive members of the Board do not receive pensionable remuneration, there are no entries in respect of pensions for these individuals. A cash-equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

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

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

There are no lump sums to be disclosed in respect of Tom Simons or Anthony Ollis as they are not members of the 1995 section of the NHS Pension scheme. There is nothing to disclose in respect pensions for Brian Steven or Bernie Bluhm, who were not direct employees of the Trust.

The information contained within the tables above has been subject to audit by the Trust's auditors, BDO LLP

Compensation for loss of office

There was nothing to disclose with regards to compensation for loss of officer for Board directors in respect of 2017/18. This statement is subject to audit by the Trust's auditors, BDO LLP.

Staff report

This section covers:

- Staff numbers and costs
- Staff composition
- Workforce data
- Off-payroll engagements
- Exit packages

Staff numbers and costs

The table below summarises the Trust's workforce by category stated as full-time equivalents (FTEs), not headcount.

Average number of employees	2017/18			2016/17
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	771	53	**824**	800
Administration and estates	1,466	125	**1,591**	1,657
Healthcare assistants and other support staff	738	126	**864**	816
Nursing, midwifery and health visiting staff	1,587	230	**1,817**	1,826
Scientific, therapeutic and technical staff	372	37	**409**	407
Healthcare science staff	167	-	**167**	135
Total average numbers	**5,101**	**571**	**5,672**	**5,641**
Of which:				
Number of employees (WTE) engaged on capital projects	5	-	**5**	133

Please note – the analysis of staff numbers in the table above has been audited by the Trust's auditors, BDO LLP.

The table below summarises the Trust's employee benefits costs.

Staff costs	2017/18			2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	193,673		**193,673**	177,842
Social security costs	19,625	-	**19,625**	17,774
Apprenticeship levy	941	-	**941**	
Employer's contributions to NHS pensions	22,196	-	**22,196**	20,490
Pension cost - other	63	-	**63**	6
Termination costs	276	-	**276**	5
Temporary staffing costs	-	27,545	**27,545**	43,791
External financing				
Costs capitalised as part of assets	505	-	**505**	2,762

Please note – the analysis of staff numbers in the table above has been audited by the Trust's auditors, BDO LLP.

Staff composition

The table below summarises the composition of the Trust's workforce by gender; it is based on headcount, rather than use of full-time equivalents (FTEs).

2017/18	Male	Female	Total
Executive directors	4	3	7
Employees	1,311	4,588	5,899
Total	**1,315**	**4,591**	**5,906**

The Trust, where appropriate, should disclose the make-up of its senior managers by pay band. However, as the senior managers, in the context of the Remuneration and Staff report, are Executive Directors, who are not subject to pay bandings, this disclose is not appropriate.

Workforce data

In the table below, a summary of workforce-related statistics is provided for 2017/18, alongside figures provided for the previous three years. The figures are the average for the years ending 31 March and are expressed as full time equivalents (FTEs).

Activity	31 March 2018	31 March 2017	31 March 2016	31 March 2015
Staff employed	5,100.45	4,828.71	4,651.92	4,540.63
Vacancy rate	8.35%	12.06%	9.72%	7.11%
Turnover rate	13.48%	12.96%	12.80%	12.91%
Sickness absence rate	3.98%	4.06%	4.30%	4.12%

The Trust has increased the overall establishment by circa 22.79 wte in the financial year 2017/18. As a result of variety of recruitment campaigns launched throughout 2017/18 the current pipeline has increased significantly and in March 2018 reached 247.75 wte of external candidates.

The main areas of focus for staff retention are: the working environment; shift patterns; roster planning; training and development opportunities, including new rotational and nursing associate roles; flexible working; and staff engagement/culture. A Trust retention strategy has been developed.

Sickness absence data

Throughout 2017/18, the Trust maintained its commitment to supporting our staff in being able to maintain a good level of attendance at work through providing appropriate support, reasonable adjustments where appropriate and through early intervention. A detailed sickness absence action plan was developed, including the launch of a revised policy (which provides a more consistent and robust framework for managing sickness absence) in March 2018.

Engaging with our line managers has been essential in ensuring management processes are consistent and robust when addressing higher levels of sickness absence. On-going training to support the development of management HR capabilities, with a focus on managing sickness absence, has been put in place by the Trust's employee relations advisory service (ERAS). In particular, the new policy's launch has been supported by a high number of training sessions targeted at all managers who have a responsibility for managing sickness absence.

The Trust has continued the use of *Absence Assist*, an external centralised sickness reporting and advisory service, which has helped to address the variance in reporting and managing sickness absence across the Trust.

The table below sets out sickness absence rates for the calendar year (i.e. 2017).

Staff sickness absence	2017	2016
Total days lost	49,158	47,105
Total staff years	4,967	4,778
Average working days lost (per WTE)	**10**	**10**

Equality and diversity – staff in post

Ethnicity

The Trust's workforce continues to be more diverse than the population served; 34.49% of the workforce is from ethnic minority groups in comparison to the local community, which is 16.9% (based on 2011 Census data).

Age

In Hertfordshire, 41% of the population is aged between 30 and 59; within the Trust, 72.45% of staff fall within this age bracket. Staff are employed from all age bands across all staff grades, however the Trust appears to have a lower representation of staff aged 60 years plus across most bands and a lower representation of staff aged 29 years or less working at bands 7, 8 and 9.

Gender

Females continue to make up the majority of the workforce at 77.73%; they outnumber males in all staff groups with the exception of medical and dental, where 43.59% are female and 56.41% are male. By way of comparison, the male population of Hertfordshire is 547,110 compared to females at 568,952 (49% compared to 51%). Just under 38% of all Trust employees work part-time, with the highest percentage in nursing and midwifery (45.61%) and nursing unqualified (47.87%).

Disability

14.32% of people in the 2011 census for Hertfordshire reported they had a disability. Of the Trust's 5,906 staff, 211 did not disclose whether they have a disability and 2,336 were undefined. It is not clear why staff are unwilling to share their status, so it is difficult to draw any definitive conclusions based on these figures.

Religion

54.4%% of Hertfordshire's population state they are Christian, with the next highest group at 33.6% stating they follow no religion. The Trust's workforce is 42.19% Christian, however 22.11% have not disclosed any religion and 9.65% do not want to disclose their religion. The next largest group is atheist at 9.72%.

Sexual orientation

68.03% of the Trust's workforce state they are heterosexual, with 23.69% giving undefined responses; furthermore, 6.64% do not wish to disclose their orientation. It has not been possible to find any localised census data with which to compare these figures.

Policy overview

The Trust's sickness absence management policy has been reviewed recently and updated in partnership with staff side colleagues. This is a key policy, and the employee relations advisory service (ERAS) has been running training events for managers to support roll-out of the new arrangements.

Other policies that have been reviewed and updated in the last year include the following:

- Dealing with subject access requests
- Infection, prevention and control issues for staff
- Clinical professional registration policy
- Management guidelines for departmental personal files
- Management of independent contractors

Policies applied to support people with disabilities

In line with the Trust's recruitment and selection policy, the Trust is a *Two Tick* disability symbol user. This means that all applicants with a disability who meet the minimum person specification criteria for a job vacancy will be interviewed, provided that they make this known on their application.

