East and North Hertfordshire
NHS Trust

Annual Report and Accounts
2021/22

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 2021/22.

After another eventful year in the NHS where many have continued to see the pandemic impact on their work and home lives, I wanted to share some of our highlights and achievements.

A royal seal of approval

In July 2021 the Trust hosted her Royal Highness the Princess Royal as she presented the Lister Butterfly Service with the Queen's Award for Voluntary Service. The Princess Royal met with volunteers to thank them personally for their service.

We are so grateful to our volunteers who have continued to provide invaluable support to our patients and staff during the pandemic – I know many of you had to be more flexible, and our new rapid response volunteer roles reflect this – providing support to services at short notice.

A warm welcome to our new volunteers, and we look forward to welcoming those back who were unable to attend while restrictions were in place. We hope to be working with you for many years to come.

A new leader

I was really pleased to start the year by welcoming Adam Sewell-Jones as our new Chief Executive, following a wide and thorough recruitment process after Nick Carver announced his retirement.

Adam was most recently Chief Executive of Newham University Hospital and Group Director at Barts Health NHS Trust, and held executive roles at Monitor, NHS Improvement and Basildon and Thurrock Hospital. I'm pleased that the transition has gone so smoothly and I'd like to once again thank Nick for his leadership of the Trust for almost 19 years and for everything he achieved for our patients and staff.

Working together for patients

I'm encouraged by the ever-closer working with our health and social care partners both in our local east and north Hertfordshire area, and in the Hertfordshire and West Essex Integrated Care System (ICS).

I'm looking forward to the ICS reaching statutory footing, allowing us to deliver increasingly joined up care for our communities.

We know it's going to be another busy year ahead. We will continue to support our staff, and to ensure that we use learning from the last two years about using technology better and working more closely with our partners. We want to ensure that our care is as high quality, effective, and efficient as possible.

Thank you

Finally, I know it's been another incredibly tough year, for our patients and our staff, as we continue to feel the impact of the pandemic. We are so incredibly grateful for our community support as you donated over £1.3m to our hospitals' charity last year. And to those patients waiting for procedures, please know that we are all working incredibly hard to reduce our waiting lists as soon as we can, using all the tools at our disposal.

As we move out of the pandemic and restrictions are relaxed, I want to thank our staff who have worked tirelessly to care for our patients. We held a thank you week last July including food and wellbeing events – and a commemoration for those we lost to COVID and we plan to hold another such event this year.

I know that by working together we can achieve great things for our patients and the communities we serve.

Ellen Schroder

Chair

Performance Overview

The purpose of this section of the report is to provide summary information regarding the Trust, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. This section includes:

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

The second section of the performance report provides more detailed analysis of the Trust's performance over the period.

The financial performance figures included in this report relate to the Trust as a single entity and do not materially differ to the Group.

Chief Executive's Statement

I'd like to thank everyone who works at the Trust for their incredible hard work over the last year, through the second half of the pandemic. I know what an impact the pandemic has had, not only professionally but personally for so many. Thank you.

I'm also grateful for being welcomed so warmly to the Trust. I've spent a large part of my first months here meeting as many people and teams as I can, and I've not failed to be impressed at every turn by the commitment to delivering the best possible services for our patients and our community.

Of course, the retrospective nature of this report covers the time of Nick Carver's tenure at the Trust, and I'd also like to thank him for his leadership during the last 19 years.

I'd also like to welcome Lucy Davies to the board as chief operating officer, as we said farewell to Julie Smith who has taken up the post of chief executive at Ashford and St Peter's Hospitals NHS Foundation Trust.

High-quality, compassionate care for our patients

As we move into the next phase of the pandemic, it's clear our focus is on not only continuing to treat patients who have COVID (and the infection prevention challenges that also presents for other patients) but to restore and increase our services and treat those who are waiting for treatment.

I'm pleased to report that our elective recovery continues at pace, with more day cases taking place than in 2019-20, and increasing numbers of elective procedures. The number of outpatient appointments also exceeds pre-pandemic numbers.

However, we know that we need to reduce the number of people waiting too long for treatment. Several initiatives are in place including extra theatre sessions and efficiencies.

We should also this year see the fruits of an extensive £37m capital investment in 2021-22 including:

- 3 new procedure rooms for minor day-case procedures
- development of a community diagnostic hub at the New QEII Hospital allowing for quicker diagnoses

- purchase of a third surgical robot meaning shorter recovery times for patients
- £3.5m to begin the refurbishment of the ward block at Lister

Improving our urgent and emergency care services is key as we continue to see increased demand to pre-pandemic numbers. Refurbishment of the emergency department at Lister will see more space for triage and assessment, and improved facilities for those in mental health crisis.

Our cancer performance remains among the best in the country, ending 2021-22 exceeding 6 out of 8 of the cancer standards.

And our mortality rate remains amongst the lowest quartile in the country, including for deaths from COVID.

Our people

The experience and wellbeing of our staff remains paramount, and while staff absence during the pandemic has undoubtably had an impact, it's reassuring to see absence rates improving. Focused work on supporting staff with musculo-skeletal issues and mental ill-health has seen a positive reduction in sickness absence for these reasons.

The results of the staff survey and the regular people pulse survey will continue to inform improvements for our staff across the Trust and I'm committed to working with our staff, particularly around the areas of bullying and harassment, and Freedom to Speak Up. Indeed in February we welcomed Sylvia Gomes as our first dedicated full-time Freedom to Speak Up Guardian.

We continue to provide mental health and wellbeing support for staff, both as a Trust and through our partners.

The journey ahead

It's clear that with current pressures on our services and our staff as we increase our service delivery that we need to begin to deliver services differently. Virtual appointments will continue where appropriate, and we will continue to harness technology to drive efficient, high quality services to benefit our patients.

A refresh of our strategic vision, mission and themes will provide our direction, and refreshed values will provide a framework for how we work together in the Trust, with our patients, and with our partners.

Adam Sewell-Jones
Chief Executive
24 June 2022

About the Trust

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; the New Queen Elizabeth Hospital II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, within the London Borough of Hillingdon.

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 an urgent care centre. Hertford County also provides outpatient and diagnostic services. The Mount Vernon cancer centre provides tertiary cancer services including radiotherapy, chemotherapy and immunology 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 owned by the Hillingdon Hospitals NHS Foundation Trust.

The area served by the Trust for acute hospital care covers a population of just over 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 three million people from across Hertfordshire, Bedfordshire, Luton, 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. Since 2018, the Trust has seen a consistent reduction in mortality, with rates that are lower than our national peers.

The birth rate is slightly lower than the England average, with the Trust's core catchment population forecast to rise by approximately 6% in the years to 2030; the most significant growth is expected in people aged 65 and over (25%) with this age group also more 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. In addition, it is expected that just under 17,000 new houses are planned to be built in the Trust's core catchment area by 2030.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 6,500 staff are employed by the Trust. The Trust's annual turnover is approximately £578.5 million.

Organisational Structure

The Trust has two operational Divisions: Planned Care, and Unplanned Care. Each division has a Divisional Medical Director, who is a senior clinician, and an operational Director. Planned Care has a Divisional Nursing and Quality Director; Unplanned Care has a Divisional Nursing and Quality Director and a Director of Midwifery.

Supporting the clinical divisions are corporate teams covering areas including: finance and planning, digital; medical practice, education and research; nursing practice; strategy; estates and facilities; transformation, and workforce and organisational development.

Hertfordshire and West Essex ICS

East and North Hertfordshire NHS Trust is part of the Hertfordshire and West Essex Integrated Care System (ICS), with the ICS due to take on statutory responsibilities for the strategic commissioning of healthcare in the area from July 2022. Within the ICS, the Trust is actively collaborating with colleagues in other health and care organisations through being an active partner in the east and north Hertfordshire Health and Care Partnership (HCP).

Through the work of the HCP, the Trust is involved in projects to ensure that services and care are co-ordinated and integrated for our local population, which includes the development of a Hospital at Home service to support people to be cared for safely at home. The Trust is also working with other hospitals within the ICS to deliver care for our patients, including collaboration to create a vascular hub on the Lister site.

Further information can be found on the ICS's website: https://www.healthierfuture.org.uk/.

Strategy overview and objectives

The Trust's vision is "Proud to deliver high-quality, compassionate care to our community".

The Trust has five Strategic Priorities:

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

These are underpinned by our PIVOT values: **Putting** patients first; striving for excellence and continuous **improvement**; **valuing** everybody; being **open** and honest; and working as a **team**.

As with 2020/21, 2021/22 was impacted by, and needed to respond to the COVID pandemic, with a change of focus for clinical and operational teams throughout the year.

Streaming of patients continued at the front door of the Emergency Department (ED) to keep non-COVID and confirmed or potential COVID patients separate from each other and to reduce the risk of infection. Critical care capacity was increased, and wards switched from a

specialty focus to concentrate on care of patients with COVID, while staff were flexed into new areas and ways of working, as and when required.

System partners helped each other with projects to reduce attendances and admissions into the acute setting, and processes to enable patients to be quickly and safely discharged when it was appropriate were established.

Work did continue as far as possible on the Mount Vernon Cancer Centre (MVCC) Strategic Review, led by NHS England (NHSE). This work is in response to the Trust's strategic decision that the future of the MVCC was best served by becoming part of a tertiary cancer centre. University College Hospitals London (UCLH) was selected in January 2020 as the preferred provider by a panel of stakeholders following expressions of interest. Work has continued throughout 2021/22 with UCLH, the Trust, NHSE and key stakeholders, including HealthWatch, to develop a recommended future clinical model for MVCC, which best meets future patient and service needs. Due diligence assessment has taken place. UCLH put in an Expression of Interest for capital funding as part of the New Hospitals Programme, for the re-provision of the cancer services at the Watford General Hospital site. This also included funding for networked radiotherapy in the north of the MVCC catchment – improving access to radiotherapy for patients in the north of the MVCC catchment areas has been a long-term strategic objective of the Trust. A decision on the capital funding has not yet been made.

The future change of ownership of MVCC prompted consideration of a new cancer strategy to continue to develop and provide innovative, high quality cancer services from the Lister and other sites, such as the New QEII, as well as a focus on enhancing rapid diagnostic services. The new Cancer Strategy was signed off by Cancer Board in February 2022, with delivery planned over the next five years. Additionally, the Trust was successful in securing capital and revenue funding to establish the Community Diagnostic Hub at the New QEII hospital, with further investment and expansion of services planned for 2022/23.

In 2021/22, we established the new Hertfordshire and West Essex Vascular Surgery Network, working with our partner organisations in West Hertfordshire and Harlow to improve the resilience and quality of vascular care for our communities. We plan to commence building a hybrid theatre at Lister in 2022/23.

Renal patients in the Luton area also benefited from the relocation of the renal dialysis unit, away from the Luton & Dunstable University Hospital to a nearby facility, giving a purpose-built space, with additional chair capacity, enhanced multi-disciplinary team and clinical areas, and easy car parking.

We also continued to invest in our robotic surgery programme, with expansion into colorectal, gynaecological, and head and neck specialties. The Trust now has three robots, benefiting patients by better access to less invasive surgery, with improved recovery and outcomes.

The Trust has continued to work with system partners more locally through the East & North Hertfordshire Integrated Care Partnership (ICP). This reinforces the Trust's commitment to play a leading role in working with our partners to develop integrated pathways of care for our local community and collaborate to find ways to enhance corporate efficiency and reduce back-office costs. The ICP Partnership Board includes representation from our county council, primary care and mental health colleagues, who will together oversee the strategic development of the ICP, informed by input from our people, patients and community. This will be a key focus of our work over the coming years building on the excellent system-wide response to the COVID pandemic.

Strategy and Values refresh

During 2021/22, the Trust has undertaken an extensive refresh of its strategy, including a bottom-up review of service ambitions and a strategic review of the Trust's vision, mission and strategic objectives. This work will be concluded during 2022/23. The Trust is also in the process of refreshing its values, which will be reported in next year's annual report.

Our 2021/22 objectives

The Trust identified nine key objectives for 2021/22 designed to support delivery of our strategic priorities. All nine were partially achieved, with progress being made despite further waves of COVID throughout the year. These are summarised in the figures below.

Our 2022/23 Objectives

The Trust's 2022/23 priorities are very much focussed on playing a leading role in supporting our local recovery from the pandemic, re-establishing services, whilst providing the best possible support for our staff. Alongside this we will continue to work collaboratively with our partners to innovate, improve and integrate the way we care for our community in order to provide high quality, sustainable and compassionate services that we and our community can be proud of.

The national and local healthcare environment within which the East and North Hertfordshire NHS Trust (ENHT) operates is changing rapidly and its significant impacts are already being felt. The ongoing impact of the COVID pandemic is of course a key element, with recovery to, and in excess of, 2019 activity levels, a key focus. The reorganisation of health systems at all levels in the NHS continues to gather pace, as does the large-scale infrastructure and

build projects at provider sites near to us, such as West Hertfordshire Hospitals NHS Trust (WHHT), Princess Alexandra Hospitals NHS Trust (PAH) and Luton & Dunstable University Hospital. The reshaping of the Trust's service portfolio with the expected transfer of the Mount Vernon Cancer Centre to UCLH will also represent a significant change.

As a result, the Trust will undertake a strategy refresh during 2022/23. This refresh project will ensure that we are able to understand and adapt to the changes we can see around us, develop appropriate responses to mitigate risks and maximise opportunities.

It will be a year of change as the ICS works to become a statutory body, with finances allocated at a system level rather than directly to the Trust. With reduced budgets the Trust will also need to have a renewed focus on efficiency. Work with the East and North Hertfordshire Integrated Care Partnership will also continue to be key, reviewing patient pathways and making our services across the system easier to use.

Throughout 2022/23 the Trust will continue to work with Specialised Commissioners, UCLH and stakeholders to ensure the sustainability and safe transfer of cancer services provided by the MVCC, maintaining services at, or near, the current Mount Vernon site with a commitment not to reduce access for patients.

Further detail on the risks associated with achieving the Trust's objectives is provided within the Annual Governance Statement.

Performance Appraisal

2021/22 was a year where the COVID pandemic continued to have a significant impact on all aspects of the Trust's performance. Broadly in line with the national trend, the Trust experienced increased operational pressures during COVID pandemic waves, with periods of reduced COVID activity in between. During this time, the Trust initiated plans to restore services and began to address the demand that had accumulated as a result of the required pausing of certain services. The Trust maintained a command control structure throughout the period in line with business continuity arrangements and returned to business as usual arrangements as soon as was safe and appropriate to do so.

The key performance headlines from the year are:

Financial performance:

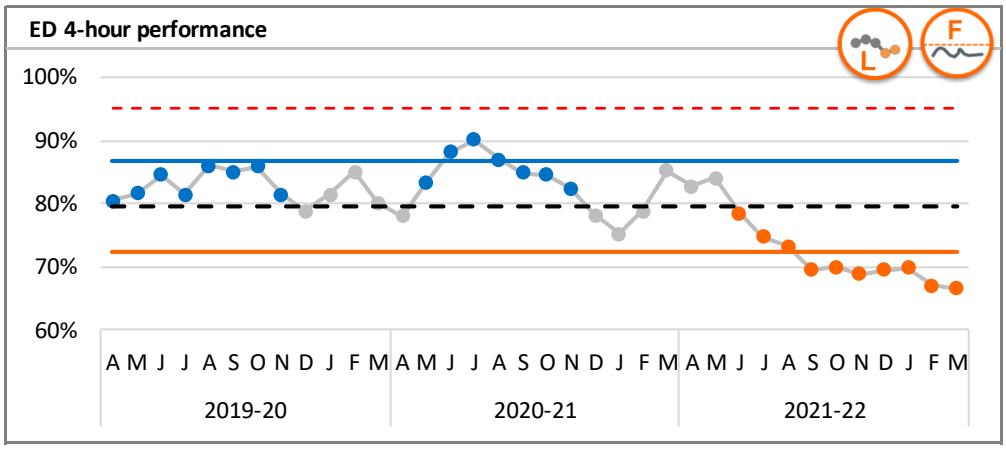
- As was the case in 2020/21, NHS England / Improvement (NHSE / I) attempted to remove financial barriers and burdens that could impede the NHS's continuing response to the pandemic but also introduced targets and incentives to accelerate the recovery of elective services.
- At year end, East and North Hertfordshire NHS Trust reported a deficit before technical adjustments of £0.6m.
- Including technical adjustments, the Trust reported a surplus of £0.4m against a planned deficit of £0.4m.

Operational performance:

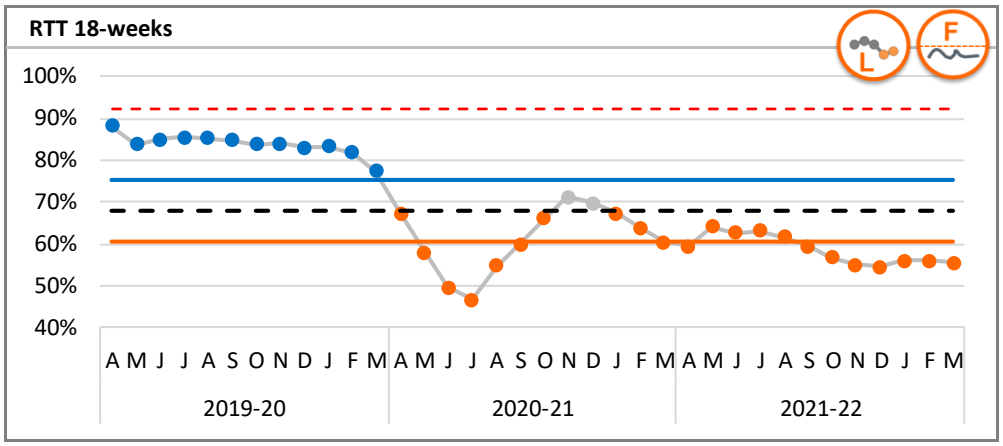
- In response to the COVID pandemic, the Trust reconfigured services and wards to provide COVID and Non COVID areas for patients, within the emergency department, assessment areas and across the wards. All minor injuries and illnesses were redirected to the Urgent Care Centre at the New QEII Hospital to support these reconfigurations. The Trust also increased capacity in the Critical Care Unit and

worked in partnership with the independent sector to continue to treat urgent and cancer patients.

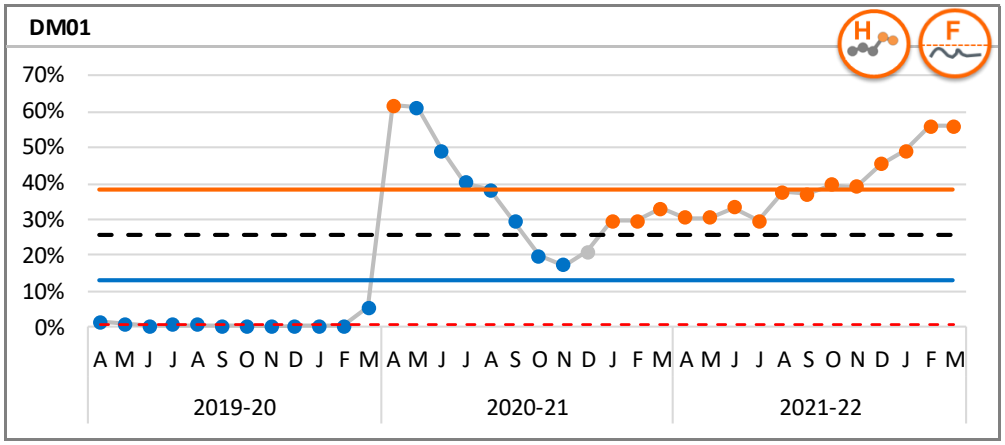
- All surge capacity has been filed away or 'flatpacked' to ensure that the detailed response to COVID demand and the resultant service capacity can re – emerge in response to triggers, so that the organisation remains responsive to any potential and subsequent surges.
- Performance against the key operational standards should be considered in the context of the unique challenges posed by the pandemic. The year-end performance was as follows:
    - Emergency Department (ED) Performance – the four hour wait time year-end performance was 72.78%, 10% lower compared to 2019/20 year end.



    - Cancer performance was sustained over the course of 2021/22. Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards.
    - Referral to Treatment (RTT) performance was below the national average, though it is recognised that waiting times increased substantially as a result of the COVID pandemic.

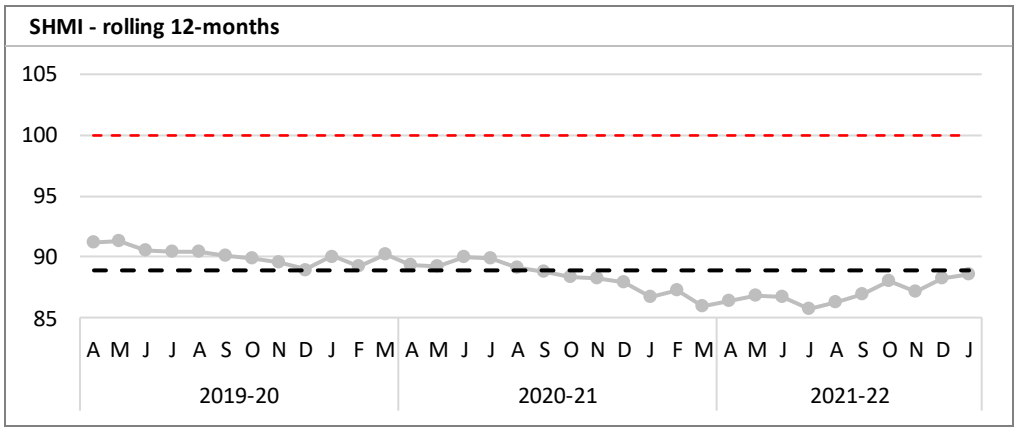


    - DM01 (no more than 1% of patients should wait for a diagnostic test; measured against of the patients waiting at the end of the month, every month). Diagnostics performance was lower than national average performance and reduced in-year due to the ongoing impact of the COVID pandemic.

