East and North Hertfordshire NHS Trust

Annual Report and Accounts 2018/19

Proud to deliver high-quality, compassionate care to our community

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Performance Report

Introduction

Welcome to the Trust's annual report and accounts for 2018/19. 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.

I would like to start my introduction to this report and accounts by thanking our staff for their continued hard work over the last year. I am frequently impressed by examples of the commitment of our staff to help each other and our patients. From the feedback I receive from the communities we serve, I know that their efforts are very much appreciated.

As detailed by Nick Carver in his report, we have made significant progress in 2018/19 towards improving our financial and operational performance. We are now in a stronger position in both these areas and despite the challenges, we have been able to invest in improving quality within our hospitals through the launch of our quality transformation programme.

One impressive development over the last year that I believe will have major benefits has been the significant improvements that have been made to our business intelligence and data quality, which culminated in the production of a new monthly report we call the 'Integrated Performance Report'. This report is considered at our Trust Board meetings and is available on our website with the meeting papers. It provides a snapshot of performance in key areas across the Trust and not only helps with performance management and accountability but also increases the Trust's openness and transparency.

A particular highlight from the last year – both for this Trust and the NHS in general – was the celebrations for the 70th anniversary of the formation of the NHS. A range of activities took place across our sites and the Trust also performed well in the national NHS70 Parliamentary Awards, with two of our teams making it to the final stage of the awards. The Trust's Butterfly volunteer service, funded by the hospital charity, was announced as winner of the care and compassion award. Congratulations again to all those involved.

I would also like to take this opportunity to introduce the Trust's new vision which was approved by the Board in January 2019: 'Proud to deliver high-quality, compassionate care to our communities'. This vision places the ambition to deliver high quality, compassionate care to our patients and carers at the heart of the Trust's clinical strategy, which has been designed to be our overarching strategy from 2019 to 2024.

The Trust has continued to contribute and participate as a member of the Herts and West Essex Sustainability and Transformation Partnership (STP). The aim we are working to as a 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 healthcare services. This work will continue over the next year as we work towards implementing an Integrated Care System and Integrated Care Partnerships within our STP. This is an exciting opportunity that has the potential to transform healthcare in our region over the longer term.

Ellen Schroder
Chair

Performance overview

The purpose of this section of the performance report is to set out in summary terms the Trust's clinical, operational and financial performance for 2018/19, 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 and legal requirements and our sustainability duties.

Chief Executive's statement

Whilst the Trust continued to face many pressures during 2018/19, I am pleased to report on a number of areas where significant progress was made.

The Trust continued to make good progress in terms of improving financial sustainability in 2018/19. The underlying deficit has improved for the second consecutive year and is now less than half the figure reported in 2016/17. A key element of our financial recovery work in 2018/19 was the development of a series of cost improvement programmes and productivity initiatives which delivered savings equating to £18m. Many of the programmes not only delivered savings but also improved processes and quality within the Trust. Examples of some of the successes include a one day reduction in length of stay for our inpatients and a 2.7% reduction in our Did Not Attend rate in Outpatients. Crucially, all programmes were reviewed for clinical impact prior to implementation by either the Director of Nursing or Medical Director.

Whilst appreciating the 2018/19 financial achievements, we are not complacent about what will be required for 2019/20. Further improvements can of course be made and we continue to explore opportunities carried over from 2018/19 as well as new ideas and initiatives for 2019/20.

I am delighted that 2018/19 saw a steady improvement in many of our operational performance standards. We resumed reporting of RTT performance in October 2018 and our performance has remained consistently above the national average since that time.

Similarly, the Trust resumed reporting on diagnostic measures in October 2018 and whilst performance was below the national average position at that time, there has been a significant improvement, and we now perform better than the national average and close to the target level of 1% breach compliance.

With regard to the eight standards relating to cancer waiting times, there has been good progress over the year, leading to compliance of five out of eight standards for March 2019. Plans are in place to address capacity issues which should enable us to deliver on the remaining standards over 2019/20, with delivery of a compliant 62 day standard in October 2019.

This last year has seen significant developments in relation to quality within the Trust. This began with the launch of the Trust's quality transformation programme in the autumn of 2018. As part of this programme we have invested in a Quality Improvement team who will work with and coach our clinical and non-clinical teams to drive quality improvements for our patients. An early highlight from the programme is the launch of our Harm-Free Care Collaborative, where improvement teams have adopted Improvement Science to reduce avoidable harms across key areas such as Pressure Ulcers, Falls, Thrombosis, Medication errors and Catheter Associated Urinary Infections. A new quality strategy for the Trust was developed and approved by the Trust Board in April 2019.

The Trust's mortality metrics have continued to improve and we now perform better than expected in terms of the Hospital-Standardised Mortality Ratio (HSMR). The Summary Hospital-level Mortality Indicator (SHMI) has also improved. This is an impressive achievement which reflects well on the quality of care provided by our staff.

Another significant development in 2018/19 was the approval by the Trust Board in January 2019 of a new clinical strategy for the Trust for the period 2019-2024. This sets out our key objectives and introduces a refreshed Trust vision (further details can be found later in the annual report). What was particularly impressive about how the strategy was developed was the comprehensive engagement programme that enabled valuable input from our clinical staff. I look forward to seeing the implementation of the strategy and the development of the supporting strategies over the course of 2019/20.

Finally, I would like to note that following a period of interim cover at the start of the financial year, our Chief Operating Officer, Julie Smith, joined the Trust in June 2018. I have no doubt that Julie's contributions have been a significant factor in the progress that has been made in relation to operational performance.

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

Nick Carver
Chief Executive
24 May 2019

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: Trust management; 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

The Trust is an active partner in the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP). The vision of the 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 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)

2018/19 was the final year of the Trust's current strategy, and throughout this year we have developed a new five-year strategy for the Trust. The aim of this is to ensure that the Trust is fit for the future and able to provide high quality services for the populations we serve.

In April 2019 the Trust will launch its new vision and strategic priorities. These have been developed over the last year with input from our staff, patients, their families and carers, members and key stakeholders, including the Hertfordshire and West Essex STP.

The new vision will be: ***"Proud to deliver high-quality, compassionate care to our community".***

A detailed examination of the challenges and opportunities facing the Trust resulted in the development of a Case for Change. This work included understanding our local population and their healthcare needs; the national strategic context; the commissioning landscape; the Trust's clinical quality and safety; patient experience; research and development; workforce issues; market share; the Trust's financial position; and information technology and innovation.

This showed that the Trust delivers high-quality care to the communities it serves, but that there was a need both for greater consistency in delivering high-quality as well as improvements to the way services are organised and managed, to ensure that they are easy to access and navigate both for patients and for those referring patients. It showed that there was an opportunity to develop services and our workforce across traditional organisational boundaries and play a proactive and leading role in the development of services as part of the Sustainability and Transformation Partnership (STP). It showed that there is an opportunity for the Trust to provide a range of services which compete with the best in terms of efficiency, productivity and clinical sustainability.

Responding to the Case for Change, five Strategic Priorities were developed, and these are:

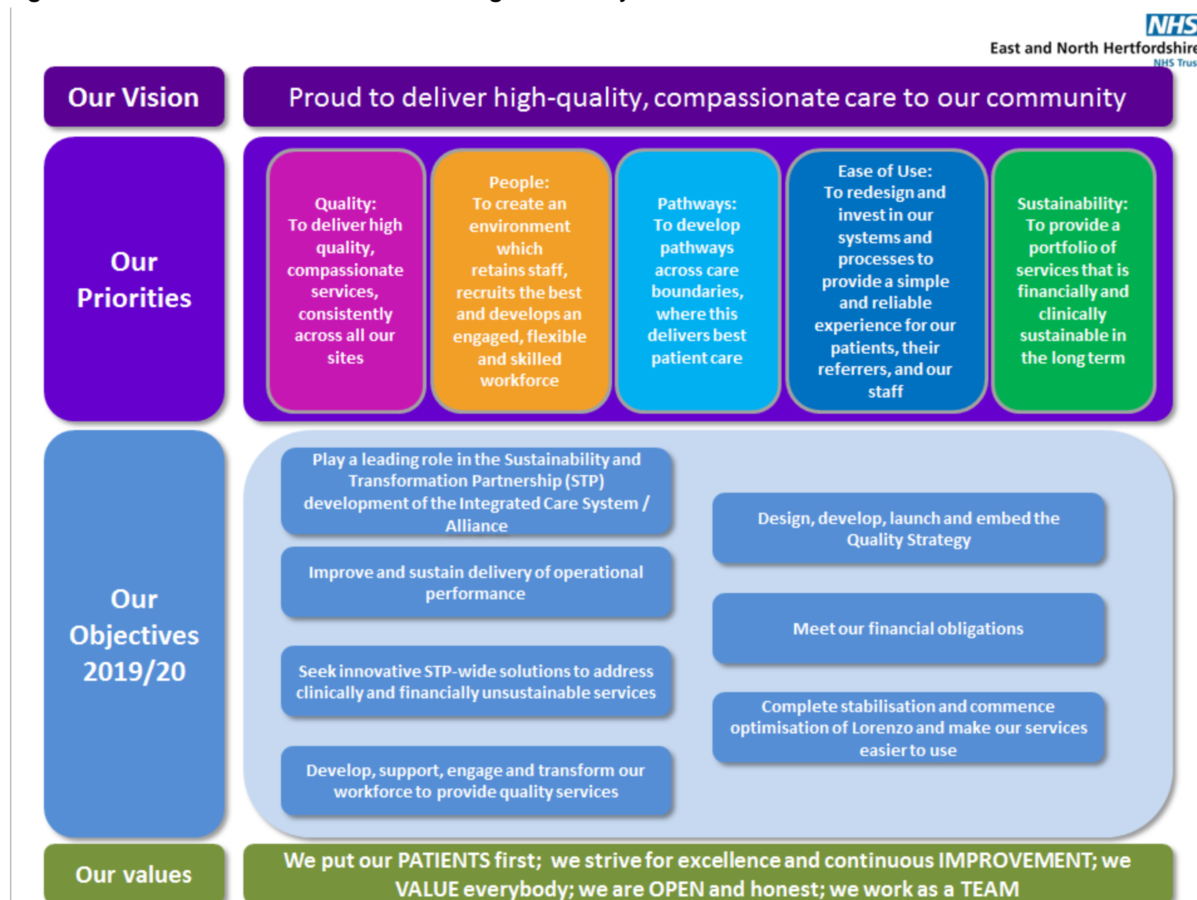
- Quality – We deliver high-quality, compassionate services consistently across all our sites.
- People – We create an environment which retains staff, recruits the best and develops an engaged, flexible and skilled workforce.
- Pathways – We develop pathways across care boundaries, where this is in the best interests of patients.
- Ease of Use – We redesign and invest in our systems and processes to provide a simple and reliable experience for our patients, their referrers, and our staff.
- Sustainability – We provide a portfolio of services that is financially and clinically sustainable in the long term.

These are underpinned by our PIVOT values, which remain unchanged:

Putting patients first; striving for excellence and continuous **improvement**; **valuing** everybody; being **open** and honest; and working as a **team**.

Our 2019/20 objectives

The Trust has identified seven key objectives for 2019/20. These are shown below. Progress against these will be measured throughout the year.



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. 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 during the financial year but is forecast to breakeven in the forthcoming year.

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 Trust has provided its regulatory body, NHSI, with its financial plans for 2019/20. There is no identified reason for the Directors to assess that there is a likelihood that the Trust will be wound up in the foreseeable future, and therefore for its assets and liabilities to be valued on a basis other than the 'going concern' basis.

The financial statements do not include any adjustments that would be required if the going concern basis were not appropriate.

Key performance summary

Clinical / quality performance summary

In 2018/19, the headline performance figures were:

- MRSA bacteraemia (blood infections) – 2 cases in 2018/19
- Trust-allocated case against a ceiling target of ten Clostridium difficile infections – 27 year to date (as of 25 March 2019)
- Crude mortality rates – 1.15% for the 12 months to February 2019, compared to 1.43% for the last three years
- HSMR – 93.01 for the 12 months to December 2018, which statistically is in the better than expected range
- SHMI – 94.1 for the 12 months to December 2018, which places the Trust within the as expected band two range
- In Hospital Cardiac arrest rate reduced by 43%, now at a rate of 0.8 per 1000 admissions.
- 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 2018/19 were:

- A&E (the target is for 95% of patients seen, treated and either admitted or discharged within four hours of arrival) – 85.85% end of year performance for 2018/19.
- 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 (the average year-end figures for 2018/19 are 94.8% and 92.6% respectively).
- Cancer 62-day referral to treatment – average year-end figures for 2018/19 are 69.1% pre-breach/compliance sharing and post –breach sharing 73.1% against the national 85% standard. A revised recovery trajectory has been agreed with external stakeholders and shows that the Trust will deliver 85% in October 2019 with associated investment.
- Cancer 31-day decision to treat to first definitive treatment – 93.9% against a national standard of 96.0%.
- 18-weeks referral to treatment (RTT) – The Trust returned to reporting RTT performance in October 2018 following a prolonged period of data validation and Patient Tracking List (PTL) development. The Trust is reporting an improving position against this standard and whilst The Trust is not currently compliant with the mandated standard it is significantly above the national aggregate position. The Trust has significantly reduced the numbers of patients waiting greater than 52 weeks for treatment. There is a high degree of confidence that a position of zero 52 week breaches can be maintained for the long term.
- Diagnostics (DM01) – The Trust returned to reporting Diagnostics performance at the same time as RTT and in line with RTT has reported an improving position since.

The Trust is confident that it will achieve a compliant DM01 position in 2019/20 and maintain it going forward.

Financial performance summary

The Trust agreed its financial plan for 2018/19 with NHS Improvement based on a control total of a deficit of £0.28 million. In order to deliver this control total, the Trust required support from the national Provider and Sustainability Fund of £14.36 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 £13.54 million. Whilst the Trust's reported financial performance for 2018/19 has improved compared with 2017/18, it was at variance material from plan expectations.

The key features of financial performance during 2018/19 and explanations for the gap between planned and actual performance were:

- The Trust earned significantly more income from patient activities than it had planned for the year. The over-performance was largely driven by high levels of emergency activity, particularly over the winter period from October 2018 onwards.
- The impact of local health economy schemes to reduce and redirect demand for emergency services proved less significant than the Trust had envisaged and this resulted in higher levels of emergency activity than planned.
- The Trust experienced significant operational issues with laminar-flows in Theatres which impacted our ability to drive improved Theatre throughput and efficiency in relation to inpatient elective activity.
- The additional emergency activity outlined above contributed to a material over-spend on the Trust's pay-bill, that outweighed the additional income generated. All staff groups involved in the direct delivery of patient care overspent against their budget in year. There was also a significant pay increase for staff on Agenda for Change contracts, which was not fully funded by the Department of Health.
- The Trust continued to identify and deliver significant cost efficiencies in 2018/19, £18.0 million across the year. Unfortunately, this did fall short of the ambitious target (£24.2 million) that the Trust had set for the year.
- 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 Provider and Sustainability Funding that it had anticipated within its financial plan.

Workforce performance summary

Key headline figures for 2018/19 were:

- 803 attendances at the Leadership, Management and Coaching Development Pathway against a target of 600, aimed at developing our culture through leadership
- 21 LEND programmes held with a total of 685 attendances, establishing the Trusts leadership philosophy, cultural ambitions and organisational priorities
- The Trust ended the year with a vacancy rate of 7.2% (down from 8.4% the previous year), with 8.4% vacancy rate for nursing and midwifery posts and 3.7% for medical posts
- The Trust closed the year 2% under the agency spend ceiling target with agency spend making up 4.3% of the overall pay bill

- The average rate of sickness absence was 4.3% which was equal to the previous year but did not meet the planned improvement trajectory
- The Trust turn-over rate ended at 13.3%, down from 13.5% at the same point the previous year.

Performance analysis

In this part of the performance report for 2018/19, 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 including 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

2018/19 saw the development of a new clinical strategy which outlines the strategic priorities and objectives for the Trust. This strategy supersedes several previous strategies and provides details of the objectives agreed for each of the divisions, as well as the enabling strategies that will be required to meet these objectives. The remaining enabling strategies will be developed over the course of 2019/20.

The Trust's Board recognised 2018/19 as being a challenging year, with operational and financial challenges. Other key risks included staff recruitment, delivery of performance targets and financial pressures, as well as the stabilization work required following the implementation of a new electronic patient record system in 2017.

During 2018/19 we have made significant progress towards implementing our revised 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. During 2018/19 the Board and Audit Committee have regularly reviewed progress. During quarter 4 2018/19 we have undertaken an annual review of progress and updated the Risk Management Strategy. The review included developing and approving a risk maturity and capability assessment and development of a comprehensive set of risk appetite statements and a review of the key strategic risks. We have 14 principle strategic risks to achieving our strategic objectives identified on the Board Assurance Framework. The Board and its committees review and monitor key actions and assurances. The Accountability Framework implemented at the end of 2017/18 has now been embedded into practice supported by an integrated performance report. This supports divisional to Board assurance – the information that supports this model to monitor and support the delivery of key organisational objectives and targets and support continuous improvement. Further detail on this is provided in the Governance Statement on page 59.

The Integrated Performance Report includes the key performance measures for the Trust. The report is reviewed at every Quality and Safety Committee, Finance and Performance Committee and Trust Board meeting. This provides the lead director an opportunity to highlight any risk issues relating to the metrics.

Delivery against our Trust objectives

Summary information about the delivery against the Trust's 2018/19 objectives can be found on pages 9 to 12.

Care Quality Commission – Essential Standard 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 Care Quality Commission inspected nine of the core services provided by East and North Hertfordshire NHS trust across Lister Hospital, the Queen Elizabeth II (QEII) Hospital and Mount Vernon Cancer Centre, between 20 and 22 March 2018. They returned on 2 April 2018 for an unannounced, follow-up inspection of the surgery core service at Lister Hospital. The well led inspection took place from 23 to 25 April 2018. The Use of Resources inspection, which is led by NHS Improvement, took place on 11 April 2018.

<u>Summary of the Trust's Ratings:</u>

Our overall rating stayed the same - requires improvement.

We were rated as good for caring and requires improvement for and safe, effective, responsive and well led.

We were rated as requires improvement for use of resources

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Lister Hospital	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Queen Elizabeth II Hospital	Inadequate ↓ Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Inadequate ↓ Jul 2018	Inadequate ↓ Jul 2018
Mount Vernon Cancer Centre	Requires improvement ↑ Jul 2018	Good →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Hertford County Hospital	Good Mar 2016	N/A	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018
Community	Good Mar 2016	Good Mar 2016	Outstanding Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Overall trust	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Good →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018	Requires improvement →← Jul 2018

The CQC have issued a number of requirement notices and set out a number of areas for improvement - "Must Do's" and "Should Do's". An action plan was developed against all of these and was submitted to CQC on 24 August 2018. This continues to be monitored by the Quality Transformation Board Improvement Board, chaired by the Medical Director or Director of Nursing and reported to Board through the Quality and Safety Committee. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded across the organisation.

In-depth performance review

Over the next few pages, the annual report sets out in more detail the Trust's performance in 2018/19 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

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. We recognise the value in accurate risk assessment and early escalation to prevent the harm from Hospital Acquired skin damage occurring.