For staff who become disabled in service or may suffer from a condition that may be considered as disabled under the Equality Act, the Trust seeks to retain their service and make reasonable adjustments to their role. The Trust's Health at Work Service supports this process by providing recommendations on adjustments and suitability of the post, based on the member of staff's condition. The Sickness absence management policy includes a provision to consider a temporary or permanent health-related redeployment where staff are no longer able to undertake their substantive role.

The Trust-wide policy for annual performance appraisal requires staff and managers to discuss the issue of disability and any adjustments that may be required. A question included in the appraisal form prompts this discussion, and also prompts discussion about any related support or training that may be required.

Equality impact assessments

The Trust ensures that equality impact assessments (EIAs) are completed for all policies and changes to services. All Trust policies are ratified through appropriate channels and the Trust's clinical governance process ensures all clinical policies have an EIA attached. The Trust has a guide to assist managers in completing the EIA process.

Expenditure on consultancy

In 2017/18 £4,652,000 was spent on consultancy costs. This included expenditure on schemes agreed with NHS Improvement to review the overall strategy and efficiency of the Trust's clinical operations and finances.

Off-payroll engagements

The Government reformed the Intermediaries legislation, introducing *Chapter 10 Part 2 Income Taxes (Earnings and Pensions) Act 2003 (ITEPA 2003)*, often known as IR35. Under the reformed rules, public sector bodies must determine whether the rules apply when engaging a worker through a personal service company (PSC).

The Trust is required to report arrangements where individuals, earning over £245 per day, are paid through their own services company and how these individuals have been assessed for tax purposes for payments made after 6 April 2017.

The table below looks at all off-payroll engagements as of 31 March 2018 (more than £245 per day and last longer than six months).

Category	Number
Number of existing engagements as of 31 March 2018	6
Of which, the number that have existed:	
- for less than one year at the time of reporting	3
- for between one and two years at the time of reporting	0
- for between two and three years at the time of reporting	0
- for between three and four years at the time of reporting	2
- for four or more years at the time of reporting	1

This second table discloses the number of new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months.

Category	Number
Number of new engagements, or those that reach six months duration, between 1 April 2017 and 31 March 2018	3
Of which:	
Number assessed as caught by IR35	3
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracting to Trust) and are on Trust's payroll	3
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change in IR35 status following the consistency review	n/a

The Trust is also required to disclose the off-payroll engagements of any Board members and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Category	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	1
Number of individuals that have been deemed *board members, and/or senior officers with significant financial responsibility* during the financial year. This figure includes both off-payroll and on-payroll engagements	11

This information has not been subject to audit by the Trust's auditors, BDO LLP.

Reporting of compensation schemes - exit packages 2017/18

As part of the requirement to rationalise its administration areas, the Trust agreed with NHS Improvement the running of a mutually-agreed resignation scheme, which led to several mutually-agreed departures. In addition, the restructuring of some areas led to the inability to slot staff into the available roles, which led to a small number of compulsory redundancies – see table overleaf for more information.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	-	15	**15**
£10,001 to £25,000	-	2	**2**
£25,001 to 50,000	2	2	**4**
£50,001 to £100,000	2	-	**2**
Total number of exit packages by type	**4**	**19**	**23**
Total resource cost (£)	£214,000	£160,000	**£374,000**

Reporting of compensation schemes - exit packages 2016/17

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	1	-	**1**
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£5,000	£0	**£5,000**

Exit packages: other (non-compulsory) departure payments	2017/18		2016/17	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	5	79	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	13	40	-	-
Exit payments following Employment Tribunals or court orders	1	41	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**19**	**160**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

The tables containing information on exit packages has been subject to audit by the Trust's auditors, BDO LLP.

Parliamentary accountability and audit report

This part of the annual report looks at the following areas:

- Fees and charges
- Remote contingent liabilities
- Losses and special payments
- Gifts
- Statement of directors' responsibilities in respect of the accounts
- Independent auditor's report to the directors of East and North Hertfordshire NHS Trust

Fees and charges

As outlined in note 5 of the annual accounts, The Trust does not undertake any activities for the sole purpose of generating income of over £1 million.

Remote contingent liabilities

Details of the Trust's contingent liabilities are included within note 27 to the accounts.

Losses and special payments

The Trust is required to declare if it has had any loss, made any special payment or made a gift more than £300,000. The Trust has included information on losses and special payments in note 32 of the financial statements.

During 2017/18 the Trust made payments for two claims that exceeded £300,000. These claims were:

- A back-dated claim made at the end of a contract for the use of software licences for a pharmacy system over and above the licence agreement within that contract. Although the software provider had not raised a claim during the lifetime of the contract, legal advice was that there was a contractual liability for the payment of £330,000.

- Two payments, with a combined value of £832,000, which represented the Trust's share in a joint arrangement for pathology testing after the point that it was wound up for liabilities of that arrangement. As the Trust had ceased to benefit from services under this arrangement it was considered this represented a fruitless payment.

Gifts

No gifts have been made using Trust monies during 2017/18.

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 HM 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, the directors are required to:

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

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

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

By order of the Board

Date: 24 May 2018  **Nick Carver, chief executive**

Date: 24 May 2018 **Martin Armstrong, finance director**

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

Opinion on financial statements

We have audited the financial statements of East and North Hertfordshire NHS Trust (the Trust) for the year ended 31 March 2018 which comprise the combined group and single entity Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18 and the Accounts Directions issued by the Secretary of State for Health and Social Care.

In our opinion the financial statements:

- give a true and fair view of the financial position of East and North Hertfordshire NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- give a true and fair view of the financial position of the Group as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust and the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Board of Directors of East and North Hertfordshire NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is described in that report as having been audited.

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18.

Matters on which we are required to report by exception

Report to the Secretary of State

On 24 May 2018 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust generated a deficit in 2017/18 and that as a result the Trust has incurred unlawful expenditure.

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, with the exception of the matter(s) reported in the Basis for qualified conclusion on use of resources paragraph below, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018

Basis for qualified conclusion on use of resources

In considering the Trust's arrangements for the sustainable deployment of resources, we identified that:

- The Trust recorded a deficit for 2017/18 of £24.4m, this being an improvement compared to 2016/17 (£29.5m) but a significant deterioration in year.
- The Trust had agreed a CIP target of £23m for 2017/18 and is targeting a higher level of CIP next year of £24m, which is a challenging target given that the Trust fell short of a lesser CIP target this year.
- Other reasons for financial deterioration included not qualifying for Sustainability and Transformation Funding after quarter one and problems with the implementation of a new patient activity system within the year.

These matters are evidence of significant weaknesses in arrangements to ensure that the Trust deployed its resources to achieve planned and sustainable outcomes for taxpayers and local people.

Other matters

We have nothing to report in respect of the following other matters in relation which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Governance statement does not comply with the guidance issued by NHS Improvement; or
- except as reported above we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

Responsibilities of the Directors and the Accountable Officer

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, and for such internal control as the they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the Trust's and the group's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless informed by the Department of Health and Social Care of its intention for dissolution of the Trust without transfer of services or function to another entity or for the Trust to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Chief Executive is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.
Annual report and accounts 20L7lt8

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion.