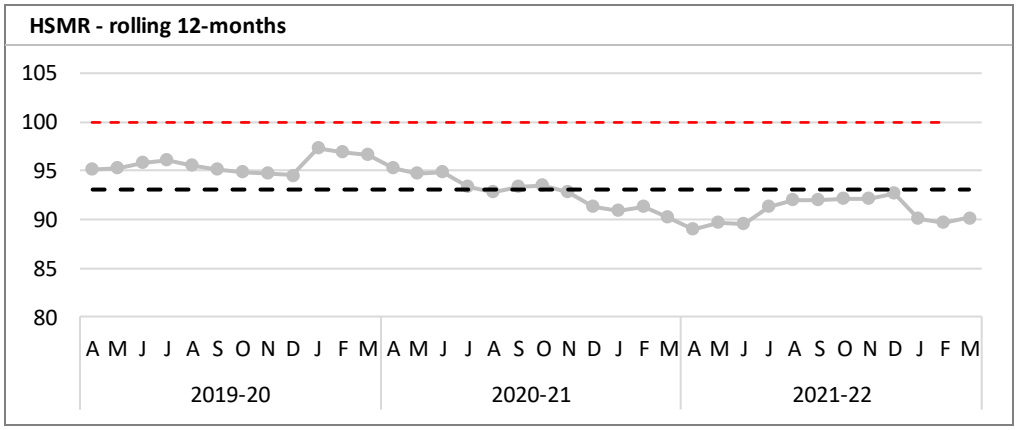


Quality and safety performance:

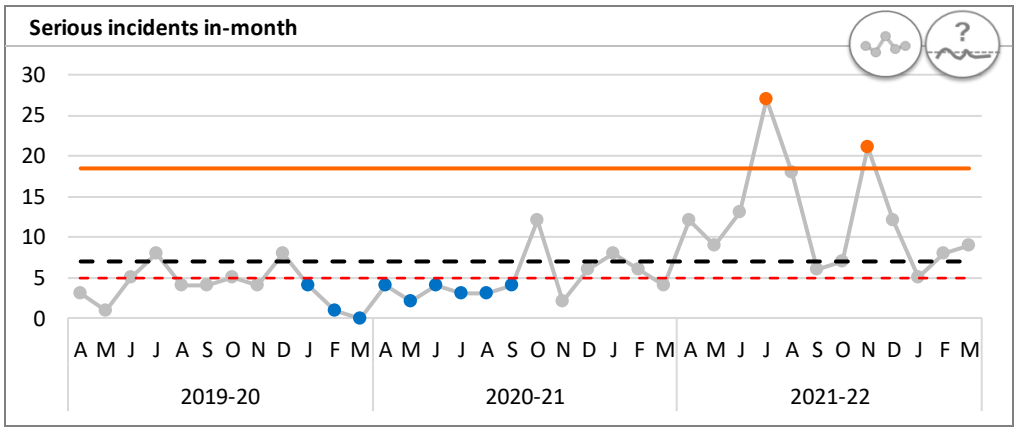
- The Trust continued to implement a range of safety and quality interventions in response to the COVID pandemic. It is recognised that there was a significant risk to the delivery of high-quality care during these periods, particularly an increased risk associated with staffing pressures and ongoing high operational activity.
- The Trust treated 1609 patients with COVID across the period.
- In terms of the Trust's mortality performance over the period, this remained favourable when benchmarked:
    - Summary Hospital-level Mortality Indicator (SHMI) – 0.8858 for the 12 months to January 2022, which places the Trust within Band 3, the 'lower than expected' range. Our position relative to our national peers stood at 13th out of all acute non-specialist Trusts (121).



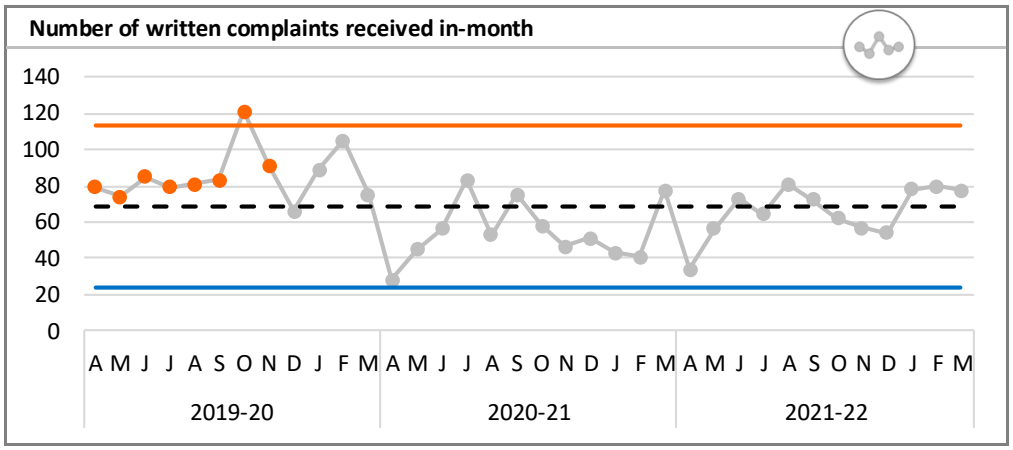
    - Hospital Standardised Mortality Ratio (HSMR) – 90.15 for the 12 months to March 2022, which statistically is in the second lowest/best quartile of Trusts. (Further information regarding the mortality metrics is provided in the performance analysis section below).



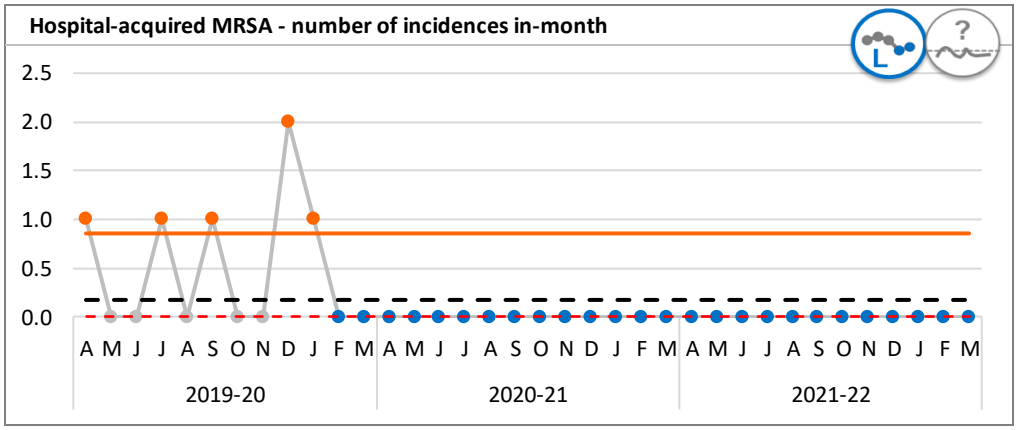
- 147 serious incidents were reported (55 in 2020/21) including five never events (3 in 2020/21). See the quality performance section for more information.



- In 2021/22, 777 formal complaints were received across all services (from 654 in 2020/21) within the Trust, and 3614 PALS enquiries (from 2930 PALS 2020/21).

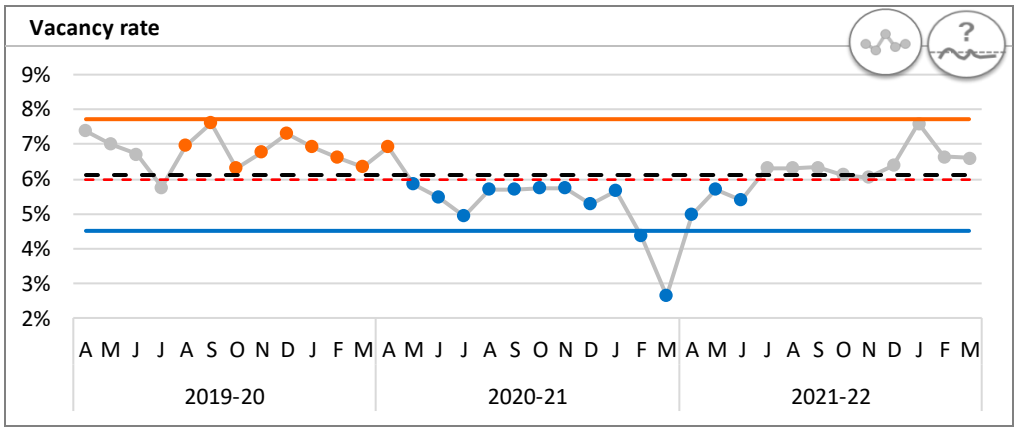


- Zero MRSA cases for the second year in a row.

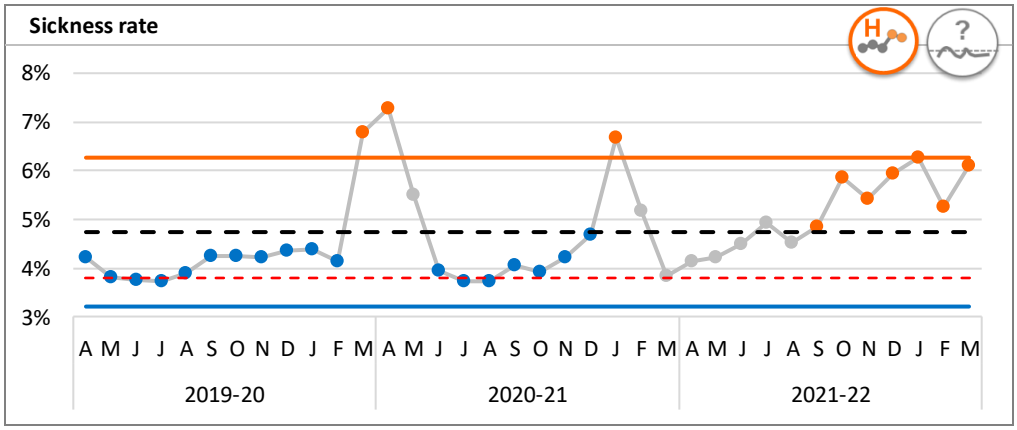


People performance:

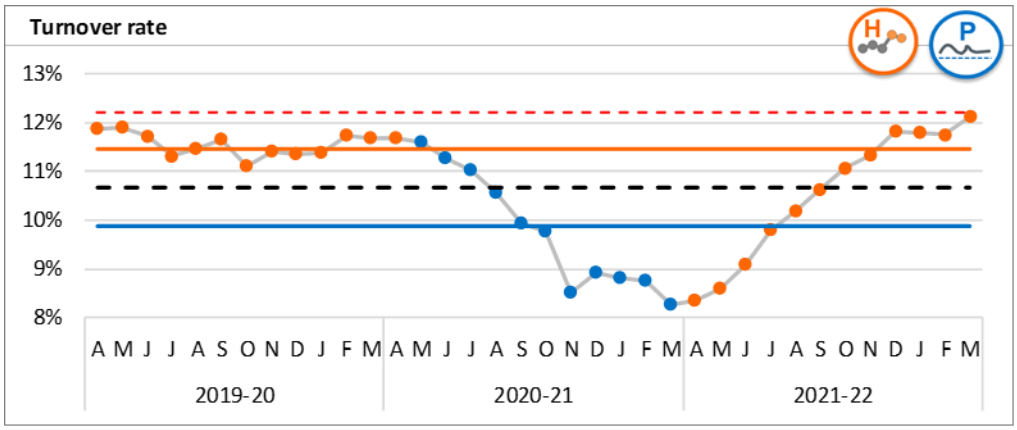
- Over the year there has been a relentless focus on ensuring there are enough people in the right roles at the right time. By the end of the year the Trust had a 6.6% vacancy overall but achieved a 3.4% vacancy for qualified nursing and midwifery and 2% for medical and dental.



- Despite higher levels of turnover in the last year the Trust ended the year with an increase of 50 whole time equivalent nurses and 36 whole time equivalent medical staff.
- The Trust made maximum use of its flexible (bank) workforce with an average of 85% of filled shifts covered be bank staff. Agency workforce overall was kept to a minimum and end the year £1.1m under its control total.
- Sickness absence averaged at 5.2% and increased in line with the peaks of when COVID was most prevalent within the community. However, the number of days lost to sickness absence due to musculoskeletal issues has reduced throughout the last year, and by March 2022 was 31% lower than March 2021.



- The days lost due to sickness caused by stress and mental health issues has significantly decreased since October 2021 and is currently 9.4% lower than March 2021. This demonstrates that the interventions to protect and promote mental health and wellbeing are having a positive effect. However, promoting mental wellbeing must continue given days lost due to sickness absence related to stress and mental health issues in 2021-2022 remains 36% higher than pre-pandemic levels in 2019-2020.
- Turnover rates have shown a steady increase since March 2021. However, this reflects pre-pandemic levels, with the underlying turnover rate at 10.2% at the end of the year. Improving staff retention remains a key priority for the Trust.



Statement on adopting Going Concern basis

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

In accordance with IAS 1 (the requirements for presentation, structure and content of financial statements), management has made an assessment of the Trust's ability to continue as a going concern. In making this assessment management has taken into account the Trust's income and expenditure plan for 2022/23, which is to break-even, and the current cash position of the Trust. The Trust's current cash plan for 2022/23 is not reliant on Department of Health and Social Care (DHSC) funding for cash financing with a forecast cash balance of £49m at 31st March 2023. The Board concludes there to be no material uncertainty around going concern for the period to 30 June 2023.

In light of these considerations, and having made appropriate enquiries, the Directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As directed by the Department of Health and Social Care Group Accounting Manual 2021/22, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future in the public sector. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Performance Analysis

This section provides a more detailed analysis and explanation of the performance of the Trust during the year. Information covered includes:

- Key performance indicators, including how performance against them is monitored and their link to risk and uncertainties.
- An in-depth review of the Trust's clinical, quality and safety, operational, financial and workforce performance.
- Statements relating to social matters (human rights, anti-corruption and anti-bribery matters).
- A sustainability summary statement.

Key performance indicators

The Trust's key performance metrics are collated on a monthly basis into an 'integrated performance report', which is reviewed by the Board and a number of its subcommittees. This report allows effective triangulation between the data from different parts of the organisation. Ultimately, the Trust's key metrics are those that demonstrate quality and safety performance (such as infection prevention and control, incidents and complaints data), operational performance (including national performance standards such as the ED 4 hour standard and referral to treatment targets), financial performance (month end position against plan and the factors affecting that performance) and workforce performance metrics (including recruitment and retention rates, training and appraisals compliance and staff survey responses).

Risks in relation to achieving these targets are recorded and monitored through the Trust's risk management process, and ultimately the Board Assurance Framework if it is deemed that there is a risk to the Trust's strategic objectives.

Delivery against our Trust objectives

Summary information about the delivery against the Trust's 2021/22 objectives can be found in the strategy and objectives sections earlier in the report.

Care Quality Commission

The Trust 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 CQC has not taken enforcement action against the Trust during 2021/22. The following conditions remain on the Trust's registration following the 2019 Inspection:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The Trust has participated in special reviews or investigations by the CQC during 2021/22 relating to the following areas; the system wide Children and Young People Provider Collaborative Review and a speciality investigation which was closed without any action following CQC's review of the Trust's information.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. During the COVID pandemic, the CQC changed and evolved their approach to regulating. This new approach has ensured the CQC has had oversight of our Trust and services. The Direct Monitoring Approach focused on safety, how effectively a service is led and how easily people can access the service.

In 2021/2022 the CQC held the following virtual reviews:

- under the Transition Monitoring Approach:
  - Medicine Core Service (MVCC), April 2021
  - Medicine Pharmacy Engagement call, June 2021
  - Outpatients Core Service (MVCC), June 2021
  - Maternity Core Service (Lister), July 2021
  - Outpatients Core Service (Lister and QEII), August 2021
  - End of Life Core Service, August 2021
  - Diagnostic Services, December 2021
  - Children & Young People Service, April 2022

All the reviews were positively received, and no follow up information was requested.

To support these reviews with the Care Quality Commission each core service developed a gap analysis against the streamlined key lines of enquiry, including any gaps and mitigating actions.

An action plan was developed with the teams against all of these requirements and was submitted to the CQC in January 2020. 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 sustained delivery a new Compliance and Risk Framework has been developed and approved by the Quality and Safety Committee.

During 2021/22 we continued to adapt our compliance framework. We have continued a streamlined programme of audits and reviews to support monitoring of compliance against standards, including retesting our previous actions from inspection. In April 2021 we formally recommenced our internal unannounced inspections to the clinical areas. These are held jointly with our Clinical Commissioning Group (CCG). In addition, the pathways to excellence programme support providing assurance on the continued progress against the fundamental standards in ward areas.

In-depth performance review

This section of the annual report sets out in more detail the Trust's performance in 2021/22 in relation to key areas including clinical, operational, financial and workforce performance.

Quality and Safety

The Trust has implemented multiple safety and quality interventions in response to the national pandemic incident. It has been recognised there has been a significant risk to delivering high quality care during these periods, particularly an increased risk associated with staffing pressures and ongoing high operational activity.

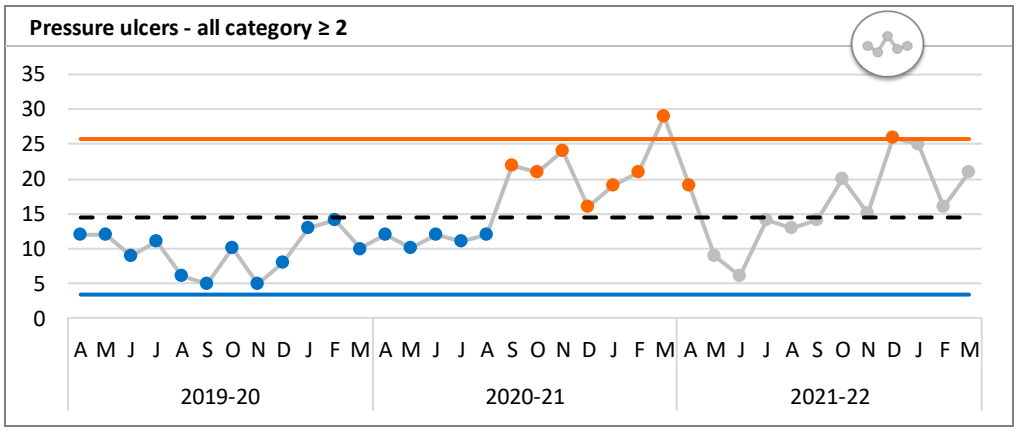
Financial Year	# IP Falls	Change from the previous year	% trend	Falls with Serious Harm
2019-2020	747			14
2020-2021	652	-95	12.72% ↓	11
2021-2022	672	+20	3.07% ↑	19

New staffing models were introduced at several points throughout the year in response to significant pandemic surges, supported with rapid deployment of upskilling programmes to support staff deployment to work in unfamiliar areas as safely as possible.

The following subsections look in more detail at some specific areas of focus in relation to quality and safety:

1. **Reducing pressure ulcers**

The Trust has reported 205 Hospital Acquired Pressure Ulcers (HAPU) for 2021/22 which is a 12.7% reduction on our previous year's data.



Every HAPU is investigated by a Tissue Viability Nurse (TVN) to enable identification of gaps in care so that learning can be identified and improvements delivered. A Root Cause Analysis (RCA) investigation is performed at the time of validation and outcomes are fed back directly to ward staff. Our most prevalent themes are reduced skin inspection (24.4%) and repositioning (19%). One category 4 PU was escalated for Serious Incident investigation in 2021/22.

The Trust has seen a reduction in medical device related pressure ulcers within critical care, from 56 in 2020/21 to 37 in 2021/22, as a result of the quality improvement projects and increased awareness of quality improvement methodology.

The Tissue Viability Team have identified 3 priorities for improvement work over the coming year.

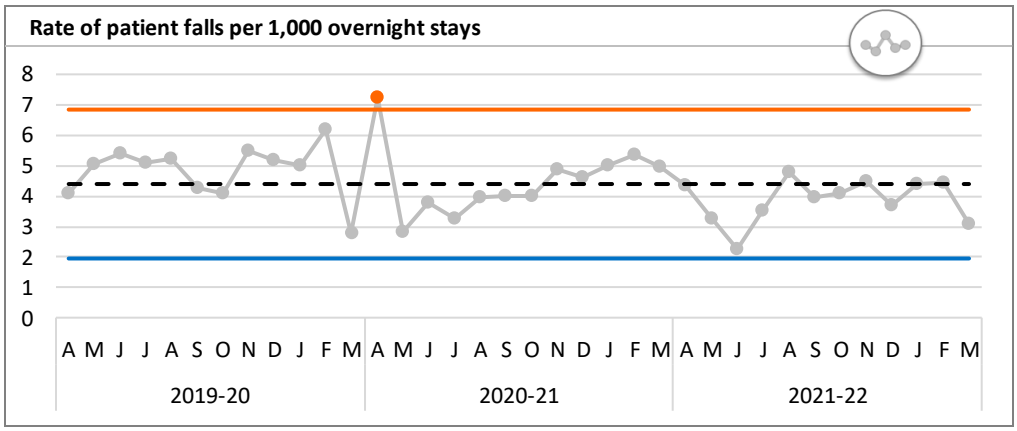
1. To sustain the reduction in medical device related pressure ulcers within critical care

2. To improve the quality of repositioning care on general wards in collaboration with the clinical practice team
3. To improve the quality of SSKIN (Surface, Skin inspection, Keep moving, Incontinence, and Nutrition) care documentation to facilitate delivery of care across the Trust. (This was paused during 2021/22 due to the impending implementation of a new digital care planning system)

2. Preventing inpatient falls

The Trust has an average falls rate of 3.78 per 1000 bed days which is lower than the previous year (4.30). This represents a 12.01% falls rate reduction from the previous year, despite a slight increase in the number of falls (see below). We continue to record a significantly lower falls rate compared to the national average of 6.6 (NHSI).

During 2021/22 there were 672 inpatient falls. This represents a 3.07% increase when compared to 2020/21. However, this needs to be interpreted in the context that the Trust has also seen an increase of 18.71% occupied bed days compared to the previous year. Preventing falls remains a Trust priority.



3. Mortality rates and learning from deaths

Mortality rates

The Trust continues to work hard on minimising mortality and learning from deaths, which can be seen in the two key performance indicators:

- Hospital Standardised Mortality Ratio (HSMR) – 90.15 for the 12 months to March 2022, which statistically is in the second lowest/best quartile of Trusts.
- Summary Hospital-level Mortality Indicator (SHMI) – 0.8858 for the 12 months to January 2022, which places the Trust within Band 3, the 'lower than expected' range. In the January 2021 data release, the Trust achieved a Band 3 ranking for the first time since the inception of the SHMI metric in 2010. Our position relative to our national peers stood at 13th out of all acute non-specialist Trusts (121).

The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

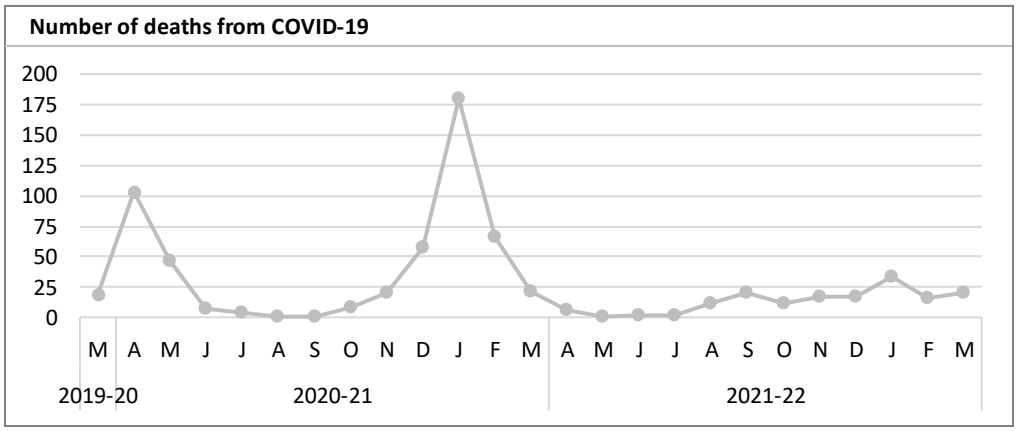
COVID

The multi-layered effects of the COVID pandemic have made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and

case-mix have varied during the pandemic. The Trust's position has been closely aligned with national peers for both spells and deaths reported with COVID:

The Trust's reported number of COVID deaths for the year 2021/22 are as follows:

COVID Deaths 1 Apr-21 to 31 Mar-22	Definition
160	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publicly reported mortality rates.
139	Patients who had a laboratory-confirmed positive COVID test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.



Learning from deaths

The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

While our mortality rates have remained strong, it has been increasingly recognised that while monitoring these rates has a role to play in mortality governance, there is limited correlation between them and the quality of care provided by organisations.

In order to learn from deaths and improve the quality of our care, we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life. We have reviewed our current processes and are currently introducing a number of reforms which we believe will build on the solid mortality review processes already embedded at the Trust, enabling us to further improve our learning framework and subsequently the quality of the care we provide.