Nationally the measurement and reporting of pressure ulcer has changed, and 'grading' of skin damage secondary to pressure is now referred to as 'category' of skin damage. The Department of Health and Social Care's has also mandated that definition of avoidable/ unavoidable should not be used.

The Trust is committed to reducing harm associated from skin damage due to pressure and from March 2018- Feb 2019, the total number of hospital-acquired pressure ulcers, including SDTIs (suspected deep tissue injuries) was 82.

Unfortunately this year we have reported a Category 4 pressure ulcer (1.2%); this was reported as a serious incident and the final report and learning currently in progress. No category 3 pressure damage has been reported this year, with the majority of reported pressure ulcer damage relates to Deep Tissue Injury category = 37% and Category 2 damage (32%). A smaller proportion of reported skin damage Unstageable (18.5%); mucosal membrane device related (7.4%)

The Trust's tissue viability nursing team continues to support this improvement through providing a range of resources to support staff; and through adopting an Improvement Science approach within the trust wide Harm Free Care Collaborative, we will prioritise clinical areas and specific patient population needs to reduce harm from hospital acquired skin damage. The team also welcome participation in national point prevalence study to be undertaken across the organisation in partnership with NHS Improvement.

Preventing inpatient falls

The Trust reported a 3.14% annual reduction in falls in 2018/19, surpassing our target of a 2.5% reduction. Our target for 2019/20 is to achieve a further 2.5% annual decrease. Through 2018/19 the falls prevention policy has been revised and work continues to digitalise our falls risk assessments within the ongoing stabilisation work.

From April 2018 – March 2019 845 inpatient falls were recorded, a high percentage of these falls result in low or no harm to patients, with 20 resulting in moderate or severe harm.

Reducing harm from in-patient falls remains a trust patient safety priority and improvement work this year shall focus on prioritising the root causes of incidents in clinical areas where harm has occurred; and successful adherence to 2019/20 CQUIN that requires all patient > 65ys old who are admitted to hospital during an episode of acute illness, to have reliable documentation of postural BP monitoring.

This approach will enable a collaborative multidisciplinary team effort to locally apply NICE guidance and adoption of Royal College of Physician fall safe care bundle approach. There will be cross team learning to understand individual patient population needs, and seeking to discover what key themes require local improvement e.g. Bay watch processes, risk assessment etc.

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 2019) – 1.4%
- Average for the last rolling 12 months (to February 2019) – 1.1%.

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. Scores greater than 100 can suggest a potential problem may exist and may potentially warrant further investigation.

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

- HSMR – the most recently published data, for the rolling annual 12-month period to December 2018, is 93.01. Statistically speaking, this falls within the better than expected range.
- SHMI – the most recently published score, for the 12 months to December 2018, is 94.1 and is in the as expected band 2 range. This is an improvement on the Trust's position last year (102.9) and is the first time that the Trust has recorded a SHMI of below 100.

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. Of particular importance is the work of the Deteriorating Patient Group which includes measures to support the early identification and treatment of Sepsis.

An area for improvement this in 2019/20 supports the recognition that for some of our patients who are approaching the end of their life, an admission to hospital may be neither helpful nor desirable. With this insight we are committed to developing ways of caring for these patients in a more suitable, patient-centred approach.

Learning from deaths

We have an established mortality review process to enable learning and this is reported through the Mortality Surveillance Committee to the Quality and Safety Committee and Board.

We continue to perform well and our HSMR position for the twelve months to December 2018 is rated statistically as "better than expected" and is better than the national average (93.01). The SHMI for the 12 months to December 2018, is 94.1 and remains within the 'as expected' range. This is the first time that the Trust has achieved a SHMI of below 100. We continue to seek ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are in place.

This year we have reported six never events in 2018/19 (April 2018-March 2019):

- One related to wrong connection of 02 tubing

- One related to misplaced NG tube placement
- Four incidents were related to invasive procedures

Each of these incidents has been 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:

- Flaps have been placed over airflow outlets to act as a barrier to accidental use. They have to be purposely removed for use
- Development of a nasogastric feed pathway with clarity over assessments and ongoing checks
- Register of nursing staff with naso-gastric tube competencies to ensure appropriate expertise is available
- Revision of lung biopsy consent form
- Instigation of a 'safer surgery' collaborative to redesign checklists; standardise communication boards and introduce human factors training

Ongoing multidisciplinary quality improvement efforts include:

- The need to publish a trust policy that reflects National Safety Standard Invasive procedure Policy (NatSSIP)
- Review current local surgery checklists to reflect Natssip requirements
- Trust wide learning event & communication of easy to read 'Natssip' guidance
- Develop a 12month rolling programme for invasive procedural teams to access, where they can consider and map 'Human Factors Contributory Factors' across their local invasive procedures. Plans for team videoing and learning materials are underway.
- Review team practises related to site marking and publish clear site marking guidance
- Update induction programmes to reflect learning form Never Events

The safer surgery collaborative shall enable clinical leadership of high prevalence specialities undertaking invasive procedures. To compliment this, we are planning to undertake trust wide annual 'Never Event Risk Assessments', in all clinical areas, and across all current Never event categories.

2018-19 CQUIN Performance

The CQUIN indicators agreed with the East and North Hertfordshire Clinical Commissioning Group 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
- 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 e.g. alcohol and tobacco (2018/19 indicator only)
- Engagement with STPs
- CQUIN risk reserve

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 currently awaiting responses from Commissioners on performance for Q3 2018-19 in order to forecast performance for the remainder of the year.

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 2018/19 the Trust has continued to work closely with the Herts IDVA (independent domestic violence advisor) to support victims of domestic abuse and through raising awareness of domestic abuse has seen an increase in the number of cases being referred to the IDVA. More victims are therefore being offered practical support to escape abusive relationships.

Work has also been undertaken in partnership with other health organisations and the Modern Slavery partnership to raise awareness of modern slavery and victims.

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 Admiral Nurse and the enhanced care team.

During 2018/19 the Trust's ophthalmology service at the Lister Treatment centre 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 was the fourth service to receive the accreditation. The Emergency Departments and Endoscopy services also began the work to achieve accreditation.
The Trust has also developed action plans to improve the care for adults with Learning Disability following concerns about the care of patients with LD. The Trust has taken part in the NHSI LD standards benchmarking exercise, established the LD working group and committed to ensuring staff have the skills and knowledge to provide appropriate care for patients with LD.

Our learning disability population are also a priority in the Deteriorating Patient Collaborative, where we have captured learning to improve recognition and management of the deteriorating patient with Learning Disability.

The Trust has an 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.

During 2018/19 emphasis has been given to patient safety, including actions to promote and use safety huddles on wards and whole site, the aim of which is to make sure that the whole team is sited on risks or actions that need to be taken to promote safety and reduce the risk of harm to patients. This has included highlighting at a senior level any situations where delays or blockages have occurred in delivering patient care so that actions can be taken to resolve issues or concerns.

The Butterfly volunteers, who provide support to patients and their families at the end of life, particularly where an individual may not have anyone who can stay with them, were winners of the NHS70 Care and Compassion award in 2018. This recognised the commitment these volunteers have given to patients when they are at a particularly vulnerable stage in their life's journey.

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.

Children's Safeguarding services promote the welfare of children and prevent 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 Partnership through Trust's director of nursing and executive safeguarding lead attending these meetings. The children's safeguarding team attend a number of working groups to ensure representation in yearly work plan and objectives.

During 2018/19 the Children's safeguarding service has continued to manage a continued increase in workload including referrals to children's services and information requests.

The service has completed the organisation's Section 11 inspection and associated action for 2018/19 and the service work plan including a number of audits and ensuring policies and guidance is updated.

In response to the CQC inspection the service has developed and piloted a workbook for staff in adult areas caring for young people aged 16 and 17years. This was successful and is now being launched across the organisation.

The children's safeguarding team continue to carry out safeguarding supervision and peer review sessions for all staff within the service and these have also been audited for quality and changes made as appropriate and feedback to participants.

The service has also been actively involved within the organisations emphasis on patient safety including the site safety meetings which a member of team attends to ensure representation and promote safeguarding of our younger patients across the organisation and escalating areas of concern and helping mitigate issues and concerns that are highlighted.

The service is actively involved in developing a joint safeguarding quality dashboard across the whole organisation for children and adults, measuring key performance indicators.

Infection prevention and control

Infection prevention and control has been a priority for the trust this year. Recognising that there was a need to strengthen compliance against the Code of Practice Hygiene Code, the trust embraced an improvement programme which resulted in the trust achieving a Green rating by the Regulators in terms of infection prevention and control in December 2018. This was the result of a significant investment in equipment replacement, further training and development of our clinical staff, improved audit programmes and a commitment from all care givers to keep our patients free from harm in relation to reducing healthcare acquired infection.

The trust is achieving its trajectories for improvement against key measures.

The trust had few increases of incidence of norovirus and influenza during the winter period resulting in limited loss of capacity.

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;
- Specifically at weekly the weekly Access board, chaired by the COO
- Exception reporting via the Trust's executive committee, and divisional 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, and works closely with commissioning colleagues from ENHCCG to maximize achievement of those targets.

The 2018/19 year represented a continuation of a challenging time for the Trust, to include an ongoing period of recovery post 'go live' of Lorenzo, culminating in the launch of the Lorenzo stabilisation programme. The programme has a number of work streams defined to address the failures and non-compliance within the system and use of the Lorenzo PAS system. It is anticipated that at the end of the stabilisation programme a significant number of issues will be been resolved delivering improved system use, adherence to process and visibility of patients through more effective use of the relative Lorenzo PAS and Nerve centre systems within the emergency footprint and patient monitoring.

The stabilisation programme is coupled with improved operational grip and control which resulted in a return to national reporting for RTT- 18 week referral to treatment and the diagnostic target of DMO1 within the year. The performance of RTT was above the national average position and although DMO1 was slightly less favourable the combination of stabilisation improvements around reporting and validation of data coupled with increased capacity has provided a strong basis for improvement towards compliant levels for the diagnostic operational target.

There remained a focus during the year on delivering the core standards of:

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

A&E four-hour waiting time standard

The Trust's emergency care pathway project continued during the 18/19, focusing on enhancements to ED processes and work to improve ward efficiency through the safer and red to green programme with the aim of reducing length of stay and improving patient flow. The project also included redesign of the acute pathway with an emphasis on streaming patients away from the Emergency Department and reducing admissions through patient pathway changes.

This work has delivered some improvements to performance during the summer, with 90.34% performance delivered in November 2018. Subsequently, demand and capacity challenges over the winter period caused deterioration in performance, this is coupled with

staffing gaps across a range of professional groups who are key to the ongoing ED delivery to include ED middle grades, Consultants, nurses and GP cover.

During 18/19, the Trust did not achieve the A&E standard, delivering a year-end position of 85.85%.

The ED remedial action plan lists a number of key deliverables to support ED performance improvement:

- Triage and streaming process
- Ambulance offload and rapid assessment/treatment
- Majors non admitted patients
- Resuscitation DTA process
- Continued improvements to patient flow and pathway redesign

There are regular management meetings in place across the week reviewing the impact of the weekend performance and drivers around issues, delivering improved governance and ownership of ED performance. This starts on a Monday at 8.00am and across the week culminating in a Friday preparation meeting for the on call teams for the coming weekend with the aim of ensuring a focused plan is agreed to maintain a safe emergency department service, maximizing on patient care and experience and minimizing avoidable breaches.

62-day urgent GP cancer referral to treatment standard

For the second year running, 2018/19 saw under-performance against this target, a trend that started in 2015/16 across the NHS. Our average year-end performance for 2018/19 – against the 85% target – was 69.1% (pre breach reallocation).

During the year an extensive piece of work has been undertaken to determine the capacity needed to meet and sustain a Trust aggregate 2 week wait (2ww) and 62 day compliant performance. This work was undertaken in collaboration with NHSI IMAS and the CCG. This included review of the cancer governance and PTL structure to include MDT's, demand and capacity analysis for 2ww, radiology, endoscopy, radiotherapy and brachytherapy and RALP, end to end pathway analysis of the five challenged specialties of lung, H&N, Gynaecology and Urology. This has resulted in a 19/20 cancer expansion business case for consideration as part of the contracting round and detailed NHSI endorsed recovery action plans by tumor site. Assuming support for the business case the Trust has agreed a revised recovery plan for 62 day compliance of 85% in October 19.

31 day subsequent treatment standards

During 18/19 the Trust recovered its noncompliance for 31day subsequent chemotherapy and radiotherapy standards and was taken off remedial recovery plan reporting. Since June 2018 this compliant position has been sustained. Lack of capital to replace 1 of our 8 Linac platforms put this performance at risk for 19/20 and so as a result the Trust has embarked on a radiotherapy mapping exercise with NHSE that looks at options for patient flow.

Electronic patient record system and digital stabilisation programme

Our new electronic patient record system – 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.

The Trust embarked on a challenging programme of stabilisation which will be completed in May 2019. An external consultancy company was engaged to support the delivery of the stabilisation program which has also been strongly backed by our regulators and NHS Digital. A Lorenzo Stabilisation Board was established to monitor progress. This included representation from NHS Improvement and NHS Digital, with reports being taken to the Trust's finance and performance committee.

The key deliverables of the stabilisation program as they relate to Lorenzo were:

- Business and administrative processes that are fit for purpose using Lorenzo as it was intended.
- Training for all Lorenzo users in the processes mentioned above and other related activities eg RTT
- A clear plan to enhance and optimize the way Lorenzo is used in the future

We have maintained a governance framework to manage data quality and clinical risks to ensure the impact on clinical quality and patient safety is mitigated and no patients are missed on the patient tracking list.

Where patients have waited over 52 weeks for routine treatment or over 100 days for Cancer treatment, a harm review has been undertaken. The harm review process has been agreed with our commissioners and the progress and outcomes is reported to quality and safety committee and Board at each meeting.

For financial impact, please see finance performance summary on page 29.

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 specialized 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. 2019/20). This information, along with comparisons against the previous year's performance, is set out in the table overleaf. The trust continues to work with commissioning colleagues on opportunities for QIPP – quality improvement productivity and prevention and demand management schemes to ensure the acute trust setting is maintained as the place of care giving for our most sick patients, so that community care and primary care provision can be accessed wherever possible.

Activity	2018/19 Actual	2019/20 Planned*
A&E attendances (includes urgent eye clinic service)	152,080	151,913
Outpatients – first appointments (includes non face-to-face and procedures)	172,213	167,533
Outpatients – follow-up appointments (includes non face-to-face and procedures)	374,898	379,991
Elective inpatients (i.e. planned admissions)	8,395	8,797
Elective day cases	63,379	64,710
Non-elective inpatients (i.e. emergency admissions)	48,272	47,604
Deliveries**	5,502	5,508

* As at end of April 2019

**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 2018/19, the Trust has reviewed and updated its Major Incident, Chemical, Biological, Radiology Nuclear and Explosive (CBRNE) plans. The Cooperate and Departmental Business continuity plans have been implemented to improve its Emergency Preparedness Resilience and Response. The Business Continuity plans have been exercised with live events with National issues with the Waste Company and IM&T issue with Lorenzo and an IT/Telecommunication and updated as required.

The Trust also made its annual core standards submission to NHS England during the year, clarifying its levels of competency. In our EPRR Core Standards self-assessment, we rated our overall level of compliance as substantially compliant. Following the assurance meeting with NHS England and review of our submission, NHS England agreed with our EPRR Core Standards Assurance rating of: SUBSTANTIALLY COMPLIANT.

Governance for emergency preparedness within the Trust is controlled through the emergency planning committee, quality and safety committee and the Trust board. This duty is discharged by the Deputy Chief Operating Officer reporting to the Chief operating Officer as the accountable officer, with the support of the Emergency Planning Manager.

The EU Exit preparedness team are continuing to meet to ensure that plans are in place to minimise the impact on the Trust. This team was created in response to EU Exit Operational Guidance from the Department of Health and Social Care regarding the scenarios that the UK leaves the EU on the 29th March 2019 without a withdrawal agreement. The EU Exit Senior Responsible Officer is the Interim Director of Strategy with the support of the Emergency Planning Manager.

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Financial performance

The Trust's pre-audited reported financial performance was an adjusted retained deficit of £13.54 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 (NHSI), 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 2018/19, the Trust agreed that its financial performance, its control total, would be a deficit of £0.28 million.

The Trust's pre-audited reported financial performance was an adjusted retained deficit of £13.54 million, which includes the consolidated profits of the Trust's wholly owned subsidiary, ENH Pharma of £0.7 million. The breakeven position was -3.0% in year, which contributes to the cumulative position of -17.0%. Therefore, the Trust has not met its financial duty in this respect. As a consequence of the deficit outturn position in 2018/19, the Trust's external auditors BDO LLP will refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014.

External Financing Limit

The Trust is given an External Financing Limit (EFL) each year, which it is permitted to undershoot. In 2018/19, the Trust's EFL was £34.95 million, of which it utilised the full amount (financial duty achieved). Included in this is £0.4 million cash balance relating to ENH Pharma.

Incorporated within the EFL cash flow financing, was £26.6 million of Working Capital Support Loans, necessitated by the Trust's increased deficit position, together with £13.6 million of Loans to fund capital expenditure. The capital loans relate to the Lorenzo PAS system and Mount Vernon Bunkers. In addition, the Trust received allocations of Public Dividend Capital totalling £0.4 million. The Trust has repaid £5.9 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 2018/19 was £18.89 million, against which it expended £18.88 million – an undershoot of £0.01 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 41 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 65.1% of non-NHS trade invoices paid within target during 2018/19.

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, this is essential in ensuring that we are able to consistently deliver safe and effective care to patients.

Through improved financial control and efficient and effective use of resources, the Trust will aim to deliver service improvements and cost improvement programmes in 2019/20 that will support the achievement of its agreed 2019/20 control total target. Whilst 2019/20 is likely to be another challenging year the Trust remains confident that it will be successful in delivering its financial recovery plan and will return to financial balance in the year ahead.

Workforce performance

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 quality and safety committee

Trust's culture

Leadership Development

The Trust has maintained its focus on the development of culture through leadership. Part of this is the Leadership, Management and Coaching Development Pathway (LMCDP) which covers some core management skills for senior leaders and wider teams, including aspiring leader, leadership awareness, appraisal and feedback, as well as building and developing teams, and a new programme called 'Compassionate Service' which replaces previous customer service modules. The reach of these programmes is extensive, with over 700 people having taken part in one of the programmes in the year.

Part of this is the quarterly LEND programme based on the Trust's leadership behaviours: Listen, Empower, Nurture and Develop. The quarterly leadership LEND fora, has offered the following opportunities:

- An opportunity to meet and network with others
- An opportunity to hear from the CEO on the position and ambition of the organisation
- An educational opportunity as we share some leadership practice and techniques
- A revalidation opportunity as we produce attendance certificates for each event
- A time out opportunity to reflect from a different perspective on activity and work
- An opportunity to be supportive, connect with colleagues and have a little fun.

The LEND events have also been used to discuss and launch the Trust's new Vision and Strategy, as well as the staff survey results.