Reasonable assurance is a high [eve[of assurance, but is not a guarantee that an audit conducted in accordance with lSAs (UK) wilt always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.orq.uk/auditorsresponsibitities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under section 21(3)(c)of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21 (5Xb) of the Local Audit and Accountability Act2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

As set out in the Matters on which we report by exception section of out report there are certain other matters which we are required to report by exception.

Certificate

We certify that we have completed the audit of the accounts of East and North Hertfordshire NHS Trust in accordance with the requirements of the Local Audit and Accountability Acf.2014 and the Code of Audit Practice issued by the National Audit Office.

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
lpswich, UK

25 May 2018

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

East and North Hertfordshire NHS Trust

Annual accounts for the period

1 April 2017 to 31 March 2018

Statement of Comprehensive Income

		Group		Trust Only	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	376,309	372,704	376,213	371,684
Other operating income	4	44,659	39,166	31,955	39,353
Operating expenses	6, 8	(444,300)	(443,071)	(432,175)	(442,546)
Operating surplus/(deficit) from continuing operations		**(23,332)**	**(31,201)**	**(24,007)**	**(31,509)**
Finance income	11	32	31	32	31
Finance expenses	12	(4,620)	(4,142)	(4,620)	(4,137)
PDC dividends payable		(418)	(1,852)	(418)	(1,852)
Net finance costs		**(5,006)**	**(5,963)**	**(5,006)**	**(5,958)**
Corporation tax expense		(133)	-	-	-
Surplus / (deficit) for the year		**(28,471)**	**(37,164)**	**(29,013)**	**(37,467)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(10,645)	(907)	(10,645)	(907)
Revaluations	16	4,890	3,319	5,003	3,319
Other recognised gains and losses		113	-	113	-
Other reserve movements		(200)	-	(200)	-
Total comprehensive income / (expense) for the period		**(34,313)**	**(34,752)**	**(34,742)**	**(35,055)**

The Trust is allowed to adjust its retained earnings, above, to take into account the impact certain technical accounting entries when reporting its financial performance against its control total. This adjusted figure is shown below:

Surplus / (deficit) for the year	**(28,471)**	**(37,164)**
Prior Period Errors	-	4,099
Impairments taken to Income and Expenditure	3,938	3,466
Capital Donations	109	66
Remove Impact of 16/17 CQUIN Risk Reserve	(1,336)	-
Adjusted financial performance surplus / (deficit)	**(25,760)**	**(29,533)**

The Trust has a wholly-owned subsidiary, ENH Pharma, which dispenses Outpatient Pharmaceutical prescriptions, principally to the Trust's patients. The Trust is required to incorporate the financial results of its subsidiary with its own as a single entity in the assessment of financial performance for 2017/18. However, performance of the Trust has also been provided alongside.

The Notes in the Accounts support the consolidated results above.

Statement of Financial Position

		Group		Trust	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	13	18,567	12,860	18,454	12,720
Property, plant and equipment	14	175,555	185,953	175,430	185,698
Other investments / financial assets	18	-	-	1,000	1,000
Trade and other receivables	19	2,636	3,125	2,636	3,125
Total non-current assets		**196,758**	**201,938**	**197,520**	**202,543**
Current assets					
Inventories	18	6,401	5,535	5,321	4,943
Trade and other receivables	19	43,320	46,810	41,372	45,716
Cash and cash equivalents	21	2,127	2,064	1,499	1,369
Total current assets		**51,848**	**54,409**	**48,192**	**52,028**
Current liabilities					
Trade and other payables	22	(54,470)	(55,146)	(52,261)	(53,916)
Borrowings	25	(9,775)	(3,480)	(9,775)	(3,480)
Other financial liabilities	23	(163)	(157)	(163)	(157)
Provisions	26	(387)	(2,669)	(388)	(2,669)
Other liabilities	24	(742)	(1,510)	(742)	(1,510)
Total current liabilities		**(65,537)**	**(62,962)**	**(63,329)**	**(61,732)**
Total assets less current liabilities		**183,069**	**193,385**	**182,383**	**192,839**
Non-current liabilities					
Trade and other payables	22	(4,610)	(4,813)	(4,610)	(4,813)
Borrowings	25	(151,813)	(130,238)	(151,814)	(130,238)
Other financial liabilities	23	(2,274)	(2,437)	(2,274)	(2,437)
Provisions	26	(585)	(1,143)	(585)	(1,143)
Total non-current liabilities		**(159,282)**	**(138,631)**	**(159,283)**	**(138,631)**
Total assets employed		**23,787**	**54,754**	**23,100**	**54,208**
Financed by					
Public dividend capital	SOCIE	174,998	171,652	174,998	171,652
Revaluation reserve	SOCIE	40,009	46,309	40,009	46,309
Other reserves	SOCIE	-	546	-	-
Income and expenditure reserve	SOCIE	(191,220)	(163,753)	(191,907)	(163,753)
Total taxpayers' equity		**23,787**	**54,754**	**23,100**	**54,208**

The notes on pages 98 to 136 form part of these accounts.