Central to this work is the adoption of the Structured Judgement Review Plus format for review, developed by the "Better Tomorrow" team. "Better Tomorrow" is a new collaborative initiative hosted on the FutureNHS platform, whose aim is "To support effective learning from deaths in order to improve care for the living". Additionally, its reporting approach has been designed in collaboration with NHSE's Making Data Count team and aligns with wider Trust data reporting initiatives. While the COVID pandemic slowed the pace of reform, the project is now well under way, with adoption of the new process schedule for summer 2022.

4. Serious Incidents and Never Events

During 2021-22, the Trust formally declared 147 Serious Incidents (SIs). The total number of SIs was an increase from the previous year (55) but a significant proportion of this increase

was attributable to the hospital onset hospital acquired COVID cases being declared as SIs, which was a new requirement from 2021. 57 SIs were Hospital acquired COVID cases. Of the 147 cases, 5 were 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. All the Never Events were classified as minimum to no harm. Four of the five never events were cases of wrong site surgery. It is of note that they related to different specialties. The fifth case concerned a retained dressing following surgery.

The Never Events were investigated by a dedicated team of patient safety managers working in collaboration with Trust staff to identify causes and learning. The findings have informed a range of quality improvement projects including:

- All affected areas have implemented changes to their procedures and Local Safety Standard for Invasive Procedures (LocSSIPS). Changes have been made to department inductions about LocSSIPS following these events.
- Plans to develop a 12-month rolling programme for invasive procedural teams to access, where they can consider and map 'Human Factors Contributory Factors' across their local invasive procedures.
- Within Planned Care, a programme of simulation training across theatres is planned in recognition of the Human Factors elements influencing Never Events.
- There will be monthly live sessions focussing on debriefs, the World Health Organisation (WHO) checklist, situational awareness and ensuring learning is cascaded across the surgical and theatre teams.
- Plans are also in progress for a Patient Safety Day on 23 September 2022.

Improving reliability of safety checks across invasive procedures pathways remains a quality improvement priority for 2022/23.

Adult and children's safeguarding services

Safeguarding adults and children remains an integral priority of patient care within the Trust, and The Trust continues to undertake its duties under the statutory frameworks of the Care Act (2014), Children's Act (1989 and 2004), Working Together to Safeguard Children (2018) and the Mental Capacity Act (2005)

Safeguarding is most effectively delivered through strategic and organisational multi-agency arrangements with key partners working collaboratively to achieve a shared vision. The Trust safeguarding team, along with the Chief Nurse (as the executive lead for safeguarding) are key members of the Hertfordshire safeguarding boards and partnerships. Work in 2021/22 looked at task and finish groups for sudden unexpected death in infancy, procedure updates, child protection medicals, consent for medical procedures and Children Looked After (CLA).

The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels under guidance of the intercollegiate documents for children and adults. The current safeguarding training is designed to ensure that every member of staff is aware of their safeguarding responsibilities, is able to recognise abuse, and knows the response required to act upon the concern. The Safeguarding Training passport for level 3 safeguarding children continues to be embedded in practice, and the adult level 3 passport was launched, offering the same blended learning opportunities to safeguarding practice.

Learning from case reviews continued with work around medical neglect, bruising, and professional curiosity.

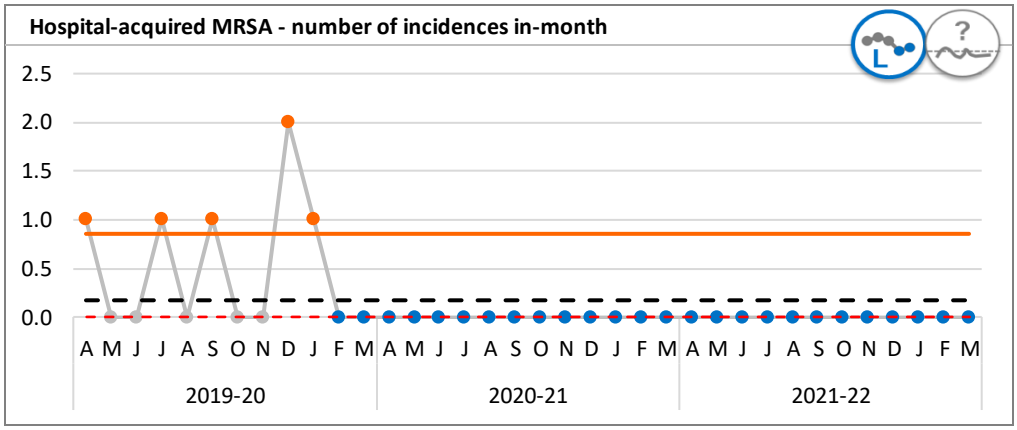
The Trust has continued to receive positive reviews from the Clinical Commissioning Group (CCG) in its annual adult assurance and children's compliance against section 11 of the Children's Act (2004) visit.

5. Infection prevention and control

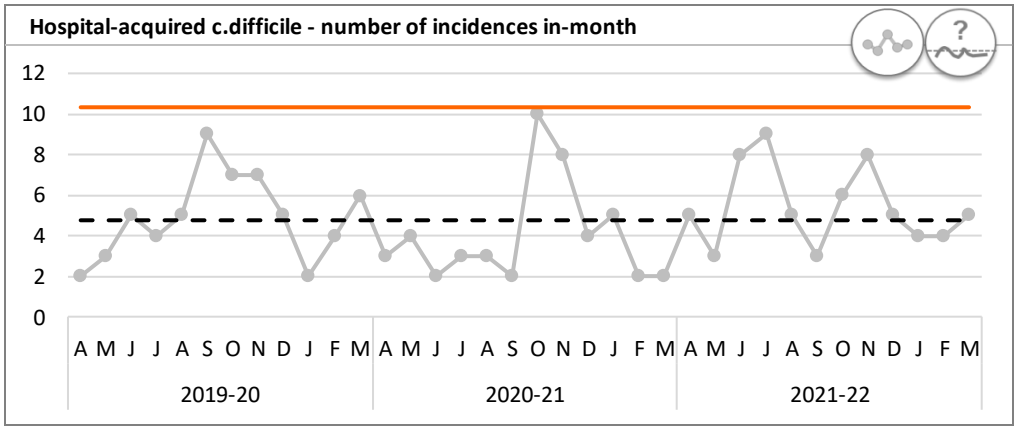
COVID Infection and Prevention Control (IPC) has continued to be a fundamental Trust focus in 2021/22.

For non-COVID related key infection control performance indicators for 2021/22:

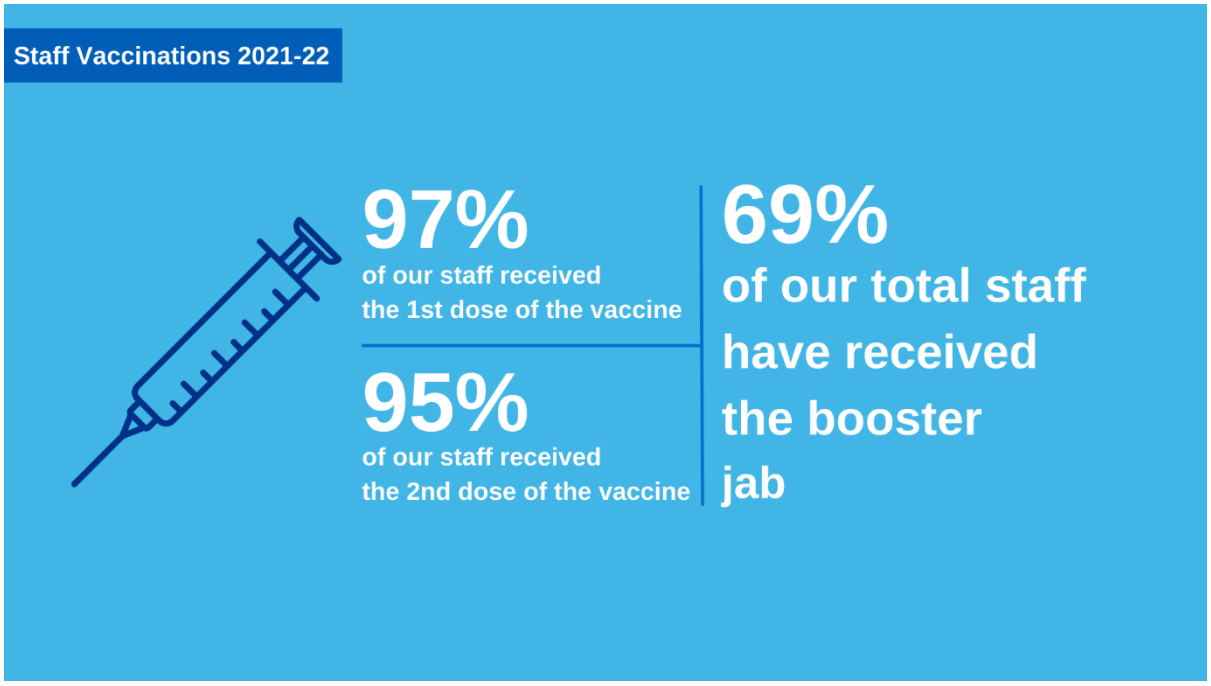
- The Trust reported a total of 0 hospital onset MRSA bacteraemia (blood infections) for the second year in a row.



- Trust-allocated cases of Clostridium Difficile infections – 59 against a ceiling of 52 (40 cases in 2020/21).



- The Trust reported 3 cases of 'Flu through winter of 2021/22.



Patient Experience

In 2021/22 19,733 patients responded to our friends and family test (FFT) survey. 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.

Throughout 2021/22 visiting has been restricted due to the pandemic to end of life family members and where carer support has been required for vulnerable adults e.g. dementia, delirium and learning disability patients. Visiting has been supported through introduction of a family liaison service and a virtual keeping in touch service.

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 Programme Board (PACE programme) which includes patient and carer representatives.

We continue to aim to provide patients and their carers with the best possible experience whilst they are using the Trust's services. Key themes from our patient advisory liaison service are related to delays in care/treatments and poor communication.

The aim of the programme board is to drive continuous improvement and focus on doing what matters most to our patients, carers and our teams. Going forward a key objective is to build an infrastructure that supports how staff learn from examples of excellence and develop meaningful partnership and co-design working through ensuring patient and family feedback is shared with direct care giving teams.

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

- A co-production shared decision-making council is being set up – this will measure the number of projects and programme that involve service users as part of the project delivery group.

- Volunteers continued to support patients across the hospital. The roles of rapid response volunteers were set up as a response to COVID for teams to request various kinds of team support from a volunteer on the day.
- The What Matters to you team facilitated 1945 virtual visits in 26 clinical areas and had global reach to 18 countries outside of England. The team also delivered 2322 messages and 2447 photos to patients from families and friends.
- In 2021/22, 777 formal complaints were received across all services (from 654 in 2020/21) within the Trust, and 3614 PALS enquiries (from 2930 PALS 2020/21).

Operational Performance

A summary of performance against the key metrics is provided below:

- **A&E** (the target is for 95% of patients seen, treated and either admitted or discharged within four hours of arrival)

In year, the monthly performance figure ranged from 84.06% (May 21) to 66.64% (March 22). There was a circa 54% increase in the number of attendances. Infection, prevention and control processes implemented in ED during the pandemic continued in 2021/22, including the separation of patients into COVID and non COVID areas. The changes ensured that the Trust was compliant with infection, prevention, and control standards, by supporting the reduction of microbial infections. The reconfiguration has continued to impact on the operational efficiency of the Trust and wider NHS.

- **Cancer performance** (eight national standards)

Cancer performance was sustained over the course of 2021/22. The 62-day cancer target was achieved for all months except for December 2021, and our performance against this standard remains one of the best regionally and nationally. Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards.

Standard	Target	Trust Performance
Two week waits: Suspected cancer	93%	97.16%
Two week waits: Breast symptomatic	93%	96.63%
31-day: First definitive treatment	96%	97.26%
31-day subsequent treatment: Anti-cancer drugs	98%	99.73%
31-day subsequent treatment: Radiotherapy	94%	99.06%
31-day subsequent treatment: Surgery	94%	88.66%
62-day: GP referral to treatment	85%	86.75%
62-day: Specialist screening service	90%	79.32%

- **18-weeks referral to treatment** (RTT)

RTT performance in 2021/22 was below the national average. The year-end position was 55.82%. The number of patients waiting over 52 weeks and those waiting over 104 weeks have both increased as a result of our response to the COVID pandemic. To support the Trust's response to COVID, staff were redeployed and there was a need to free up essential capacity. This required a reduction in elective activity although most cancer services were maintained. During the second COVID surge the lessons learned from the first wave were re-enacted as part of a 'flat packing' process, resulting in a more balanced response, with cancer and outpatients continuing as expected with a smaller reduction in surgical and diagnostic activity.

The Trust achieved the set percentages for elective activity recovery. A comprehensive demand and capacity review has been completed and a recovery plan is in place to restore services to pre-pandemic levels.

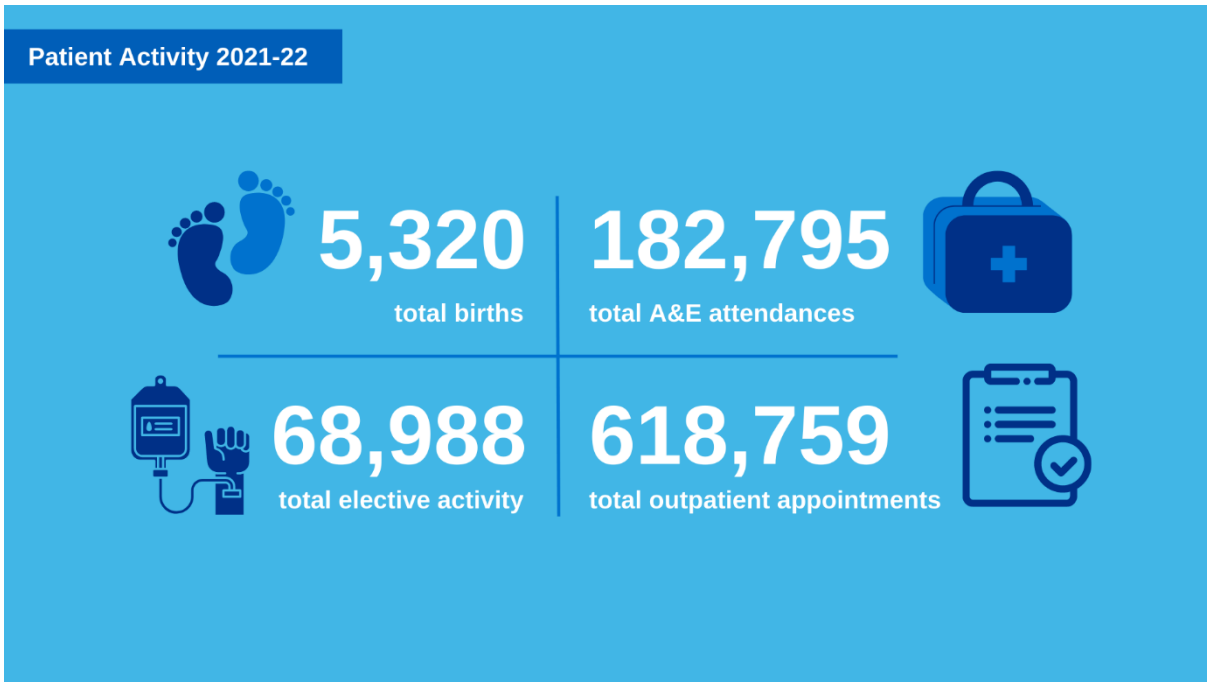
- **Diagnostics (DM01)** (less than 1% of patients should wait 6 weeks or more for a diagnostics test)

The Diagnostics performance (45.14% against the 1% target) was lower than national average performance, and this reduced in-year due to the ongoing impact of COVID incident management which saw a reduction in routine diagnostic activity. Diagnostic recovery focuses on delivering maximum productivity from the available diagnostic resources, supported by fundamental demand and capacity modelling work.

- **Stroke performance**

Stroke performance continued to be negatively impacted during the pandemic and this contributed to a further deterioration of performance. During Quarter 1 2021/22, the Trust's SSNAP grade reduced from C to D. A recovery plan and road map were developed, led by the clinical teams and performance returned to C in Quarter 3 21/22. Plans included fast tracking the diagnostic pathway and ensuring capacity on the wards. Following the development of the plan, performance has started to improve. However, it is recognised that whilst there has been an improvement in performance, the Trust remains some way short of the national target.

Patient Activity 2021/22:



Financial Performance

The Trust reported a deficit before technical adjustments of £0.6 million. Including technical adjustments, the Trust reported a surplus of £0.4 million against a planned deficit of £0.4 million.

The Trust's financial performance during 2021/22 needs to be set within the context of the overall NHS COVID pandemic funding framework. As was the case in the preceding year NHS England / Improvement (NHSE / I) acted to remove financial barriers and burdens that could impede the NHS's continuing response to the pandemic and associated recovery arrangements.

Within this framework NHS providers continued to receive fixed block allocations of core funding that were further supplemented by specific additional COVID allocations. This additional supplement was intended to allow the Trust to mitigate against anticipated pandemic impacts, including income shortfalls, compliance with enhanced infection control measures and to support increased levels of staff absences impacting upon operational performance. For the Trust in 2021/22 specific COVID funding totalled £28.2 million.

The 2021/22 financial framework also made provision for NHS providers to access additional allocations in order to cover the costs of initiatives to recover the levels of elective activity delivered. This was facilitated through the terms of an Elective Recovery Fund (ERF) mechanism.

Within the parameters of this general framework, it is important to note that the funding arrangements in place were marginally different across the first (H1) and second (H2) halves of the financial year.

For the first 6 months of this financial year Integrated Care Systems (ICS), of which the Trust is part of the Hertfordshire and West Essex ICS, were issued with system funding envelopes to distribute to healthcare providers. These system funding envelopes were cascaded to Trusts in the form of block contracts, the basis of which was the Trust's financial run-rate for 4 months over the winter 2019/20. This run-rate was extrapolated across a full year and adjusted for inflationary increases, resulting in a very modest efficiency target of 0.28% and the ongoing impact of COVID.

In the latter half of 2021/22 two key elements of the framework did change. The first related to changes of the terms of the Elective Recovery Fund and adjusted the threshold at which additional income could be earned. The second change saw an increase in the efficiency requirement. An additional efficiency of 0.82% was applied to all block contract payments and a targeted reduction was made to individual healthcare systems. This resulted in the Trust having an efficiency target in the second half of the year of 1.2%.

The key features of financial performance during 2021/22 were:

- Income from patient care activities

Income from patient care activities increased from £479.6 million in 2020/21 to £529.9 million in 2021/22 (£50.3 million / a 10.5% increase). This increase was driven by a required reclassification of income directly relating to the pandemic (£28.2 million) and the Trust earning £13.6 million as part of the elective recovery fund initiative described above. The elective recovery fund income was almost wholly earned in the first quarter of 2021/22 and reflected the high levels of elective activity delivered by the Trust at the start of the year in line with the incentive mechanism in place at that point in time.

- COVID lost income

Much Research and Development (R&D) activity was paused and private patient activities within acute hospital settings were suspended at the outset of the pandemic but these income sources began to recover in 2021/22. Total R&D income increased from £3.9 million

in 2020/21 to £5.6 million in 2021/22. The Trusts' catering facilities were restricted to staff only and car parking was initially made free for all staff and visitors (and has remained free for staff since the pandemic began). Changes to rules on visitors and increased footfall in the Trust led to increases in income levels in these areas although not yet to pre-pandemic levels.

- COVID pandemic expenses

The Trust continued to incur significant direct revenue expenditure associated with the pandemic in 2021/22 totalling £28.2 million for the year. This expenditure was incurred through enhanced staffing rotas, backfilling staff that had tested COVID positive or were required to self-isolate, expanded bed capacity, the segregation of patient pathways including the initiation of a red and yellow emergency department, enhanced cleaning and infection control regimes and much more.

- Spend on Pay (including temporary staff)

Pay costs increased year on year by £15.9 million from £328.4 million to £344.3 million. The increase was driven by national pay awards (£9.0 million) and increased costs (£7.2 million) due to increased activity across the Trust year-on-year (offset by a small reduction in COVID related spend). Expenditure on temporary staff increased year on year by £2.1 million from £41.1 million to £43.2 million. This was driven by increased bank and agency costs as activity increased and the Trust continued to manage significant levels of staff absences as a result of the pandemic.

- Spend on non-pay (excluding financing costs)

Expenditure on non-pay (excluding financing costs) increased year on year by £25.4 million from £201.7 million to £227.1 million. The largest component of the increase related to an increase in dilapidations at a number of properties the Trust leases including the Mount Vernon Cancer Centre and Renal satellite units. There were further increases relating to Drugs which was both price and volume driven.

- PPE impact

A major impact of the pandemic has been the increase in the use of personal protective equipment (PPE). From an early stage of the pandemic the Department of Health and Social Care (DHSC) decided that PPE would be purchased centrally and 'pushed' out to healthcare organisations daily on a needs basis. This continued in 2021/22 and will continue until at least 31 March 2023. The Trust was required to account for the cost of this PPE in its accounts, with matching income to offset, thereby meaning a nil effect on the Trust's bottom line in year. The cost of PPE donated to the Trust by the DHSC was £1.8 million.

- Capital investment / donated equipment

The Trust expended £37.4 million on capital investments in 2021/22. This represents a further marked increase from recent years. Significant investments were made completing the refurbishment of the emergency department (£9.0 million), across medical equipment (£5.2 million) and within our digital environment (£6.9 million).

- Cash

The Trust's cash balance has increased by £32.5 million from £52.5 million to £84.9 million. The increase in cash has been driven by an increase in accruals and provisions, which are

expected to crystallise in 2022/23. In addition, the Trust has continued to work hard to reduce its level of outstanding debts.

People Performance

The Trust continues to deliver against the key objective set out within is people strategy and the four pillars of: work, grow, thrive and care.

Work Together

Recruitment

During 2021/22, the Trust worked tirelessly to recruit to vacancies across all staff-groups and ends the year with an overall vacancy rate of 6.6%. There were successes in both the Nursing & Midwifery qualified and Medical staff groups, with a 3.4% and 2% respective vacancy rate.

This was achieved through a mixture of standard recruitment activity and international nurse recruitment. International nurse recruitment has increased significantly due to diversifying roles and by operating an exceptional support and onboarding programme which has now been adopted across the Integrated Care System (ICS).

Overall, the Trust has seen a net increase of 50 whole time equivalent (WTE) qualified nurses and 35 WTE doctors throughout 2021/22 which is a significant achievement in what continued to be a challenging pandemic environment.

Ensuring our recruitment practices are fully inclusive are a key priority for the Trust. Through the implementation of our inclusion ambassador scheme we are ensuring, equity and accessibility to roles, and to champion equality, diversity and inclusion throughout the

selection process. We have also been focused on improving the selection process for consultants with a greater focus on values in the selection process.

Temporary Staffing

Demand for temporary staffing increased by 6% compared to the previous financial year. This was due to the higher levels of absence and increased service demands due to COVID. However, agency spend remained £1.1m below NHSE/I agency ceiling targets despite another challenging year. Bank spend (as % of total WTE spend) averaged at 9.7% across 2021/22, which was just below the target of 10%. Agency spend (as % of total WTE spend) also averaged under the target for 2021/22 at 3.3%. The Trust ranked first (best-performing) for agency spend across the ICS region for 2021/22. Overall bank fill rate performance averaged at 85% across the year.

The Trust hosts a temporary staffing division across the ICS ensuring consistent governance processes and procedures are in place, along with transparent cost controls focusing on all staff-groups.