Talent Management

The Trust has a strong history of supporting its most talented staff with a range of development programmes. The Chief Executive chairs the Regional Talent Board and plays an active part in replicating this good practice locally. The Trust and the region have a wide range of programmes for developing talent at all levels. The Trust's approach complements the regional approach, and covers the whole organisation. It starts from the fundamental belief that the organisation is full of talented and exceptional people whose talent the Trust wants to recognise and nurture. The approach has covered all professions and levels in the organisation, key initiatives as follows:

- National Leadership Academy programmes – Developed be NHS Leadership Academy, the Trust actively supports participants with the programs including Mary Seacole and Nye Bevan
- Graduate Management Training Scheme (GMTS) – The Trust has worked with the STP to fund and bid for places
- Aspire Together Programme – The Trust leads on the Regional Talent Boards strategy for identifying future people for senior leadership appointments
- Accelerated Directors Development Scheme (ADDS) – Hosted by the Trust, ADDS is a regional development scheme for aspiring executives who have the motivation and potential to become a director in the next 9-36 months
- Apprenticeships – The Trust has continued to develop apprenticeship roles

Staff health and well-being

The Trust recognises the importance and benefits of optimising staff health and wellbeing. Taking positive action to promote staff wellbeing not only reduces sickness absence but can

improve morale, rates of staff retention, improve working relationships, reduce errors, enhance patient experience and improve patient care.

The Health at Work service has focused on two priority areas of wellbeing – mental health and musculoskeletal health. These priorities reflect the biggest challenges for our workforce and are in alignment with NICE guidelines and the NHS staff health and wellbeing framework. The Health at Work Service has delivered a range of services and wellbeing initiatives that promote employees physical and mental health and wellbeing with the aim of reducing sickness absence due to stress and musculoskeletal issues, respond to issues raised in the staff survey and achieve the staff wellbeing CQUIN.

Staff Health and wellbeing initiatives are planned and delivered by the Health at Work service working in partnership with other teams such as pharmacy, employee relations, staff side, health and safety and infection prevention and control. Key initiatives taken forward in 18/19 include:

- A staff minor ailments service provided in partnership with 'Your Health Pharmacy'.
- Fast track physiotherapy for employees who report a musculoskeletal injury or disorder affecting their fitness for work.
- A Health at Work advice line, for employees and managers to request confidential advice on any health at work issue.
- Health at Work advice to managers on adjustments to prevent sickness absence and promote health improvement, and return to work plans to support safe and sustained early return to work.
- Early assessment and advice for staff unable to work due to a stress or mental health issue or MSK issue or following an injury at work.
- A range of initiatives to promote exercise and physical fitness such as walking groups, reduced gym membership, promotion of local exercise classes/groups, free weight management classes, referrals to stop smoking services.
- Referrals for to counselling and / or online CBT.
- Employee Assistance Programme, which provides free access to confidential advice and counselling.
- Weekly Mindfulness drop in sessions delivered by the hospital chaplains.
- Monthly staff wellbeing events to promote healthier life styles and support services within the trust and in the local community held on a range of health and wellbeing issues such as: Mental health awareness, healthy eating, alcohol, skin health, free health checks such as cholesterol monitoring, blood pressure, height, weight and body fat measurements.

NHS national staff survey 2018

The Trust's response rate to the staff survey was 42.8%, a little below the national average of 44%, and a significant improvement on 2017 when the trust's response rate was 29%. 2389 staff completed the questionnaire which means that the results were more representative of their views.

The results compare the trust's position with other trusts in the benchmark group of acute trusts in England. In relation to the ten indicators, the trust scored better than average in two

areas: Quality of Appraisals and Violence, but worse than average in the following areas (which represent the results for groups of questions):

- Staff engagement
- Health and Wellbeing
- Equality Diversity and Inclusion
- Morale
- Immediate Managers
- Bullying and Harassment
- Quality of Care
- Safety Culture

It is encouraging that in areas where the trust has had some focus over the past year, the results have improved compared with the previous position, for example, for some of the questions on safety culture which cover the way the trust treats staff who are involved in an error, near miss or incident, the action taken in such cases and the feedback given, the trust's scores have improved since the previous year.

Many of the results are not where the trust would want them to be, with 5 out of the 9 indicators which are comparable with last year having fallen. Some of these deteriorations are in line with national trends, for example on staff health and wellbeing which is declining on most measures.

People performance

Recruitment and retention

The Trust has continued to work to reduce vacancy rates during 2018/2019, and works within a robust approvals process where vacancies are only filled where there is a demonstrable need and are within budget. In addition, the time taken to recruit to vacancies has been a key focus to ensure that positions are filled as quickly as possible and without delays.

One of the key areas of work has been to continue the work in reducing the number of band two clinical support worker (CSW) vacancies as well as band five staff nurses vacancies. The clinical support worker vacancy rate has seen a significant reduction over the year to 12% through targeted local and social media campaigns, the introduction of different career pathways and regular recruitment open days. The Trust's approach to nursing recruitment has been a blend of UK recruitment to hold staffing levels against turnover, and international recruitment to fill vacant posts. International recruitment has seen the Trust working closely with trusted partners to welcome nurses mainly from the Philippines and India, and a variety of methods to aid UK recruitment such as regular recruitment open days, an improved streamlined recruitment process for student nurses guaranteeing them a post and attendance at national jobs fairs.

The time to hire has remained stable at 8.7 weeks from approval through to unconditional offer and this is scrutinised regularly to ensure that processes are as streamlined as possible.

Whilst the Trust's turnover rate remains the lowest locally, there continues to be a focus on retention during 2018/2019, with a multi-disciplinary steering group regularly meeting to review turnover trends and reasons, as well as making a variety of improvements through a number of sub groups.

Temporary staffing

The Trust has had continued with reducing its reliance on bank and agency staff during 2018/19, particularly within the nursing and midwifery staff group, with agency spend reducing by 57%. By the end of the year, the Trust saw a positive variance of 2% against the agency ceiling target set by NHS Improvement. Better alignment with Resourcing activity and electronic rostering systems has allowed a coordinated approach to tackling agency fill. This has enabled more than 80 wards of departments to declare themselves as 'agency free'. At the same time the number of staff being available to work on the Trusts staff bank has increased. This was most significant for the nursing and midwifery staff group which showed an improvement in bank fill of 44% since April 2018.

Key initiatives have included, leading the regional hub across Hertfordshire and Bedfordshire to ensure maximum efficiencies around agency pay rates and aligning bank pay rates. The Trust was one of the national pilot sites for two of the Department of Health and Social Care work streams on 'building a national bank' which resulted in the launch of a social engagement app of which 14% of the substantive workforce are signed up and using as well as building a Medical bank concept, from roster through to payroll which went live in March 2019.

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. A robust Temporary Staffing action plan is in place for all staff-groups which tracks core activity around progress to reduce agency spend and Temporary costs in general.

The temporary staffing office for doctors (TSOD) function continues to evolve allowing further scrutiny around Bank and Agency bookings. Any agency request requires Medical or Finance Director sign-off before proceeding. Reliance on Bank has reduced over the year by 31% as more posts are filled substantively. Compliance with agency ceiling rates set across the East of England continue to make progress, with March's figures showing 73% compliance from a starting point of 42% in April.

2019/20 has ambitious action plans to target Medical and all other clinical, non-nursing, agency spend of which progress has been slower to achieve in 18/19.

Employee relations advisory service (ERAS)

As an employer we recognise that the way we manage and support our workforce is essential to recruiting and retaining our most valuable asset: our staff. While we would ideally never have the need, with a staff headcount of 6000+ there are the few occasions where managers are required to intervene to improve individual poor performance, conduct or attendance. The ERAS team support managers in having these most difficult conversations to support staff through life changing events such as living with terminal illness and personal caring responsibilities and in addressing poor performance or conduct to ensure that the care provided to our patients is of the highest quality.

Daily activity for the team can vary from providing staff and managers with telephone advice on the application of Trust policies, employment law and NHS terms and conditions of service, to leading facilitated meetings between individuals or groups of staff who have difficult working relations and training managers in how to conduct formal investigation or give evidence at employment tribunal. In conjunction with the HR Business Partners, the preferred approach is to identify concerns and provide early intervention before a situation escalates, however, where necessary more formal action can be supported to ensure that staff are able to remain at work, or return to work at the earliest opportunity, whilst ensuring there is no risk to them or our patients.

The employee relations team have been focused on reducing sickness absence by providing significant levels of intervention to managers whose team members require reasonable adjustments. Additional coaching and discussions are taking place to accurately articulate why adjustments may or may not be reasonable.

Going forward the key objectives for ERAS for the coming year are to develop and deliver an easy to use service, that develops and supports people to deliver in their role, while reducing sickness absence and placing zero tolerance on bullying and harassment.

Appraisal

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. Appraisal rates at the end of March 2019 are at 81.8%.

Statutory and Mandatory Training

Overall statutory and mandatory training compliance of the Trust, as of March 2019, was 88.90%. Overall compliance relates to the compliance across all training requirements per role.

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 committed to putting our hospitals at the heart of our local communities and this work continued to feature strongly in our activities throughout 2018/19.

Working with local charities

The Trust is very grateful for the received from local charities in 2018/19. 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

We took the opportunity of the new General Data Protection (GDPR) legislation to review the way we work with our public members. We are delighted that over 500 members actively

consented to opt-in to continue their association and involvement with us. As at 21 March 2019 we have 546 public members in total.

Our members continue to contribute to the Trust's Care Environment and Patient Experience Committees and so play an important role in the governance of the Trust.

During 2018/19 we have been engaging patients, staff and members to get involved with the development of our new Strategy. In particular, public members supported a number of workshops across our hospital sites to have their say on what is important to them and were instrumental in determining our new vision - *proud to deliver high quality, compassionate care to our community*.

Engagement with public and partners

In July 2018 we held our Annual General Meeting (AGM) at the Gordon Craig Theatre in Stevenage. Around 300 staff, patients, partners and public / members attended the event. This is always a fantastic opportunity for us to showcase the range and quality of services we provide – we always attract very positive feedback on the infectious enthusiasm of our staff talking about the very many roles they play in delivering such a high standard of care to our patients.

The Trust continues to play a proactive role on a range of health and care partnerships across Hertfordshire, West Essex and beyond. In particular, we have contributed to the council's strategy for health and wellbeing in Welwyn and Hatfield and we are working with Stevenage borough council on their excited plans for town centre regeneration.

The Trust has just taken part in Hertfordshire County Council's annual scrutiny of health services. We are delighted that scrutiny councillors were overall impressed with the Trust's continued efforts to improve the quality of care for local residents and in particular the development of new ways of recruiting new staff including our apprenticeships scheme.

Work with GPs

The Trust continues to deliver a successful GP query helpline. We now deal with approaching 200 queries a month and we continue to improve the timeliness and quality of responses back to primary care colleagues.

We are also working with GP locality teams to better understand local issues in primary care as well as provide a regular link to enable effective communication and working between our hospitals and GPs.

We continue to promote our services and how to access them as well as practical tips and pointers to promote good self-care at GP Patient Participation Groups (PPGs) – for example, our top-rated stroke service will be presenting at the Knebworth and Marymead PPG event in July 2019. Experience tells us that primary care colleagues and local patients really value this opportunity to engage with hospital consultants on life-saving acute services.

Volunteers

The Voluntary Services team aims to provide a variety of services to patients, carers and

visitors that complement the high-quality, compassionate care provided by the Trust, in order to improve the community's outcomes and experience.

The Trust currently has over 300 active volunteers dedicated to assisting staff and enhancing patient experience and care. On average, there were 308 active volunteers each month for 2018-19; 53 student volunteers and 255 regular volunteers.

Lister Hospital has an average of 345 shifts per week provided by active volunteers in different capacities. Volunteers normally complete 3 hour shifts within each role; on this basis it is estimated that they are currently providing the hospital with roughly 4,485 hours of support each month – and 53,820 hours across a year. (Note: these are registered hospital volunteers only. It does not include visits made by community volunteers such as non-registered therapy dogs, beauticians, musicians etc.)

Voluntary Services also work with the local community and hospital departments to improve patient experience within the Trust. We have developed a dedicated team of volunteers and community groups over the last year who offer activities and entertainment benefiting all in the hospital (including card making with patients/carers, North Herts College beauty therapy students providing patients and staff with hand massages/manicures, performing choirs, therapy dogs, etc.).

Voluntary Services strive to make a positive impact on the working lives of staff in the hospital by providing additional help in practical tasks, and improving patient mood through positive interactions with volunteers on the ward. The team aim to continue developing long term projects to facilitate better patient outcomes and experience. Voluntary Services also want to ensure volunteers have a personally rewarding experience and are able to utilise and develop their skills.

Improving patient experience

In 2018 the Trust's vision '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' was reviewed with input from clinical, staff and the public and a new Vision launched at the beginning of 2019: ***Proud to deliver high-quality, compassionate care to our community***.

The aim to provide patients and their carers with the best possible experience whilst they are using the Trust's services remains consistent.

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 actively encourages feedback 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 (PEC), including patient and carer representatives, who discuss and review actions to improve patient experience. Each Division (Medicine, Surgery, Cancer, Women's and Children and Clinical Support Services) have a patient experience action plan which is regularly presented to PEC. A quarterly patient experience report combining patient experience feedback in one report (Friends and Family Test surveys (FFT), local and national surveys, social media, complaints and concerns). The Trust ensures that all feedback is shared with the relevant ward/department. The Patient and Carer Experience Committee produce an annual report on progress towards the milestones set out within the Patient and Carer Experience Strategy.

In 2018/19 across all services in the Trust 55,136 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'. The Trust's FFT responses for inpatient and day cases are consistently higher than the national average for both the response rate and the proportion of patients who would recommend the Trust to their friends and family.

Initiatives to improve patient and carer experience during the year include:

- Introduced empathy project with Youth Connect, young volunteers providing peer support in Children's Emergency Department.
- 'Whose Shoes' maternity engagement workshop to explore continuity of carer
- Establishment of the Maternity Voices Partnership providing a forum to promote collaborative working.
- Development of a young carers App including useful information to support young carers
- Development of a carers handbook including information to support carers whilst the person they care for is in hospital and signpost them to organisations providing help for carers.
- 135 carers referred to Carers in Hertfordshire/Bedfordshire
- Launch of the enhanced recovery pathway and outpatient induction of labour which has helped to reduce delays in discharge and length of stay
- Refurbishment of the bereavement room on the Consultant Led Unit and transformed the Bancroft garden into a children's play area.
- Introduction of screen with information for cancer outpatients at Mount Vernon Cancer Centre.
- Increased the number of patient information leaflets available on the Trust website to 445.

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 2018/19 across all services within the Trust, 1,036 formal complaints and 4,479 informal concerns were received. Examples of learning outcomes following a formal investigation include:

- A review of the Ambulatory Majors Waiting Area was undertaken to provide more privacy and dignity for patients and relatives when discussions about care and treatment are being held.
- Improvements to the out of hours service for dispensing medication.

- Additional administrative staff recruited in the Contact Centre to improve waiting times for patients wishing to make or change appointments.
- Fans installed to improve the temperature for patients undergoing chemotherapy. Future plans for refurbishment of the department and installation of air conditioning.
- Recruitment of additional phlebotomists and an electronic ticketing system to reduce the waiting times was recommended.
- Improvements made to signage in car park at Hertford County Hospital
- Cardiology appointment letters revised to give clearer instructions of location of clinic

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 approved by the Trust's audit committee in January 2018 and Trust Board in February 2018.

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 (red)

The Trust reported an overall outcome of amber for the 2018/19 self-assessment against the NHS Counter Fraud Authority Standards. Of the 23 standards, three were assessed as red and a further three were assessed as amber. An action plan is being developed to improve these areas during 2019/20.

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 report directly to the director of finance.

Sustainability summary statement

The target of reducing our carbon emissions by 34% by 2020 is challenging; from extensive stakeholder engagement within 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 provides the focus for the work undertaken by the Trust.

The new Sustainability Development Assessment Tool (SDAT) is an online self-assessment tool to help organisations understand their sustainable development work, measure progress and help make plans for the future. It uses four cross cutting themes 'Governance & Policy',

'Core responsibilities', 'Procurement and Supply chain' and 'Working with Staff, Patients & Communities' – and is made up of ten modules;

Corporate Approach	Green Space & Biodiversity
Asset Management & Utilities	Sustainable Care Models
Travel and Logistics	Our People
Adaptation	Sustainable use of Resources
Capital Projects	Carbon / GHGs

The Sustainability Development Unit reviewed and compared 9 large acute hospitals completed SDAT submissions. Our trust scored slightly below the average at 42%, this will require significant further commitment from the trust in achieving the goals outlined in the tool.

Acute Large	Max Score 85%	Average Score 51%	Min Score 24%

More emphasis needs to be given to sustainability across the trust gaining support from all staff, visitors and patients.

Context
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 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 implementation of specific initiatives throughout the year. As part of the day for action, the Trust has taken part in healthy eating promotions, energy awareness and health and wellbeing initiatives over recent years.

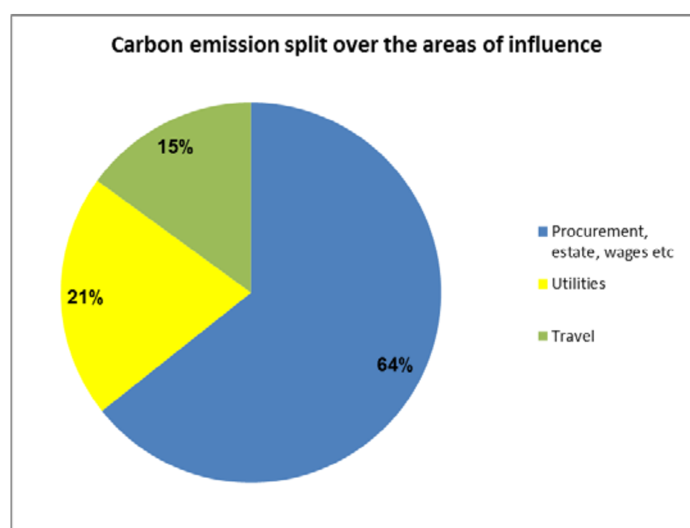
- The Trust is committed to meeting the target, which will only be achieved through a combination of specific carbon reduction schemes, behavioural change, and most importantly with engagement not only within the Trust itself, but also within the wider NHS and local communities.

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 highlights improvements made within the organisation from the 2007 baseline information.)

The chart below breaks down The Trust's 2018/19 Carbon footprint (tCO_2e)

Scope	2007 Baseline	2014/15	2015/16	2016/17	2017/18	2018/19	2020 Target
Procurement, estate, wages etc	58,231	44,819	44,814	44,882	44,257	45,159	38,432
Utilities	16,382	15,498	12,765	12,079	12,249	14,540	10,812
Travel	8,309	8,174	7,966	7,875	10,599	10,511	5,484
Total footprint (tC02e)	82,922	68,491	65,545	64,836	67,105	70,210	54,728
Climate Change Act Target		80,716	77,488	74,259	71,030	67,802	



This output information is taken from the Sustainability Annual Returns submitted by the Trust. Final submission date October 2019.

Overall in 2018/19 our carbon emissions are 18.10% reduction on the 2007 baseline. Emissions from utilities has reduced as the total energy used in 2018/19 decreased due to the disposal of the old QEII site and the associated utilities, along with the vacation of a storage facility previously used by the Trust as part of the Our Changing Hospitals project.

The increase in tc02e under the *travel* scope is due to an increase of business mileage across the trust including patient transport service mileage. Alternative travel arrangements will be promoted i.e. intersite bus public transport, car share and video conferences could be used as an alternative for cross site meetings. Travel is an area targeted for improvement in 2019/20.