Mr Nick Carver
Chief Executive
24 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**171,652**	**46,309**	**546**	**(163,753)**	**54,754**
Surplus/(deficit) for the year	-	-	-	(28,471)	**(28,471)**
Impairments	-	(10,645)	-	-	**(10,645)**
Revaluations	-	4,890	-	-	**4,890**
Other recognised gains and losses	-	113	-	-	**113**
Public dividend capital received	3,346	-	-	-	**3,346**
Other reserve movements	-	(658)	(546)	1,004	**(200)**
Taxpayers' and others' equity at 31 March 2018	**174,998**	**40,009**	**-**	**(191,220)**	**23,787**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**169,950**	**45,069**	**243**	**(127,458)**	**87,804**
Surplus/(deficit) for the year	-	-	-	(37,164)	**(37,164)**
Other transfers between reserves	-	(1,172)	-	1,172	**-**
Impairments	-	(907)	-	-	**(907)**
Revaluations	-	3,319	-	-	**3,319**
Public dividend capital received	1,702	-	-	-	**1,702**
Other reserve movements	-	-	303	(303)	**-**
Taxpayers' and others' equity at 31 March 2017	**171,652**	**46,309**	**546**	**(163,753)**	**54,754**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**171,652**	**46,309**	**(163,753)**	**54,208**
Surplus/(deficit) for the year	-	-	(29,013)	**(29,013)**
Other transfers between reserves	-	(659)	659	**-**
Impairments	-	(10,645)	-	**(10,645)**
Revaluations	-	5,003	-	**5,003**
Public dividend capital received	3,346	-	-	**3,346**
Other reserve movements	-	-	200	**200**
Taxpayers' and others' equity at 31 March 2018	**174,998**	**40,008**	**(191,907)**	**23,099**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**169,950**	**45,069**	**(127,458)**	**87,561**
Surplus/(deficit) for the year	-	-	(37,467)	**(37,467)**
Other transfers between reserves	-	(1,172)	1,172	**-**
Impairments	-	(907)	-	**(907)**
Revaluations	-	3,319	-	**3,319**
Public dividend capital received	1,702	-	-	**1,702**
Taxpayers' and others' equity at 31 March 2017	**171,652**	**46,309**	**(163,753)**	**54,208**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
The Trust has a wholly-owned subsidiary, ENH Pharma. Other Reserves relate to the reserves, net of the investment in it by the Trust, of this subsidiary.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)	SOCI	(23,332)	(31,201)	(24,007)	(31,538)
Non-cash income and expense:					
Depreciation and amortisation	6	8,107	7,285	8,064	7,246
Net impairments	7	3,938	3,466	3,938	3,466
Income recognised in respect of capital donations	4	(201)	(148)	(201)	(148)
(Increase)/decrease in receivables and other assets	19	4,814	(5,024)	5,668	(5,169)
(Increase)/decrease in inventories	18	(866)	471	(378)	321
Increase/(decrease) in payables and other liabilities	22	(3,403)	(12,213)	(4,252)	(11,574)
Increase/(decrease) in provisions	26	(3,175)	2,682	(3,175)	2,682
Tax (paid)/received		(92)	-	-	-
Other movements in operating cash flows		-	-	200	-
Net cash flows from / (used in) operating activities		**(14,210)**	**(34,682)**	**(14,143)**	**(34,714)**
Cash flows from investing activities					
Interest received	11	32	31	32	31
(Purchase)/sale of financial assets / investments	17	-	(4,788)	-	(4,788)
Purchase of intangible assets	13	(8,401)	(4,980)	(8,401)	(4,950)
Sales of intangible assets	20	-	1,700	-	1,700
Purchase of PPE and investment property	14	(2,805)	(6,785)	(2,805)	(6,646)
Net cash flows from / (used in) investing activities		**(11,174)**	**(14,822)**	**(11,174)**	**(14,653)**
Cash flows from financing activities					
Public dividend capital received	SOCIE	3,346	1,702	3,346	1,702
Movement on loans from DHSC	25	28,298	38,431	28,298	38,431
Movement on other loans	25	(72)	323	(72)	323
Capital element of PFI, LIFT and other service concession payments	29	(356)	(289)	(356)	(289)
Interest paid on PFI, LIFT and other service concession obligations	12	(930)	(850)	(930)	(850)
Other interest paid	12	(3,586)	(2,999)	(3,586)	(2,995)
PDC Dividend (paid)/refunded		(1,253)	(1,449)	(1,253)	(1,449)
Net cash flows from / (used in) financing activities		**25,447**	**34,869**	**25,447**	**34,873**
Increase / (decrease) in cash and cash equivalents		**63**	**(14,635)**	**130**	**(14,494)**
Cash and cash equivalents at 1 April - b/f		**2,064**	**16,699**	**1,369**	**15,863**
Cash and cash equivalents at 31 March		**2,127**	**2,064**	**1,499**	**1,369**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health. The accounting policies contained in the GAM 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 GAM permits a choice of accounting policy, the accounting policy that 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 are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 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.

Note 1.1.2 Going concern

The Trust has prepared its financial plans and cash flow forecasts on the assumption that support funding will continue to be received through the Department of Health. These funds are expected to be sufficient to prevent the Trust from failing to meet its obligations as they fall due and to continue until adequate plans are in place to achieve financial sustainability for the Trust. The Trust incurred a deficit and is forecast to incur a deficit in the forthcoming financial year, furthermore the Trust is reliant on the aforementioned funding for the foreseeable future.

Whilst the Directors are certain that the provision of services will continue, there are material uncertainties within the Trust's financial performance that may cast significant doubt over the Trust's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business, and around the form of the Trust that delivers those services. This provision will also be dependent on both acceptance and delivery of the financial recovery plans and continuation of support from the Department of Health. Notwithstanding the material uncertainty, the Directors have not had any communication indicating that necessary support funding will not be made available for the foreseeable future and have therefore prepared these financial statements on a going concern basis. A full statement of the risks and concerns are included in this Annual Report.

There are thus material uncertainties which may cast significant doubt as to the Trust's ability to continue as a going concern and therefore may be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would be required if the going concern basis were not appropriate.

The following factors could potentially impact the Trust's performance and position:

- Commissioner's ability to pay for increasing demand for services;
- Essential capital expenditure exceeds the funding secured for delivery;
- Unplanned capital investment required to maintain the Trust's estate and infrastructure;
- Lorenzo stabilisation is not completed to timetable

Note 1.2 Critical accounting judgements and key sources of estimation uncertainty

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The Trust has previously treated the cash calls in respect of the Pathology Partnership as and Investment under Ias39, Financial Instruments and impaired its value to zero at the end of the previous financial year. Cash calls in 2017/18 have been treated as expenses and reported under Losses and Special Payments.

The Trust has consolidated the performance of its wholly-owned subsidiary into its financial results, as being under common control as defined by IAS27. The results of the Trust as a single entity are provided for information purposes only. All Notes to the Accounts have been prepared on a consolidated basis.

The Trust has judged that the financial performance and position of its Charity is not material to the results of the Trust and, as a result, the decision has been made not to consolidate for 2017/18.

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
Valuation of Intangible and Tangible Assets - Notes 13 & 14
Provision for the Impairment of Receivables - Note 19.2
Expenditure accruals - Note 6.1
The likelihood, amount and timing of provisions and contingent liabilities - Note 26
Liabilities under the Private Finance Inititative - Note 29

Note 1.3 Income
Income 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 income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from Government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

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

Note 1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.6 Property, plant and equipment

Note 1.6.1 Recognition

Property, plant and equipment is capitalised where:

• 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 be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.6.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs 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 valuation.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that the carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

▪ Land and non-specialised buildings - market value in existing use.
▪ Specialised buildings - depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service provided, an alternative site can be valued.

IT equipment, transport equipment, furniture and fittings and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short economic lives or low

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.6.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.6.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM* , are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

Note 1.6.6 Useful Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Land	Infinite	Infinite
Buildings, excluding dwellings	10	83
Plant & machinery	5	15
Information technology	5	10
Furniture & fittings	5	20

Note 1.7 Intangible assets

Note 1.7.1 Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.7.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.7.3 Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	10
Development expenditure	5	10
Software licences	5	10
Licences & trademarks	5	10

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.9 Cash and cash equivalents

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

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

Note 1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made. All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets of the Trust are categorised as loans and receivables.

Financial liabilities of the Trust are classified as other financial liabilities.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced either directly through the use of a bad debt provision.

A bad debt provision is used where there is evidence of impairment but approval for the write down is required to be obtained through the Trust's governance processes, leading to a timing difference between identification of impairment to the financial asset and de-recognition in the financial statements. The full value of the financial asset is included within the provision.

Note 1.11 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.

Note 1.11.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
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.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11.2 The Trust as lessor

Finance leases
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 to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating 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 as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 27 but is not recognised in the Trust’s accounts.

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 NHS Resolution 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 when the liability arises.

Note 1.13 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 28, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 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.

Note 1.16 Corporation tax

The Trust's wholly-owned subsidiary is liable for Corporation Tax on its profits. An estimate for the taxation payable on each year's profits is included within these financial statements. However, given that this tax will be payable within the next financial year, no allowance is made for discounting in assessing the liability.