Electronic Rostering

Currently 82% of clinical staff are on the e-roster, there are ambitions to have all staff, including Medical on a roster by March 2023 providing a holistic overview across the organisation and supporting better deployment and decision making.

The Trust procured new medical rostering software in Quarter 4 (Q4) and will begin implementation in early Q1 of 2022/23 resulting in all medical staff on e-rostering software by March 2023.

Medical Workforce

The Trust has engaged in bringing in a new e-job planning system to improve our ability to conduct flexible team job planning in all clinical departments. This will also include detailed reporting that allows the Trust to accurately assess the senior clinical workforce levels in terms of workload, productivity, flexibility, and personal development options with a view to creating a 'Centre of Excellence' for Job Planning by 2024.

The Local Clinical Excellence Awards for 2021/22 were deployed as per national guidance and paid in March 2022 to all eligible consultants.

Grow together

Clinical Education

The People team continue to focus on supporting the increase in the numbers of registered nurses in the organisation. Educational placement capacity for students continues to increase, including the numbers of International nurses undergoing training to register with the Nursing and Midwifery Council.

In 2021/22 we saw an Increase in our Clinical Support Workers intake with approximately 115 clinical support workers undertaking apprenticeships at the Trust in 2021/22. We expect this number to continue to increase by similarly in 2022/23. With our international recruitment offer in nursing roles, our 2021/22 recruitment target of 100 international nurses will be achieved this year with a target to recruit a further 100 by March 2023. The Trust has evidenced a high clinical examination (OSCE) pass rate for this cohort of staff, with approximately 85% achieving Nursing & Midwifery registration (pin) at the first attempt.

The Trust continued to prioritise its Nurse Associate programme in 2021/22 as the main route of supporting career pathways into qualified Nursing roles, with an intake of approximately 50 staff annually across Degree Nurse and Student Nurse Programmes. This is a successful programme and in the last year three of our staff, student Nurses and their teams have been nominated for a Student Nursing Times awards for 2022.

Medical Education

The Trust hosts placements for 4th year Cambridge, 5th year University College London (UCL) and Cambridge and final year UCL and Cambridge medical students. The feedback for teaching at the Trust continues to be exceptional. Students consistently rate the Trust above other Trusts. In addition, many medical students choose to become foundation trainees at the Trust.

In the last year, as in the first wave of the pandemic, medical students volunteered to provide support in ward areas as part of the Trust's COVID response. The students were able to provide continuity of care and were a vital part of the team. Feedback from the students that have been able to volunteer has been positive.

Statutory and Mandatory training

The Trust continues to develop the use of a single Learning Management System (LMS), the ENH Academy, as the main area to access for all mandatory training including booking any face-to-face learning sessions. As part of the Trust's pandemic response, since June 2020, wherever possible, statutory and mandatory training was moved online or delivered through a blended webinar approach. This has allowed staff access to essential learning resources to keep the Trust's patients and people safe.

Appraisal and Talent Management

Grow Together is our approach to establishing continuous feedback to colleagues through a range of processes to help identify learning requirements, agree objectives and support everyone to fulfil their potential. The process culminates each year with 'Grow Together Review' becoming the appraisal. First launched in 2020 in line with regional and national work on career conversations and in 2021 a digital recording version utilising the ENH Academy was implemented. The Trust recognises the importance of continuous improvement for individuals and for processes and so Grow Together has listened and taken action to develop the process. An updated and improved version was launched on 1st April 2022.

Talent Review Forums have commenced over the year and the insight from Grow Together reviews is utilised to inform succession planning aligned to individual aspirations and potential. The process of Talent Forums is adapting continuously to respond to the organisation, ensure information from Grow Together is accessed and to reflect the national work under way on talent, career conversations and succession.

Leadership Development

Leadership development of colleagues throughout the organisation continued to adapt as the situation changed during 2021/22. The pandemic has emphasised how wellbeing and leadership are bound together and we have grown our leadership portfolio offer to reflect this.

Models connecting both leadership and wellbeing have been developed and been shared across the Trust and the wider system. Our *Care Support Pyramid* is a model that brings together working conditions, leadership approaches and wellbeing as an integrated approach. The *Healthy Leadership Rhythm* creates a series of required leadership, team and culture initiatives and establishes them as concurrent practices with the delivery of our services.

Apprenticeships and Widening Participation

The team is working on increasing the number of apprentices across the Trust. In 2021/22 the Trust had over 250 staff undertaking apprenticeships both in clinical and in non-clinical roles. These include Quality Improvement and degree and postgraduate level apprenticeships, to support leadership development and developing core and functional skills including digital innovation.

Thrive Together

Retention

The overall turnover rate in March 2022 was 14% with the average being 12.9% for the whole year. Turnover has consistently increased since March 2021 when the turnover rate was the lowest it had been for many years at 7%. The current turnover rate is more in line with pre-pandemic rates and is consistent with the regional and national trends. The main reasons for leaving remained consistent with the previous year with 24% of staff stating voluntary resignation (other), Relocation (12%) and Work/life Balance (11%).

Staff survey

Following 2020 and 2021 staff survey responses we worked to better promote staff wellbeing and engagement through the winter pressure period with several new initiatives. Each scheme provided for staff aimed to improve direct staff experience and wellbeing. The schemes included sending a seasonal greetings cards to all staff from the Board, an all staff prize draw to win a food hamper, a make a workplace wish campaign, a range of free refreshments and beverages for staff through the winter period, time to talk initiatives and continuation of work on the hygiene factors project.

Inclusion and engagement

Civility Matters is a tool to improve inclusion and recognition of differences. Alongside this, throughout the year the Freedom To Speak Up (FTSU) Guardian ran several listening sessions and was instrumental in identifying and supporting resolution of concerns raised by staff.

A full time FTSU Guardian commenced in role in February 2022 bringing wider capacity to continue this important work and to ensure as a Trust we continue to build and create a safe place to work where staff can and do speak up about things that cause them worry or concern. In the coming year FTSU champions will be identified and developed to support the FTSU work and areas of focus.

The Trust focused on increased representation both in leadership and in decision making. Over the last two years the percentage of Black, Asian and minority ethnic colleges in roles 8a and above has increase from 17% to 22%. Equally, with a workforce where 33% of its people are from a BAME background, there is still further work to be done.

The Trust have 5 thriving staff networks including Black, Asian, and minority ethnic (BAME), Lesbian, gay, bisexual, transgender, questioning plus (LGBTQ+), Women's, Disability and Carers. The networks continue to influence decision making, support policy development and provide a key support network for our people. With the networks, the Trust has celebrated the diversity of its people in all its forms including international nursing day, black history month, Hertfordshire pride, disability history month and international women's day.

Flexible Working

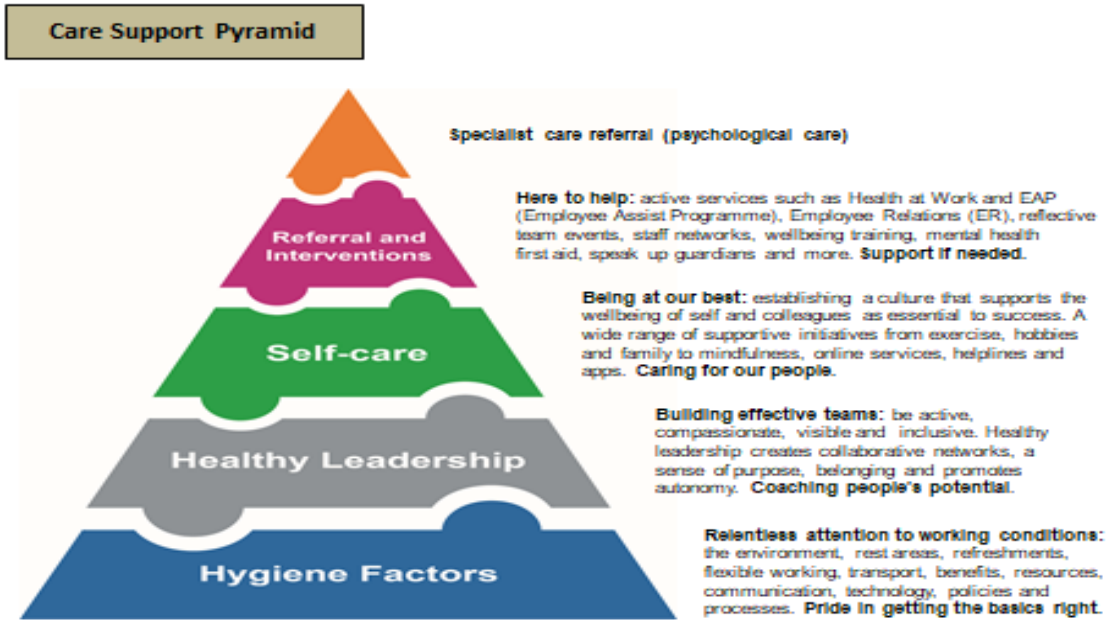
Whilst the pandemic and winter pressures delayed progress, we have continued to encourage managers to take an inclusive approach in reviewing and accommodating, where possible, flexible working requests. We have a robust appeal process for staff to use, to ensure equity of reviews where requests are declined by managers and overall this is working well in the Trust.

During 2021 groundwork on upskilling members of the people through participating in Timewise took place and these staff are now our 'Flex for the Future' team, they are tasked with defining the organisational direction on flexible working with development of a programme of work.

Care Together

Care Support Pyramid

The Care Support Pyramid model is adapted from Maslow's Hierachy[1] of needs as a practical engagement tool enabling managers and staff to understand levels of engagement and support needed to retain health and wellbeing in the workplace. The model has been well received and has been adopted at regional and national level within the NHS.



Over the last year, to ensure the 'hygiene' factors are better met, work was undertaken to increase engagement, including generating thanking staff schemes through award badges,

[1] A conceptual model of human motivation developed by the American behavioral scientist Abraham Maslow in 1954

greeting cards of recognition as well as running a make a wish scheme. In this case, teams or staff could make a wish for a small item that would make a difference to their area of work, from a toaster, a radio or microwave to comfortable furniture for break out areas. The Charity supported funding requests and all wishes were granted which will begin to roll out, completing in May 2022.

Healthy Team Leadership sessions are run regularly with leadership and front-line teams, arising from a range of qualitative and quantitative measures, in recognition of the need to improve how things operate. The interventions include a series of bite size sessions exploring relationships, inclusion, good management practice and engagement to ensure everyone's voice is heard. The sessions are well received by participants and in 2022/23 we will measure differences in staff survey results in areas that have benefitted from health leadership interventions.

Health at Work

The Health and Wellbeing service experienced an increase in referrals and has thus been integral over the last year in providing clear guidance and support to all staff in relation to COVID and the ever-developing guidance and testing requirements. The service has been instrumental in enabling the Trust to deliver its vaccination programmes for its staff, achieving a vaccination take up of 63% for flu, 95% for first and second doses of COVID and 89% for boosters. The ease of access, as well as good information and support has been essential.
In the past year we have developed 66 Mental Health first aiders to support and appropriately signpost colleagues for help with mental wellbeing and there is a monthly mental health first aiders' network meeting chaired by The Head of Health at Work to facilitate peer support.

The mental health hub ***'Here for You'*** provides staff with free confidential access to 24 hours, 7 days a week telephone support, signposting to appropriate support and fast track access to specialist psychological services when required including counselling, psychotherapy and trauma therapy for those experiencing post-traumatic stress disorder. For the coming year the Trust plans to focus on increasing events where teams and individuals may benefit from debriefs to acknowledge and address the signs of burnout at work, given service demands continue to remain higher than pre-pandemic levels.

Health at work undertook specific interventions in areas with high absence levels to ensure mechanisms and adjustments were in place to support people returning to work. Associated work included all wards and departments being encouraged to nominate wellbeing champions and there are now over 50 in place.

East and North Hertfordshire Hospitals Charity

2021/22 was another exceptional year for the East and North Hertfordshire Hospitals' Charity thanks to the incredible generosity, kindness and hard work of supporters, volunteers, colleagues and benefactors. Despite visiting restrictions being in place for much of the year, the highlights include: The Butterfly Volunteers being presented with the Queen's Award for Voluntary service by Her Royal Highness The Princess Royal; a week long staff thank you event; new celebrity supporters; a rebrand, and the launch of a £440k capital appeal to create new outside spaces for staff and patients.

Digital performance

The Digital programme benefited from a number of National funding streams in 21/22 including the Front-line digitisation and elective recover fund which allowed significant progress in the strategy to focus on supporting Clinical areas in direct patient care.

In the first half of the year The Digital team supported the COVID response by rapidly delivering applications, these included LFT tracking, online patient booking for Blood tests and booking for patient visiting.

The Digital programme is broken down into 3 areas, Keeping our patients safe (KOPS), Evolving our Technology (EOT) and supporting our specialties.

Keeping our patients safe (KOPS)

The KOPS programme is aimed specifically at supporting Clinical teams with direct patient care leveraging value from existing deployed systems. During the year we equipped every Doctor with a smartphone to enable them to receive patient alerts to help react quickly to deteriorating patients along with taking clinical notes at a ward level to save time in transcribing later, also enabling the information to be available to clinical colleagues on-line.

The most significant delivery was the deployment of Electronic Prescribing and Medicines Administration (ePMA) which is live across the whole Trust. This enables Clinicians to prescribe electronically and create patient drugs charts, which is proven across the NHS to reduce prescribing errors and again allow the relevant information to be seen by Clinical colleagues in the care of the patient.

Working with ICS colleagues we have implemented the first phase of a shared care record. This programme is linking up the electronic patient records across the ICS and includes Primary care, Community, Mental health and Acutes and will securely allow clinicians in one organisation to see relevant patient data that may be held elsewhere.

Evolving our technology (EOT)

Any successful deployment of systems requires a robust and stable Infrastructure and End user devices (EUD's). During 21/22 we were awarded £3.6M to address the legacy PC's across our clinical areas. This has included replacing all the screens with dual large monitors to enable Doctors to see Radiology images clearly and significantly increased the number and specification of ward-based PC's. In order to enable quick access, clinical staff can now login in rapidly by using their NHS Smart card; this not only reduces the time to get to the patient record, yet if they move to another screen the patient record follows them.

During the year we started the migration of our Microsoft products to the NHS cloud (N365) which will complete later in 2022. This will ensure that we are able to mitigate Cyber risks along with giving our teams the ability to share documents across the Trust and the wider NHS.

Alongside this, there has been a focus on both our servers and desktop PC's to ensure that they are all up to date with the latest patching standards to further mitigate Cyber risks.

Supporting our specialties

A number of the clinical teams require specialist systems for function that are not covered under a general electronic patient record (EPR). During 21/22 we delivered a system into gastroenterology that connects to the scopes to enable video and picture to be captured and we have started delivery on a new Theatre scheduling system to manage the whole theatre process more efficiently. Supporting the theatre system is a portal that will allow Clinicians to

gain consent from patients and provide information in most cases without the need for the patient to come in before surgery.

Working with Clinical ICS colleagues we have started to implement a Digital system to cover all Maternity functions across the Local Maternity and Neonatal System (LMNS) to allow a joined up view across the ICS.

Digital Strategy

In parallel to the Digital roadmap deliveries, we have been working on our Strategy outline Case (SOC) which will set out the Trust Digital strategy for the next 10 years aligned with the Integrated Business plan (IBP). This will be published later in 2022.

Research and Development

In 2021/22 2,350 patients were recruited to participate in research at the Trust. All research at the Trust is approved by a designated NHS research ethics committee. These 2,350 patients received relevant research-related health services, provided by or sub-contracted by the Trust during 2021/22.

The Trust is part of the National Institute for Health and Care Research (NIHR) and supports research of national and international importance. During 2021/22 the top five areas of highest research activity by participation were: Cancer (775), Theatres (398), Renal (360), Organisational research (242) and Cardiology (172). It is worth noting the increase in research publications over the last two years (184 in 2019, 294 in 2020 and 421 in 2021) and to acknowledge that 42 of these publications in 2021 were jointly written with the University of Hertfordshire, which is an indicator of excellent partnership working.

Helping address the COVID challenge

COVID research at the Trust has directly led to treatment innovations, such as GenOMICC, a large UK-wide study examining genetic susceptibility in critical care patients with COVID. GenOMICC has now found 23 genetic associations and identified a causal role for coagulation factors and platelet activation in critical COVID patients, providing answers for why some people with COVID suffer blood clots. We have also innovated by developing new studies around treating hearing loss as a result of COVID.

In addition to research directly on COVID, we also created novel approaches to dealing with the COVID related backlog of patients requiring treatment. DELTA - integrate**D** diagnostic solution for **E**ar**L**y de**T**ection of oesophageal c**A**ncer, is a project based on the use of the innovative Cytosponge approach - a '*Sponge on a string'* test that samples cells from the oesophagus without the need for gastroscopy.

Cancer research award

The Research team at the Trust were announced as winners of the inaugural Cancer Research Excellence Team Award at the regional 2021 National Institute for Health Research (NIHR) Clinical Research Network (CRN) Cancer Conference.

The Trust's Trust team were recognised for their enormous efforts to ensure cancer research continued in the face of the challenges presented by the pandemic, including offering significant opportunities to patients to take part.

Social matters

Throughout the pandemic, the Trust has continued to communicate with, and involve local communities and partners.

Public membership

The Trust currently has 568 public members – people who have expressed an interest in:

- Being kept informed about the work of the Trust
- Sharing views and feedback with the Trust
- Getting involved in focus groups and service improvement

Over the last year, our members have been involved in projects including:

- Research on data in healthcare
- The Mount Vernon Cancer Services review
- Our patient and carer experience group
- The Trust's annual general meeting in 2021 and related events

The Trust is planning further public engagement throughout 2022/23, harnessing online technology to improvement engagement and access.

Annual General Meeting (AGM) week 2021

The Trust's AGM in 2021 took place once again as a virtual event, during a week of engagement on topics voted on by members and staff.
Over 650 people took part in the online the events over the course of the week, asking questions of speakers. The audience included stakeholders, partner organisations and charities, along with patients, member of the public, and staff.

Topics covered in the engagement webinars included digital innovation, supporting our people, a greener NHS, research and development, and a look at how we are improving our hospitals.

Work with GPs

The Trust continues to deliver a successful GP query helpline, providing a link between primary care and our clinicians.

While the number of GP enquiries dropped significantly during the first wave of the pandemic, calls have increased each month since, and at March 2022 we answered 101 queries, with 98% being answered within the deadline.

Our fortnightly GP email bulletin continues to share service updates, changes, and improvements with our GP community and to seek views on how the Trust could develop further support for GPs.

We also continue to host monthly online patient case forums for GPs to discuss particular anonymised cases with specialty consultants.

Risk Profile

The Trust currently has 12 principal risks defined on the Board Assurance Framework each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified. In 2021, the Board approved two changes to the articulation of risk relating to capital (Risk 4) reflection of the emerging shorter-term risk, and ICP (Risk 6) reflecting wider

ICS emerging structures. The 2022 annual review of the principle risks has commenced to ensure these align with the Trusts new organisational strategy.

At the end of 2021/22 one risk remained rated a ‘20’ (Risk 1: Operational Performance). This compared to two risks rated ‘20’ at the end of 2020/2021 (Risk 4: Capital and Risk 10: Estates and Facilities). These were both reviewed and reduced in June 2021 following discussion at the relevant Board Committee.

Overall in 2021/22, in addition to the reduction of the two risks noted above, a further two risks were reduced:

- Risk 3 (Finance) reduced from a 16 to the target risk of 12 in October 2021, taking into account the current and forecast position and consideration of the H2 planning and CIP guidance.
- Risk 12 (Pandemic) met the target risk in June 2021 and remains rated ‘10’. Trust demonstrated a complaint position against the national standards.

Two risk scores were increased:

- Risk 1 (Operational Performance) was rated a 15 but this increased to 20 in October following discussion at FPPC (Finance, Performance and Planning Committee) regarding the impact of the operational performance, system and recovery challenges. Mitigations and cycle of deep dives in place.
- Risk 11 (Mount Vernon Cancer Centre) was increased from a 12 to 16 in June 2021 due to the risks of the delay to the programme increasing.

Risk 8 (Quality): This risk has remained rated a 15 throughout 2021/22 due to the profile of the issues impacting on the risk changing over the course of the year. This was also supported by a QSC and Board discussion in March 2022.

The Board and its committees receive regular reports on the above to assure that the mitigations are operating (where this is within the Trust’s ability to do so) and that those mitigations are effective or further actions are identified. During 2021/22 the Audit Committee will continue to undertake deep dive reviews of specific risks on the BAF.

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 June 2020.

At the time of writing, the Trust is anticipating reporting an overall outcome of green for the 2021/22 self-assessment against the NHS Counter Fraud Authority Standards; however, this may be subject to change upon submission.

TIAA 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.

Equality of service delivery

The Trust is committed to ensuring equality of service delivery throughout the organisation and also to ensuring the Public sector equality duty is fulfilled more broadly.

Initial analysis of the patient treatment lists undertaken in the year indicated that the ethnicity of patients on the list mirrored that of the local population. This will be re-checked regularly. The Trust has also monitored outcomes in relation to COVID by ethnicity. The initial findings from that analysis have indicated that mortality rates by ethnicity broadly mirror the demographics of the local population.

The Trust established a new Trust Board committee, the Equality and Inclusion Committee (EIC), which focused on the Trust's equality and inclusion agenda for both staff and patients, which met for the first time in May 2021. In May 2022 the Board agreed to establish a new People Committee and merge the EIC with the new People Committee, with the new committee having responsibility for both people (staff) matters and also equality and inclusion to ensure a co-ordinated approach. Additionally, the Kings Fund supported a Trust Board development session regarding equality and diversity in March 2022.

The Trust engaged with colleagues from National, Regional and system partners to address inequalities and eliminate discrimination. We continued to review our policies and procedures as well as mark and celebrate our diversity. Our internal inclusion ambassadors' scheme aims to foster diversity within the Trust at all staff levels.

The Trust is in the process of establishing more robust mechanisms and use of data to monitor and measure performance of our key objectives in relation to action plans derived from the Workforce Disability Equality Standard, Workforce Race Equality Standard, Gender Pay Gap and Equality Delivery System.

Sustainability statement

Sustainability: What have we achieved?

In January 2022 East and North Herts NHS Trust formally adopted its Green Plan (2021-2024), a live strategy outlining our aims, objectives, and delivery plans for sustainable development.

The Green Plan sets out the Trusts' carbon emission reduction targets and resource use reduction targets in line with the Greener NHS 'Net Zero NHS' national ambitions and the UK Climate Change Act (2008).

These targets support the NHS Long Term Plan commitments related to health and the environment, including efforts to tackle climate change, reduce single-use plastics, improve air quality, and minimise waste and water use. We want sustainability to be embedded across all our Trust enabling strategies and operations so that we can effectively deliver on these commitments.

This plan will guide our organisation, staff, suppliers, patients, and communities to take action on sustainability, working together helping to make a difference to reduce our impacts and improve health and social care outcomes.

The Green Plan is anchored around 4 key goals that reflect the ambition and need for action within our Trust. These goals were developed and approved by our Trust's Sustainability Working Group.

Trust Green Plan Goals

1. Increase sustainability awareness
2. Support our community
3. Improve resource efficiency
4. Reduce carbon emissions

The Green Plan Programme – activity is being driven and taken forward via the following eight key work streams:

Corporate approach

Our people

Greenspace and biodiversity

Procurement

Sustainable care models

Estates & facilities

Climate Adaptation

Travel and logistics

Governance is key to the effective implementation of the actions and commitments made in the Green Plan. Everyone within the Trust has a responsibility to ensure the objectives defined in this Green Plan are met.