The increase in tc02e under the utilities scope has been identified; there has been an increase in the demand for triad generator runs during peak times and due to a fault with the metering on Lister site. Action has been taken in order to rectify this identified issue.

A number of influencing factors contribute towards our overall foot print. A key impact has been the general increase in clinical activity with both ED and patient admissions this has an impact throughout the trust increasing the use of utilities, equipment and travel.

In 2018/19 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.

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
24 May 2019

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 ensures 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 include 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 2018/19, 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, one associate non-executive director and 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 2018/19, two non-executive directors left the Board. Following a recruitment process with NHS Improvement, Dr Peter Carter joined the Board in September 2018 and Mrs Karen McConnell in January 2019. In addition, Dr David Buckle was appointed as an associate non-executive director in September 2018. The chair continues to review the skills and experience required for the challenges ahead.

During 2018/19 there have been three changes to the executive team. The interim chief operating officer left the Trust in June 2018. Mrs Julie Smith joined the Trust as chief operating officer in the same month.

Ms Kate Lancaster left the Trust in January 2019. Mrs Sarah Brierley had acted as the Trust's director of strategy since that time.

Mr Thomas Simons left the Trust in February 2019. Mrs Susan Young has been the interim chief people officer since that time. A substantive chief people officer has recently been appointed and is due to start at the Trust in June 2019.

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 2018/19.

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, including as members of their communities, 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 2018/19

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
QSC –quality and safety committee (formerly risk and quality committee until September 2018)
RC – remuneration committee
CTC – charity trustee committee

Notes to committee attendance
1. The executive committee (EC) is a weekly meeting that is attended by all executive directors, unless absent from the Trust.
2. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. In particular, the Trust chair attends the finance and performance and quality and safety committees although she is not a designated member. 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 7 out of 7; FPC 9 out of 10; QSC 10 out of 11; RC 3 out of 3

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 healthcare 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), QSC (core attendee), AC (attendee), RC (attendee)
Attendance: Trust Board 5 out of 7; FPC 8 out of 10; QSC 6 out of 10 (due to required attendance at system wide STP meetings); AC 0 out of 5; RC 1 out of 3

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: QSC (until October 2018), FPC (from November 2018), AC, CTC, RC
Attendance: Trust Board 7 out of 7; QSC 6 out of 6; FPC 5 out of 5; AC 5 out of 5; CTC 4 out of 4; RC 3 out of 3

John Gilham, non-executive director (until end of June 2018)
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 and was chair of the committee until he left the Trust in June 2018. 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.
Committee membership: QSC, RC
Attendance: Trust Board 1 out of 2; QSC 3 out of 3; RC 1 out of 1

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: QSC, RC, CTC
Attendance: Trust Board 5 out of 7; QSC 11 out of 11; CTC 2 out of 4; RC 3 out of 3

Jonathan Silver, non-executive director

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 and also has a non-executive role at Henderson High Income Trust plc. Jonathan chairs the Audit Committee.
Committee membership: FPC, AC, RC
Attendance: Trust Board 7 out of 7; FPC 10 out of 10; AC 5 out of 5; RC 3 out of 3

Nick Swift, non-executive director (until October 2018)

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 chaired the Finance and Performance Committee until he left the Trust in October 2018.
Committee membership: FPC, RC
Attendance: Trust Board 4 out of 4; FPC 3 out of 5; AC 3 out of 4; RC 1 out of 2

Peter Carter OBE, non-executive director (from September 2018)

Peter was chief executive at the Royal College of Nursing from January 2007 to August 2015. Prior to his role at the RCN, he was chief executive of the Central and North West London NHS Foundation Trust for 12 years. Now an independent healthcare consultant, Peter was awarded an OBE for services to the NHS in 2006. Peter chairs the Quality and Safety Committee.
Committee membership: QSC, RC
Attendance: Trust Board 3 out of 4; QSC 7 out of 7; RC 1 out of 1

David Buckle, associate non-executive director (from September 2018)

A GP in Woodley, Berkshire for over 30 years, David also has had a long career in clinical leadership and, subsequently, medical management. In 2015, he was appointed as the medical director for the Herts Valleys Clinical Commissioning Group before retiring in early 2018; he is also a non-executive director of the Berkshire Healthcare NHS Foundation Trust.

David has been a member of the Society for the Assistance of Medical Families for over three decades, becoming a director of this charity in 2017 before being voted its President in May 2018. He is also a trustee for the Stroke Association, the country's largest stroke charity.
Committee membership: QSC, RC, CTC
Attendance: Trust Board 3 out of 4; QSC 6 out of 7; CTC 2 out of 2; RC 1 out of 1

Karen McConnell, non-executive director (from January 2019)
Karen studied Bacteriology at Newcastle University before joining the Northern Regional Health Authority as a finance trainee in 1983. In 1985 she joined the Audit Commission where she completed her accountancy training.
Karen held a variety of senior positions at the Audit Commission, including as a district auditor and regional director, before leading the Audit Practice and its 900 staff through the transition of outsourcing the Commission's work to the private sector during 2011 and 2012.
Karen was appointed as the Comptroller and Auditor General (C&AG) for Jersey in January 2013 and will complete her 7 year term in December 2019. In her role as C&AG she provides the States of Jersey with independent assurance that the public finances of Jersey are being regulated, controlled and accounted for in accordance with the law. Karen chairs the Finance and Performance Committee.
Committee membership: FPC, AC, RC
Attendance: Trust Board 1 out of 2; FPC 2 out of 3; AC 0 out of 1; RC 1 out of 1

Tom Simons, chief people officer (until February 2019)
Thomas joined the Trust in February 2013, and was a full board from January 2014. He was responsible for staff recruitment, medical staffing, managing organisational and cultural change and leadership and management development. He also oversaw 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 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.
Committee membership: EC, FPC (core attendee), QSC (core attendee), RC (attendee)
Attendance: Trust Board 4 out of 6; FPC 4 out of 8; QSC 1 out of 9; RC 1 out of 2

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 7 out of 7; FPC 10 out of 10

Kate Lancaster, director of strategy (until January 2019)
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 (core attendee), CTC
Attendance: Trust Board 5 out of 7; FPC 4 out of 7; CTC 3 out of 3

Bernie Bluhm – Interim Chief Operating Officer (until June 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), QSC (core attendee),
Attendance: Trust Board 1 out of 2; FPC 2 out of 2; QSC 2 out of 3

Michael Chilvers, medical director
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 (core attendee), QSC (core attendee),
Attendance: Trust Board 6 out of 7; FPC 6 out of 10; QSC 9 out of 11

Rachael Corser, director of nursing
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), QSC (core attendee), CTC (from end of January 2019)
Attendance: Trust Board 6 out of 7; FPC 1 out of 10; QSC 11 out of 11; CTC 1 out of 1

Julie Smith, chief operating officer (from June 2018)
Julie qualified as a diagnostic radiographer in 1989 and as an ultrasonographer in 1993. She has worked in a number of NHS trusts, including North West Anglia NHS Foundation Trust and Princess Alexandra Hospital NHS Trust. Julie joined our Trust in 2018 from Cambridge University Hospitals NHS Foundation Trust, where she worked for 19 years and held a number of roles – including executive intern, associate director and operations director. She was also interim chief operating officer for a three month period.
Committee membership: EC, FPC (core attendee), QSC (core attendee)
Attendance: Trust Board 4 out of 6; FPC 8 out of 9; QSC 5 out of 9

Sarah Brierley, acting director of strategy (from January 2019)
Sarah qualified as an occupational psychologist and has worked in a number of NHS trusts, including the Royal Free NHS Trust and the Royal London NHS Trust (St Bartholomew's Hospital). Sarah joined East and North Hertfordshire NHS Trust in 2001 and has held a

number of roles including divisional director and director of business development and partnerships within the Trust.
Committee membership: EC, FPC (core attendee)
Attendance: Trust Board 1 out of 1; FPC 2 out of 3

Susan Young, interim chief people officer (from February 2019)
Susan is an experienced HR professional who has worked in both central and local government and the NHS. She is a Chartered Fellow of the Chartered Institute of Personnel and Development with 17 years experience in HR, organisational development and broader transformation in the public sector at Board level. Susan is Interim Chief People Officer (CPO) at the Trust, pending the appointment of a permanent CPO.
Committee membership: EC, FPC (core attendee), QSC (core attendee), RC (attendee)
Attendance: Trust Board 1 out of 1; FPC 2 out of 2; QSC 0 out of 2

Name	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
Robert Niven	Non-executive director designate*	1 September 2013	n/a	n/a
	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	
	Non-executive director	1 June 2015	Two years plus further two years	Left the Trust end of June 2018
Val Moore	Non-executive director	1 September 2016	Four Years	31 August 2020
Nick Swift	Non-executive director	20 November 2017	Four Years	Left the Trust end of October 2018
Jonathan Silver	Non-executive director designate*	16 October 2017	n/a	n/a
	Non-executive director	1 February 2018	Two Years	31 January 2020
Peter Carter	Non-executive director	3 September 2018	Four Years	2 September 2022
David Buckle	Non-executive director associate*	17 September 2018	n/a	n/a
Karen McConnell	Non-executive director	7 January 2019	Four years	6 January 2023
Tom Simons*	Chief People Officer	January 2014	n/a	Left the Trust on 15 February 2019
Martin Armstrong	Director of Finance	31 October 2016	n/a	n/a
Kate Lancaster*	Director of Strategy	1 February 2017	n/a	Left the Trust on 20 January 2019
Bernie Bluhm	Interim Chief Operating Officer	11 September 2017	n/a	Left the Trust on 29 June 2018
Michael Chilvers	Medical Director	18 December 2018	n/a	n/a
Rachael Corser	Director of Nursing	2 January 2018	n/a	n/a
Julie Smith	Chief Operating Officer	25 June 2018	n/a	n/a
Susan Young*	Interim CPO	1 February 2019	n/a	n/a
Sarah Brierley*	Interim Director of Strategy	21 January 2019	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

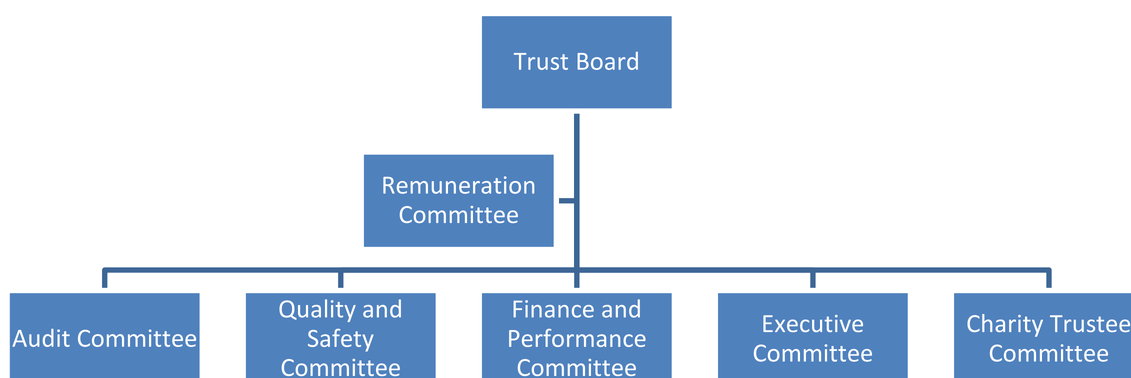
The Board of Directors undertakes an annual review of it Register of Declared interests. At each meeting of the Board and at the sub committees of the Board a standing item also requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda, and any changes to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

Joseph Maggs, Trust Secretary
Trust Management Offices Corey Mill Lane
Stevenage SG1 4AB
Email: joseph.maggs@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 each committee is undertaken annually to ensure that it continues to meet its terms of reference and operate effectively.



Executive directors are accountable 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 audit committee membership consists of the following non-executive directors: Jonathan Silver (chair), Bob Niven and Karen McConnell.

The *quality and safety committee* (previously the risk and quality committee until September 2018) meets monthly and has a membership of three non-executive directors who hold the executive to account for quality, safety and compliance.

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 some senior managers. 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. As of April 2019, the meetings with the divisional chairs and directors are currently on hold whilst the most effective means of communication with the divisional and corporate teams is reviewed. 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, Palmer Winstanley)
- 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 chair, Mr Douglas Salvesen and divisional director, Palmer Winstanley)

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

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 has established a framework to support compliance with the ten data security and protection standards and GDPR.

The Trust's Information Governance Assessment Report overall score for 1 April 2018 – 31 March 2019 demonstrates 39 out of 40 assertions were confirmed as compliant under the

new Data Security and Protection Toolkit. The Trust is rated as ‘Standards Not Fully Met (Plan Agreed)’. The action plan to achieve compliance of the remaining assertion during quarter one 2019/20 is in progress is monitored by the Associate Director of Corporate Governance and SIRO and reported to the Information Governance Steering Group.

During 2018/19 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner’s Office (ICO). All information governance incidents are reviewed by the Information Governance team and potential and actual serious incidents are reviewed in line with the national guidance through the Trust’s incident review process to support learning.

Compliance with data security and cyber essentials has been reviewed by Internal Audit and a comprehensive risk assessed action plan was agreed and has been monitored by the Audit Committee. Investment funds have been made available to support the improvement and mitigate the risks.

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. With the exception of the Quality Account limited assurance review, BDO LLP does not provide non-audit services to the Trust.

BDO LLP has previously been the Trust’s external auditor for 2015/16, 2016/17 and 2017/18 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 auditor, 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.

I confirm that, as far as I am aware, there is no relevant audit information of which the Trust’s auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the Trust’s auditors are aware of that information.

I confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed: Nick Carver, Chief Executive

Date: 24 May 2019

East and North Hertfordshire NHS Trust Annual Governance Statement 2018/19

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 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors set the policy framework and strategy and provides leadership for the management of risk across the organisation. The Director of Strategy is the Executive Lead for risk management supported by the Associate Director of Corporate Governance. The executive team lead on the areas of risk within their portfolios and are nominated as the lead for specific strategic risks on our Board Assurance Framework.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with the key controls and assurances and any gaps in those controls and assurances. Through this framework the Board gains assurance from the appropriate Executive Director that risks are being appropriately managed throughout the organisation. This is reviewed each month by the Executive Director Lead for each risk and jointly by Executive Committee. The BAF is considered by the Audit Committee, relevant Board Committee and 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 clinical division or corporate directorate. Each of the Trust's clinical divisions has a Divisional Chair (clinical), 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 Audit Committee, Quality and Safety Committee (QSC), Finance

and Performance Committee (FPC) and the Trust Board. Each of the Divisions attends QSC on an annual basis for further scrutiny of their quality governance and compliance processes.

During 2018/19 we have made significant progress towards implementing our revised 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. During 2018/19 the Board and Audit Committee have regularly reviewed progress. During quarter 4 2018/19 we have undertaken an annual review of progress and updated the Risk Management Strategy and supporting procedure. The review included developing and approving a risk maturity and capability assessment and development of a comprehensive set of risk appetite statements and a review of the key strategic risks for 2019/20. The final documents were approved by the Audit Committee and Board in April and May 2019.

The Associate Director of Corporate Governance ensures the Board receive support and training on risk management and in February 2019 the Board had a risk management workshop, facilitated by the Risk Manager focusing the areas outlined above. The Risk Manager provides support and training to staff and leadership teams 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.

In addition to training, during 2018/19 the Board had a series of development sessions to consider key areas of strategic significance and risk, including our strategic plan, quality strategy strategic risks, CQC and the well led framework, staff survey outcomes, and development regards working as a Board. 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. There have been a number of changes within the Board over the last year and a Board Development programme has supported the Executive Team, Non Executive Director and full Board development during 2018/19. Board members have also sought to increase the amount of time they spend with front line services in the Trust.

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 serious incident review panels and divisional risk clinics are held to support the management and scrutiny of organisational risk.

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 & 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 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 Audit Committee a risk management improvement plan was developed and progress of implementation regular reviewed to support embedding proactive risk management across the organisation, provide greater scrutiny and level of oversight. A risk clinic for each division and a review of the corporate risks has continued through 2018/19. We will commence the implementation of our new risk appetite statements included in our revised Risk Management Strategy during 2019/20.

Board Assurance and Reporting

Our Trust Board has three established committees to discharge its responsibilities on Board assurance. These are the Audit Committee, Quality and Safety 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 a 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 2018/19 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. From May 2019 the committee will lead on the oversight of workforce.

The Quality and Safety Committee (QSC), a formal committee of the Board, ensures that the Trust has an effective management of quality and safety and clinical governance framework that includes 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 Quality and Safety 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 QSC include:

- Clinical Effectiveness Committee.
- Patient Safety Committee.
- Patient Experience Committee.
- Health, Safety and Fire Committee.
- Emergency Planning Committee.
- Infection Prevention and Control Committee.

Key Committees supporting FPC include:

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

The Accountability Framework implemented at the end of 2017/18 has now been embedded into practice supported by an integrated performance report. The Integrated Performance Report includes the key performance measures for the Trust. The report is reviewed at every Quality and Safety Committee, Finance and Performance Committee and Trust Board meeting. This provides the lead director an opportunity to highlight any risk issues relating to the metrics. In addition the Committees receive detailed reports and deep dives into specific issues, and local and national data to support its scrutiny under strategy, culture and accountability.

The implementation of the new Accountability Framework 2018 supports information flow and reporting from ward to Board. The supporting quality and safety structures have been reviewed and implemented to support the delivery of the Quality Transformation Programme (QTP) and Quality Strategy. 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 Quality and Safety Committee.

Developing Workforce Safeguards

Ensuring effective workforce planning, deployment of staff and safe staffing levels remains a priority and we have continued to invest in recruiting permanent staff and have reduced the use of agency staff and locums. This supports our staff, patient safety and quality. The Director of Nursing undertakes a formal review of the nursing establishment twice a year and reports the outcome and recommendations to QSC and Board. This is informed by evidence-based tools (for example, care hours per patient), skill mix, professional judgement, acuity and outcomes. Mechanisms are in place to forward plan and enable effective use of temporary staff and to review and deploy staff during each shift to support safety and the staff staffing levels in each area. In addition safer staffing is reported each month to QSC and Board. This information is triangulated with the Integrated Performance Report and new Quality and Safety Dashboard.

Our Nursing and Midwifery strategy was reviewed in 2019 and approved by Board in May 2019. Our People Strategy is due for review in 2019 and this work has commenced. It will be fully aligned to our new five year clinical strategy and operational plan. We will continue to use the model hospital bench mark data to inform this and progress our workforces programme on recruitment and retention, workforce planning and skill mix reviews. All proposed clinical workforce and skill mix changes are reviewed, risk assessed for any impact on quality and signed off by the Medical Director and Director of Nursing prior to implementation.

The Trust's workforce performance relates to standards set both nationally and locally, which are reviewed with due consideration to risk 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 quality and safety committee

Principal Risks

As stated above the Trust has 14 principal 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 2019, the Board sees its major risks as:

- 003/18: There is a risk that the Trust is unable to achieve financial performance in 18/19 as a result of not securing the required efficiency improvement within its cost improvement plan and its income. (rated 25)

- 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 18/19 (rated 20)
- 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. (rated 20)
- 006/18: There is a risk that there is insufficient capital funding to address all high/medium estates backlog maintenance, including fire estates work, and funding for medical equipment (rated 20)
- 014/18: There is a risk that the Trust's Estates and Facilities compliance arrangements including fire management are inadequate leading to harm or loss of life. (added 22/01/19 – rated 20)

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. The BAF risk and framework for 2019/20 have been reviewed.