Note 1.17 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. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.20 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 9 Financial Instruments - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM. Early adoption is not permitted. Assessment of the impact of this standard is that the provision for the impairment of receivables, through use of the 'expected credit losses' approach will require an increase to the bad debt provision and this is being included in 18-19 plans. However, this impact will not be material to the Trust's financial statements.

IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1st January 2018, but not yet adopted by the FReM. Early adoption is not permitted. A key requirement of the change is that income should only be recognised as and when the Trust provides services. This is not expected to have a material impact, but there may be an impact on the Trust's treatment of partially completed spells and may impact on maternity pathway income.

IFRS 16 - Leases - Application required for accounting periods beginning on or after 1st January 2019, but not yet adopted by the FReM. Early adoption is not permitted. The Trust has a large number of operating leases for medical equipment and will be assessing these for possible treatment as finance leases, to be recognised in the Statement of Financial Position. The Trust will need to review managed service agreements to see whether these include embedded leases, also requiring a change in accounting treatment. Reviews of agreements relating to accommodation/site occupation will be undertaken in this regard too. This could have a material impact on both asset and liability balances for the Trust

Note 2 Operating Segments

The Trust has assessed that services provided by each of its Divisions or geographical locations all fall within the description of 'provision of healthcare'. Therefore there is no one unit with income of over 10% of total income that the chief operating decision maker, the Trust Board, would make operating decisions based on segmented reporting.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
Elective income	51,491	49,987
Non elective income	94,692	92,491
First outpatient income	24,460	22,038
Follow up outpatient income	25,620	29,206
A & E income	22,001	19,579
High cost drugs income from commissioners (excluding pass-through costs)	38,328	39,401
Other NHS clinical income	113,969	110,250
Private patient income	3,459	3,448
Other clinical income	2,289	6,304
Total income from activities	**376,309**	**372,704**

Note 3.2 Income from patient care activities (by source)

	2017/18	**2016/17**
Income from patient care activities received from:	**£000**	**£000**
NHS England	93,089	93,270
Clinical commissioning groups	277,283	267,820
Department of Health and Social Care	-	2,197
Other NHS providers	93	3,013
NHS other	-	179
Local authorities	-	351
Non-NHS: private patients	3,459	3,448
Non-NHS: overseas patients (chargeable to patient)	766	747
NHS injury scheme	1,244	589
Non NHS: other	375	1,090
Total income from activities	**376,309**	**372,704**
Of which:		
Related to continuing operations	376,309	372,704
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	766	747
Cash payments received in-year	223	257
Amounts added to provision for impairment of receivables	692	453
Amounts written off in-year	30	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	5,172	5,346
Education and training	15,334	12,967
Receipt of capital grants and donations	201	258
Charitable and other contributions to expenditure	-	5
Non-patient care services to other bodies	12,596	7,884
Sustainability and transformation fund income	4,116	5,216
Rental revenue from operating leases	329	740
Other income	6,911	6,750
Total other operating income	**44,659**	**39,166**
Of which:		
Related to continuing operations	44,659	39,166
Related to discontinued operations	-	-

Other income includes:

Car parking Income of £1,792k (2016/17 £1,975k)

Catering (non-patient) of £1,182k (2016/17 £1,182k)

Note 5 Fees and charges

The Trust does not undertake any income generation activities with an aim of achieving profit in excess of £1m, or is otherwise material.

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	15,439	23,108
Purchase of healthcare from non-NHS and non-DHSC bodies	7,430	13,122
Staff and executive directors costs	260,670	254,281
Remuneration of non-executive directors	77	79
Supplies and services - clinical (excluding drugs costs)	32,225	26,955
Supplies and services - general	11,727	11,581
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	45,751	47,273
Inventories written down	268	136
Consultancy costs	4,652	973
Establishment	3,889	3,709
Premises	19,249	20,942
Transport (including patient travel)	565	511
Depreciation on property, plant and equipment	6,068	5,943
Amortisation on intangible assets	2,039	1,342
Net impairments	3,938	3,466
Increase/(decrease) in provision for impairment of receivables	56	41
Increase/(decrease) in other provisions	229	-
Audit fees payable to the external auditor		
audit services- statutory audit	52	87
other auditor remuneration (external auditor only)	10	10
Internal audit costs	148	149
Clinical negligence	15,040	13,486
Legal fees	220	114
Insurance	26	289
Research and development	3,313	3,467
Education and training	934	1,028
Rentals under operating leases	3,762	3,788
Redundancy	276	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	110	130
Car parking & security	609	567
Hospitality	65	73
Losses, ex gratia & special payments	1,168	147
Other services, eg external payroll	1,458	1,428
Other	2,837	4,846
Total	**444,300**	**443,071**
Of which:		
Relating to continuing operations	444,300	443,071
Related to discontinued operations	-	-

Note 6.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	5	-
2. Audit-related assurance services	5	10
Total	**10**	**10**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1.0m (2016/17 £1.0m)

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	3,938	(2,828)
Other	-	6,294
Total net impairments charged to operating surplus / deficit	**3,938**	**3,466**
Impairments charged to the revaluation reserve	10,645	907
Total net impairments	**14,583**	**4,373**

Impairments relating to Changes in Market Price and those Charged to the Revaluation Reserve relate to the Trust's Property, Plant and Equipment. This reflects the movements in the 'Fair Value' due to changes in property prices. The 'Other' Impairment in 2016/17 relates to the reassessment of the value of the Trust's investment in a shared Pathology venture.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	193,673	194,320
Social security costs	19,625	17,774
Apprenticeship levy	941	-
Employer's contributions to NHS pensions	22,196	20,490
Pension cost - other	63	6
Termination benefits	276	5
Temporary staff (including agency)	27,545	27,313
Total gross staff costs	**264,319**	**259,908**
Recoveries in respect of seconded staff	-	-
Total staff costs	**264,319**	**259,908**
Of which		
Costs capitalised as part of assets	505	2,762

Note 8.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £393k (£350k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The Trust offers an additional defined contribution workplace pension scheme for employees that do not wish to, or are not eligible to, join the NHS Pensions Scheme, the National Employment Savings Scheme (NEST). This is a defined contribution scheme and, as such, the Trust does not have any constructive or legal obligation for any contribution above the employer contribution rate in respect of post-employment benefits for scheme members. Employer contributions are expensed in the year to which they relate.

Note 10 Operating leases

Note 10.1 East And North Hertfordshire NHS Trust as a lessor

This note discloses income generated in operating lease agreements where East And North Hertfordshire NHS Trust is the lessor.
The Trust leases space for retail units, telephone masts and staff accommodation.

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	329	740
Total	**329**	**740**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year;	156	238
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**156**	**238**

Note 10.2 East And North Hertfordshire NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East And North Hertfordshire NHS Trust is the lessee.