What we have done already?

Corporate approach

- Created a 3-year Green Plan for 2021 to 2024 which forms our guiding principles.
- Engaged with our staff through a sustainability survey.
- Engaged (and will continue) with the local community and patients to develop schemes which prioritise the needs of the community and generate maximum social value.

Our People

- Established a Trust Sustainability Group who meet monthly to deliver against the Green Plan (membership = over 25 representatives from across the Trust).
- Established active volunteer environmental sustainability group at the Mount Vernon Cancer Centre (MVCC) to assist MVCC and allied organisations in ensuring optimum environmental stewardship and sustainable best possible practices.
- Volunteering hours reached over 60,000 and 87 work experience placements in 2019/20.

Sustainable care models

- Replaced and upgraded 1500 laptops with energy efficient alternatives and have delivered 775 video meetings and 232,750 instant messages throughout the pandemic.
- 250 new virtual desktops have been set up to support virtual clinics and one million patient observations recorded digitally.
- Electronic prescribing has removed the need for a 32 page paper drug chart per inpatient.

Travel and logistics

- Installation of 30 electric vehicle charging points at the Lister Hospital site.
- Digital enabled 1,500 home workers, reducing the need to commute to the hospital this year.
- Car parking policy review – a new policy adopted January 2022.

Asset management and utilities

- Energy saving initiatives including the replacement of fluorescent lights with LEDs in some areas.
- Combined heat and power plant operating reducing grid energy consumption.
- Catering and medical equipment upgrades and replacements with energy efficient alternatives.

Sustainable use of resources

- Reduced disposables in catering through removing plastic straws and introducing recyclable containers and Vegware products.
- Reduced food miles for produce used in meal preparation. Chilled and ambient foods are now delivered in the same transport journey.
- Recycle fluorescent tubes, lamps, batteries, food, and waste electrical and electronic equipment (WEEE waste).

Climate change adaptation

- Emergency Planning Core Standards in 2019 – fully compliant.
- Created a new role, Trust Sustainability Manager, to lead on delivering against our commitments and drive our energy and resource use efficiency.
- Prescribed dry powder inhalers (DOI), which are lower carbon inhalers, over MDI where appropriate. In 2019/20 the Lister site removed the anaesthetic gas, Desflurane for use.

Greenspace and biodiversity

- Charity funded outside space opened in maternity for children in 2019.
- Staff at Mount Vernon Cancer Centre engage with the Nature Recovery Ranger initiatives.
- Initiatives include securing funding to refurbish a woodland walk to upgrade green spaces and improve biodiversity.

Estates compliance

The estates service has achieved a high level of compliance in all critical function areas, delivering against its statutory duty. A robust programme of audit, review and improvement has been implemented on a rolling basis to ensure that all areas are fully compliant, resilient and support safe clinical and operational activity.

Carbon emissions and waste reporting

Climate change poses a major threat to our health as well as our planet. The environment is changing, that change is accelerating. This climate crisis has direct and immediate consequences for our patients, the public and the NHS. The NHS contributes 4-5% of England's carbon footprint and there are significant opportunities to reduce this impact and contribute to the UK national ambition for net zero by 2050.

A number of influencing factors contribute towards our overall footprint. A key impact over the last five years has been the general increase in clinical activity with both Emergency Department and patient admissions. This has an impact throughout the Trust increasing the use of utilities, equipment and travel.

The emissions profile over the last few years is shown in Table 1.

Table 1 – Trust carbon emissions profile showing annual tonnes of CO_2e by scope

Scope	2007/08 Baseline	2016/17	2017/18	2018/19	2019/20	2020/21
Supply chain - procurement, estate, wages etc.	58,231	44,882	44,257	45,159	47,179	45,860
Core – utilities, anaesthetic gas etc.	16,382	12,079	12,249	14,540	19,472[2]	19,958
Travel	8,309	7,875	10,599	10,511	13,522	9,490
Total footprint (tCO_2e)	82,922	64,836	67,105	70,210	80,172	75,308

Please note that the data for 2021/22 was not available at the time of Annual Report finalisation

In terms of next steps, the Trust is in the process of recruiting an energy and sustainability manager. This post's key role will be to manage a diverse range of sustainability projects, utilities consumption and cost, CO2 reduction, behavioural change, compliance, and assurance. In addition, the estates department is planning a Decarbonisation Strategy.

Waste

- Waste disposal and recycling has remained challenging during 2021/2022 because of the COVID pandemic. Clinical waste has increased by 6.11% against 2020/2021 data. Additional PPE required by staff in treating patients with COVID and return to business as usual is believed to have contributed to this. Domestic waste disposed of has increased by 33% against 2020/2021, with recycling having increased by 14.99% against 2020/2021.
- The Domestic waste contract continues to operate on a zero waste to landfill basis, whereby domestic (non-recyclable, non-clinical waste) is treated as refuse derived fuel. Cardboard compaction and recycling resumed during the latter part of 2021, the Trust having rebuilt confidence in the quality of cardboard waste disposed of (i.e., lack of contamination.) There have been some issues with contaminated waste and equipment breakdown on site, meaning that the quantity of recycled waste didn't reach the anticipated level.
- The Trust continues to recycle fluorescent tubes, lamps, batteries, food, and waste electrical and electronic equipment (WEEE waste.)
- Existing waste contracts have been extended to the end of October 2022 to provide an adequate timeline to re-tender all waste streams at the same time; thus, giving the opportunity to investigate the feasibility of a Total Waste Management Service for the Trust. The key driver within the waste specifications is to ensure sustainable contracts enabling waste minimisation, increased recycling and use of technology to avoid the use of landfill where possible.

[2] An anomaly has been identified in utilities consumption for 2019/20

Accountability Report

The accountability report consists of three sections:

- Corporate governance report
- Remuneration and staff report
- Parliamentary accountability and audit report

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

Adam Sewell-Jones, Chief Executive
Date: 24 June 2022

Corporate Governance Report

This part of the annual report consists of:

- The Directors' report
- Statement of the Accountable Officer's responsibilities
- The Governance Statement

Directors' Report

The Trust Board

The Trust Board plays a key role in setting the values, aims and strategic direction for our Trust. They also review our performance against our objectives as well as national targets in areas including quality and safety, operational performance and financial sustainability. It is their responsibility to make sure we have the financial and human resources we need to provide our services. 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. The Board does this by:

- Playing a central role in defining and then monitoring the implementation of the Trust's values and strategy,
- Promoting the desired culture for the organisation (and ensuring this is aligned with the strategic direction and values of the Trust),
- Monitoring resource requirements and performance,
- Monitoring strategic risks and considering mitigations,
- Ensuring effective engagement with stakeholders, and
- Ensuring that workforce policies and practices are consistent with the Trusts' values.

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 orders and standing financial 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 six occasions during 2021/22. The COVID pandemic meant that the Trust continued to need to hold meetings remotely. Members of the public were able to attend the Board remotely, via Microsoft Teams. The Board met on a further five occasions for a Board Development session.

The Trust Chair and Chief Executive continue to monitor the size and the balance of skills and experience of the Board to ensure it is appropriate for the requirements of the business and the future direction of the Trust.

As of 31 March 2022, the Board consists of a non-executive chair, five non-executive directors and five executive directors – the Chief Executive, Medical Director, Chief Nurse, Director of Finance and Chief Operating Officer. In addition, there is one associate non-executive director and two further executive directors – the Chief People Officer and Chief Information Officer – who 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 2021/22, there was one personnel change in terms of the Trust's non-executive director Board members. Mr Bob Niven finished his final term on the Board in January 2022. Mr Biraj Parmar replaced Mr Niven as a voting non-executive, having been serving on the Board as a non-voting associate non-executive director.

The Chair continues to review the skills and experience required from the non-executive directors for the challenges ahead.

During 2021/22 there has been one change to the executive director team. Mr Nick Carver, the Chief Executive for the Trust, retired in December 2021 after 19 years as the Trust's Chief Executive. Adam Sewell-Jones started as the Trust's new Chief Executive in January 2022.

The Chair and non-executive directors are appointed by NHS Improvement, on behalf of the Secretary of State for Health and Social Care (associate non-executive directors can be appointed following local recruitment policies). 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.

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 the Chief Executive are discussed by the non-executive directors at the Board's Remuneration and Appointments Committee. The Chief Executive is not present when his appraisal is being considered by the 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 an 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.
- Helping to shape and set the culture of the Board, which should serve as an example for the rest of the organisation to follow.
- Fostering effective relations with stakeholders, both internal and external to the Trust.
- 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. Non-executive directors use their skills and personal experience, including as members of their communities, to:

- Contribute to the formulation 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 recognise non-executive directors as a safe point of access to the Board for raising concerns; championing an open, honest and transparent culture within the organisation.
- Review 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.
- Support engagement – ensuring that the Board acts in the best interests of patients, the public and other stakeholders; being available to staff if there are unresolved concerns; showing commitment to working with key partners.

The time commitment required of the Chair is two to three days per week and 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.

To support engagement with the wider organisation and the two-way flow of information, each non–executive director has been linked with a division or corporate area to work more closely with. Additionally the non-executive directors have a range of individual roles and responsibilities that are agreed with the Trust Chair often in response to national guidance and recommendations. These lead roles were reviewed and updated by the Chair in January 2022.

The Trust Board 2021/22

This section of the annual report provides details of Board members as well as of other non-voting directors, including the Board committee membership during 2021/22.

Key to principal committee membership:
AC – Audit Committee
EIC – Equality and Inclusion Committee
FPPC – Finance, Performance and People Committee
QSC – Quality and Safety Committee
SC – Strategy Committee
RC – Remuneration Committee
CTC – Charity Trustee Committee

Notes regarding committee attendance:
1. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. The committee attendance figures listed

below do not take into account these additional attendances; rather they reflect attendances that are expected.

2. The Board members have been deemed as having attended a meeting if they attended for a majority of the agenda items. Partial attendance at a meeting is also recorded but not reported here.

3. It should be noted that temporary changes to some meeting structures and governance processes were made due to the COVID pandemic at various points in 2021/22 and that meeting attendance may also have been affected by operational pressures at certain points in the year.

Ellen Schroder, Trust Chair

Ellen Schroder became Chair of the Trust on 1st April 2016 and was reappointed for a second term of four years on 1st April 2020. She was previously Vice Chair and Lay Member of the Camden Clinical Commissioning Group and before that, a Non-Executive Director of Imperial College Healthcare NHS Trust and its predecessor St Mary's NHS Trust where she chaired both the Audit and Finance Committees.

Ellen holds various non-executive positions including chairing the PFI companies which built Amersham and part of High Wycombe hospitals. She is also a Trustee of the Radcliffe Trust, one of the oldest charities in the UK. Her professional career covered 25 years in the City, working in corporate finance for the investment banks Dresdner Kleinwort Benson and Wood Gundy Inc.

Committee membership: FPPC, QSC, SC, CTC, RC
Attendance: Trust Board 4 of 6, FPPC 11 of 11, QSC 11 of 11, SC 5 of 5, CTC 1 of 4, EIC 5 of 5, RC 5 of 5

Nick Carver, Chief Executive (until December 2021)

After initially working as a hospital porter, Nick qualified as a Registered Nurse before developing his interest in health service management. In addition to his registered general nurse qualification, he holds a BA (Hons) in political theory and government, as well as an MSc in health care management. Nick was appointed as Chief Executive in November 2002, having previously been Chief Executive of the George Eliot Hospital NHS Trust in Warwickshire, prior to which he held senior roles in the West Country and South Wales. He has led the East and North Hertfordshire NHS Trust through major service change and delivered public and political support for a major reconfiguration of hospital services that delivered substantial quality and financial benefit to the local health economy. In 2013, Nick was presented with the Inspirational Leader of the Year award by Health Education, East of England. Nick is passionately committed to leadership development and was the Chief Executive lead for the widely praised Bedfordshire and Hertfordshire Aspiring Directors Development Scheme and also chaired the Midlands and East Regional Talent Board. After 19 years as Chief Executive, Nick retired as Chief Executive in December 2021.

Committee membership: QSC (core attendee), FPPC (core attendee), SC (core attendee), AC (attendee), EIC, RC (attendee)
Attendance: Trust Board 3 of 4, FPPC 5 of 8, QSC 5 of 8, SC 1 of 1, EIC 2 of 4, RC 2 of 4

Adam Sewell-Jones, Chief Executive (from January 2022)

Adam has worked in the NHS since 1992 and is passionate about continuously improving services for patients. Having joined as a trainee accountant, he qualified as a Chartered Management Accountant and held a number of finance and operational management roles in Trusts in London and Essex. At Basildon and Thurrock University Hospitals NHS Foundation Trust he held the positions of Director of Finance and Continuous Improvement, Chief Operating Officer and Deputy Chief Executive.

He then went on to hold national leadership roles as Director of Provider Sustainability, Director of Improvement and Regional Director for the South West of England. In these roles he led a number of national programmes including the Virginia Mason NHS partnership, the Vital Signs programme, the Culture and Leadership programme and the Aspiring CEO programme, as well as national policies for improvement and leadership development.

Prior to joining the Trust Adam was the Chief Executive of Newham Hospital in East London. He also remains a faculty member of the Good Governance Institute.

Meeting membership core attendee: QSC, FPPC, Strategy, RC (attendee)
Attendance: Trust Board 2 of 2, FPPC 2 of 3, QSC 1 of 3, SC 1 of 1, RC 1 of 1

Bob Niven, Non-Executive Director (until January 2022)
Bob, 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 BA 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, Bob became the Chief Executive of the Disability Rights Commission until September 2007. After a number of Board appointments, including Chair of the Mental Health Helplines Partnership and at the Office of the Public Guardian, Bob 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 finished his final term on the Board in January 2022.

Committee Membership: FPPC, AC, CTC, RC
Attendance: Trust Board 4 of 4, FPPC 1 of 8, AC 3 of 3, CTC 3 of 4, EIC 4 of 4, RC 3 of 4

Val Moore, Non-Executive Director
Val Moore, who lives in Cambridge, 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 as a science and physical education teacher, Val moved into 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 and Peterborough, is now on her second four-year term which commenced in September 2020.

Committee membership: QSC, RC, CTC, EIC
Attendance: Trust Board 6 of 6, QSC 8 of 11, CTC 3 of 4, EIC 4 of 4, RC 3 of 5

Jonathan Silver, Non-Executive Director
Jonathan is the Senior Independent Director (SID) for the Trust. 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 Henderson High Income PLC and of Spirent Communications PLC. Jonathan is also a Non-Executive Director of ENH Pharma Ltd, the Trust's wholly owned subsidiary company.

Committee membership: FPPC, AC, RC
Attendance: Trust Board 5 of 6, FPPC 9 of 11, AC 4 of 4, RC 4 of 5

Peter Carter OBE, Non-Executive Director
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.

Committee membership: QSC, RC
Attendance: Trust Board 6 of 6, QSC 10 of 11, RC 5 of 5

David Buckle, Non-Executive Director (Associate)
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. David was a non-executive director for the Berkshire Healthcare NHS Foundation Trust where he chaired the Quality committee and is now a Non-executive for Salisbury Hospital 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 and Vice-Chair for the Stroke Association, the country's largest stroke charity.

Committee membership: QSC, RC, CTC, AC (from January 2022)
Attendance: Trust Board 6 of 6, QSC 11 of 11, CTC 4 of 4, RC 5 of 5, AC 1 of 1

Karen McConnell, Non-Executive Director and Deputy Chair
Karen, who lives in St Ippolyts (near Hitchin), 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 her role 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 completed her 7 year term in December 2019. In her role as C&AG she provided the States of Jersey with independent assurance that the public finances of Jersey were being regulated, controlled and accounted for in accordance with the law. Karen currently acts as an adviser to Public Sector Audit Appointments limited.

Committee membership: FPPC, AC, SC, RC
Trust Board 6 of 6, FPPC 11 of 11, AC 4 of 4, SC 5 of 5, RC 5 of 5

Biraj Parmar, Non-Executive Director (Associate until January 2022)

Biraj graduated from Aston Business School and has spent over 25 years mainly in the investment and commercial banking arena. Having started in corporate finance, Biraj moved into financial markets and worked at a senior level with a number of high profile banks, most recently with Lloyds Bank, until retiring from banking in 2019. Over his career, Biraj also co-founded and led two businesses, one in the healthcare sector and the other a consultancy focused on financial services. Biraj has a long family connection to medicine and healthcare. He is passionate about inclusion in its broadest sense and has proudly received inspiring leadership accolades when serving in the banking sector.

Having initially joined the Trust through NHS England's NExT Director scheme, Biraj became an associate non-executive director in April 2021. Biraj became a voting non-executive director in January 2022. Biraj also works as an independent consultant to owners of small and medium-sized businesses.

Committee membership: FPPC, SC, EIC, RC

Attendance: Trust Board 6 of 6, EIC 4 of 5, FPPC 10 of 11, SC 4 of 5, RC 5 of 5

Martin Armstrong, Director of Finance and Deputy Chief Executive
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. Martin was appointed Deputy Chief Executive in April 2020.

Committee membership: FPPC (core attendee), AC (attendee), SC (core attendee)
Attendance: Trust Board 5 of 6, FPPC 10 of 11, AC 4 of 4, SC 5 of 5

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 the Trust's surgery division for five years.

Committee membership: EIC, FPPC (core attendee), QSC (core attendee), SC (core attendee)
Attendance: Trust Board 4 of 6, FPPC 9 of 11, QSC 11 of 11, SC 5 of 5, EIC 4 of 5

Rachael Corser, Chief Nurse
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: QSC (core attendee), FPPC (core attendee), CTC (core attendee), SC (core attendee)
Attendance: Trust Board 6 of 6, QSC 10 of 11, FPPC 5 of 11, CTC 1 of 4, SC 3 of 5

Julie Smith, Chief Operating Officer
Julie qualified as a diagnostic radiographer in 1989 and as an ultra-sonographer 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: EIC, FPPC (Core attendee), QSC (Core attendee).
Attendance: Trust Board 6 of 6, FPPC 11 of 11, QSC 5 of 5, EIC 2 of 5

Thomas Pounds, Chief People Officer (non-voting Board member)
Thomas worked previously in the Trust as the Deputy Director of Workforce and Organisational Development. Thomas began his career in the NHS in 2003, working for NHS Professionals. He joined the East and North Hertfordshire NHS Trust team in 2015 as Head

of Temporary Staffing and Medical Resourcing. He then progressed to Deputy Director of Workforce and Organisational Development, leading key strategic work including the Integrated Care System bank network agreement which helped to save the NHS millions in agency costs. Thomas was appointed as the Chief People Officer in April 2021, after having carried out the acting Chief People Officer role.

Thomas is a Chartered Member of the CIPD and is passionate about the delivery of the organisation's People Strategy to create an inclusive workplace where our people can work, grow, thrive and care together.

Committee membership: EIC (core attendee), FPPC (core attendee), QSC (core attendee), SC (core attendee), RC (attendee), CTC
Attendance: Trust Board 6 of 6, FPPC 10 of 11, QSC 7 of 11, SC 5 of 5, CTC 3 of 4, EIC 5 of 5

Mark Stanton, Chief Information Officer (non-voting Board member)
Mark joined the Trust from Dudley Group NHS Foundation Trust in April 2019 – where he was Executive Chief Information Officer (CIO) for 4 years, delivering a successful digital programme including an electronic patient record system. Prior to joining the NHS, Mark held a number of senior IT roles within global private sector businesses including General Motors Europe, Siemens, GEC, BUPA and InHealth Group. Mark's early career was managing large-scale data centres before moving to consultancy – with the last 10 years spent in executive CIO-level roles. Mark's focus is to support the Trust in moving to a fit for purpose digital environment that supports our staff to deliver safe patient care and improve outcomes whilst integrating us into the wider health and social care economy.

Committee membership: Trust Board (core attendee), SC (core attendee), FPPC
Attendance: Trust Board 6 of 6, Strategy 5 of 5, FPPC 9 of 11

Name	Title	Appointment Date	Term(s) of Office	Term of Office ends
Ellen Schroder	Trust Chair	1 April 2016	Four Years + Four Years	31 March 2024
Nick Carver	Chief Executive	18 November 2002	N/A	17 December 2021
Adam Sewell-Jones	Chief Executive	1 January 2022	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 + Two years +Two years	5 January 2022
Val Moore	Non-Executive Director	1 September 2016	Four Years + Four years	31 August 2024
Jonathan Silver	Non-Executive Director Designate*	16 October 2017	N/A	N/A
	Non-Executive Director	1 February 2018	Two Years + Four Year	31 January 2024
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
Biraj Parmar	Non-Executive Director Associate*	1 April 2021	N/A	N/A
	Non-Executive Director	6 January 2022	Four Years	5 January 2026
Martin Armstrong	Finance Director & Deputy Chief Executive	31 October 2016	N/A	N/A
Michael Chilvers	Medical Director	18 December 2018	N/A	N/A
Rachael Corser	Chief Nurse	2 January 2018	N/A	N/A
Julie Smith	Chief Operating Officer	25 June 2018	N/A	N/A
Tom Pounds	Chief People Officer (Acting Chief People Officer before this)*	1 April 2021	N/A	N/A
Mark Stanton	Chief Information Officer*	9 February 2021	N/A	N/A

*****Attends and participates 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 it.

Declarations of Interests of the Board of Directors

The Board of Directors undertake a review of their conflicts of interest on at least an annual basis, as well as ensuring any interests that arise in year are declared as and when appropriate.

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 items, including any changes to a previously declared interest that is relevant to an agenda item.

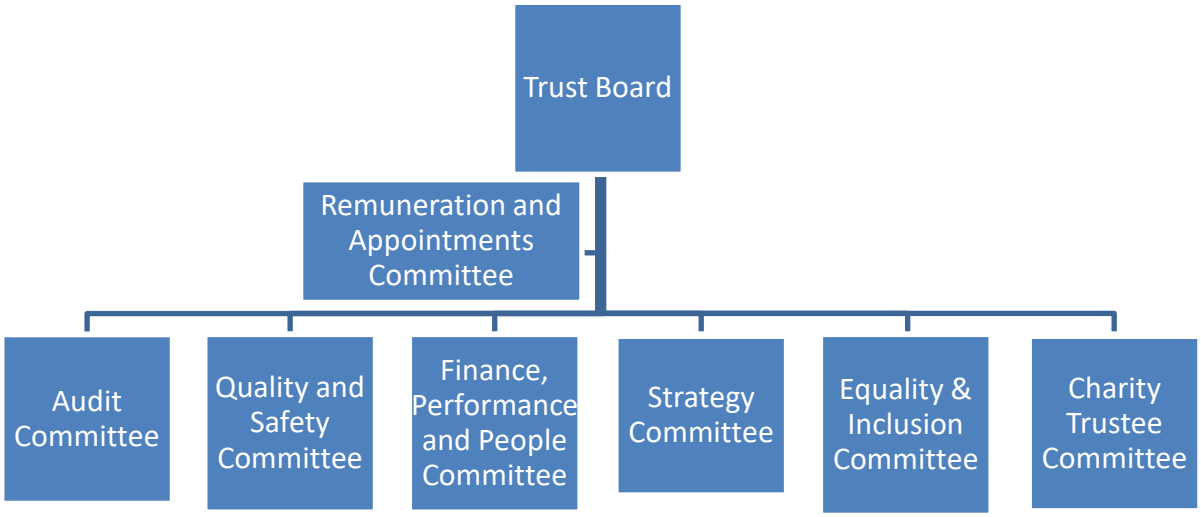
The Register of Interests is published on the Trust's website (here: https://www.enherts-tr.nhs.uk/about/board/introduction/).