Care Quality Commission

The ENHT is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The reasons for this are outlined below.

The ENHT has not participated in any special reviews or investigations by the CQC during 2018/19.

The Care Quality Commission inspected nine of the core services provided by the Trust across Lister Hospital, the New QEII Hospital and Mount Vernon Cancer Centre in March 2018 and returned in April 2018 to undertake an unannounced, follow-up inspection of the surgery core service at Lister Hospital.

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 CQC issued a number of requirement notices and set out a number of areas for improvement including in a section 29a warning notice to ensure improvements in the New QEII Urgent Care Centre and Surgery at the Lister Hospital site. The requirement notices are:

- Regulation 12 Cleanliness and infection control
- Regulation 12 Safe care and Treatment

- Regulation 17 Good governance
- Regulation 18 Staffing
- Regulation 19 Fit and proper persons employed

An action plan was been developed with the teams against all of these requirements and was submitted to CQC in August 2018. Progress is reported to Board through the Quality and Safety Committee and reported to CQC through regular engagement visits. A programme of internal and external inspections is in place to test and evidence progress and that the actions are embedded and sustained across the organisation. To support this the Quality Governance structures have been reviewed and streamlined and significant investment has been made in strengthening the teams to support quality improvement and corporate governance.

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 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 2019/20 and have developed a compliance dashboard which is reported to the Quality and Safety Committee.

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 completed this action plan in 2018. During quarter four NHSI have undertaken observations of our Board and Board Committees and we undertake 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.

Operational Performance

During 2018/19 we saw a steady improvement in many of our operational performance standards. We resumed reporting of RTT performance in October 2018 and our performance has remained consistently above the national average since that time. Similarly, the Trust resumed reporting on diagnostic measures in October 2018 and whilst performance was below the national average position at that time, there has been a significant improvement, and we now perform better than the national average and close to the target level of 1% breach compliance.

With regard to the eight standards relating to cancer waiting times, there has been good progress over the year, leading to compliance of five out of eight standards for March 2019. Plans are in place to address capacity issues which should enable us to deliver on the remaining standards over 2019/20, with delivery of a compliant 62 day standard in October 2019.

The pressures on the Emergency Department have continued in 2018/19 and we failed to deliver the 95% target to be seen within 4 hours, achieving 85.80%, however this is a

significant improvement upon the 17/18 position. It should be noted that the plan to open the winter ward was delivered with a scheduled opening at the beginning of January 2019 and was efficiently closed in early March as a result of a 'reset week'. The ED performance should be taken in the context of other improvements to flow, including 50% fewer winter contingency beds open, medical outliers halved in number and fewer instances of OPEL 3 and 4 (Operational Pressure Escalation levels) being declared.

In addition there has been a focus on ward processes to deliver a reduction in non-elective length of stay, which has supported the need for fewer winter beds to be opened. The winter bed plan was based on forecast demand for beds delivered through a comprehensive bed demand and capacity plan. It is anticipated within 2019/20 that more work will be delivered around D&C modelling which will underpin the clinical strategy plans around future use of inpatient beds.

In support of capacity and flow there is a comprehensive structure of management meetings, which include ward process meeting, acute care pathway redesign (programme for developing alternatives for acute patients to receive care outside of the ED, via ambulatory areas and assessment space) and Patient Flow Board (the schemes report up to this board, which has the overarching view of all the capacity and flow schemes).

Electronic patient record system and digital stabilisation programme

Our new electronic patient record system – 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.

The Trust embarked on a challenging program of stabilisation that completed in May 2019. An external consultancy company, was engaged to support the delivery of the stabilisation program which has also been strongly backed by our regulators and NHS Digital. A Lorenzo Stabilisation Board was established to monitor progress. This included representation from NHS Improvement and NHS Digital, with reports being taken to the Trust's finance and performance committee. The key deliverables of the stabilisation program as they relate to Lorenzo were:

- Business and administrative processes that are fit for purpose using Lorenzo as it as intended.
- Training for all Lorenzo users in the processes mentioned above and other related activities e.g. RTT
- A clear plan to enhance and optimize the way Lorenzo is used in the future.

The Digital Programme will remain a key area of focus for 2019/20. 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 the Mortality Surveillance Committee to the Quality and Safety Committee and Board. We continue to perform well and our HSMR position for the twelve months to December 2018 is rated statistically as "better than expected" and is better than the national average (93.0). The SHMI for the twelve months to December 2018 is 94.1 and remains

within the 'as expected' range. During 2018/19 we have received one CQC mortality outlier alert regarding sepsis. The higher than expected mortality rate for this group had already been identified through our governance structures and a coding and clinical audit undertaken. The Deteriorating Patient Group supports the early identification and treatment of Sepsis. The mortality rate improved and continues to do so and is now in the 'better than expected' range. We continue to seek ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are in place. We have reported six never events in 2018/19 (April 2018-Feb 2109):

- One related to wrong connection of 02 tubing
- One related to misplaced NG tube placement
- Four incidents were related to invasive procedures

The trust has established a 'Safer Surgery Collaborative' where themes from these never events have been incorporated. Learning includes key themes surrounding human factors and team work and this will also be progressed through multidisciplinary quality improvement. We are planning to undertake trust wide annual 'Never Event Risk assessments', in all clinical areas, and across all current Never event categories. We have not had a never event since end November 2018.

Discharge Summaries

Discharge summaries should be completed within 24 hours of discharge. This allows GPs to manage care effectively following departure from in hospital. A backlog of summaries not sent to GPs became apparent in early 2018 but the scale of the problem could not be confirmed due to problems in producing some reports from the new patient administration system introduced in September 2017. Since August 2018 it has been possible to produce reports of outstanding discharge summaries. Led by the Medical Director actions have been taken to ensure the backlog of discharge summaries is addressed, an audit has been undertaken which concluded that no harm had been caused to patients as a result of the delay in the discharge letter, live data is available to staff to monitor performance and in January 2019 a revised discharge summary process was piloted with the intention to significantly reduce the time taken for the summary to be completed and sent on to the GP. The new form roll-out started in March with a significant number being completed in 'real time'. This has reduced completion time to 5-11 minutes, from 45 minutes, and enabled summaries to be provided to patients and their GPs more or less immediately after discharge.

Infection Control

Infection prevention and control has been a priority for the trust this year. Recognising that there was a need to strengthen compliance against the Code of Practice Hygiene Code, the trust embraced an improvement programme which resulted in the trust achieving a Green rating by NHSI in terms of infection prevention and control in December 2018. This was the result of a significant investment in equipment replacement, further training and development of our clinical staff, improved audit programmes and a commitment from all care givers to keep our patients free from harm in relation to reducing healthcare acquired infection. The

trust is achieving its trajectories for improvement against key measures including hand hygiene. Reducing sharps injuries is a priority for 2019/20.

Data Quality

Our data quality continues to improve and is supported by the Data Quality Strategy & Policy ratified at the Audit Committee, October 2018. The strategy sets out the 10 key principles to support the production and assurance of high quality data and its management across the organisation. The most important of these is that good data management and quality of data is everyone's responsibility. The strategy is built around the aspiration of 'get it right first time' when recording data. The strategy defines responsibilities for specific roles across the organisation for its delivery. The strategy is implemented through the Data Quality Steering Group which meets bi-monthly supported by a monthly audit programme. One of the key priority areas is waiting times and availability and accuracy of data to improve / enhance data quality in order to enable better decision-making, for the benefit of our patients. The data quality and clinical coding audit confirmed meeting the requirements of the new Data Security and Protection Toolkit.

Fire, Medical Equipment and Backlog Maintenance

We have prioritised investment in our fire safety during 2018/19 including fire compartmentation on the Lister site. We have reinstated a fire safety committee which reports to the Health and Safety Committee and QSC. We have reviewed our fire evaluation plans, training and risk assessments. Where actions are identified these are recorded and monitored to ensure the agreed actions and are taken and risk is mitigated. This will continue to be a priority for 2019/20.

Capital resources available to the Trust are extremely limited, and 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.

Conflicts of Interest

The trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

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 has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its 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 agreed its financial plan for 2018/19 with NHS Improvement based on a control total of a deficit of £0.28 million. In order to deliver this control total, the Trust required support from the national Provider and Sustainability Fund of £14.36 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 £13.54 million. Whilst the Trust's reported financial performance for 2018/19 has improved compared with 2017/18, it was at variance materially from plan expectations.

The key features of financial performance during 2018/19 and explanations for the gap between planned and actual performance were:

- The Trust earned significantly more income from patient activities than it had planned for the year. The over-performance was largely driven by high levels and acuity of emergency activity, particularly over the winter period from October 2018 onwards.
- The impact of local health economy schemes to reduce and redirect demand for emergency services proved less significant than the Trust had envisaged and this resulted in higher levels of emergency activity than planned.
- The Trust experienced significant operational issues with laminar-flows in Theatres which impacted our ability to drive improved Theatre throughput and efficiency in relation to inpatient elective activity.
- The additional emergency activity outlined above contributed to a material over-spend on the Trusts pay-bill, that outweighed the additional income generated. All staff groups involved in the direct delivery of patient care overspent against their budget in year. There was also a significant pay increase for staff on Agenda for Change contracts, which was not fully funded by the Department of Health.
- The Trust continued to identify and deliver significant cost efficiencies in 2018/19, £18.0 million across the year. Unfortunately, this did fall short of the ambitious target (£24.2 million) that the Trust had set for the year.
- 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 Provider and Sustainability Funding that it had anticipated within its financial plan.

Progress against the delivery of the plan is monitored by the Finance and Performance Committee (FPC) and reported to Board. In 2018/19 the FPC undertook a number of deep

dives in to specific areas of finance and performance to provide additional level of scrutiny and challenge; this will continue during 2019/20.

Our annual Internal Audit programme provides an independent review of our key financial controls and this year they have reviewed our systems and process for our cost improvement plan and performance framework. Please refer to the review of effectiveness section and the Head of Internal Audit Opinion for further details.

NHS Improvement undertook a Use of Resources assessment in April 2018 and rated the Trust as 'requires improvement.' The Trust has used nationally available data from the NHSI model hospital and other benchmarking data which indicated poor levels of efficiency against key process measures for example, theatres, outpatients and length of stay and also a medical staffing cost model that was significantly more expensive than benchmark peers to inform delivery of the financial improvement recovery plan. The Trust has also focused upon significantly improving the quality of business intelligence reporting available across the Trust as a means of improving the quality of business and financial decision making. As a result of these consistent actions financial performance has subsequently improvement significantly. Whilst the Trust did not deliver the Control total expected in 2018/19, the size of the annual deficit has reduced by over a half compared with 2016/17.

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 has established a framework to support compliance with the ten data security and protection standards and GDPR.

The Trust's Information Governance Assessment Report overall score for 1 April 2018 – 31 March 2019 demonstrates 39 out of 40 assertions were confirmed as compliant under the new Data Security and Protection Toolkit. The Trust is rated as 'Standards Not Fully Met (Plan Agreed)'. The action plan to achieve compliance of the remaining assertion during quarter one 2019/20 is in progress is monitored by the Associate Director of Corporate Governance and SIRO and reported to the Information Governance Steering Group.

During 2018/19 we have not declared any incidents classified as Level 2 or that meet the requirements to report to the Information Commissioner's Office (ICO). All information governance incidents are reviewed by the Information Governance team and potential and actual serious incidents are reviewed in line with the national guidance through the Trust's incident review process to support learning.

Compliance with data security and cyber essentials has been reviewed by Internal Audit and a comprehensive risk assessed action plan was agreed and has been monitored by the Audit Committee. Investment funds have been made available to support the improvement and mitigate the risks.

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 2018/19 has been led by the Head of Quality and Patient Safety on behalf of the Medical Director and Director of Nursing 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 2018/19 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), Quality and Safety 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. *See section on 'data quality' for further information.*

To identify priorities for 2019/20 we have considered:

- Existing priorities and indicators from 2018/19 to ensure their ongoing relevance and progress made to date
- Current performance, to identify emerging concerns eg. complaints and survey results
- the priorities outlined our new Quality Strategy

Priorities for 2019/20 have been considered and are consistent with 2018/19 and are aligned with the Quality Transformation Plan and Quality Strategy.

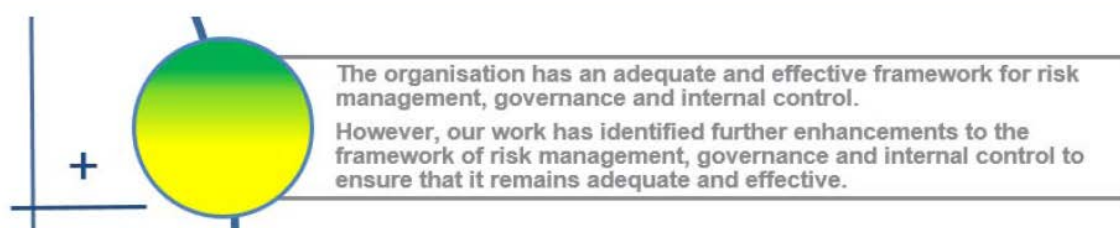
Throughout the year we will continue to ensure ongoing engagement with the Health & Well Being Board, of which I am a member, Health Scrutiny Committee and our Commissioners. We will continue to monitor performance against priorities, including by the new quality and safety dashboard. A number of the priorities already have measurement plans in place and feature on the Integrated Performance Report and / or are part of a quality improvement initiative; this will supporting ongoing monitoring of delivery.

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 Quality and Safety 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 2019, the head of internal audit opinion for East and North Hertfordshire NHS Trust is as follows:



During the year, seven partial assurance reports have been issued where action is needed to strengthen the control framework to manage the identified risks.

No 'no assurance' opinions have been issued to the Trust during the year, although erostering – locums, cash collection, discharge management, IT infrastructure, key financial controls – general ledger audits resulted in a partial assurance opinion. Other areas received a reasonable of substantial assurance opinion.

Our 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. Progress is monitored through the Audit Committee.

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 on the progress of the implementation of the risk management strategy and procedure. In 2018/19 we have seen significant improvement in the management of risk and positive engagement across the organisation.
- The Quality and Safety Committee provides assurance on the progress of all areas of quality, safety and compliance and associated risks within its terms of reference.
- The Finance and Performance Committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the Quality and

Safety 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 Effectiveness Committee and progress is monitored through the Divisions and QSC. 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 the Data Protection Officer and an Information Governance Steering Group, to provide information governance assurance via the Data Security and Protection 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. The Accountability Framework Structure and new Integrated Performance implemented in 2018/19 support this.
- During 2018/19 we have commissioned external reviews and expertise to review and strengthen our governance including stabilising our new patient administration system and board governance taking into account the well led review and feedback upon the effectiveness of our committee structures. 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

My review has established that East and North Hertfordshire NHS Trust has a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives. No significant internal control issues have been identified. I am satisfied that all internal control issues raised have been, or are being addressed, action plans produced and that these will be monitored through the governance structures and are reflected in the statement above.

Signed:

Chief Executive Date: 24 May 2019

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

Remuneration report

This section covers:

- Remuneration policy (includes fair pay disclosure for 2018/19)
- Remuneration table
- Pensions entitlement 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 chairman and all the non-executive directors. It is chaired by the vice chairman. The committee is supported by the chief executive, director of workforce and organisational development and the company secretary. The remuneration committee aims to meet quarterly to fulfil its duties and it met three times during 2018/19. 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 their portfolio and to the organisation. This is carried out in parallel with due consideration of remuneration for individual posts within regional and national markets. NHS Improvement produce a consolidated foundation and non-foundation Trust Executive salary data set which the Remuneration Committee considers each year.

Executive Director pay is based on the following agreed principles;
• What they bring to the role – their experience, capability
• Their marketability and importance to the organisation – their previous salary history, how in demand they are by other organisations and how important are they to the Trust
• The 'going rate' for the job and what it means for the person you wish to appoint or retain
• Performance against objectives and delivery in year
• Fulfilling all requirements under the CQC 'fit and proper persons test'

This is also set against an outline pay framework which is as follows;
• Median pay for Trusts – for those performing at that 'meet expectation' or 'professional talent' or where pay is significantly below median and incremental movement needs to be made (i.e. not large increases based on one year's exceptional performance)
• Upper quartile pay – for those performing at 'exceeds expectation' or 'ready now' (for promotion)

• Maximum increase in pay – pay increases should be limited to a maximum of 10% in any financial year

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

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate 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 Trust Development Authority (now part of 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 2018/19

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

The mid-point of the banded remuneration of the highest paid director in the Trust in 2018/19 was £187,500 (2017/18 – £187,500). This was 6.3 times (2017/18 – 6.3 times) the median remuneration of the workforce, which was £29,866 (2017/18 – £29,860). As the pay of the highest paid director has remained static and the median salary relatively the same, the multiple has remained the same.

In 2018/19, there were 18 employees who received remuneration in excess of the highest paid director (in 2017/18, the figure reported was 15 employees). The remuneration received by Trust staff in 2018/19 ranged from £17,460 to £294,440 per annum (for 2017/18 – the reported range was £15,404 to £288,822).

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. The salaries and allowances of directors in tabular format, table of pension benefits of directors and the pay multiples information have been audited by the Trust's auditors BDO LLP.