The Trust's operating leases relate to medical equipment.
Medical equipment is leased over a period of 5-10 years, and carries the potential option to extend at the end of this period. Ownership does not transfer to the Trust at the end of the agreement and any purchase would be carried out on an 'arm's-length' basis.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	3,762	3,788
Total	**3,762**	**3,788**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	6,550	4,408
- later than one year and not later than five years;	5,628	12,064
- later than five years.	15	247
Total	**12,193**	**16,719**

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	32	31
Total	**32**	**31**

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,603	2,942
Other loans	81	88
Interest on late payment of commercial debt	5	196
Main finance costs on PFI and LIFT schemes obligations	524	546
Contingent finance costs on PFI and LIFT scheme obligations	406	304
Total interest expense	**4,619**	**4,076**
Unwinding of discount on provisions	1	2
Other finance costs	-	64
Total finance costs	**4,620**	**4,142**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	5	196

Note 13.1 Intangible assets - 2017/18

	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**3,412**	**1,466**	**13,134**	**4,712**	**22,724**
Additions	7,781	-	-	-	**7,781**
Reclassifications	4,712	-	-	(4,712)	**-**
Disposals / derecognition	(592)	(446)	(4,398)	-	**(5,436)**
Valuation / gross cost at 31 March 2018	**15,313**	**1,020**	**8,736**	**-**	**25,069**
Amortisation at 1 April 2017 - brought forward	**1,686**	**994**	**7,184**	**-**	**9,864**
Provided during the year	770	107	1,162	-	**2,039**
Revaluations	5	4	26	-	**35**
Disposals / derecognition	(592)	(446)	(4,398)		**(5,436)**
Amortisation at 31 March 2018	**1,869**	**659**	**3,974**	**-**	**6,502**
Net book value at 31 March 2018	**13,444**	**361**	**4,762**	**-**	**18,567**
Net book value at 1 April 2017	**1,726**	**472**	**5,950**	**4,712**	**12,860**

The Opening Balance Adjustment relates to the removal of fully-depreciated assets that are likely to be disposed of in previous periods from the Trust's Fixed Asset Register.

Note 13.2 Intangible assets - 2016/17

	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**2,773**	**1,217**	**13,134**	**-**	**17,124**
Additions	639	249	-	4,712	**5,600**
Valuation / gross cost at 31 March 2017	**3,412**	**1,466**	**13,134**	**4,712**	**22,724**
Amortisation at 1 April 2016 - as previously stated	**1,423**	**893**	**6,206**	**-**	**8,522**
Provided during the year	263	101	978	-	**1,342**
Amortisation at 31 March 2017	**1,686**	**994**	**7,184**	**-**	**9,864**
Net book value at 31 March 2017	**1,726**	**472**	**5,950**	**4,712**	**12,860**
Net book value at 1 April 2016	**1,350**	**324**	**6,928**	**-**	**8,602**

Note 14.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**33,443**	**134,129**	**58,990**	**14,331**	**4,376**	**245,269**
Opening Balance Adjustment	(11,620)	-	-	-	-	**(11,620)**
Restated Opening Balance at 1April 2017	**21,823**	**134,129**	**58,990**	**14,331**	**4,376**	**233,649**
Additions	-	756	3,622	923	27	**5,328**
Impairments	(633)	(6,219)	(120)	-	-	**(6,972)**
Reversals of impairments	550	1,178	-	-	-	**1,728**
Revaluations	-	5,003	-	-	-	**5,003**
Disposals / derecognition	-	-	(18,045)	(5,959)	(1,193)	**(25,197)**
Valuation/gross cost at 31 March 2018	**21,740**	**134,847**	**44,447**	**9,295**	**3,210**	**213,539**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**12**	**44,308**	**11,763**	**3,233**	**59,316**
Provided during the year	-	2,269	2,790	845	164	**6,068**
Impairments	-	(2,281)	-	-	-	**(2,281)**
Revaluations	-	-	50	27	1	**78**
Disposals / derecognition	-	-	(18,045)	(5,959)	(1,193)	**(25,197)**
Accumulated depreciation at 31 March 2018	**-**	**-**	**29,103**	**6,676**	**2,205**	**37,984**
Net book value at 31 March 2018	**21,740**	**134,847**	**15,344**	**2,619**	**1,005**	**175,555**
Net book value at 1 April 2017	**33,443**	**134,117**	**14,682**	**2,568**	**1,143**	**185,953**

The Opening Balance Adjustment shown above relates to the Trust has revised its estimation methodology for assessing the fair value of land as required by IAS 16, Property Plant and Equipment. This has been applied for both the opening and closing balances.

Disposals / derecognition entries above relate to the removal of a large number of fully depreciated assets, with a zero net book value, for which the Trust historically held limited information that would limit the ability to prove the existence, or otherwise, of those assets. The Trust has judged that these assets were likely to have been disposed of in previous periods but not removed from the asset register.

Note 14.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**32,750**	**132,137**	**55,368**	**12,883**	**4,113**	**237,251**
Additions	-	1,871	3,622	1,448	263	**7,204**
Impairments	693	(759)	-	-	-	**(66)**
accounts.	-	880	-	-	-	**880**
Valuation/gross cost at 31 March 2017	**33,443**	**134,129**	**58,990**	**14,331**	**4,376**	**245,269**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**2,191**	**41,506**	**11,052**	**3,050**	**57,799**
Provided during the year	-	2,247	2,802	711	183	**5,943**
Impairments	-	841	-	-	-	**841**
Reversals of impairments	-	(2,828)	-	-	-	**(2,828)**
Revaluations	-	(2,439)	-	-	-	**(2,439)**
Accumulated depreciation at 31 March 2017	**-**	**12**	**44,308**	**11,763**	**3,233**	**59,316**
Net book value at 31 March 2017	**33,443**	**134,117**	**14,682**	**2,568**	**1,143**	**185,953**
Net book value at 1 April 2016	**32,750**	**129,946**	**13,862**	**1,831**	**1,063**	**179,452**

Note 14.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	21,740	125,443	-	14,207	-	2,618	838	**164,846**
On-SoFP PFI contracts and other service concession arrangements	-	7,911	-	-	-	-	-	**7,911**
Owned - donated	-	1,493	-	1,137	-	1	167	**2,798**
NBV total at 31 March 2018	**21,740**	**134,847**	**-**	**15,344**	**-**	**2,619**	**1,005**	**175,555**

Note 14.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	33,443	125,646	-	13,528	-	2,527	983	**176,127**
On-SoFP PFI contracts and other service concession arrangements	-	7,057	-	-	-	-	-	**7,057**
Owned - donated	-	1,414	-	1,154	-	41	160	**2,769**
NBV total at 31 March 2017	**33,443**	**134,117**	**-**	**14,682**	**-**	**2,568**	**1,143**	**185,953**

Note 15 Donations of property, plant and equipment

The Trust has received the donation of a number of items of equipment to enhance patient experience from the East and North Herts NHS Trust Charitable Funds.

Note 16 Revaluations of property, plant and equipment

The Trust's land and buildings were revalued at 31st March 2018 by an independent, qualified valuer, using the Modern Equivalent Asset (MEA) methodology, in accordance with DH guidance and the NHS Group Accounting Manual.

The professional valuation was carried out by Bilfinger GVA, 3 Brindleyplace, Birmingham, B1 2JB. The valuation was 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 for this type of asset except as part of an entity.

In certain circumstances, for non-specialised properties, the Existing Use Value has been derived from comparable market transactions of arm's length terms.

The Existing Use Value is defined in UKPS 1.3 of the Red Book and, in undertaking these 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 have 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".

The 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.