Members of the public can also gain access by contacting the Trust Secretary:

Stuart Dalton, Trust Secretary
Trust Management Offices, Corey Mill Lane
Stevenage, SG1 4AB
Email: Boardcommittees.enh-tr@nhs.net

Governance structure

The Trust Board has a number of formal board assurance committees (see diagram below for the committee structure on 31 March 2022) that are supported by a system of line accountability through executive directors, often supported by further operational assurance groups. Each Board assurance committee provides a summary report to the next Trust Board 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 challenges posed by the COVID pandemic required temporary changes to some of the Trust Board governance structures during 2021/22. During COVID peak periods, most meetings were streamlined to focus on core business and risks only. Board Development meetings were paused and regular (weekly or fortnightly) meetings between the Chief Executive and the Non-Executive Directors were instigated, with other attendees joining as required. The structures reverted to the 'business as usual' arrangements during non-peak periods. Lessons learned from the changes made during the earlier waves of the pandemic were taken into account for the subsequent waves.

The *Audit Committee* holds the executive to account for the effectiveness of governance systems and the processes for managing risk. The Audit Committee has a membership of the three non-executive directors.

The *Quality and Safety Committee* meets monthly (excluding August) and has a membership of three non-executive directors. The purpose of the Quality and Safety

Committee (QSC) is to ensure that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health & safety, patient and public safety, compliance with CQC regulation and some workforce issues relating to workforce capability and development, such as education and talent management, or where there is a clear and direct link to quality and safety issues. The Committee is responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy and Quality Strategy.

The *Finance, Performance and People Committee* also meets monthly (excluding August) and has a membership of three non-executive directors. The purpose of the Finance, Performance and People Committee is to provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee plays a key role in ensuring the sustainability of the Trust.

The *Strategy Committee* has a membership of three non-executive directors. The Committee meets on a bi-monthly basis and is responsible for overseeing the delivery of the Trust's vision and strategic aims to 2024 and associated transformation of services. The Committee provides Board level assurance of the leadership, commitment and alignment of corporate strategies, strategic projects and service and workforce transformation agreed under the scope of the committee.

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 *Equality and Inclusion Committee* meets bi-monthly and has a membership of three non-executive directors. The Committee started in May 2021. The Committee provides assurance to the Board that appropriate arrangements are in place to improve equality and inclusion for The Trust's people and patients.

The management of the Trust's clinical services are devolved under two divisions, Planned Care and Unplanned Care.

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 declared a fully compliant 'standards met' position of the Data Security and Protection Toolkit (DPST) 2020/ 2021 in June 2021. This was audited by the Internal Auditor and rated as 'substantial' assurance.

Progress with completion of the DSPT for 2021/22 is underway to meet the June 2022 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

During 2021/22 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.

External auditor

In compliance with the requirements of the NHS Shared Business Services Framework, the Trust opted to reappoint BDO LLP as the Trust's external auditors from 2020/21 on the expiry of the initial contract (and subsequent extensions) at the end of March 2020. Since the start of the previous contract, BDO LLP has acted as external auditor for the Trust each year since 2015/16.

The external auditors attend the Trust's Audit Committee meetings and maintain regular dialogue with the Audit Committee Chair and Director of Finance to discuss audit and other issues promptly.

Internal auditor

The Trust's internal auditor (a function that is currently outsourced) is responsible for undertaking 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.

TIAA have been appointed as the Trust's internal auditors for two years from 2020/21, with an option to extend for a further two years.

Statement of the Accountable Officer's Responsibilities

The Chief Executive of NHS England/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, other items of comprehensive income and cash flows for the year.

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 entity's auditors are aware of that information.

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

Signed: Adam Sewell-Jones, Chief Executive

Date: 24 June 2022

East and North Hertfordshire NHS Trust Annual Governance Statement 2021/22

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 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board set the policy framework and strategy and provides leadership for the management of risk across the organisation. In 2021/22 the Chief Nurse was the Executive Lead for risk management supported by the Associate Director of 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 through the Board Committees. 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 Board Committees have continued to strengthen their scrutiny of the risks through the use of deep dives into specific areas.

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 Managing Director, Divisional Medical Director, Divisional Operational Director and Divisional Nursing and Quality Director 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 and Divisional Board and Governance structures. Areas of high risk are escalated to the Audit Committee, Quality and Safety Committee (QSC), Finance, Performance and People Committee (FPPC), Strategy Committee and the Trust Board. Each of the Divisions periodically attends the Board Committees for further specific areas.

During 2021/22 we have continued to make progress towards implementing our Risk Management Strategy, Board Assurance Framework and Accountability Framework structure to ensure these provide clear and comprehensive risk management and fully support the corporate governance systems. During 2021/2022 the Board and Audit Committee have regularly reviewed progress of risk management including undertaking deep dive reviews of three BAF risks and focused reviews on those risks rated 20.

The Associate Director of Governance ensured the Board received support and training on risk management and in February 2019 the Board had a risk management workshop, facilitated by the Risk Manager focusing on the risk management strategy and risk appetite. Due to the Pandemic a formal session on risk management was not held in 2021/22, however this has been scheduled as part of the Board Development Programme for 2022/23. The Compliance and Risk Team provide support and training to staff and leadership teams on risk management and the risk register. This has been undertaken on a more individual basis over the last year with a virtual session during quarter 4. The Health, Safety and Security Team provide mandatory training on health, safety and security and fire to all staff across the organisation. The estates and facilities directorate have received bespoke training which supported a complete review of their risks.

During 2021/22 the Board had five development sessions to consider key areas of strategic significance, including our strategic priorities, health inequalities, Integrated Care System (ICS), Patient Safety and Culture. 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.

In addition, in June 2021 an Executive Population Health and Development Programme was commissioned from The King's Fund to inform plans for continuing to provide the best possible health and care for local people by understanding the health and care landscape, learning from COVID, and using latest thinking about key topics such as population health and health inequalities to inform service design. Five sessions have been held with a further five sessions scheduled for 2022.

The Chief Executive and Trust Chair continue to monitor the size and the balance of skills and experience of the Board to ensure it is appropriate for the requirements of the business and the future direction of the Trust. During 2021/22, there was one personnel change in terms of the Trust's non-executive director Board members. Mr Bob Niven finished his final term on the Board in January 2022. Mr Biraj Parmar replaced Mr Niven as a voting non-executive, having been serving on the Board as a non-voting associate non-executive director. There has been one change to the executive director team. Mr Nick Carver, the Chief Executive for the Trust, retired in December 2021 after 19 years as the Trust's Chief Executive. Adam Sewell-Jones started as the Trust's new Chief Executive in January 2022. April 2022 will see a change to the Chief Operating Officer with Ms Lucy Davies joining the Trust.

During 2021/22 Board members have sought to adapt how they keep in touch with front line services in the Trust, recognising this has been challenging whilst we are responding to the COVID pandemic. Hybrid working, on site and service visits, including examples of volunteering, has been facilitated following appropriate risk assessments.

We recognise the importance of investing in our staff and supporting their well-being to ensure high-quality care and better outcomes for our patients. We continue to develop our continuous Improvement models with the support from our quality improvement and transformation teams, providing simple, easy to understand models for staff at every level of

the organisation to adopt and use. All of which seek to develop our people capability and drive ownership and continuous improvement through services. The Quality Improvement Team has continued to support the quality improvement priorities.

The Trust is one of only 14 organisations in England chosen to be a part of the Clinical Excellence programme (part of the Pathway to Excellence programme). The Pathway to Excellence programme is recognised globally as enabling nursing excellence and offers proven strategies to help ensure that the care that we deliver to our patients is of the highest standard. The programme was paused in wave one of COVID and relaunched in July 2021. To date five wards have achieved gold awards and eleven wards have achieved silver awards. An annual reassessment is undertaken on all wards with a full comprehensive assessment being undertaken every 3 years.

We seek to learn from good practice in several 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 through governance half days, monthly patient safety newsletter, Trust daily bulletin, staff forums and the organisational development programme. Divisions use local methods including newsletters, posters, virtual 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 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, Health & Safety Executive notices, will be placed on the Risk Register.
- External Guidance / Alerts – NICE, Quality Strategies, etc. that are not yet implemented.
- Results of Feedback – Learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices etc.

Where appropriate, through consultation and direct involvement with the Trust, public stakeholders are involved in managing risks which impact on them. For example, we have patient representation on our Patient and Carer Experience Group and active patient forums in a number of our specialities.

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 and in 2021/22 we enhanced this to support consistency in scoring the likelihood of the risk occurring by introducing the frequency of the risk occurring into the assessment.

Taking into account the recommendations from internal auditors and external reviews including corporate governance and the requirements of the Audit Committee, a risk management improvement plan was developed and progress of implementation regularly reviewed to support embedding proactive risk management across the organisation, providing greater scrutiny and level of oversight.

Led by the Compliance and Risk team, a risk clinic for each division and a review of the corporate risks has continued through 2021/22. This was adapted during the surges of the COVID pandemic but remains a priority. The major incident command and control structures enabled early discussion on new and emerging risks, clear escalation and mitigating actions to be agreed. We will continue the implementation of our risk appetite statements included in our Risk Management Strategy during 2022/23. The Internal Auditor annual review of the Board Assurance Framework and Corporate Risk Register concluded ‘reasonable

assurance'. The recommendations have been used to inform the improvement plan and priorities for 2022/23.

Board Assurance and Reporting

Our Trust Board has five established committees to discharge its responsibilities on Board assurance. These are the Audit Committee, Quality and Safety Committee, the Finance Performance and People Committee, Equality and Inclusion Committee and Strategy 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 2021/22 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, Performance and People Committee (FPPC) supports the governance structures and provides assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and workforce objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee plays a key role in ensuring the sustainability of the Trust.

The Quality and Safety Committee (QSC) ensures that appropriate arrangements are in place for measuring and monitoring quality and safety including clinical governance, clinical effectiveness and outcomes, research governance, information governance, health and safety, patient and public safety, compliance with regulation (including CQC**)** and some workforce issues such as organisational culture and education and talent management. The Committee is responsible for assuring the Board that these arrangements are robust and effective and support the delivery of the Trust's Clinical Strategy 2019-2024 and Quality Strategy.

The Strategy Committee provides a more detailed specialist oversight of risks relating the Trust's Strategy, Digital Strategy, Sustainability and various strategy groups.

The Equality and Inclusion Committee was established in May 2021 following a Board development session as part of our ongoing commitment to provide oversight and assurance to the Board. The Committee provides assurance to the Board that appropriate arrangements are in place to improve equality and inclusion for the Trust's people and patients, with particular focus on delivering better health outcomes for our community and improving access and experience for our patients.

Each Executive Director is accountable to the Board and Board Committees for their defined areas of responsibility and has clear assurance systems and structures in place; these are reviewed annually with each Director.

The Accountability Framework is embedded into practice supported by an integrated performance report and enhanced business intelligence. Delivery Oversight Groups support the Accountability framework. The Integrated Performance Report includes the key performance measures for the Trust. The report is reviewed at every QSC and FPPC 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 framework and decision making is supported by business intelligence.

The quality and safety structures support the delivery of the Quality Strategy and priorities for valuing the basics, quality governance and risk, keeping our patients safe and patient experience. Progress is monitored by the Quality and Safety Committee.

COVID Pandemic

The challenges posed by the COVID pandemic required temporary changes to some of the governance structures. Most meetings were streamlined to focus on core business and risks, the structures reverted to the 'business as usual' arrangements during 2021/22 supported by hybrid working and virtual meetings. Lessons learned from the changes made during the first wave of the pandemic were taken into account during the subsequent waves. To support the winter of 2021/22 the Trust supported the mobilisation of a 'nightingale' temporary structure on the Lister site to support surge bed capacity for the region if required. Fortunately, this was not required and was deconstructed in April 2022. The business continuity structures and command and control structure have remained flexible and responsive to support the organisation.

The impact of COVID and the recovery programme will continue to be felt into 2022/23 and the Trust will continue a flexible approach to recovering safe services in line with the operational plan.

Principal Risks

The Trust currently has 12 principal risks defined on the Board Assurance Framework each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified. In 2021, the Board approved two changes to the articulation of risk relating to capital (Risk 4) reflecting the emerging shorter-term risk, and ICP (Risk 6) reflecting wider ICS emerging structures. The 2022 annual review of the principal risks has commenced to ensure these align with the Trust's new organisational strategy.

At the end of 2021/22 one risk remained rated a '20' (Risk 1: Operational Performance). This compared to two risks rated '20' at the end of 2020/2021 (Risk 4: Capital and Risk 10: Estates and Facilities). These were both reviewed and reduced in June 2021 following discussion at the relevant Board Committee.

Overall, in 2021/22, in addition to the reduction of the two risks noted above, a further two risks were reduced:

- Risk 3 (Finance): Reduced from a 16 to the target risk of 12 in October 2021, taking into account the current and forecast position and consideration of the October 2021-March 2022 planning and Cost Improvement Programmes (CIP) guidance.
- Risk 12 (Pandemic): Met the target risk in June 2021 and remains rated '10'. The Trust demonstrated a compliant position against the national standards.

And two risks were increased:

- Risk 1 (Operational Performance): This was rated a 15 but this increase to 20 in October following discussion at FPPC regarding the impact of the operational performance, system and recovery challenges. Mitigations and a cycle of deep dives are in place.

- Risk 11 (MVCC): The risk was increased from a 12 to 16 in June 2021 due to the risks of the delay to the programme increasing.

Risk 8 (Quality): This risk has remained rated a 15 throughout 2021/22 due to the profile of the issues impacting on the risk changing over the course of the year. This was also supported by a QSC and Board discussion in March 2022.

The Board and its committees receive regular reports on the above to assure that the mitigations are operating (where this is within the Trust's ability to do so) and that those mitigations are effective or further actions are identified. During 2021/22 the Audit Committee will continue to undertake a deep dive review of specific risks on the BAF.

Developing Workforce Safeguards

Ensuring effective workforce planning, deployment of staff and safe staffing levels remains a priority. The people team have been supporting the deployment of staff to deliver care through the pandemic and have been implementing changes to deliver the people strategy. The strategy is premised on the delivery of four pillars – work together, grow together, thrive together, care together.

The work together pillar focuses on the provision of sufficient staff through permanent or temporary arrangements to ensure that we have enough people with the right skills to deliver the roles that are required to meet patient need. Workforce transformation focuses on the changing roles within the NHS to achieve excellent patient outcomes with a sustainable workforce. The Chief Nurse 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. This was presented to the Board in January 2022, who approved the further investment.

As reported in 2020/21, skill mix reviews were undertaken for the critical areas in line with the surge plans relating to the pandemic and mechanisms remain 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 staffing levels in each area. In addition, safer staffing is reported each month to QSC and Board. This information is triangulated with the COVID dashboard, Integrated Performance Report and Quality and Safety Dashboard.

Our Nursing and Midwifery strategy was reviewed in 2019 and approved by Board in May 2019. Our People Strategy was reviewed in 2019 and approved by the Board in January 2020 and is aligned to support delivery of the five-year clinical strategy, operational plan and culture change. We will continue to use the model hospital benchmark 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 and risk assessed for any impact on quality and signed off by the Medical Director and Chief Nurse 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 division.
- Exception reporting via the Trust's executive committee, which meets bi-weekly.
- Monthly meetings via the Trust Board's FPPC, as well as through the committee's monthly report to the Trust Board.

The Trust is developing a new committee of the Board in 2022 to enhance oversight of our workforce strategy and supporting staff health and wellbeing - The People Committee.

CQC

The Trust 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 CQC has not taken enforcement action against the Trust during 2021/22. The following conditions remain on the Trust's registration following the 2019 Inspection:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
- Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 18 HSCA (RA) Regulations 2014 Staffing

The Trust has participated in special reviews or investigations by the CQC during 2021/22 relating to the following areas; the system wide Children and Young People Provider Collaborative Review and a speciality investigation which was closed without any action following CQC's review of the Trust's information.

Since the last inspection undertaken by the Care Quality Commission in 2019, the Trust has not received an on-site inspection. During the COVID pandemic, the CQC changed and evolved their approach to regulating. This new approach has ensured the CQC has had oversight of our Trust and services. The Direct Monitoring Approach focused on safety, how effectively a service is led and how easily people can access the service.

In 2021/2022 the CQC held the following virtual reviews:

- under the Transition Monitoring Approach:
  - Medicine Core Service (MVCC), April 2021
  - Medicine Pharmacy Engagement call, June 2021
  - Outpatients Core Service (MVCC), June 2021
  - Maternity Core Service (Lister), July 2021
  - Outpatients Core Service (Lister and QEII), August 2021
  - End of Life Core Service, August 2021
  - Diagnostic Services, December 2021
  - Children & Young People Service, April 2022

All the reviews were positively received, and no follow up information was requested.

To support these reviews with the Care Quality Commission each core service developed a gap analysis against the streamlined key lines of enquiry, including any gaps and mitigating actions.

An action plan was developed with the teams against all of these requirements and was submitted to the CQC in January 2020. 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 sustained delivery a new Compliance and Risk Framework has been developed and approved by the Quality and Safety Committee.

During 2021/22 we continued to adapt our compliance framework. We have continued a streamlined programme of audits and reviews to support monitoring of compliance against standards, including retesting our previous actions from inspection. In April 2021 we formally recommenced our internal unannounced inspections to the clinical areas. These are held jointly with our Clinical Commissioning Group (CCG). In addition, the pathways to excellence programme support providing assurance on the continued progress against the fundamental standards in ward areas.

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. All the Never Events were classified as minimum to no harm. Four of the five never events were cases of wrong site surgery. It is of note that they related to different specialties. The fifth case concerned a retained dressing following surgery.

The Never Events were investigated by a dedicated team of patient safety managers working in collaboration with Trust staff to identify causes and learning. The findings have informed a range of quality improvement projects including:

- All affected areas have implemented changes to their procedures and Local Safety Standard for Invasive Procedures (LocSSIPS). Changes have been made to department inductions about LocSSIPS following these events.
- Plans to develop a 12-month rolling programme for invasive procedural teams to access, where they can consider and map 'Human Factors Contributory Factors' across their local invasive procedures.
- Within Planned Care, a programme of simulation training across theatres is planned in recognition of the Human Factors elements influencing of Never Events.
- There will be monthly live sessions focussing on debriefs, the WHO checklist,situational awareness and ensuring learning is cascaded across the surgical and theatre teams.
- Plans are also in progress for a Patient Safety day on 23 September 2022.

Improving reliability of safety checks across invasive procedures pathways remains a quality improvement priority for 2022/23.

Infection Control

Infection prevention and control (IPC) has remained a priority for the Trust this year with the pandemic changing all infection prevention and control procedures. The IPC team have been integral to the Trust response to the COVID pandemic and recovery programme, supporting the interpretation and working collaboratively to implement the national guidance across the organisation. This is supported by a COVID Specialist Advisory Group. We continue to review our compliance against the NHSI/E Infection Control Board Assurance Framework each quarter and review the evidence to support on-going compliance.

Other key indicators show a positive picture, with perhaps a result of ongoing enhanced IPC measures in place across the Trust:

- The Trust reported a total of 0 hospital onset MRSA bacteraemia (blood infections) for the second year in a row.
- Trust-allocated cases of Clostridium Difficile infections – 59 against a ceiling of 52 (40 cases in 2020/21).
- The Trust reported 3 cases of 'Flu' through winter of 2021/22.

Operational performance:

- In response to the COVID pandemic, the Trust reconfigured services and wards to provide COVID and Non COVID areas for patients, within the emergency department, assessment areas and across the wards. All minor injuries and illnesses were redirected to the Urgent Care Centre at the New QEII Hospital to support these reconfigurations. The Trust also increased capacity in the Critical Care Unit and worked in partnership with the independent sector to continue to treat urgent and cancer patients.
- All surge capacity has been filed away or 'flatpacked' to ensure that the detailed response to COVID demand and the resultant service capacity can re-emerge in response to triggers, so that the organisation remains responsive to any potential and subsequent surges.
- Performance against the key operational standards should be considered in the context of the unique challenges posed by the pandemic and recovery programme. The FPPC oversees the progress and has a cycle of deep dives on specific areas to gain further assurance on the areas of challenge. The year-end performance was as follows:

    - Emergency Department (ED) Performance – the four hour wait time year-end performance was 72.78%, 10% lower compared to 2019/20 year end.
    - Cancer performance was sustained over the course of 2021/22. Across all of the cancer standards, the year-end position was compliant with 6 of the 8 standards.
    - RTT performance was in line with the national average, though it is recognised that waiting times increased substantially as a result of the COVID pandemic.
    - DM01 – (no more than 1% of patients should wait for a diagnostic test; measured against of the patients waiting at the end of the month, every month). Diagnostics performance was lower than national average performance and reduced in-year due to the ongoing impact of the COVID pandemic.

Health and Safety Executive (HSE)

Following inspection in September 2019, the HSE found the Trust in breach of the Health and Safety Regulations and issued three improvement notices with regards to:

- Moving and Handling - equipment, training and assurance
- Violence and Aggression – do not have an effective system for monitoring and review of preventative and protective measures with regards to work related violence and aggression including recording and investigating incidents.
- Sharps- Investigation of underlying causes and clear actions to prevent reoccurrence and compliance with policy for Post Exposure Prophylaxis (PEP).

The Trust action plan and progress is been monitored through the Health & Safety Committee, Executive Committee and QSC. At the end of April 2020, we submitted to HSE the Trust's position and actions taken against the above contraventions and seeking closure of the Violence and Aggression and Sharps Improvement notices and in July regarding compliance with the Moving and Handling Improvement Notice. In 2020 Internal Audit undertook a review of the HSE action plan and the evidence to support closure of the actions and concluded substantial assurance. The Compliance Team to work with the leads to ensure the processes have been embedded and any emerging risks are supported. The Mental Health Strategy Group, Safer Sharps Group and Moving and Handling Group and Health Safety and Security Group provide clear oversight and monitoring.

Conflicts of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) 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 plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust Board approved its green plan in January 2022 and this is supported by a sustainability group with representatives from across the Trust working together to identify opportunities to improve our environmental and social performance and deliver against initiatives.

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

The Trust reported a deficit before technical adjustments of £0.6m. Including technical adjustments, the Trust reported a surplus of £0.4m against a planned deficit of £0.4m. This performance saw the Trust meeting the duty to break even for a third successive year.

The NHS financial framework for 2021/22 continued to be defined by specific arrangements put in place to allow the service to manage the impact of the COVID pandemic. Funding received by the Trust was predominantly allocated under fixed block arrangements, although this was supplemented by specific COVID monies to manage direct financial impacts of the

pandemic upon the Trust and also by access to recovery fund monies to support the costs of restoring elective activity levels.

Progress against the delivery of the financial plan is monitored by the Finance, Performance and People Committee (FPPC) and reported to Board. In 2021/22 the FPPC received detailed reports on the COVID Financial Framework and associated risks and challenges. This included a number of deep dives into specific areas of finance and performance to provide additional level of scrutiny and challenge; this will continue during 2022/23.

The Trust's annual Internal Audit programme provides an independent review of our key financial controls and this year they have reviewed our systems and processes for our payroll (substantial assurance), core financial systems (substantial assurance), budget setting and financial reporting (reasonable assurance), capital programmes (reasonable assurance) and business planning (reasonable assurance).