Remuneration tables

Name and title	2018/19 Salary (bands of £5,000) £000	2018/19 Expense payments (taxable) total Rounded to nearest £100 £00	2018/19 Performance pay and bonuses (bands of £5,000) £000	2018/19 Long term performance pay and bonuses (bands of £5,000) £000	2018/19 All pension related benefits (bands of £2,500) £000	2018/19 TOTAL (bands of £5,000) £000	2017/18 Salary (bands of £5,000) £000	2017/18 Expense payments (taxable) total Rounded to nearest £100 £00	2017/18 Performance pay and bonuses (bands of £5,000) £000	2017/18 Long term performance pay and bonuses (bands of £5,000) £000	2017/18 All pension related benefits (bands of £2,500) £000	2017/18 TOTAL (bands of £5,000) £000
Executive directors												
Nick Carver	185-190	19	0	0	0	190-195	185-190	6	0	0	0	185-190
Chief Executive												
Martin Armstrong	135-140	0	0	0	87.5-90	225-230	135-140	0	0	0	0	135-140
Director of Finance												
Liz Lees (from 07/11/16 to 01/01/18)	n/a	n/a	n/a	n/a	n/a	n/a	70-75	36	0	0	105-107.5	180-185
Acting Director of Nursing												
Rachael Corser (from 02/01/18)	115-120	0	0	0	52.5-55	170-175	25-30	0	0	0	12.5-15	40-45
Director of Nursing												
Bernie Bluhm (02/08/16-08/01/17 and from11/09/17-29/06/18)	100-105	0	0	0	0	100-105	135-140	0	0	0	0	135-140
Chief Operating Officer												
Nigel Kee (from 09/01/17 to 01/09/17))	n/a	n/a	n/a	n/a	n/a	n/a	55-60	0	0	0	40-42.5	95-100
Chief Operating Officer												
Jane McCue (to 15/12/17)	n/a	n/a	n/a	n/a	n/a	n/a	115-120	1	0	0	0	115-120
Medical director												
Michael Chilvers (from 18/12/17)	185-190	18	0	0	172.5-175	360-365	50-55	0	0	0	30-32.5	80-85
Medical director												

Name and title	2018/19 Salary (bands of £5,000)	2018/19 Expense payments (taxable) total Rounded to nearest £100	2018/19 Performance pay and bonuses (bands of £5,000)	2018/19 Long term performance pay and bonuses (bands of £5,000)	2018/19 All pension related benefits (bands of £2,500)	2018/19 TOTAL (bands of £5,000)	2017/18 Salary (bands of £5,000)	2017/18 Expense payments (taxable) total Rounded to nearest £100	2017/18 Performance pay and bonuses (bands of £5,000)	2017/18 Long term performance pay and bonuses (bands of £5,000)	2017/18 All pension related benefits (bands of £2,500)	2017/18 TOTAL (bands of £5,000)
Sarah Brierley (from 21/01/19)	20-25	14	0	0	15-17.5	35-40	n/a	n/a	n/a	n/a	n/a	n/a
Acting Director of Strategy												
Kate Lancaster (01/02/17-20/01/19)	100-105	4	0	0	0	100-105	125-130	20	0	0	35-37.5	160-165
Director of Strategy												
Tom Simons (to 03/03/19)	105-110	69	0	0	0	110-115	115-120	65	0	0	27.5-30	150-155
Chief People Officer												
Julie Smith (from 25/06/18)	100-105	6	0	0	685-687.5	785-790	n/a	n/a	n/a	n/a	n/a	n/a
Chief Operating Officer												
Susan Young (from 01/02/19)	20-25	2	0	0	0	20-25	n/a	n/a	n/a	n/a	n/a	n/a
Interim Chief People Officer												

Name and title	2018/19						2017/18					
	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 £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(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 01/04/16)	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Chair												
Alison Bexfield (to 31/01/18)	n/a	n/a	n/a	n/a	n/a	n/a	5-10	0	0	0	0	5.-10
Vice-chair												
Julian Nicholls (to 31/07/17)	n/a	n/a	n/a	n/a	n/a	n/a	0-5	0	0	0	0	0-5
Bob Niven	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5.-10
John Gilham (to 31/06/18)	0-5	1	0	0	0	0-5	5-10	1	0	0	0	5.-10
Val Moore (from 01/09/16)	5-10	5	0	0	0	5-10	5-10	1	0	0	0	5.-10
Jonathan Silver (from 16/10/17)	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Nick Swift (to 31/10/18)	0-5	0	0	0	0	0-5	0-5	0	0	0	0	0-5
Peter Carter (from 03/09/18)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
David Buckle (from 17/09/18)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Karen McConnell (from 07/01/19)	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 page 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 2018/19 (14.3% in 2017/18). 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 2017/18 and 2018/19.

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 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash equivalent transfer value at 1 April 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2019	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£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	5-7.5	5-7.5	40-45	85-90	511	132	663	0
Director of Finance								
Kate Lancaster (to 20/01/19)*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Director of strategic development								
Rachael Corser	2.5-5	2.5-5	25-30	55-60	316	75	408	0
Director of Nursing								
Michael Chilvers	7.5-10	15-17.5	60-65	160-165	1,019	258	1,303	0
Medical Director								
Tom Simons (to 03/03/19)*	0-2.5	n/a	20-25	n/a	185	23	226	0
Chief People Officer								
Sarah Brierley (from 21/01/19)*	0-2.5	0-2.5	30-35	80-85	521	26	659	0
Acting Director of Strategy								
Julie Smith (from 25/06/18)*	30-32.5	75-77.5	40-45	95-100	0	579	770	0
Chief Operating Officer								

- Nick Carver left the pension scheme with effect from 31st March 2016, so the full range of disclosures is not possible.
- Kate Lancaster left the pension scheme with effect from 1st March 2018, so the full range of disclosures is not possible.
- There is no mandatory lump sum available for Tom Simons.
- Susan Young is not in the pension scheme.
- We have no prior year data available for Julie Smith, hence the high real increase in cash equivalent transfer value.

Notes to pensions table

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

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 as he is not a member of the 1995 section of the NHS Pension scheme. There is nothing to disclose in respect pensions for Bernie Bluhm who is not a direct employee of the Trust.

Compensation for loss of office

There was nothing to disclose with regards to compensation for loss of office for Board directors in respect of 2018/19. 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	2018/19			2017/18
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	772	56	828	824
Administration and estates	1,502	145	1,647	1,591
Healthcare assistants and other support staff	753	141	894	864
Nursing, midwifery and health visiting staff	1,611	216	1,827	1,817
Scientific, therapeutic and technical staff	375	47	422	409
Healthcare science staff	182	-	182	167
Total average numbers	5,195	605	5,800	5,672
Of which:				
Number of employees (WTE) engaged on capital projects	8	-	8	5

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	2018/19			2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	196,238	-	196,238	188,588
Social security costs	20,682	-	20,682	19,625
Apprenticeship levy	1,005	-	1,005	941
Employer's contributions to NHS pensions	23,442	-	23,442	22,196
Pension cost - other	49	-	49	63
Termination costs	80	-	80	276
Temporary staffing costs	-	38,288	38,288	35,692
Recoveries in respect of seconded staff	(2,607)	-	(2,607)	(3,062)
External financing				
Costs capitalised as part of assets	457	-	457	505

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

Staff sickness absence	2018	2017
Total days lost	51,137	49,158
Total staff years	5,106	4,967
Average working days lost (per WTE)	10	10

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 (FTE).

2018/19	Female	Male	Total
Exec Directors	4	3	7
Employees	4653	1334	5987
Total	4657	1337	5994

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 disclosure is not appropriate.

Workforce data

In the table below, a summary of workforce-related statistics is provided for 2018/19, alongside figures provided for the previous three years. The figures are expressed as full time equivalents (FTE).

Activity	March 2019	March 2018	March 2017	March 2016	March 2015
Staff Employed	5195.24	5100.45	4828.71	4661.92	4540.63
Vacancy Rate	7.21%	8.35%	12.06%	9.72%	7.11%
Turnover Rate	13.29%	13.48%	12.96%	12.80%	12.91%
Sickness Absence Rate	4.18%	3.98%	4.06%	4.30%	4.12%

See page 33 for information regarding recruitment and retention in 2018/19.

Sickness absence data

The table below sets out the sickness absence rates by staff group.

Staff Groups	Sickness %
Admin and Estates	4.21%
Clinical support	5.28%
Medical & Dental	0.81%
Nursing qualified	3.52%
Nursing unqualified	6.51%
Scientific, Technical and Therapeutic (ST& T)	3.24%
Grand Total	**3.69%**

See pages 31 – 32 and 34 - 35 for information regarding sickness absence in 2018/19.

Equality and diversity – staff in post

Equality Diversity and Inclusion

The Trust is placing equality, diversity and inclusion (EDI) at the heart of what it does through the delivery of the culture, learning and development programmes. The Trust has successfully embedded EDI within education/training through sessions that inform and influence staff behaviours and therefore organisational culture. Key developments throughout the year have included:

- The appointment of a specialist EDI role to lead the agenda for the Trust
- Development of new training package to enhance skills for leaders
- Achieving the disability confidence level 2 and now working to achieve level 3
- Set up of four new staff networks
- The Trust website equality diversity and inclusion page will also be reviewed, including the four-year objectives to ensure alignment with the Equality Act 2010 Public Sector Duties.

- The Trust continues its second-year involvement in the NHS Diversity Partners Program.
- Changing the Trust approach to incidents and formal investigations by introducing 'just and learning culture' methodologies
- New equality impact assessment introduced for all staff policies
- In preparation of the workforce disability equality standards (WDES) our recruitment policy and other workforce policies have been reviewed to ensure that effective support and reasonable adjustments for those with disabilities

Ethnicity

The Trust's workforce continues to be more diverse than the population served; 30.73% 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, 71.79% 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 77.69%; they outnumber males in all staff groups with the exception of medical and dental, where 44.96% are female and 55.04% 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 37% of all Trust employees work part-time, with the highest percentage in nursing and midwifery (44.93%) and clinical support (44.06%).

Disability

14.32% of people in the 2011 census for Hertfordshire reported they had a disability. Of the Trust's 5,994 staff, 198 did not disclose whether they have a disability and 2,095 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 45.30% Christian, however 19.20% have not disclosed any religion and 10.06% do not want to disclose their religion. The next largest group is atheist at 10.26%.

Sexual orientation

70.87% of the Trust's workforce state they are heterosexual, with 20.44% giving undefined responses; furthermore, 6.84% 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

Trust policies are reviewed on a regular basis to ensure compliance with legislation, best practice and to ensure the workforce is supported to provide the best patient care possible. Staff side are consulted with on all workforce policies to enable partnership and joint working to improve the working life of our staff. All policies are made available to staff through the trust intranet pages or in hard copy from their line manager.

Policies applied to support people with disabilities

In line with the Trust's recruitment and selection policy, the Trust is a disability confident employer. 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.

Staff partnership

Our partnerships with unions and representative bodies are important to us. The Trust's management and staff representatives meet monthly to review policies and staff experience.

The Joint Negotiating Committee (JNC) is held monthly and is well attended by Trust management and Trade Unions and staff representatives. There is also the Local Negotiating Committee held quarterly for medical staff representatives which is chaired jointly by the Medical Director and staff side chair.

Trade Union Facility Time Reporting

The Trust is required to publish the following information relating to Trade Union Facility Time:

Table 1 - Relevant union officials

What was the total number of our employees who were relevant union officials during the period April 2018 to March 2019

Number of employees who were relevant union officials during the relevant period	*Full-time equivalent employee number*
33	5275*

** March 2019*

Table 2 - Percentage of time spent on facility time

How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	5
1-50%	25
51%-99%	0
100%	3

Table 3 - Percentage of pay bill spent on facility time

First Column	*Figures*
Provide the total cost of facility time	£201,679*
Provide the total pay bill	£276,798,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.07%

**estimate*

Table 4 - Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	100%

Expenditure on consultancy

In 2018/19 £1,807,483 was spent on consultancy costs.

Off-payroll engagements

The Trust is required to report arrangements where individuals, earning over £245 per day, are paid through their own companies (and so are responsible for their own tax and NI arrangements).

Payroll engagements as of 31 March 2019, greater than £245 per day and that last longer than six months:

	Number
Number of existing arrangements as of 31 March 2019	4
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	1
For between 2 and 3 years at the time of reporting	
For between 3 and 4 years at the time of reporting	
For 4 or more years at the time of reporting	2

For all new off-payroll engagements, or those that reached six months in duration between 1 April 2018 and March 2019, for more than £245 per day and that last longer than six months:

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	1
Of which…	
No. assessed as caught by IR35	1
No. assessed as not caught by IR35	
No. engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	1
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to 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 2018 and 31 March 2019.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	1
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	10

The off-payroll engagement of a board member referred to above was for an interim period whilst recruitment to the post took place.

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

Reporting of compensation schemes – exit packages 2018/19

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	-	12	**12**
£10,001 to £25,000	-	3	**3**
£25,001 to 50,000	1	-	**1**
£50,001 to £100,000	1	-	**1**
Total number of exit packages by type	**2**	**15**	**17**
Total resource cost (£)	£80,000	£64,000	**£144,000**

Reporting of compensation schemes - exit packages 2017/18

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**

Exit packages: other (non-compulsory) departure payments	2018/19		2017/18	
	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	15	64	13	40
Exit payments following Employment Tribunals or court orders	-	-	1	41
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**15**	**64**	**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 6 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 30 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 34 of the financial statements.

During 2018/19 the Trust has no case of Losses and Special Payments in year that exceeded £300,000.

Gifts

No gifts have been made using Trust monies in 2018/19.

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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

24 May 2019 Nick Carver, Chief Executive

24 May 2019 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 2019 which comprise the combined Group and single entity Statement of Comprehensive Income, Statement of Financial Position and Statement of Cash Flows and the Group and single entity Statements of Changes in Taxpayers' Equity, 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 2018-19 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2018-19.

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 2019 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 2019 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2018-19; and
- have been prepared in accordance with the Health and Social Care Act 2012.

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 in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council'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.

Material uncertainty related to going concern

We draw attention to Note 1.1.2 to the financial statements which sets out the Directors' assessment of the financial position of the Trust in the context of the National Health Service framework in which it operates and their conclusion that there are material uncertainties related to the financial sustainability of the Trust which may cast significant doubt about the ability of the Trust to continue as a going concern. Our opinion is not qualified in respect of this matter

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.

We have nothing to report in this regard.

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's Group Accounting Manual 2018-19.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion on use of resources (Except for)

For 2018/19 the Trust had set a deficit budget of £0.3m and outturn for the year was £13.5m, which represents a £13.2m adverse variance to the plan.

The Trust has set a budget to breakeven for 2019/20, subject to achieving its control total and receiving £9.1m of Financial Recovery Funding, £7.1m Provider Sustainability Funding and £4.7m Marginal Rate Efficiency Tariff in the year. Although a breakeven outcome in 2019/20 would be a notably positive achievement, it will not reduce the £75.4m of revenue reserves deficit accumulated to 31 March 2019. Further, as at 31 March 2019, the Trust has £189m of borrowing from DHSC, of which a net repayment of just £1.2m is planned for 2019/20.

The Trust set a Cost Improvement Programme (CIP) target of £24.1m for 2018/19 and achieved £18m during the year. A CIP target of £15m has been set for 2019/20. Whilst the Trust exceeded this target in both of the previous two years, and the full £15m of 2019/20 savings has been identified, achieving these savings will be a challenge and failing to do so would impact on eligibility for other funding.

Significant issues remain in terms of cumulative deficits, borrowing and cash flow.

This is evidence of weaknesses in proper arrangements regarding sustainable resource deployment.

Report to the Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 20 May 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 as the Trust has breached its statutory breakeven duty. That referral made explicit reference to the budgeted deficit for 2018/19, and so the referral remains valid for this year.

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 Annual 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 in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as 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 ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors either intend to liquidate the Trust or 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 ensuring that value for money is achieved from the resources available to the Trust.

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 level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will 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.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), 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(5)(b) of the Local Audit and Accountability Act 2014 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 our 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 Act 2014 and the Code of Audit Practice issued by the National Audit Office.

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.

David Eagles
For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK
28 May 2019

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

NHS
East and North Hertfordshire
NHS Trust

East and North Hertfordshire NHS Trust

Annual accounts for the period

1 April 2018 to 31 March 2019

Statement of Comprehensive Income

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
					Restated
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	397,141	376,309	397,028	376,213
Other operating income	4	47,762	44,659	47,238	43,492
Operating expenses	7, 9	(453,445)	(444,300)	(453,652)	(443,712)
Operating surplus/(deficit) from continuing operations		**(8,542)**	**(23,332)**	**(9,386)**	**(24,007)**
Finance income	12	87	32	87	32
Finance expenses	13	(4,956)	(4,620)	(4,956)	(4,620)
PDC dividends payable		-	(418)	-	(418)
Net finance costs		**(4,869)**	**(5,006)**	**(4,869)**	**(5,006)**
Corporation tax expense		(161)	(133)	-	-
Surplus / (deficit) for the year		**(13,572)**	**(28,471)**	**(14,255)**	**(29,013)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Downward revaluation	8	(1,885)	(10,645)	(1,885)	(10,645)
Revaluations	20	306	4,890	306	5,003
Other recognised gains and losses		-	113	-	113
Other reserve movements		(32)	(200)	551	(200)
Total comprehensive income / (expense) for the period		**(15,183)**	**(34,313)**	**(15,283)**	**(34,742)**

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 period	**(13,572)**	**(28,471)**
Impairment taken to Income and Expenditure	395	3,938
Remove I&E impact of capital donations	(366)	109
CQUIN risk reserve adjustment (2017/18 only)	-	(1,336)
Adjusted financial performance surplus / (deficit)	**(13,543)**	**(25,760)**

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 2018/19. However, performance of the Trust has also been provided alongside. The corporate tax payable is due from the subsidiary.

The Notes in the Accounts support the consolidated results above.

Statement of Financial Position

		Group		Trust	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018 Restated
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15&16	26,982	18,567	26,925	18,492
Property, plant and equipment	17&18	175,416	175,555	175,278	175,392
Other investments / financial assets	21	-	-	1,000	1,000
Receivables	23	2,586	2,636	2,586	2,636
Total non-current assets		**204,984**	**196,758**	**205,789**	**197,520**
Current assets					
Inventories	22	6,465	6,401	5,295	5,321
Receivables	23	47,243	43,320	46,799	41,372
Non-current assets for sale and assets in disposal groups	24	354	-	354	-
Cash and cash equivalents	25	1,521	2,127	1,148	1,499
Total current assets		**55,583**	**51,848**	**53,596**	**48,192**
Current liabilities					
Trade and other payables	26	(46,746)	(54,470)	(46,351)	(52,261)
Borrowings	29	(33,771)	(9,775)	(33,771)	(9,775)
Other financial liabilities	27	(170)	(163)	(170)	(163)
Provisions	30	(284)	(387)	(284)	(388)
Other liabilities	28	(1,697)	(742)	(1,697)	(742)
Total current liabilities		**(82,668)**	**(65,537)**	**(82,273)**	**(63,329)**
Total assets less current liabilities		**177,899**	**183,069**	**177,112**	**182,383**
Non-current liabilities					
Trade and other payables	26	(4,404)	(4,610)	(4,404)	(4,610)
Borrowings	29	(162,119)	(151,813)	(162,119)	(151,814)
Other financial liabilities	27	(2,104)	(2,274)	(2,104)	(2,274)
Provisions	30	(543)	(585)	(543)	(585)
Total non-current liabilities		**(169,170)**	**(159,282)**	**(169,170)**	**(159,283)**
Total assets employed		**8,729**	**23,787**	**7,942**	**23,100**
Financed by					
Public dividend capital	SOCIE	175,376	174,998	175,376	174,998
Revaluation reserve	SOCIE	38,430	40,009	38,429	40,009
Income and expenditure reserve	SOCIE	(205,077)	(191,220)	(205,863)	(191,907)
Total taxpayers' equity		**8,729**	**23,787**	**7,942**	**23,100**

The notes on pages 108 to 162 form part of these accounts.