As stated in note 14.1, the Trust has reviewed the estimation technique used to assess the fair value of its land under the Modern Equivalent Asset approach. The value of land has been assessed on the basis of the construction of a modern equivalent asset, over a number of storeys, with the associated footprint that such a construction would require.

There have been no other changes to valuation or estimation techniques.

Property is held at existing use value and is not materially different from its open market value.

Note 17 Investments in associates and joint ventures

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**-**	**1,505**
Acquisitions in year	-	4,789
Net impairments	-	(6,294)
Carrying value at 31 March	**-**	**-**

Note 18 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	2,761	2,258
Consumables	3,397	3,083
Energy	243	194
Total inventories	**6,401**	**5,535**
of which:		
Held at fair value less costs to sell	-	-

Note 19.1 Trade receivables and other receivables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade receivables	26,135	20,785
Accrued income	6,801	13,512
Provision for impaired receivables	(1,060)	(620)
Prepayments (non-PFI)	4,010	6,430
PDC dividend receivable	1,063	228
VAT receivable	2,871	1,304
Other receivables	3,500	5,171
Total current trade and other receivables	**43,320**	**46,810**
Non-current		
Provision for impaired receivables	(404)	(404)
Prepayments (non-PFI)	1,148	1,198
Other receivables	1,892	2,331
Total non-current trade and other receivables	**2,636**	**3,125**
Of which receivables from NHS and DHSC group bodies:		
Current	26,945	27,487
Non-current	-	-

Note 19.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
	1,024	1,370
Prior period adjustments		-
At 1 April - restated	**1,024**	**1,370**
Transfers by absorption	-	-
Increase in provision	56	41
Amounts utilised	384	(387)
Unused amounts reversed	-	-
At 31 March	**1,464**	**1,024**

Note 19.3 Credit quality of financial assets

	31 March 2018	31 March 2017
	Trade and other receivables	
Ageing of non-impaired financial assets past their due date		
0 - 30 days	4,481	3,406
30-60 Days	3,031	1,471
60-90 days	2,215	946
90- 180 days	2,231	4,023
Over 180 days	6,947	6,658
Total	**18,905**	**16,504**

Note 19.4 Credit quality of financial assets (continued)

The Trust requires there to be objective evidence of impairment to the value of receivables, through the use of credit agencies and other organisations specialising in the recovery of outstanding debts. Evidence of impairment will include the inability to trace the debtor using sector methods or the inability to recover goods and services to the value of the debt based on Court official updates.

Note 20 Other assets

	2018	2017
Current	£000	£000
Total other current assets	**-**	**-**
Non-current		
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	1,700
Assets sold in year	-	(1,700)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**2,064**	**16,699**
Broken down into:		
Cash at commercial banks and in hand	643	721
Cash with the Government Banking Service	1,484	1,343
Total cash and cash equivalents as in SoCF	**2,127**	**2,064**

Note 21.1 Third party assets held by the trust

East And North Hertfordshire NHS Trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	2017/18	2016/17
	£000	£000
Bank balances	-	-
Monies on deposit	4	3
Total third party assets	**4**	**3**

Note 22 Trade and other payables

	2017/18	2016/17
	£000	£000
Trade payables	27,380	30,351
Capital payables	3,516	1,864
Accruals	13,954	13,474
Receipts in advance (including payments on account)	6	-
Social security costs	2,943	2,698
Other taxes payable	2,623	2,391
Accrued interest on loans	208	104
Other payables	3,840	4,264
Total current trade and other payables	**54,470**	**55,146**
Other payables	4,610	4,813
Total non-current trade and other payables	**4,610**	**4,813**
Of which payables from NHS and DHSC group bodies:		
Current	16,867	12,374
Non Current	-	-

Note 22.1 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	2017/18	2016/17
	£000	£000
- outstanding pension contributions	3,225	2,936

Note 23 Other financial liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Other financial liabilities	163	157
Total current other financial liabilities	**163**	**157**
Non-current		
Other financial liabilities	2,274	2,437
Total non-current other financial liabilities	**2,274**	**2,437**

Note 24 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	742	1,510
Total other current liabilities	**742**	**1,510**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 25 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from DHSC	9,405	3,043
Other loans	63	81
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	307	356
Total current borrowings	**9,775**	**3,480**
Non-current		
Loans from DHSC	145,173	123,237
Other loans	188	242
Obligations under PFI, LIFT or other service concession contracts	6,452	6,759
Total non-current borrowings	**151,813**	**130,238**

Note 26 Provisions for liabilities and charges analysis

Group	Pensions - early departure costs	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**729**	**75**	**-**	**3,008**	**3,812**
Arising during the year	33	47	149	-	**229**
Utilised during the year	(101)	(36)	-	(2,933)	**(3,070)**
Unwinding of discount	1	-	-	-	**1**
At 31 March 2018	**662**	**86**	**149**	**75**	**972**
Expected timing of cash flows:					
- not later than one year;	77	86	149	75	**387**
- later than one year and not later than five years;	272	-	-	-	**272**
- later than five years.	313	-	-	-	**313**
Total	**662**	**86**	**149**	**75**	**972**

Early Departure costs relate to a constructive obligation with the NHS Pensions Agency to refund it the costs of pensions paid to staff who have retired due to ill-health in earlier years. The value of the obligation is assessed using actuarial tables and the uncertainty relates to the length of time these pensions will be payable.

Legal claims relate to claims made under the Trust's Employer Liability and Public Liability Schemes, for which the Trust is responsible for the payment of an excess should the claim be successful. Uncertainty relates to the potential for success and an amount has been included for all those assessed at a probability of over 50% by NHS Resolve.

Other provisions consist of a provision for costs associated with Carbon Trading Units

Restructuring provision relates to costs that are likely to be paid as a result of restructuring departments. Affected staff have been fully communicated with.
The discount rate applied to provisions above is 0.1%.

Note 26.1 Clinical negligence liabilities

At 31 March 2018, £284,955k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire NHS Trust (31 March 2017: £236,767k).

Note 27 Contingent assets and liabilities

	2018	2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(49)	(54)
Gross value of contingent liabilities	**(49)**	**(54)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(49)**	**(54)**

Contingent liabilities relate to claims under the Trust's Employer Liability and Public Liability Schemes, referred to in Note 25, where the probability of success has been assessed as being between 20% and 50%

Note 28 Contractual capital commitments

	Group	
	2018	2017
	£000	£000
Property, plant and equipment	148	2,584
Intangible assets	-	-
Total	**148**	**2,584**

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has one PFI Scheme, relating to the Hertford County Hospital. The hospital 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 Trust pays a monthly contractual unitary payment, which covers the cost of facilities management services, financing and lifecycle replacement of assets components. Further information on the nature and value of these payments is included below.