NHS Improvement undertook a Use of Resources assessment in August 2019 and rated the Trust as 'requires improvement.' This has not been reviewed in this reporting year. The Trust has continued to focus upon improving the quality of business intelligence reporting available across the Trust as a means of improving the quality of business and financial decision making.

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 declared a fully compliant 'standards met' position of the Data Security and Protection Toolkit 2020/ 2021 in June 2021. This was audited by the Internal Auditor and rated as 'substantial' assurance.

Progress with completion of the DSPT for 2021/22 is underway to meet the June 2022 submission and is monitored at the Trust's Information Governance Steering Group meetings which are held quarterly.

During 2021/22 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.

Data quality and governance

Our data quality continues to improve and is supported by the Data Quality Strategy and 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 and defines responsibilities for specific roles across the organisation for its delivery. The strategy is implemented through the Data Quality Steering Group and supported by a monthly audit programme. The Audit Committee receives a quarterly update on all the key workstreams to continue to improve data quality, to progress and improve patient experience, service delivery and patient flow which include accuracy of data recording.

The data quality team adapted their way of working during the pandemic to support the operational teams and different ways of working. Key workstreams that have continued include clinical prioritisation and validation of the elective waiting lists and validation of the patient waiting lists, supporting specific specialities and developing a data quality key performance indicators dashboard.

The data quality and clinical coding audit confirmed meeting the requirements of the new Data Security and Protection Toolkit.

Emergency Planning

The Trust has a rating of "Fully Compliant" against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance rating in 2021/2022.

Over the last year the Trust has continued to respond to the changes to the NHS national incident level and flexed the internal incident strategic and tactical command structure accordingly, supported by task and finish groups. The Trust continues to work with its partners to enable a system-wide response to the pandemic, supporting outside the Trust where it is possible to ensure continuity across the system. The EPRR Committee reports to the Quality and Safety Committee.

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, 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 2022, the head of internal audit opinion for East and North Hertfordshire NHS Trust is as follows:

"TIAA is satisfied that, for the areas reviewed during the year, East and North Hertfordshire NHS Trust has reasonable and effective risk management, control and governance processes in place. Not having completed all of the planned work due to the global Covid-19 pandemic has not impacted on our overall assessment.

This opinion is based solely on the matters that came to the attention of TIAA during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or your ability to meet financial obligations which must be obtained by East and North Hertfordshire NHS Trust from its various sources of assurance."

For the Premises Assurance Model (PAM) internal audit limited assurance finding, inconsistencies were found in terms of scoring both within the PAM self-assessment process and the PAM submission to NHSE/I. To address this a Head of Compliance has been recruited and a monthly Estates Compliance Meeting has been established, with pure focus on the PAM action plan which reports into a newly established Estates and Facilities monthly Board.

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 2022/23 we continue to see improvement in the management of risk and positive engagement across the organisation. The Internal Audit concluded a 'Reasonable Assurance' opinion.
- 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, Performance and People 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.
- The Strategy Committee provides a more detailed specialist oversight of risks relating the Trust's Strategy, Digital Strategy, Sustainability and various strategy groups.
- The new Equality and Inclusion Committee provides oversight of the related risks for both staff and patients.
- 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.
- Reviews of the Trust's Standing Orders, Scheme of Reservation and Delegation and the Standing Financial Instructions and making improvements to these governance instruments.
- 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, people, quality, governance and risk issues. The Accountability Framework Structure and Integrated Performance Report support this.
- We commission and support external reviews and expertise to review and strengthen our governance. Examples include pathways changes and demand and capacity modelling. This has provided assurance and additional recommendations, which have been progressed.
- We provide programme and enhanced governance support to areas under pressure or where additional support is required. Examples include Maternity, Emergency Department, Paediatrics, Mental health, Gastroenterology and Mortuary.

- We have Authorised Engineers who provide an independent review of our compliance and effective management of safety against a number of statutory requirements including water, electrical, fire, decontamination, ventilation and medical gases.
- 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, recent Internal Audit reports and sustained response to the current COVID pandemic; a level 4 major incident.

Conclusion

My review has established that East and North Hertfordshire NHS Trust have 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:

Adam Sewell-Jones, Chief Executive Date: 24 June 2022

Modern Slavery Act 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 2021/22)
- Remuneration tables
- Pension entitlement table
- Pension benefits table

Remuneration policy

The Trust's Remuneration and Appointments 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 and Appointments Committee is a committee of the Trust Board, consisting of the Chair and all the non-executive directors. It is chaired by Mr Jonathan Silver (who is also the chair of the Audit Committee). The Committee is supported by the Chief Executive, Chief People Officer and the Trust Secretary. The Remuneration and Appointments Committee aims to meet four times a year, but will schedule additional meetings if needed. It met five times in total during 2021/22. Details of directors' remuneration are given later in this section of the report.

Every year, the Board's Remuneration and Appointments 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. To support this work, the Remuneration and Appointments Committee considers the latest benchmarking data produced by NHS England and NHS Improvement regarding foundation and non-foundation Trust executive salaries.

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 they are 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'.

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 NHS England/Improvement. In September 2019 NHS England & NHS Improvement published a structure to align remuneration for chairs and non-executive directors of NHS Trusts and NHS foundation Trusts. These recommendations have been implemented by the Trust. The level of remuneration is paid for a minimum of two and a half days per month for non-executive directors and three and a 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.

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

Staff sharing scenarios

With effect from 1st October 2020 Mrs Sarah Brierley (Director of Strategy) was seconded on a part time basis to Hertfordshire Community NHS Trust and has taken on the role of Director of Strategy for both Trusts. The costs of her employment continue to be borne by the East and North Hertfordshire NHS Trust in full.

With effect from 1st September 2020 Sam Tappenden, who was previously the Director of Strategy for Hertfordshire Community NHS Trust, was seconded to the East and North Hertfordshire Integrated Care Partnership as Development Director. The costs of his employment continue to be borne by Hertfordshire Community NHS Trust in full.

By continuing to bear the full costs of employment of the two individuals, both East and North Hertfordshire NHS Trust and Hertfordshire Community NHS Trust are effectively making a broadly equitable financial contribution to the development of the Integrated Care Partnership in East and North Hertfordshire.

Remuneration tables

Name and title	2021/22							2020/21						
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Compensation for loss of office	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Compensation for loss of office	TOTAL
	(bands of £5,000)	Rounded to nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	Rounded to nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000	£000
Executive directors														
Nick Carver (to 31.12.2021)	145-150	1	0	0	0	0	145-150	195-200	3	0	0	0	0	195-200
Chief Executive														
Martin Armstrong	155-160	0	0	0	22.5-25	0	180-185	150-155	1	0	0	62.5-65	0	210-215
Director of Finance														
Rachael Corser	125-130	0	0	0	10-12.5	0	135-140	125-130	1	0	0	32.5-35	0	160-165
Director of Nursing														
Michael Chilvers	200-205	0	0	0	0	0	200-205	195-200	1	0	0	0	0	195-200
Medical Director														
Sarah Brierley	120-125	3	0	0	30-32.5	0	150-155	120-125	3	0	0	37.5-40	0	160-165
Director of Strategy														
Julie Smith (to 01.05.22)	140-145	0	0	0	7.5-10	0	150-155	140-145	0	0	0	12.5-15	0	155-160
Chief Operating Officer														
Duncan Forbes (to 16.10.20)	0	0	0	0	0	0	0	115-120	19	0	0	0	0	115-120
Chief People Officer														
Thomas Pounds (from 23.09.20)	115-120	0	0	0	80-82.5	0	195-200	60-65	0	0	0	25-30	0	85-90
Chief People Officer														
Mark Stanton (from 09.02.21)	120-125	0	0	0	27.5-30		150-155	15-20	0	0	0	20-25		40-45

						0								
Chief Information Officer														
Adam Sewell-Jones (from 01.01.22)	45-50	0	0	0	0	0	45-50	0	0	0	0	0	0	0
Chief Executive														

Name and title	2021/22						2020/21					
	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	40-45	0	0	0	0	40-45	35-40	0	0	0	0	35-40
Chair												
Bob Niven (to 05.01.2022)	5-10	0	0	0	0	5-10	10-15	0	0	0	0	10-15
Val Moore	10-15	1	0	0	0	10-15	10-15	2	0	0	0	10-15
Jonathan Silver	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Peter Carter	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
David Buckle	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Karen McConnell	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Biraj Parmar	15-20	0	0	0	0	15-20	0-5	0	0	0	0	0-5

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

- The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. The Trust's contribution to directors' pensions was 14.3% of salary for 2021/22 (this was topped up to 20.6% by NHSE) (20.6% in 2020/21). 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 2020/21 and 2021/22.
- Duncan Forbes received an amount in relation to compensation for loss of office in 2020/21 which relates to payment in lieu of notice. This is reflected within the exit packages section of the Staff report.

The single total figure of remuneration for Directors is subject to audit by the Trust's auditors, BDO LLP.

Pension benefits

Name and title*	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2022	Lump sum at pension age related to accrued pension at 31 March 2022	Cash equivalent transfer value at 1 April 2021	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2022	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* (to 31.12.2021)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Chief Executive								
Martin Armstrong	0-2.5	0	20-25	95-100	820	21	867	0
Director of Finance								
Rachael Corser	0-2.5	0	10-15	55-60	505	6	531	0
Director of Nursing								
Michael Chilvers*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medical Director								
Sarah Brierley	0-2.5	0	30-35	95-100	887	37	946	0
Director of Strategy								
Julie Smith (to 01.05.2022)	0-2.5	0	5-10	100-105	937	14	975	0
Chief Operating Officer								
Thomas Pounds	2-5-5	5-7.5	80-85	45-50	308	49	375	0
Interim Chief People Officer								
Mark Stanton	0-2.5	0	25-30	0	191	17	224	0
Chief Information Officer								
Adam Sewell-Jones* (from 01.01.2022)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Chief Executive								

- Nick Carver left the pension scheme with effect from 31st March 2016.
- Michael Chilvers left the pension scheme with effect from 1st April 2019.
- Duncan Forbes was not in the pension scheme.
- Adam Sewell-Jones opted out of the pension scheme in June 2020 before joining the Trust on 1 January 2022.

Notes to pensions table

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

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a

senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the *Institute and Faculty of Actuaries*

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

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement. During the year, the Government announced that public sector pension schemes will be required to provide indexation on the Guaranteed Minimum Pension element of the pension. NHS Pensions has updated the methodology used to calculate CETV values as at 31 March 2020. The impact of the change in methodology is included within the reported real increase in CETV for the year.

This information is subject to audit by the Trust's auditors, BDO LLP.

Compensation on early retirement or for loss of office

There were no such payments in 2021/22. This information is subject to audit by the Trust's auditors, BDO LLP.

Payments to past directors

There were no such payments in 2021/22. This information is subject to audit by the Trust's auditors, BDO LLP.

Pay multiples (fair pay disclosure) for 2021/22

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 2021/22 was £202,500 (2020/21 – £197,500). This was 6.0 times (2020/21 – 6.2 times) the median remuneration of the workforce, which was £33,688 (2020/21 – £31,855).

Regarding the ratio of highest paid director to median remuneration of the workforce, as the median pay has increased this has resulted in a slightly lower ratio.

In the prior year, the median pay ratio was overstated due to an incorrect assessment of the bank and agency staff. The prior year ratio has now been restated to reduce the median pay ratio from 6.3 to 6.2.

In the prior year, the median remuneration of the workforce disclosed was understated due to an incorrect assessment of the bank and agency staff. The prior year figures have been restated to increase median remuneration of the workforce from £31,365k to £31,855k.

Further fair pay disclosures required for 2021/22

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in East and North Hertfordshire NHS Trust in the financial year 2021-22 was £200k-£205k (2020-21, £195k-£200k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table along with the percentage change in remuneration of highest paid director.

Percentage change in salary in respect of highest paid director	**21/22 Increase / (decrease)**
Change in salary and allowances from the previous year in	
respect of the highest paid director:	2.53%
Change in performance pay and bonuses from the previous	
year in respect of the highest paid director:	N/A
Average change in salary and allowance from the previous	
year in respect of all employees (excluding highest paid director):	5.87%
Average change in performace pay and bonuses from the previous	
year in respect of all employees (excluding highest paid director):	N/A

2021-22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	23,983.03	33,687.66	45,921.50
Salary component of total remuneration (£)	23,881.02	33,398.55	45,839.00
Pay ratio information	8.44	6.01	4.41
2020-21			
Total remuneration (£)	22,578.80	31,854.88	44,262.59
Salary component of total remuneration (£)	-	-	-
Pay ratio information	8.75	6.20	4.46

Year	**25th percentile total remuneration ratio**	**25th percentile salary ratio**	**Median total remuneration ratio**	**Median salary ratio**	**75th percentile total remuneration ratio**	**75th percentile salary ratio**
21/22	8.44	8.48	6.01	6.06	4.41	4.42
20/21	8.75	8.78	6.20	6.22	4.46	4.51

In 2021/22, 27 employees (2020/21, 15 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £10,000 to £296,269 per annum (for 2020/21, – the reported range was £10,000 to £279,768).

In the prior year, the number of employees who received remuneration in excess of the highest paid director was understated due to an incorrect assessment of the bank and agency staff. The prior year figures have been restated to increase the number of employees who received remuneration in excess of the highest paid director from 6 to 15.

In the prior year, the remuneration range was wrongly reported due to an incorrect assessment of the bank and agency staff. The prior year range has been restated to amend the remuneration range from £18,005 - £274,160 to £10,000 - £279,768.

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

This information is subject to audit by the Trust's auditors, BDO LLP.

Staff report

This section covers:

- Staff numbers and costs
- Staff composition
- Sickness absence data
- Staff turnover percentage
- Staff engagement
- Staff policies regarding equality and diversity
- Trade Union Facility Reporting Time
- Other employee matters
- Expenditure on consultancy
- 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	2021/22			2020/21
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	911	62	**973**	951
Administration and estates	1,656	140	**1,796**	1,780
Healthcare assistants and other support staff	877	157	**1,034**	1,034
Nursing, midwifery and health visiting staff	1,778	241	**2,020**	1,895
Scientific, therapeutic and technical staff	440	51	**491**	478
Healthcare science staff	166	-	**166**	164
Total average numbers	**5,828**	**651**	**6,479**	6,302
Of which:				
Number of employees (WTE) engaged on capital projects	10	-	10	4

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	2021/22			2020/21
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	239,599	-	**239,599**	229,494
Social security costs	25,720	-	**25,720**	23,894
Apprenticeship levy	1,209	-	**1,209**	1,133
Employer's contributions to NHS pensions	41,044	-	**41,044**	38,709
Pension cost - other	85	-	**85**	80
Termination costs	-	-	**-**	376
Temporary staffing costs	-	43,177	**43,177**	41,152
Recoveries in respect of seconded staff	(2,881)	-	**(2,881)**	(2,577)
External financing				
Costs capitalised as part of assets	526	-	**238**	238

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

Staff composition

The table below summarises the composition of the Trust's workforce by gender.

Gender	Headcount March 2022	FTE March 2022
Female	5044	4393.3
Male	1557	1486.8
Total	6601	5880.1

The composition of the Trust Board by gender is as follows:

Gender	Headcount March 2022
Female	5
Male	10

Sickness absence data

Sickness absence rates have gradually risen over the year with notable peaks at the times when COVID was most prevalent within the local community. The absence rate over the year absence rate for the 12 months ending March 2022 was 4.4% this peaked at 6.3% in January 2022. The fluctuations have largely been for short-term sickness absence, while long-term absence has remained static. Positively, we have seen reduced rates of sickness absence due to musculoskeletal and mental health conditions; this is attributed to the focussed work in both these areas. The Trust continues to experience higher levels of absence due to chest/respiratory issues followed by gastrointestinal related reasons.

Trust sickness absence by month:

Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
4.1%	4.2%	4.5%	4.9%	4.5%	4.9%	5.9%	5.4%	6.0%	6.3%	5.3%	6.1%

The highest levels of absence are observed with front-line staff and may well correlate with research emerging linked to burnout and fatigue. This is likely due to staff in planned and unplanned care areas continuing to experience a relentless pressure of patients requiring care for longer and with more acute conditions as well as managing the impact of the COVID surge waves and increased inpatient admissions throughout the year. We will continue to promote a range of support for staff to remain well in work and encourage proper rest periods, the taking of annual leave and we intend to triangulate absence data with staff survey results, patient complaints and staff complaints to identify areas that may require higher levels of development and support to create healthy work places in those team areas.

Staff turnover percentage

The Trust's staff turnover percentages are captured as part of a separate publication – NHS Digital's workforce statistics. This publication can be accessed via the following link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Staff Engagement

The table below shows the Trust's staff engagement score over the last 5 years, as recorded in the NHS staff survey. The engagement score for 2021 should be noted in the context of the COVID pandemic.

	2017	2018	2019	2020	2021
Score	6.7	6.8	6.9	6.9	6.8
Number of responses	1608	2373	2600	2641	2640

Staff policies regarding equality and diversity

Trust staff and candidates for roles with disabilities are supported in recruitment through the Trust's compliance with the two tick accreditation and throughout their employment with the newly developed reasonable adjustment passport.

In August 2020 the Trust introduced the role of inclusion ambassadors in the appointment process for all posts graded at Band 8a and above. The scheme has 11 inclusion ambassadors trained to support recruitment activity, with a view to extending to other protected characteristics as the scheme develops. A full review of the scheme and other aspects of equality, diversity and inclusion in recruitment and selection is currently underway.

Further information regarding Trust policies and the approach to equality and diversity is available in the performance report section.

Trade Union Facility Reporting Time

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 2021 to March 2022?

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
14	5,880.68*

**March 2022*

Table 2 – Percentage of time spent on facility time

How many of your employees who were relevant unions 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%	
1 – 50%	12
51 - 99%	
100%	2

Table 3 Percentage of pay bill spend on facility time

Provide the total cost of facility time	£165,541*
Provide the total pay bill	£336,018,619
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.05%

**estimate*

Table 4 Paid trade union activities

Time spent on paid trade union activities as a percentage of total pay 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%

Other employee matters

Other employee matters are outlined in the People performance analysis section of the report.

Expenditure on consultancy

In 2021/22 £841,559 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).

Table 1: Length of all highly paid off-payroll engagements

For all off-payroll engagements as of 31 March 2022, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2022	1
Of which the number have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	1

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2021 and 31 March 2022, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	0
Of which…	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	0
No. of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
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.	9

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

Reporting of compensation schemes - exit packages 2021/22

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.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	-	11	**11**
£10,001 to £25,000	-	7	**7**
£25,001 to 50,000	-	1	**1**
£50,001 to £100,000	-	-	**-**
£100,001 to £150,000	-	-	**-**
Total number of exit packages by type	**-**	**19**	**19**
Total resource cost (£)	£0	£193,829	**£193,829**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Pensions Scheme. Exit costs in this note are the full costs of departures agreed in the year. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year.

Reporting of compensation schemes - exit packages 2020/21

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
<£10,000	1	13	**14**
£10,001 to £25,000	1	6	**7**
£25,001 to 50,000	-	2	**2**
£50,001 to £100,000	3	6	**9**
£100,001 to £150,000	-	1	**1**
Total number of exit packages by type	**5**	**28**	**33**
Total resource cost (£)	£206,000	£680,000	**£886,000**

In the prior year, the number of other departures agreed in the £10,001 to £25,000 band was understated due to a calculation error. The prior year number has been restated from 5 to 6 and the 'total number of exit packages by type' has been restated from 27 to 28. This also affects the total number of exit packages in the £10,001 to £25,000 band. This has been restated from 6 to 7 and from 32 to 33 in the total number of exit packages by type.

Exit packages: other (non-compulsory) departure payments	2021/22		2020/21	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	8	500
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	19	194	18	159
Exit payments following Employment Tribunals or court orders	-	-	2	21
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**19**	**194**	**28**	**680**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

This information is subject to audit is subject to audit by the Trust's auditors, BDO LLP.

Parliamentary accountability and audit report

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

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

Fees and charges

As outlined in note 5.3 of the annual accounts, the Trust does not undertake any activities for the sole purpose of generating income of over £1 million.

Remote contingent liabilities

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

Losses and special payments

The Trust is required to declare if it has had any loss, made any special payment or made a gift more than £300,000. The Trust has included information on losses and special payments in note 31 of the financial statements.

During 2021/22 the Trust has no individual case of Losses and Special Payments in year that exceeded £300,000.

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, other items of comprehensive income 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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.

Date: 24 June 2022 Adam Sewell-Jones, Chief Executive

Date: 24 June 2022 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) and its subsidiaries (the group) for the year ended 31 March 2022, which comprise the combined group and single entity Statement of Comprehensive Income, the Statements of Financial Position, the Statements of Changes in Equity, the Statements of Cash Flows and 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), and as interpreted and adapted by the 2021-22 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2021-22.

In our opinion the financial statements:

- give a true and fair view of the financial position of East and North Hertfordshire NHS Trust and the group as at 31 March 2022 and of its expenditure and income for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2021-22; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust and the group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the 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.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust and the group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

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 subject to audit, being all those 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 2021-22.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21(2A)(c) of the Local Audit and Accountability Act 2014 as amended by the Health and Care Act 2022 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. 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.

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Other matters on which we are required to report by exception

Report to the Secretary of State

On 27 May 2020 we reported to the Secretary of State under section 30 of the Local Audit

and Accountability Act 2014 that the Trust has planned a cumulative deficit position and that

as a result the Trust has begun to take a course of action that would be unlawful.

We have nothing to report in respect of the following other matters 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' reponsibilities 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.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

Our procedures included the following:

- inquiring of management, the Trust's head of internal audit, the Trust's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's and group's policies and procedures relating to:
    - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
    - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
    - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements;
- discussing among the engagement team, including regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, expenditure cut-off and posting of unusual journals;
- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. The key laws and regulations we considered in this context included the National Health Service Act 2006 as amended by the Health and Social Care Act 2012, which requires that each NHS trust must ensure that its revenue is not less than sufficient, taking one financial year with another, to meet outgoings properly chargeable to the revenue account and legislates the Trust's activities and expenditure. Other relevant laws and regulations identified include VAT legislation, and PAYE legislation.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit Committee and in-house legal counsel concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business, and substantively testing an increased sample of expenditure around the year end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

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

As set out in the Other 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 - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for East and North Hertforshire NHS Trust for the year ended 31 March 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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 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.

Rachel Brittain

For and on behalf of BDO LLP, Statutory Auditor

London, UK

24 June 2022

East and North Hertfordshire NHS Trust
Annual accounts for the period
1 April 2021 to 31 March 2022

Statement of Comprehensive Income

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	529,895	479,601	529,782	479,521
Other operating income	4	48,566	61,299	49,037	61,213
Operating expenses	6, 8	(571,582)	(530,227)	(572,918)	(531,294)
Operating surplus from continuing operations		**6,879**	**10,673**	**5,901**	**9,440**
Finance income		39	5	39	5
Finance expenses	11	(2,095)	(2,177)	(2,095)	(2,177)
PDC dividends payable		(4,666)	(3,356)	(4,666)	(3,356)
Net finance costs		**(6,722)**	**(5,528)**	**(6,722)**	**(5,528)**
Other losses	12	(479)	(1,560)	(479)	(1,560)
Corporation tax expense		(286)	(243)	-	-
(Deficit) / surplus for the year		**(608)**	**3,342**	**(1,300)**	**2,352**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(187)	(2,682)	(187)	(2,682)
Revaluations	18	11,618	8,060	11,618	8,060
Other reserve movements		-	-	-	500
Total comprehensive income for the period		**10,823**	**8,720**	**10,131**	**8,230**

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

Adjusted financial performance (control total basis):		
(Deficit) / surplus for the period	(608)	3,342
Remove net impairments not scoring to the Departmental expenditure limit	155	1,599
Remove I&E impact of capital grants and donations	182	(2,095)
Remove net impact of inventories received from DHSC group bodies for COVID response	153	(318)
Remove loss recognised on return of donated COVID assets to DHSC	479	-
Adjusted financial performance surplus	**361**	**2,528**

The Trust has a wholly-owned subsidiary, ENH Pharma Limited, 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 2021/22. However, performance of the Trust has also been provided alongside. The corporate tax payable is due from the subsidiary.