Name	Mr Nick Carver
Position	Chief Executive
Date	**24 May 2019**

Statement of Changes in Equity (SOCIE) for the year ended 31 March 2019

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 2018 - brought forward	**174,998**	**40,009**	**-**	**(191,220)**	**23,787**
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	(253)	**(253)**
Surplus/(deficit) for the year	-	-	-	(13,572)	**(13,572)**
Downward revaluation	-	(1,885)	-	-	**(1,885)**
Revaluations	-	306	-	-	**306**
Public dividend capital received	378	-	-	-	**378**
Other reserve movements	-	-	-	(32)	**(32)**
Taxpayers' and others' equity at 31 March 2019	**175,376**	**38,430**	**-**	**(205,077)**	**8,729**

Statement of Changes in Equity (SOCIE) 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)**
Downward revaluation	-	(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 (SOCIE) for the year ended 31 March 2019

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**174,998**	**40,008**	**(191,906)**	**23,100**
Impact of implementing IFRS 9 on 1 April 2018	-	-	(253)	**(253)**
Surplus/(deficit) for the year			(14,255)	**(14,255)**
Downward revaluation	-	(1,885)	-	**(1,885)**
Revaluations	-	306	-	**306**
Public dividend capital received	378	-	-	**378**
Other reserve movements			551	**551**
Taxpayers' and others' equity at 31 March 2019	**175,376**	**38,429**	**(205,863)**	**7,942**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
forward	**171,652**	**46,309**	**(163,753)**	**54,208**
Surplus/(deficit) for the year	-	-	(29,012)	**(29,012)**
Other transfers between reserves	-	(659)	659	**-**
Downward revaluation	-	(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**	**(191,906)**	**23,100**

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

	Note	Group 2018/19 £000	Group 2017/18 £000	Trust 2018/19 £000	Trust 2017/18 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(8,542)	(23,332)	(9,386)	(24,007)
Non-cash income and expense:					
Depreciation and amortisation	7	8,939	8,107	8,895	8,064
Net impairments	8	395	3,938	395	3,938
Income recognised in respect of capital donations	4	(664)	(201)	(664)	(201)
(Increase) / decrease in receivables and other assets		(5,003)	4,814	(6,505)	5,668
(Increase) / decrease in inventories		(64)	(866)	26	(378)
Increase / (decrease) in payables and other liabilities		(3,960)	(3,403)	(2,109)	(4,252)
Increase / (decrease) in provisions		(147)	(3,175)	(147)	(3,175)
Tax (paid) / received		(123)	(92)	-	-
Other movements in operating cash flows		(32)	-	551	200
Net cash flows from / (used in) operating activities		**(9,201)**	**(14,210)**	**(8,944)**	**(14,143)**
Cash flows from investing activities					
Interest received		87	32	87	32
Purchase of intangible assets		(11,009)	(8,401)	(11,011)	(8,401)
Purchase of PPE and investment property		(11,542)	(2,805)	(11,542)	(2,805)
Receipt of cash donations to purchase assets		664	-	664	-
Net cash flows from / (used in) investing activities		**(21,800)**	**(11,174)**	**(21,802)**	**(11,174)**
Cash flows from financing activities					
Public dividend capital received		378	3,346	378	3,346
Public dividend capital repaid		-	-	-	-
Movement on loans from DHSC		34,333	28,298	34,333	28,298
Movement on other loans		(63)	(72)	(63)	(72)
Capital element of PFI, LIFT and other service concession payments		(307)	(356)	(307)	(356)
Interest on loans		(3,813)	(3,500)	(3,813)	(3,500)
Other interest		(90)	(86)	(90)	(86)
Interest paid on PFI, LIFT and other service concession obligations		(920)	(930)	(920)	(930)
PDC dividend (paid) / refunded		877	(1,253)	877	(1,253)
Net cash flows from / (used in) financing activities		**30,395**	**25,447**	**30,395**	**25,447**
Increase / (decrease) in cash and cash equivalents		**(607)**	**63**	**(352)**	**130**
Cash and cash equivalents at 1 April - brought forward		**2,127**	**2,064**	**1,499**	**1,369**
Cash and cash equivalents at 31 March	25	**1,521**	**2,127**	**1,148**	**1,499**

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 2018/19 issued by the Department of Health and Social Care. 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 the 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 during the financial year but is forecast to breakeven in the forthcoming year.

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 Trust has provided its regulatory body, NHSI, with its financial plans for 2019/20. There is no identified reason for the Directors to assess that there is a likelihood that the Trust will be wound up in the foreseeable future, and therefore for its assets and liabilities to be valued on a basis other than the 'going concern' basis.

The financial statements do not include any adjustments that would be required if the going concern basis were not appropriate.

Note 1.1.3 Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

The Trust has a wholly owned subsidiary company, ENH Pharma Ltd. The accounts for this company have been consolidated into the Trust's annual accounts. The primary statements and notes to the accounts have been presented with separate 'Group' and 'Trust' columns. Where the difference between the 'Group' and 'Trust' figures is considered immaterial, the 'Trust' version of the note has been omitted.

Note 1.2 Critical judgements in applying accounting policies

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 consolidated the performance of its wholly-owned subsidiary into its financial results, as being under common control as defined by IAS 27. The results of the Trust as a single entity are provided for information purposes only.

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 2018/19.

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 15 to 18
- Allowances for credit losses on Receivables - Note 23.2
- Expenditure accruals - Note 7.1
- The likelihood, amount and timing of provisions and contingent liabilities - Note 30
- Liabilities under the Private Finance Inititative - Note 33

Note 1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

A receivable is recognised when goods are delivered as this is the point in time that the consideration is unconditional and because only the passage of time is required before the payment is due.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

For example: Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end and this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Trust does not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less. The Trust recognises revenue in line with the right to consideration where this corresponds directly with value of the performance completed to date.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.3.1 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 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 1.3.2 Other income

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.

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. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

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 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 which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values 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 for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

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 useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 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’ cease 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 abandoned 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 useful 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) transactions

PFI 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive

Note 1.6.6 Useful lives of property, plant and equipment

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

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

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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

	Min life Years	Max life Years
Information technology	5	10
Development expenditure	5	10
Software licences	5	15
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 assets and financial liabilities

Note 1.10.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.10.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

The Trust determines expected credit losses using a matrix of percentage based on the class of financial asset and prior recoverability. The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.10.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

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

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 as an item of property plant and equipment.

The annual rental charge 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 29 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 assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 30, 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 of 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 2018/19.

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

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. The Trust is still assessing the impact of this.

IFRS 14 - Regulatory Deferral Accounts - Applies to first adopters of IFRS after 1 January 2016. Therefore not applicable to the Trust.

IFRS 17 - Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. It is estimated that there will be no impact on the Trust accounts if adopted.

IFRIC 23 - Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019. There will be no impact on the Trust if adopted

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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

	Group		Trust	
Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**	**2018/19**	**2017/18**
	£000	**£000**	**£000**	**£000**
Elective income	54,939	51,491	54,939	51,491
Non elective income	102,404	94,692	102,404	94,692
First outpatient income	24,173	24,460	24,173	24,460
Follow up outpatient income	27,541	25,620	27,541	25,620
A & E income	24,141	22,001	24,141	22,001
High cost drugs income from commissioners (excluding pass-through costs)	39,146	38,328	39,146	38,328
Other NHS clinical income	116,200	113,969	116,200	113,969
Private patient income	3,229	3,459	3,229	3,459
Agenda for Change pay award central funding	3,632	-	3,632	-
Other clinical income	1,736	2,289	1,623	2,193
Total income from activities	**397,141**	**376,309**	**397,028**	**376,213**

Agenda for change pay award relate to amount received from Department of Health and Social Care to fund increase in staff pay

Note 3.2 Income from patient care activities (by source)

	2018/19	**2017/18**	**2018/19**	**2017/18**
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	99,328	93,089	99,328	93,089
Clinical commissioning groups	288,602	277,283	288,602	277,283
Department of Health and Social Care	3,632	-	3,632	-
Other NHS providers	485	93	485	93
NHS other	129	-	129	-
Non-NHS: private patients	3,229	3,459	3,229	3,459
Non-NHS: overseas patients (chargeable to patient)	505	766	505	766
Injury cost recover scheme	937	1,244	937	1,244
Non NHS: other	294	375	181	279
Total income from activities	**397,141**	**376,309**	**397,028**	**376,213**
Of which:				
Related to continuing operations	397,141	376,309	397,028	376,213

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

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Income recognised this year	505	766	505	766
Cash payments received in-year	208	223	208	223
Amounts added to provision for impairment of receivables	199	692	199	692
Amounts written off in-year	-	30	-	30

Note 4 Other operating income (Group)

	2018/19	2017/18	2018/19	2017/18
				Restated
	£000	£000	£000	£000
Other operating income from contracts with customers:				
Research and development (contract)	5,513	5,172	5,513	5,172
Education and training (excluding notional apprenticeship levy income)	15,571	15,242	15,571	15,242
Non-patient care services to other bodies	12,414	12,596	11,787	11,326
Provider sustainability / sustainability and transformation fund income (PSF / STF)	9,455	4,116	9,455	4,116
Other contract income	3,754	6,911	3,754	6,911
Other non-contract operating income:				
Education and training - notional income from apprenticeship fund	95	92	95	92
Receipt of capital grants and donations	664	201	664	201
Rental revenue from operating leases	296	329	399	432
Total other operating income	**47,762**	**44,659**	**47,238**	**43,492**
Of which:				
Related to continuing operations	47,762	44,659	47,238	43,492

Other contract income includes:

Car parking Income of £1,830k (2017/18 £1,792k)

Catering (non-patient) of £1,287k (2017/18 £1,182k)

Other operating income for the Trust for 2017/18 has been re-stated following consolidation error in income and expenditure. The Trust's deficit for the year 2017/18 is unchanged.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	727
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	1,697
after one year, not later than five years	-
after five years	-
Total revenue allocated to remainig performance obligations	**1,697**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6.1 Fees and charges (Group)

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

Note 7.1 Operating expenses (Group)

	Group		Trust	
	2018/19	2017/18 Restated	2018/19	2017/18 Restated
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	12,492	15,439	12,492	15,439
Purchase of healthcare from non-NHS and non-DHSC bodies	8,780	7,430	8,780	7,430
Purchase of social care	-	-	-	-
Staff and executive directors costs	273,541	260,670	272,526	259,675
Remuneration of non-executive directors	78	77	78	77
Supplies and services - clinical (excluding drugs costs)	35,383	32,225	35,603	32,330
Supplies and services - general	12,318	11,727	12,318	11,727
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	48,714	45,751	48,111	45,422
Inventories written down	146	268	146	268
Consultancy costs	1,807	4,652	1,807	4,627
Establishment	4,959	3,889	4,842	3,843
Premises	13,453	13,717	13,395	13,678
Transport (including patient travel)	699	565	699	565
Depreciation on property, plant and equipment	6,345	6,068	6,317	6,053
Amortisation on intangible assets	2,594	2,039	2,578	1,998
Net impairments	395	3,938	395	3,938
Movement in credit loss allowance: contract receivables / contract assets	250	-	250	-
Movement in credit loss allowance: all other receivables and investments	-	56	-	56
Increase/(decrease) in other provisions	159	229	159	229
Audit fees payable to the external auditor				
audit services- statutory audit	59	52	52	52
other auditor remuneration (external auditor only)	5	10	5	5
Internal audit costs	151	148	151	148
Clinical negligence	14,457	15,040	14,457	15,040
Legal fees	179	220	179	220
Insurance	29	26	22	20
Research and development	3,833	3,313	3,833	3,313
Education and training	960	934	960	934
Rentals under operating leases	9,419	9,294	9,419	9,294
Early retirements	-	-	-	-
Redundancy	80	276	80	276
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	115	110	115	110
Car parking & security	620	609	620	609
Hospitality	34	65	34	65
Losses, ex gratia & special payments	18	1,168	18	1,168
Other services, eg external payroll	1,327	1,458	1,327	1,458
Other	46	2,837	1,884	3,645
Total	**453,445**	**444,300**	**453,652**	**443,712**
Of which:				
Related to continuing operations	453,445	444,300	453,652	443,712

Operating expenditure for the Group for 2017/18 has been re-stated following reclassification of building rents from 'Premises' to 'Rentals under operating leases'. The Group total operating expenditure for the year 2017/18 is unchanged.

Operating expenditure for the Trust for 2017/18 has been re-stated following consolidation error in income and expenditure. The Trust's deficit for the year 2017/18 is unchanged.

Note 7.2 Other auditor remuneration

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£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	5	5	5
Total	**5**	**10**	**5**	**5**

Note 7.3 Limitation on auditor's liability (Trust)

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets

	Group and Trust	
	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	395	3,938
Total net impairments charged to operating surplus / deficit	**395**	**3,938**
Impairments charged to the revaluation reserve	1,885	10,645
Total net impairments	**2,280**	**14,583**

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.

Note 9 Employee benefits

	Group		Trust	
	2018/19	2017/18 Restated	2018/19	2017/18
	Total	Total	Total	Total
	£000	£000	£000	£000
Salaries and wages	196,238	188,588	195,223	187,593
Social security costs	20,682	19,625	20,682	19,625
Apprenticeship levy	1,005	941	1,005	941
Employer's contributions to NHS pensions	23,442	22,196	23,442	22,196
Pension cost - other	49	63	49	63
Termination benefits	80	276	80	276
Temporary staff (including agency)	38,288	35,692	38,288	35,692
Total gross staff costs	**279,784**	**267,381**	**278,769**	**266,386**
Recoveries in respect of seconded staff	(2,607)	(3,062)	(2,607)	(3,062)
Total staff costs	**277,177**	**264,319**	**276,162**	**263,324**
Of which				
Costs capitalised as part of assets	457	505	457	505
Included in Research & development	3,099	2,868	3,099	2,868
Included in Redundancy	80	276	80	276

Employee benefits for the year 2017/18 has been re-stated following a re-classification of locum staff cost to temporary staff and disclosure of recoveries in respect of seconded staff. Total staff costs for the year 2017/18 is unchanged.

Note 9.1 Retirements due to ill-health (Group)

During 2018/19 there were 3 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £113k (£393k in 2017/18).

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

Note 10 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 The Trust as a lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

The Trust leases space for retail units, telephone masts and staff accommodation.

	Group and Trust	
	2018/19	2017/18
	£000	£000
Operating lease revenue		
Minimum lease receipts	296	329
Total	**296**	**329**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	296	156
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Total	**296**	**156**

Note 11.2 The Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

The Trust's operating leases relate to medical equipment and lease cars.
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.

	Group and Trust	
	2018/19	2017/18 Restated
	£000	£000
Operating lease expense		
Minimum lease payments	9,419	9,294
Total	**9,419**	**9,294**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	8,597	12,115
- later than one year and not later than five years;	4,848	6,947
- later than five years.	19,005	19,284
Total	**32,450**	**38,346**

Operating lease for the Group for 2017/18 has been re-stated following reclassification of building rents from 'Premises' to 'Rentals under operating leases'. The Group total operating expenditure for the year 2017/18 is unchanged.

Note 12 Finance income

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

	Group and Trust	
	2018/19	2017/18
	£000	£000
Interest on bank accounts	87	32
Total finance income	**87**	**32**

Note 13.1 Finance expenditure (Group)

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	3,944	3,603
Interest on late payment of commercial debt	15	5
Main finance costs on PFI schemes obligations	498	524
Contingent finance costs on PFI scheme obligations	422	406
Total interest expense	**4,879**	**4,538**
Unwinding of discount on provisions	2	1
Other finance costs	75	81
Total finance costs	**4,956**	**4,620**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	15	5

Note 15.1 Intangible assets - 2018/19

Group	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**15,313**	**1,020**	**8,736**	**-**	**25,069**
Additions	11,009	-	-	-	**11,009**
Valuation / gross cost at 31 March 2019	**26,322**	**1,020**	**8,736**	**-**	**36,078**
Amortisation at 1 April 2018 - brought forward	**1,869**	**659**	**3,974**	**-**	**6,502**
Provided during the year	1,394	123	1,077	-	**2,594**
Amortisation at 31 March 2019	**3,263**	**782**	**5,051**	**-**	**9,096**
Net book value at 31 March 2019	**23,059**	**238**	**3,685**	**-**	**26,982**
Net book value at 1 April 2018	**13,444**	**361**	**4,762**	**-**	**18,567**

Note 15.2 Intangible assets - 2017/18

Group	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**

Note 16.1 Intangible assets - 2018/19

Trust	Software licences	Licences & trademarks	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**15,209**	**1,020**	**8,736**	**-**	**24,965**
Additions	11,009	-	-	-	**11,009**
Valuation / gross cost at 31 March 2019	**26,218**	**1,020**	**8,736**	**-**	**35,974**
Amortisation at 1 April 2018 - brought forward	**1,840**	**659**	**3,974**	**-**	**6,473**
Transfers by absorption					**-**
Provided during the year	1,376	123	1,077	-	**2,576**
Amortisation at 31 March 2019	**3,216**	**782**	**5,051**	**-**	**9,049**
Net book value at 31 March 2019	**23,002**	**238**	**3,685**	**-**	**26,925**
Net book value at 1 April 2018	**13,369**	**361**	**4,762**	**-**	**18,492**

Note 16.2 Intangible assets - 2017/18

Trust	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	**3,334**	**1,466**	**13,134**	**4,712**	**22,646**
Additions	7,755	-	-	-	**7,755**
Reclassifications	4,712	-	-	(4,712)	**-**
Disposals / derecognition	(592)	(446)	(4,398)	-	**(5,436)**
Valuation / gross cost at 31 March 2018	**15,209**	**1,020**	**8,736**	**-**	**24,965**
Amortisation at 1 April 2017 - brought forward	**1,671**	**994**	**7,184**	**-**	**9,849**
Provided during the year	756	107	1,162	-	**2,025**
Reclassifications	5	4	26	-	**35**
Disposals / derecognition	(592)	(446)	(4,398)	-	**(5,436)**
Amortisation at 31 March 2018	**1,840**	**659**	**3,974**	**-**	**6,473**
Net book value at 31 March 2018	**13,369**	**361**	**4,762**	**-**	**18,492**
Net book value at 1 April 2017	**1,663**	**472**	**5,950**	**4,712**	**12,797**

Intangible asset net book value for 2017-18 has been restated due to consolidation adjustment error. The adjustment is between intangible asset and property, plant and equipment. No impact on the net asset of the Trust.