Note 29.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	31 March 2018 £000	31 March 2017 £000
Gross PFI liabilities	**11,523**	**12,402**
Of which liabilities are due		
- not later than one year;	805	880
- later than one year and not later than five years;	2,856	2,905
- later than five years.	7,862	8,617
Finance charges allocated to future periods	(4,764)	(5,287)
obligation	**6,759**	**7,115**
- not later than one year;	307	356
- later than one year and not later than five years;	1,058	1,030
- later than five years.	5,394	5,729

Note 29.2 Total on-SoFP PFI commitments

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the PFI arrangements	**25,709**	**27,094**
Of which liabilities are due:		
- not later than one year;	1,419	1,385
- later than one year and not later than five years;	6,042	5,894
- later than five years.	18,248	19,815

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2017/18 £000	2016/17 £000
Unitary payment payable to service concession operator	**1,446**	**1,378**
Consisting of:		
- Interest charge	524	546
- Repayment of finance lease liability	356	289
expenditure	110	130
- Capital lifecycle maintenance	50	109
- Contingent rent	406	304
Total amount paid to service concession operator	**1,446**	**1,378**

Note 31 Financial instruments

Note 31.1 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 these activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners 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 are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

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

Currency risk

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

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. 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.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2018 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 organisations, 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.

Note 31.2 Carrying values of financial assets

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non financial assets	35,476	**35,476**
Cash and cash equivalents	2,127	**2,127**
Total at 31 March 2018	**37,603**	**37,603**

	Loans and receivables	Total book value
	£000	£000
Assets as per SoFP as at 31 March 2017		
Trade and other receivables excluding non financial assets	33,701	**33,701**
Cash and cash equivalents	2,064	**2,064**
Total at 31 March 2017	**35,765**	**35,765**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2018		
Borrowings excluding finance lease and PFI liabilities	154,829	**154,829**
Obligations under PFI, LIFT and other service concession contracts	6,759	**6,759**
Trade and other payables excluding non financial liabilities	53,305	**53,305**
Other financial liabilities	2,437	**2,437**
Total at 31 March 2018	**217,330**	**217,330**

	Other financial liabilities	Total book value
	£000	£000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	126,603	**126,603**
Obligations under PFI, LIFT and other service concession contracts	7,115	**7,115**
Trade and other payables excluding non financial liabilities	45,136	**45,136**
Other financial liabilities	2,594	**2,594**
Total at 31 March 2017	**181,448**	**181,448**

Note 31.3 Fair values of financial assets and liabilities

The book value (carrying value) of financial assets and liabilities is considered a reasonable approximation of fair value.

Note 31.4 Maturity of financial liabilities

	Group	
	31 March 2018	31 March 2017
	£000	£000
In one year or less	58,633	48,773
In more than one year but not more than two years	27,708	9,691
In more than two years but not more than five years	82,271	75,510
In more than five years	48,718	47,474
Total	**217,330**	**181,448**

Note 32 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	15	15	5	0
Fruitless payments	1	832	-	-
Bad debts and claims abandoned	252	41	56	1
Stores losses and damage to property	14	268	-	-
Other	-	-	11	136
Total losses	**282**	**1,156**	**72**	**138**
Special payments				
Compensation under court order or legally binding arbitration award	1	330	1	42
Ex-gratia payments	40	42	47	57
Total special payments	**41**	**372**	**48**	**99**
Total losses and special payments	**323**	**1,528**	**120**	**237**

Cases over £300,000

The Trust has had two cases of Losses and Special Payments in year that exceed £300,000 which are:

- Two 'cash call' payments with a combined total of £832,000 in respect of its obligations under a shared Pathology venture that was being wound up. At this point, the venture was no longer providing the Trust with Pathology services. This total is included under Fruitless Payments above.

- A payment under a legal contractual arrangement, including associated legal costs, for the backdated supply of licences for a Pharmacy IT system following the termination of that contract. The amount of £330,000 in included within Compensation under legal obligation above

Note 33 Gifts

The value of Gifts did not exceed £300,000 in year.

Note 34 Related parties

During the year none of the Department of Health and Social Security Ministers, Trust board members or key management staff, or parties related to them has undertaken any material transactions with East and North Hertfordshire NHS Trust. The Department of Health and Social Security is the Trust's parent department and there has been a number of material transactions with other public sector bodies, the most significant of which were with East and North Hertfordshire CCG, NHS England, Health Education England, the Hillingdon Hospitals NHS Foundation Trust, HMRC, the NHS Pension Scheme, NHS Resolution, Bedfordshire CCG, Hertfordshire Valleys CCG and NHS Professionals. In addition to the above bodies, there were a number of transactions between the Trust and its charity, the East and North Hertfordshire NHS Trust Charitable Fund. In 2017-18 the Trust received £787k from the charity (2016-17 £1,346k). The majority of these receipts were for the re-imbursement of running costs and donations made for the benefit of patients and staff. There was no outstanding balance between the Trust and the charity at the end of either financial year.

Note 35 Events after the reporting date

There have been no events after the Balance Sheet date that have materially impacted, or cast doubt on, the values and balances recorded within these Financial Statements. There is therefore no requirement for the Trust to adjust, or disclose potential impacts on, the values herein.

Note 36 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	67,111	193,911	68,173	212,051
Total non-NHS trade invoices paid within target	45,370	133,927	26,670	67,407
Percentage of non-NHS trade invoices paid within target	67.60%	69.07%	39.12%	31.79%
NHS Payables				
Total NHS trade invoices paid in the year	2,183	32,875	1,886	33,827
Total NHS trade invoices paid within target	1,394	16,031	1,269	8,273
Percentage of NHS trade invoices paid within target	63.86%	48.76%	67.29%	24.46%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

The Trust adopts the NHS Standard Terms and Conditions when entering into contractual arrangements, which requires invoices to be paid within 30 days of receipt. For the purpose of this disclosure, it has been assumed that all invoices which were paid within the 30 day target were due to be paid within that period.

Obligations for Late Payment Interest for failure to pay within the due terms are included within Note 12.

Note 37 External financing

The trust is given an external financing limit against which it is permitted to underspend

	2017/18 £000	2016/17 £000
Cash flow financing	31,153	54,802
External financing requirement	31,153	54,802
External financing limit (EFL)	34,366	56,900
Under / (over) spend against EFL	3,213	2,098

Note 38 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	13,109	12,804
Less: Disposals	-	(1,700)
Less: Donated and granted capital additions	(201)	(258)
Charge against Capital Resource Limit	12,908	10,846
Capital Resource Limit	13,195	11,548
Under / (over) spend against CRL	287	702

Note 39 Breakeven duty financial performance

	2017/18 £000
Surplus / (deficit) for the period	(28,471)
Add back all I&E impairments / (reversals)	3,938
Surplus / (deficit) before impairments and transfers	(24,533)
	109
CQUIN Risk Reserve - 1617 CT non achievement adjustment	(1,336)
Adjusted financial performance surplus / (deficit) (control total basis)	(25,760)
Remove CQUIN risk reserve adjustment	1,336
Breakeven duty financial performance surplus / (deficit)	(24,424)

Note 1 Breakeven duty rolling assessment

	Periods prior to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
		2,500	3,328	3,568	532	109	(3,613)	(16,226)	(29,533)	(24,424)
Breakeven duty cumulative position	1,825	4,325	7,653	11,221	11,753	11,862	8,249	(7,977)	(37,510)	(61,934)
Operating income		331,312	340,309	346,402	350,543	365,313	376,050	384,712	411,870	420,968
Cumulative breakeven position as a percentage of operating income		1.31%	2.25%	3.24%	3.35%	3.25%	2.19%	-2.07%	-9.11%	-14.71%