Note 17.1 Property, plant and equipment - 2018/19

Group	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**21,740**	**134,847**	**44,447**	**9,295**	**3,210**	**213,539**
Additions	-	5,866	1,690	968	10	**8,534**
Impairments	-	(5,360)	-	-	-	**(5,360)**
Reversals of impairments	-	680	-	-	-	**680**
Revaluations	-	306	-	-	-	**306**
Transfers to / from assets held for sale	(345)	(9)	-	-	-	**(354)**
Valuation/gross cost at 31 March 2019	**21,395**	**136,330**	**46,137**	**10,263**	**3,220**	**217,345**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**29,103**	**6,676**	**2,205**	**37,984**
Provided during the year	-	2,404	2,942	844	155	**6,345**
Impairments	-	(2,400)	-	-	-	**(2,400)**
Accumulated depreciation at 31 March 2019	**-**	**4**	**32,045**	**7,520**	**2,360**	**41,929**
Net book value at 31 March 2019	**21,395**	**136,326**	**14,092**	**2,743**	**860**	**175,416**
Net book value at 1 April 2018	**21,740**	**134,847**	**15,344**	**2,619**	**1,005**	**175,555**

Note 17.2 Property, plant and equipment - 2017/18

Group	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**
Prior period adjustments	(11,620)	-	-	-	-	**(11,620)**
Valuation / gross cost at 1 April 2017 - restated	**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	**21,823**	**134,117**	**14,682**	**2,568**	**1,143**	**174,333**

Note 17.3 Property, plant and equipment financing - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019										
Owned - purchased	21,395	127,223	-	-	12,515	-	2,743	706	-	**164,582**
On-SoFP PFI contracts and other service concession arrangements	-	7,647	-	-	-	-	-	-	-	**7,647**
Owned - donated	-	1,456	-	-	1,577	-	-	154	-	**3,187**
NBV total at 31 March 2019	**21,395**	**136,326**	**-**	**-**	**14,092**	**-**	**2,743**	**860**	**-**	**175,416**

Note 17.4 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£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 18.1 Property, plant and equipment - 2018/19

Trust	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**21,740**	**134,847**	**44,447**	**9,232**	**3,059**	**213,325**
Transfers by absorption						**-**
Additions	-	5,866	1,690	966	10	**8,532**
Impairments	-	(5,360)	-	-	-	**(5,360)**
Reversals of impairments	-	680	-	-	-	**680**
Revaluations	-	306	-	-	-	**306**
Transfers to / from assets held for sale	(345)	(9)	-	-	-	**(354)**
Valuation/gross cost at 31 March 2019	**21,395**	**136,330**	**46,137**	**10,198**	**3,069**	**217,129**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**-**	**29,103**	**6,651**	**2,179**	**37,933**
Transfers by absorption						**-**
Provided during the year	-	2,404	2,942	831	141	**6,318**
Impairments	-	(2,400)	-	-	-	**(2,400)**
Accumulated depreciation at 31 March 2019	**-**	**4**	**32,045**	**7,482**	**2,320**	**41,851**
Net book value at 31 March 2019	**21,395**	**136,326**	**14,092**	**2,716**	**749**	**175,278**
Net book value at 1 April 2018	**21,740**	**134,847**	**15,344**	**2,581**	**880**	**175,392**

Note 18.2 Property, plant and equipment - 2017/18

Trust	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**	**14,268**	**4,225**	**245,055**
Prior period adjustments	(11,620)	-	-	-	-	**(11,620)**
Valuation / gross cost at 1 April 2017 - restated	**21,823**	**134,129**	**58,990**	**14,268**	**4,225**	**233,435**
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**	**9,232**	**3,059**	**213,325**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**12**	**44,308**	**11,750**	**3,222**	**59,292**
Provided during the year	-	2,269	2,790	833	149	**6,041**
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**	**6,651**	**2,179**	**37,933**
Net book value at 31 March 2018	**21,740**	**134,847**	**15,344**	**2,581**	**880**	**175,392**
Net book value at 1 April 2017	**21,823**	**134,117**	**14,682**	**2,518**	**1,003**	**174,143**

Property, plant and equipment net book value for 2017-18 has been restated due to consolidation adjustment error. The adjustment is between property, plant and equipment and intangible asset. No impact on the net asset of the Trust.

Note 18.3 Property, plant and equipment financing - 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	21,395	127,223			12,515	-	2,716	595	**164,444**
On-SoFP PFI contracts and other service concession arrangements	-	7,647			-	-	-	-	**7,647**
Owned - donated	-	1,456			1,577	-	-	154	**3,187**
NBV total at 31 March 2019	**21,395**	**136,326**	**-**	**-**	**14,092**	**-**	**2,716**	**749**	**175,278**

Note 18.4 Property, plant and equipment financing - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	21,740	125,443			14,207	-	2,580	713	**164,683**
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**	**-**	**2,581**	**880**	**175,392**

Note 19 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. The amount received in 2018-19 was £664k (2017-18 £201k).

Note 20 Revaluations of property, plant and equipment

The Trust's land and buildings valuations were reviewed at 31 March 2019 by an independent, qualified valuer, using the Modern Equivalent Asset (MEA) methodology, in accordance with DH guidance and the NHS Group Accounting Manual.

The desktop valuation was carried out by Avison Young (previously known as Bilfinger GVA), 3 Brindleyplace, Birmingham, B1 2JB. This 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.

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.

Non specialised property is held at existing use value and is not materially different from its open market value.

Increase in the valuation of property, plant and equipment which was transferred to revaluation reserve during the year was £306k

Note 21 Other investments / financial assets
The Trust's principal subsidiary undertakings as included in its consolidated accounts are below.

The Trust holds a £1,000k investment in ENH Pharma Ltd. The accounting date of the financial statements for the subsidiary is 31 March 2019.

ENH Pharma Ltd is 100% owned and was incorporated on 28 July 2014 in the United Kingdom. Its principal activity is Outpatient Pharmacy. As at 31 March 2019, the subsidiary's total profit for the year was £683k, with a gross assets of £3,492k and net asset of £1,788k.

Note 22 Inventories

	Group		Trust	
	31 March 2019	**31 March 2018**	**31 March 2019**	**31 March 2018**
	£000	**£000**	**£000**	**£000**
Drugs	2,787	2,761	1,617	1,681
Consumables	3,435	3,397	3,435	3,397
Energy	243	243	243	243
Total inventories	**6,465**	**6,401**	**5,295**	**5,321**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £48,860k (2017/18: £45,685k). Write-down of inventories recognised as expenses for the year were £146k (2017/18: £268k).

Note 23.1 Receivables

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Contract receivables*	38,194		38,173	-
Contract assets*	-		-	-
Trade receivables*		26,135	-	24,646
Accrued income*		6,801	-	6,801
Allowance for impaired contract receivables / assets*	(1,563)		(1,563)	-
Allowance for other impaired receivables	-	(1,060)	-	(1,060)
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	5,376	4,010	5,376	4,010
PDC dividend receivable	186	1,063	186	1,063
VAT receivable	2,372	2,871	1,948	2,412
Other receivables	2,678	3,500	2,678	3,500
Total current receivables	**47,243**	**43,320**	**46,798**	**41,372**
Non-current				
Contract receivables*	1,892		1,892	-
Contract assets*	-		-	-
Allowance for impaired contract receivables / assets*	(404)		(404)	-
Allowance for other impaired receivables	-	(404)	-	(404)
Prepayments (non-PFI)	1,098	1,148	1,098	1,148
Other receivables	-	1,892	-	1,892
Total non-current receivables	**2,586**	**2,636**	**2,586**	**2,636**
Of which receivable from NHS and DHSC group bodies:				
Current	30,625	26,945	30,625	26,945
Non-current	-	-	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.2 Allowances for credit losses - 2018/19

	Group and Trust	
	receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 April 2018 - brought forward		**1,464**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,717	(1,464)
Changes in existing allowances	250	-
Allowances as at 31 March 2019	**1,967**	**-**

Note 23.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group	Trust
	All receivables	All receivables
	£000	£000
Allowances as at 1 Apr 2017 - brought forward	**1,024**	**1,024**
Increase in provision	56	56
Amounts utilised	384	384
Allowances as at 31 March 2018	**1,464**	**1,464**

Note 23.4 Exposure to credit risk

Ageing of non-impaired financial assets past their due date

	Group and Trust	
	31 March 2019	31-March-2018
	Trade and other receivables	
0 - 30 days	5,917	4,481
30-60 Days	440	3,031
60-90 days	407	2,215
90- 180 days	4,223	2,231
Over 180 days	6,111	6,947
Total	**17,098**	**18,905**

Note 24 Non-current assets held for sale and assets in disposal groups

	Group and Trust	
	2018/19	2017/18
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2018	**-**	**-**
Assets classified as available for sale in the year	354	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2019	**354**	**-**

The asset classified as held for sales relates to Hydebrook house land situated on the original QEII Hospital site. The building is currently used for non-clinical services and is reported on the NHS Surplus Land Collection as surplus and available for disposal. Management has approved to sell and a buyer identified as at 31 March 2019

Note 25 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.

	Group		Trust	
	2018/19	**2017/18**	**2018/19**	**2017/18**
	£000	**£000**	**£000**	**£000**
At 1 April	**2,127**	**2,064**	**1,499**	**1,369**
Net change in year	(606)	63	(352)	130
At 31 March	**1,521**	**2,127**	**1,148**	**1,499**
Broken down into:				
Cash at commercial banks and in hand	406	643	33	384
Cash with the Government Banking Service	1,115	1,484	1,115	1,115
Total cash and cash equivalents as in SoFP	**1,521**	**2,127**	**1,148**	**1,499**

Note 25.1 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 Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2019	**31 March 2018**
	£000	**£000**
Bank balances	-	-
Monies on deposit	4	4
Total third party assets	**4**	**4**

Note 26.1 Trade and other payables

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Trade payables	27,364	27,380	26,991	25,171
Capital payables	508	3,516	508	3,516
Accruals	12,913	13,954	12,913	13,954
Receipts in advance and payments on account	-	6	-	6
Social security costs	3,163	2,943	3,163	2,943
Other taxes payable	2,798	2,623	2,776	2,623
Accrued interest on loans*	-	208	-	208
Other payables	-	3,840	-	3,840
Total current trade and other payables	**46,746**	**54,470**	**46,351**	**52,261**
Non-current				
Other payables	4,404	4,610	4,404	4,610
Total non-current trade and other payables	**4,404**	**4,610**	**4,404**	**4,610**
Of which payables from NHS and DHSC group bodies:				
Current	6,984	16,867	6,984	16,867
Non-current	-	-	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 29. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 27 Other financial liabilities

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Other financial liabilities	170	163	170	163
Total other current liabilities	**170**	**163**	**170**	**163**
Non-current				
Net pension scheme liability	2,104	2,274	2,104	2,274
Total other non-current liabilities	**2,104**	**2,274**	**2,104**	**2,274**

Note 28 Other liabilities

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	1,697	742	1,697	742
Total other current liabilities	**1,697**	**742**	**1,697**	**742**
Non-current				
Total other non-current liabilities	**-**	**-**	**-**	**-**

Note 29 Borrowings

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Loans from DHSC	33,469	9,405	33,469	9,405
Other loans	63	63	63	63
Obligations under PFI or other service concession contracts (excl. lifecycle)	239	307	239	307
Total current borrowings	**33,771**	**9,775**	**33,771**	**9,775**
Non-current				
Loans from DHSC	155,780	145,173	155,780	145,173
Other loans	126	188	126	188
Obligations under PFI or other service concession contracts	6,213	6,452	6,213	6,452
Total non-current borrowings	**162,119**	**151,813**	**162,119**	**151,813**

Note 29.1 Reconciliation of liabilities arising from financing activities

Group and Trust	Loans from DHSC	Other loans	Finance leases	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2018	**154,578**	**251**	**-**	**6,759**	**161,588**
Cash movements:					**-**
Financing cash flows - payments and receipts of principal	34,333	(63)	-	(307)	**33,963**
Financing cash flows - payments of interest	(3,813)	-	-	(498)	**(4,311)**
Non-cash movements:					**-**
Impact of implementing IFRS 9 on 1 April 2018	208	-	-	-	**208**
Application of effective interest rate	3,944	-	-	498	**4,442**
Carrying value at 31 March 2019	**189,250**	**188**	**-**	**6,452**	**195,890**

Note 30.1 Provisions for liabilities and charges analysis

Group and Trust

Group and Trust	Pensions: early departure costs	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**662**	**86**	**149**	**75**	**972**
Arising during the year	65	95	-	-	**160**
Utilised during the year	(104)	(41)	(86)	(75)	**(306)**
Reversed unused	(1)	-	-	-	**(1)**
Unwinding of discount	2	-	-	-	**2**
At 31 March 2019	**624**	**140**	**63**	**-**	**827**
Expected timing of cash flows:					
- not later than one year;	81	140	63	-	**284**
five years;	-	-	-	-	**-**
- later than five years.	543	-	-	-	**543**
Total	**624**	**140**	**63**	**-**	**827**

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 Resolution
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 30.2 Clinical negligence liabilities

At 31 March 2019, £310,337k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire NHS Trust (31 March 2018: £284,955k).

Note 31 Contingent assets and liabilities

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(96)	(49)
Gross value of contingent liabilities	**(96)**	**(49)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(96)**	**(49)**
Net value of contingent assets	**-**	**-**

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 32 Contractual capital commitments

	Group and Trust	
	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	196	-
Intangible assets	-	148
Total	**196**	**148**

Note 33 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 1 November 2004 with a contract period of 28.5 years. The contract is due to end on 31 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 33.1 Imputed finance lease obligations

The following are obligations in respect of the finance lease element of on-Statement of Financial Position PFI schemes:

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Gross PFI liabilities	**10,717**	**11,523**
Of which liabilities are due		
- not later than one year;	716	805
- later than one year and not later than five years;	2,893	2,856
- later than five years.	7,109	7,862
Finance charges allocated to future periods	(4,265)	(4,764)
Net PFI obligation	**6,452**	**6,759**
- not later than one year;	239	307
- later than one year and not later than five years;	1,176	1,058
- later than five years.	5,037	5,394

Note 33.2 Total on-SoFP PFI commitments

Total future obligations under these on-SoFP schemes are as follows:

	Group and Trust	
	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the PFI arrangements	**24,290**	**25,709**
Of which liabilities are due:		
- not later than one year;	1,455	1,419
- later than one year and not later than five years;	6,193	6,042
- later than five years.	16,642	18,248

Note 33.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group and Trust	
	2018/19	**2017/18**
	£000	**£000**
Unitary payment payable to service concession operator	**1,499**	**1,446**
Consisting of:		
- Interest charge	498	524
- Repayment of finance lease liability	307	356
- Service element and other charges to operating expenditure	115	110
- Capital lifecycle maintenance	157	50
- Contingent rent	422	406
Total amount paid to service concession operator	**1,499**	**1,446**

Note 34 Financial instruments

Note 34.1 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 31 March 2019 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 34.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	40,797	-	-	**40,797**
Cash and cash equivalents	1,521	-	-	**1,521**
Total at 31 March 2019	**42,318**	**-**	**-**	**42,318**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
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**

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	40,352	-	-	**40,352**
Other investments / financial assets				**-**
Cash and cash equivalents	1,148	-	-	**1,148**
Total at 31 March 2019	**41,500**	**-**	**-**	**41,500**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	33,528	-	-	-	**33,528**
Other investments / financial assets					**-**
Cash and cash equivalents	1,499	-	-	-	**1,499**
Total at 31 March 2018	**35,027**	**-**	**-**	**-**	**35,027**

Note 34.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	189,249	**189,249**
Obligations under finance leases	-	**-**
Obligations under PFI and other service concession contracts	6,452	**6,452**
Other borrowings	189	**189**
Trade and other payables excluding non financial liabilities	45,189	**45,189**
Other financial liabilities	2,274	**2,274**
Total at 31 March 2019	**243,353**	**243,353**

Group	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	154,578	**154,578**
Obligations under PFI and other service concession contracts	6,759	**6,759**
Other borrowings	251	**251**
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**

Trust	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	189,249	**189,249**
Obligations under PFI and other service concession contracts	6,452	**6,452**
Other borrowings	189	**189**
Trade and other payables excluding non financial liabilities	44,794	**44,794**
Other financial liabilities	2,274	**2,274**
Provisions under contract		**-**
Total at 31 March 2019	**242,958**	**242,958**

Trust	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	154,578	**154,578**
Obligations under PFI and other service concession contracts	6,759	**6,759**
Other borrowings	251	**251**
Trade and other payables excluding non financial liabilities	51,051	**51,051**
Other financial liabilities	2,437	**2,437**
Total at 31 March 2018	**215,076**	**215,076**

Note 34.4 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 34.5 Maturity of financial liabilities

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
In one year or less	79,130	58,633	78,735	56,379
In more than one year but not more than two years	71,464	27,708	71,464	27,708
In more than two years but not more than five years	51,705	82,271	51,705	82,271
In more than five years	41,054	48,718	41,054	48,718
Total	**243,353**	**217,330**	**242,958**	**215,076**

Note 35 Losses and special payments

Group and trust	2018/19 Total number of cases	2018/19 Total value of cases	2017/18 Total number of cases	2017/18 Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	-	15	15
Fruitless payments	-	-	1	832
Bad debts and claims abandoned	2	3	252	41
Stores losses and damage to property	13	147	14	268
Total losses	**16**	**150**	**282**	**1,156**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	330
Ex-gratia payments	41	58	40	42
Total special payments	**41**	**58**	**41**	**372**
Total losses and special payments	**57**	**208**	**323**	**1,528**
Compensation payments received		-		-

Cases over £300,000

The Trust has no case of Losses and Special Payments in year that exceed £300,000.

Note 36 Gifts

The value of Gifts did not exceed £300,000 in year

Note 37.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £208k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £253k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,852k.

Note 37.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

We estimated the impact of the implementation of IFRS 15 on the accounts as an increase of £1,623k.

Note 38 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 2018-19 the Trust received £1559k (2017-18 £787k) from the charity. 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 £246k (2017-18 £0) receivable balance from the charity at the end of either financial year.

Note 39 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 40 Prior period adjustments (Trust only)

Statement of comprehensive income:

	As previously stated in 2017/18 audited Accounts	As stated in 2018/19 Accounts	Total PPA Adjustment
	31 Mar 2018	31 Mar 2018	31 Mar 2018
	£000	£000	£000
Operating income from patient care activities	376,213	376,213	-
Other operating income	31,955	43,492	11,537
Operating expenses	(432,175)	(443,712)	(11,537)
Operating surplus/(deficit) from continuing operations	**(24,007)**	**(24,007)**	**-**
Finance income	32	32	-
Finance expenses	(4,620)	(4,620)	-
PDC dividends payable	(418)	(418)	-
Net finance costs	**(5,006)**	**(5,006)**	**-**
Surplus / (deficit) for the year	**(29,013)**	**(29,013)**	**-**

The prior period adjustment relate to the Trust accounts due to consolidation adjustment error. No impact on the deficit position or the reserve of the Trust for 2017-18

Note 41 Better Payment Practice code

	2018/19	2018/19	2017/18	2017/18
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	73,130	194,482	67,111	193,911
Total non-NHS trade invoices paid within target	47,581	132,188	45,370	133,927
Percentage of non-NHS trade invoices paid within target	65.1%	68.0%	67.6%	69.1%
NHS Payables				
Total NHS trade invoices paid in the year	2,346	34,512	2,183	32,875
Total NHS trade invoices paid within target	1,533	23,948	1,394	16,031
Percentage of NHS trade invoices paid within target	65.3%	69.4%	63.9%	48.8%

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 13

Note 42 External financing

The Trust is given an external financing limit against which it is permitted to underspend

	2018/19	2017/18
	£000	**£000**
Cash flow financing	34,947	31,153
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**34,947**	**31,153**
External financing limit (EFL)	34,950	34,366
Under / (over) spend against EFL	**3**	**3,213**

Note 43 Capital Resource Limit

	2018/19	2017/18
	£000	**£000**
Gross capital expenditure	19,543	13,109
Less: Donated and granted capital additions	(664)	(201)
Charge against Capital Resource Limit	**18,879**	**12,908**
Capital Resource Limit	18,889	13,195
Under / (over) spend against CRL	**10**	**287**

Note 44 Breakeven duty financial performance

	2018/19
	£000
Surplus / (Deficit) for the period	(13,572)
Add back all I&E impairments / (reversals)	395
Remove capital donations / grants I&E impact	(366)
Breakeven duty financial performance surplus / (deficit)	**(13,543)**

Note 45 Breakeven duty rolling assessment

	to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,500	3,328	3,568	532	109	(3,613)	(16,226)	(29,533)	(24,424)	(13,543)
Breakeven duty cumulative position	1,825	4,325	7,653	11,221	11,753	11,862	8,249	(7,977)	(37,510)	(61,934)	(75,477)
Operating income		331,312	340,309	346,402	350,543	365,313	376,050	384,712	411,870	420,968	444,903
Cumulative breakeven position as a percentage of operating income		1.3%	2.2%	3.2%	3.4%	3.2%	2.2%	(2.1%)	(9.1%)	(14.7%)	(17.0%)