The Notes to the Accounts support the consolidated results above.

Statements of Financial Position

	Note	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	13, 14	30,178	26,962	30,168	26,944
Property, plant and equipment	15, 16	231,434	199,644	231,360	199,556
Other investments	19	-	-	1,000	1,000
Receivables	21	1,581	2,485	1,581	2,485
Total non-current assets		**263,193**	**229,091**	**264,109**	**229,985**
Current assets					
Inventories	20	7,896	8,087	6,625	6,737
Receivables	21	24,627	23,491	23,933	22,837
Cash and cash equivalents	22	84,947	52,459	83,323	51,574
Total current assets		**117,470**	**84,037**	**113,881**	**81,148**
Current liabilities					
Trade and other payables	23	(79,393)	(62,994)	(78,985)	(62,572)
Borrowings	25	(2,973)	(2,967)	(2,973)	(2,967)
Other financial liabilities		(184)	(184)	(184)	(184)
Provisions	26	(696)	(563)	(696)	(563)
Other liabilities	24	(7,542)	(3,299)	(7,542)	(3,299)
Total current liabilities		**(90,788)**	**(70,007)**	**(90,380)**	**(69,585)**
Total assets less current liabilities		**289,875**	**243,121**	**287,610**	**241,548**
Non-current liabilities					
Trade and other payables	23	(3,799)	(4,004)	(3,799)	(4,004)
Borrowings	25	(40,860)	(43,782)	(40,860)	(43,782)
Other financial liabilities		(1,566)	(1,743)	(1,566)	(1,743)
Provisions	26	(14,249)	(1,532)	(14,249)	(1,532)
Total non-current liabilities		**(60,474)**	**(51,061)**	**(60,474)**	**(51,061)**
Total assets employed		**229,401**	**192,060**	**227,136**	**190,487**
Financed by					
Public dividend capital		371,259	344,741	371,259	344,741
Revaluation reserve		58,163	46,732	58,163	46,732
Income and expenditure reserve		(200,021)	(199,413)	(202,286)	(200,986)
Total taxpayers' equity		**229,401**	**192,060**	**227,136**	**190,487**

The notes on pages 107 to 159 form part of these accounts.

Name	Mr Adam Sewell Jones
Position	Chief Executive
Date	24 June 2022

Consolidated Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**344,741**	**46,732**	**(199,413)**	**192,060**
(Deficit) for the year	-	-	(608)	**(608)**
Impairments	-	(187)	-	**(187)**
Revaluations	-	11,618	-	**11,618**
Public dividend capital received	26,518	-	-	**26,518**
Taxpayers' and others' equity at 31 March 2022	**371,259**	**58,163**	**(200,021)**	**229,401**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**175,608**	**41,354**	**(202,755)**	**14,207**
Surplus for the year	-	-	3,342	**3,342**
Impairments	-	(2,682)	-	**(2,682)**
Revaluations	-	8,060	-	**8,060**
Public dividend capital received	169,133	-	-	**169,133**
Taxpayers' and others' equity at 31 March 2021	**344,741**	**46,732**	**(199,413)**	**192,060**

Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**344,741**	**46,732**	**(200,986)**	**190,487**
(Deficit) for the year	-	-	(1,300)	**(1,300)**
Impairments	-	(187)	-	**(187)**
Revaluations	-	11,618	-	**11,618**
Public dividend capital repaid	26,518	-	-	**26,518**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2022	**371,259**	**58,163**	**(202,286)**	**227,136**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**175,608**	**41,353**	**(203,838)**	**13,123**
Surplus for the year	-	-	2,352	**2,352**
Impairments	-	(2,682)	-	**(2,682)**
Revaluations	-	8,061	-	**8,061**
Public dividend capital received	169,133	-	-	**169,133**
Other reserve movements	-	-	500	**500**
Taxpayers' and others' equity at 31 March 2021	**344,741**	**46,732**	**(200,986)**	**190,487**

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.

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

Statements of Cash Flows

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus		6,879	10,673	5,901	9,440
Non-cash income and expense:					
Depreciation and amortisation	6	13,157	11,856	13,129	11,813
Net impairments	7	155	1,599	155	1,599
Income recognised in respect of capital donations	4	(405)	(2,549)	(405)	(2,549)
(Increase) / decrease in receivables and other assets		(1,498)	27,593	(1,457)	27,680
Decrease / (Increase) in inventories		191	(1,103)	111	(1,161)
Increase in payables and other liabilities		21,983	8,217	22,040	8,434
Increase in provisions		12,860	1,401	12,860	1,401
Tax (paid)		(243)	(209)	-	-
Other movements in operating cash flows		-	-	-	500
Net cash flows from operating activities		**53,079**	**57,478**	**52,334**	**57,157**
Cash flows from investing activities					
Interest received		39	5	39	5
Purchase of intangible assets		(5,912)	(4,214)	(5,912)	(4,214)
Purchase of PPE		(33,220)	(24,592)	(33,214)	(24,590)
Receipt of cash donations to purchase assets		405	371	405	371
Net cash flows used in investing activities		**(38,688)**	**(28,430)**	**(38,682)**	**(28,428)**
Cash flows from financing activities					
Public dividend capital received		26,518	169,133	26,518	169,133
Loans repaid to DHSC		(2,588)	(149,474)	(2,588)	(149,474)
Other loans repaid		(63)	(63)	(63)	(63)
Capital element of PFI and other service concession payments		(262)	(219)	(262)	(219)
Interest on loans		(1,177)	(1,589)	(1,177)	(1,589)
Other interest		(58)	(66)	(58)	(66)
Interest paid on PFI and other service concession obligations		(873)	(860)	(873)	(860)
PDC paid		(3,400)	(4,840)	(3,400)	(4,840)
Net cash flows from financing activities		**18,097**	**12,022**	**18,097**	**12,022**
Increase in cash and cash equivalents		**32,488**	**41,070**	**31,749**	**40,751**
Cash and cash equivalents at 1 April - brought forward		**52,459**	**11,389**	**51,574**	**10,823**
Cash and cash equivalents at 31 March	22	**84,947**	**52,459**	**83,323**	**51,574**

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 2021/22 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 Group and 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.

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 1.2 Going concern
These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

In accordance with IAS 1, management has made an assessment of the Trust's ability to continue as a going concern. In making this assessment management has taken into account the Trust's income and expenditure plan for 2022/23 which is to break-even, and the current cash position of the Trust. The Trust's current cash plan for 2022/23 is not reliant on Department of Health and Social Care (DHSC) funding for cash financing with a forecast cash balance of £49m at 31st March 2023. The Board concludes there to be no material uncertainty around going concern for the period to 30 June 2023.

In light of these considerations, and having made appropriate enquiries, the Directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As directed by the Department of Health and Social Care Group Accounting Manual 2021/22, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future in the public sector. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Note 1.3 Consolidation
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 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 1.4 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 Group and 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 IFRS 10. 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 2021/22.

The Trust has valued its land and buildings on a modern equivalent asset (MEA) basis - Note 18

The Trust has made provisions for dilapidation where there is contractual or constructive obligation to reinstate leased buildings at a future date. These are of uncertain timing or amount as at the reporting date but where the liability meets the recognition criteria of IAS37. These are based on judgements and estimates of future cash flows.

Note 1.5 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 Tangible Assets - Notes 18

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Economic lives are determined in a number of different ways such as valuations (external professional opinion) and management estimation for equipment and intangible assets.

The valuation exercise was carried out in March 2022 with a valuation date of 31 March 2022. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

The uncertainty in valuation relates to land and buildings. The valuer in arriving at the value of specialised buildings estimate the build costs based on current market indices. A 5% change in estimated build costs will result in a 4.91% change in the carrying value of buildings. Land valuation is based on current market rate per Acre. A 5% change in the market rate will result in a 4.88% change in the carrying value of land.

- The likelihood, amount and timing of provisions for liabilities and charges (Note 26).

Provisions have been made for legal and constructive obligations of uncertain timing or amount as at the reporting date where the liability meets the recognition criteria of IAS37. These are based on judgements and estimates of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made. Provision for dilapidation is based on estimate provided by independent valuer. Pensions provisions are based on information received from NHS Pension Agency (previously NHS Business Service Authority).

Note 1.6 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).

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. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

The 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. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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 1.7 Other forms of income

Grants and donations

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. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Revenue from education and training

Health Education England provide funding to maintain education and training capacity, retain students on education and training programmes, and enable students to provide their skills to the NHS to support the response. Income is recognised in line with the requirements of IFRS 15. 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 obligation.

Non-patient care services to other bodies

The Trust provides non-patient related services to other NHS bodies for which income is recognised in line with IFRS 15. Revenue is recognised when 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 obligation.

Note 1.8 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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 1.9 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 1.10 Property, plant and equipment

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.

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.

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.

Land and buildings 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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Where the Trust own property under the Private Finance Initiative (PFI) scheme, the Trust opinion is that the fair value of the freehold interest in the property is based on the modern equivalent basis of Depreciated Replacement Cost and has valued such property gross of VAT.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

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.

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 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 expenditure.

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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

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.

In 2021/22 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent 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 Income.

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 Years	Max life Years
Land	-	-
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 1.11 Intangible assets

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.

Expenditure on research is not capitalised. Expenditure on development is capitalised 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

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value 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.

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.

Useful lives 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
Development expenditure	5	10
Software licences	5	15
Licences & trademarks	5	10

Note 1.12 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.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.13 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.

Cash, bank and overdraft balances are recorded at current values.

Note 1.14 Financial assets and financial liabilities

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.

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 liabilities in respect of assets acquired 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 or assets measured at fair value through other comprehensive income, 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.

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 1.15 Leases

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

The trust as a lessee

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

The trust as a lessor
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 1.16 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 HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Provisions for dilapidation are based on best estimate provided by independent quantity surveyors. Where possible, BCIS elemental rates and inflation figures are used while bespoke items are valued on case-by-case basis.

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 26 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 1.17 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 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27, 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 1.18 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.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.19 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 1.20 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 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.23 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.

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 1.24 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 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

IFRS 16 Leases (Cont'd)

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	110,393
Additional lease obligations recognised for existing operating leases	(110,678)
Changes to other statement of financial position line items	285
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(9,019)
Additional finance costs on lease liabilities	(1,021)
Lease rentals no longer charged to operating expenditure	9,590
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(450)**
Estimated increase in capital additions for new leases commencing in 2022/23	**2,500**

The forecast position for 2022/23 above excludes the impact of IFRS 16 on the Trust's PFI scheme.

The 2022/23 GAM confirms that IFRS 16 will apply to the subsequent measurement of the Trust's PFI liability which are currently accounted for under the finance lease provisions of IAS 17. Applying the transitional provisions of IFRS 16, the lease liability and PFI asset measured under IAS 17 at 31 March 2022 will be the opening IFRS 16 ROU asset and lease liability on 1 April 2022.

As set out in note 29, the payments that the Trust make under the PFI contract are linked to RPI. Under IAS 17 the indexation element of the payment is expensed in the year it is incurred as contingent rent (for 21/22 the contingent rent expensed was £426k). Under IFRS 16, the lease liability will need to be re-measured within the 22/23 year and on an ongoing basis as indexation is applied. The increase in lease liability will initially be debited to the ROU asset however, as the Trust's policy is to carry leased assets at existing use value, the increase in liability is expected to ultimately be recognised as a loss on valuation of the asset in the Statement of Comprehensive Income. The Trust is awaiting further guidance from HM Treasury on the re-measurement of the liability for indexation changes and as such has not yet estimated the quantitative effect that will result from the re-measurement in the 2022/23 year.

Other standards, amendments and interpretations

There is no other standard that has been issued that will have material effect on the Trust.

Note 2 Operating Segments

The Trust has assessed that services provided by each of its Divisions or geographical locations all fall within the description of 'provision of healthcare' and operate as a single operating segment. 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 (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.6

	Group		Trust	
Note 3.1 Income from patient care activities (by nature)	**2021/22**	**2020/21**	**2021/22**	**2020/21**
	£000	**£000**	**£000**	**£000**
Block contract / system envelope income	393,861	388,229	393,861	388,229
High cost drugs income from commissioners (excluding pass-through costs)	51,909	47,939	51,909	47,939
Other NHS clinical income	53,845	28,735	53,845	28,735
Private patient income	3,314	2,205	3,314	2,205
Elective recovery fund	13,632	-	13,632	-
Additional pension contribution central funding*	12,559	11,788	12,559	11,788
Other clinical income	775	705	662	625
Total income from activities	**529,895**	**479,601**	**529,782**	**479,521**

*The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	Group		Trust	
	2021/22	**2020/21**	**2021/22**	**2020/21**
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	132,051	128,126	132,051	128,126
Clinical commissioning groups	393,158	348,101	393,158	348,101
Other NHS providers	597	464	597	464
Non-NHS: private patients	3,314	2,205	3,314	2,205
Non-NHS: overseas patients (chargeable to patient)	182	254	182	254
Injury cost recovery scheme	412	338	412	338
Non NHS: other	181	113	68	33
Total income from activities	**529,895**	**479,601**	**529,782**	**479,521**
Of which:				
Related to continuing operations	529,895	479,601	529,782	479,521

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

	2021/22	2020/21
	£000	£000
Income recognised this year	182	254
Cash payments received in-year	111	130
Amounts added to provision for impairment of receivables	52	138
Amounts written off in-year	119	1

Note 4 Other operating income

	Group					
	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,646	-	**5,646**	3,932	-	**3,932**
Education and training	17,438	187	**17,625**	16,475	123	**16,598**
Non-patient care services to other bodies	17,908	-	**17,908**	6,293	-	**6,293**
Reimbursement and top up funding	3,871	-	**3,871**	23,072	-	**23,072**
Receipt of capital grants and donations	-	405	**405**	-	2,549	**2,549**
Charitable and other contributions to expenditure	-	1,688	**1,688**	-	7,983	**7,983**
Rental revenue from operating leases	-	110	**110**	-	85	**85**
Other income	1,313	-	**1,313**	787	-	**787**
Total other operating income	**46,176**	**2,390**	**48,566**	**50,559**	**10,740**	**61,299**
Of which:						
Related to continuing operations			48,566			61,299

	Trust					
	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,646	-	5,646	3,932	-	**3,932**
Education and training	17,438	187	17,625	16,475	123	**16,598**
Non-patient care services to other bodies	17,776	-	17,776	6,104	-	**6,104**
Reimbursement and top up funding	3,871	-	3,871	23,072	-	**23,072**
Receipt of capital grants and donations	-	405	405	-	2,549	**2,549**
Charitable and other contributions to expenditure	-	1,688	1,688	-	7,983	**7,983**
Rental revenue from operating leases	-	213	213	-	188	**188**
Other income	1,313	500	1,813	787	-	**787**
Total other operating income	**46,044**	**2,993**	**49,037**	**50,370**	**10,843**	**61,213**
Of which:						
Related to continuing operations			49,037			61,213

Other contract income includes:

Car parking income of £287k (2020/21 £56k)

Catering (non-patient) of £730k (2020/21 £660k)

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

	Group and Trust	
	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,299	1,949

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March 2022	31 March 2021
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	7,542	3,299
after one year, not later than five years	-	-
after five years	-	-
Total revenue allocated to remaining performance obligations	**7,542**	**3,299**

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 5.3 Fees and charges

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

Note 6.1 Operating expenses

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,300	10,151	8,300	10,151
Purchase of healthcare from non-NHS and non-DHSC bodies	11,148	7,415	11,165	7,426
Staff and executive directors costs	344,318	328,421	342,952	327,092
Remuneration of non-executive directors	145	116	145	116
Supplies and services - clinical (excluding drugs costs)	40,092	40,684	40,193	40,750
Supplies and services - general	13,203	13,209	13,203	13,209
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	62,014	56,451	64,883	59,122
Inventories written down	317	434	317	434
Consultancy costs	842	1,504	834	1,495
Establishment	5,638	4,670	5,483	4,459
Premises	22,167	17,688	22,106	17,626
Transport (including patient travel)	1,242	1,241	1,242	1,241
Depreciation on property, plant and equipment	10,155	9,267	10,135	9,243
Amortisation on intangible assets	3,002	2,589	2,994	2,570
Net impairments	155	1,599	155	1,599
Movement in credit loss allowance: contract receivables	30	7	30	7
Increase/(decrease) in other provisions	12,656	1,164	12,656	1,164
Change in provisions discount rate(s)	18	26	18	26
Fees payable to the external auditor				
audit services- statutory audit *	83	91	74	82
Internal audit costs	141	131	141	131
Clinical negligence	16,064	15,622	16,064	15,622
Legal fees	459	240	459	240
Insurance	324	271	316	265
Research and development	3,673	3,763	3,673	3,763
Education and training	1,888	1,277	1,888	1,277
Rentals under operating leases	10,785	8,633	10,785	8,633
Redundancy	-	376	-	376
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	121	120	121	120
Car parking & security	478	412	478	412
Hospitality	3	25	3	25
Losses, ex gratia & special payments	45	37	45	37
Other services, eg external payroll	1,670	2,145	1,670	2,145
Other	406	448	390	436
Total	**571,582**	**530,227**	**572,918**	**531,294**
Of which:				
Related to continuing operations	571,582	530,227	572,918	531,294

* The audit fee is stated on a gross basis for the Trust and net for the subsidiary. The total amount NET of VAT is £71k

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2020/21: £1 million).

Note 7 Impairment of assets

	Group and Trust	
	2021/22	2020/21
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	155	1,599
Total net impairments charged to operating surplus / deficit	**155**	**1,599**
Impairments charged to the revaluation reserve	187	2,682
Total net impairments	**342**	**4,281**

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 value of properties based on their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis.

Note 8 Employee benefits

	Group		Trust	
	2021/22 Total £000	2020/21 Total £000	2021/22 Total £000	2020/21 Total £000
Salaries and wages	239,599	229,494	238,233	228,326
Social security costs	25,720	23,894	25,720	23,894
Apprenticeship levy	1,209	1,133	1,209	1,133
Employer's contributions to NHS pensions	41,044	38,709	41,044	38,709
Pension cost - other	85	80	85	80
Termination benefits	-	376	-	376
Temporary staff (including agency)	43,177	41,152	43,177	40,991
Total gross staff costs	**350,834**	**334,838**	**349,468**	**333,509**
Recoveries in respect of seconded staff	(2,881)	(2,577)	(2,881)	(2,577)
Total staff costs	**347,953**	**332,261**	**346,587**	**330,932**
Of which				
Costs capitalised as part of assets	527	238	527	238
Included in Research & development	3,108	3,226	3,108	3,226
Included in Redundancy	-	376	-	376

Note 8.1 Retirements due to ill-health (Group and Trust)

During 2021/22 there was 1 early retirement from the trust agreed on the grounds of ill-health (3 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £144k (£129k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 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 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

NEST Pension Scheme

Where staff are not eligible for, or choose to opt out of, the NHS Pension Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme. NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme. The employer's contribution rate in 2021/22 was 3% (2020/21: 3%).

Note 10 Operating leases

Note 10.1 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		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Operating lease revenue				
Minimum lease receipts	110	85	213	188
Total	**110**	**85**	**213**	**188**

	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	110	85	213	188
- later than one year and not later than five years;	-	-	-	-
- later than five years.	-	-	-	-
Total	**110**	**85**	**213**	**188**

Note 10.2 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 buildings, 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	
	2021/22	2020/21
	£000	£000
Operating lease expense		
Minimum lease payments	10,785	8,633
Total	**10,785**	**8,633**

	31 March 2022	31 March 2021 Restated
	£000	£000
Future minimum lease payments due:		
- not later than one year;	9,898	7,895
- later than one year and not later than five years;	23,909	22,449
- later than five years.	74,769	78,685
Total	**108,576**	**109,029**

In the prior year, the operating lease commitments disclosed were understated due to an incorrect assessment of the lease term for one lease. The prior year figures have been restated to increase total commitments from 32,785k to 109,029k.

Note 11 Finance expenditure

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

	Group and Trust	
	2021/22	2020/21
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,174	1,254
Interest on late payment of commercial debt	1	4
Main finance costs on PFI and LIFT schemes obligations	447	464
Contingent finance costs on PFI and LIFT scheme obligations	426	396
Total interest expense	**2,048**	**2,118**
Unwinding of discount on provisions	(10)	(3)
Other finance costs	57	62
Total finance costs	**2,095**	**2,177**

Note 11.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Group and Trust	
	2021/22	2020/21
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	1	4

Note 12 Other gains / (losses)

	Group and Trust	
	2021/22	2020/21
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(479)	(1,560)
Total other (losses)	**(479)**	**(1,560)**

Note 13.1 Intangible assets - 2021/22

Group	Software licences £000	Licences & trademarks £000	Internally generated assets £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	**32,800**	**1,127**	**4,788**	**9**	**38,724**
Additions	4,894	86	-	932	**5,912**
Reclassifications	2,493	(1,213)	-	(941)	**339**
Valuation / gross cost at 31 March 2022	**40,187**	**-**	**4,788**	**-**	**44,975**
Amortisation at 1 April 2021 - brought forward	**7,436**	**844**	**3,482**	**-**	**11,762**
Provided during the year	2,774	55	173	-	**3,002**
Reclassifications	932	(899)	-	-	**33**
Amortisation at 31 March 2022	**11,142**	**-**	**3,655**	**-**	**14,797**
Net book value at 31 March 2022	**29,045**	**-**	**1,133**	**-**	**30,178**
Net book value at 1 April 2021	**25,364**	**283**	**1,306**	**9**	**26,962**

Note 13.2 Intangible assets - 2020/21

Group	Software licences	Licences & trademarks	Internally generated assets	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**28,804**	**1,020**	**6,012**	**-**	**35,836**
Additions	3,378	218	-	618	**4,214**
Reclassifications	618	-	-	(609)	**9**
Disposals / derecognition	-	(111)	(1,224)	-	**(1,335)**
Valuation / gross cost at 31 March 2021	**32,800**	**1,127**	**4,788**	**9**	**38,724**
Amortisation at 1 April 2020 - as previously stated	**5,216**	**866**	**3,642**	**-**	**9,724**
Provided during the year	2,220	31	338	-	**2,589**
Disposals / derecognition	-	(53)	(498)	-	**(551)**
Amortisation at 31 March 2021	**7,436**	**844**	**3,482**	**-**	**11,762**
Net book value at 31 March 2021	**25,364**	**283**	**1,306**	**9**	**26,962**
Net book value at 1 April 2020	**23,588**	**154**	**2,370**	**-**	**26,112**

Note 14.1 Intangible assets - 2021/22

Trust	Software licences £000	Licences & trademarks £000	Internally generated assets £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2021 - brought forward	**32,696**	**1,127**	**4,788**	**9**	**38,620**
Additions	4,894	86	-	932	**5,912**
Reclassifications	2,493	(1,213)	-	(941)	**339**
Valuation / gross cost at 31 March 2022	**40,083**	**-**	**4,788**	**-**	**44,871**
Amortisation at 1 April 2021 - brought forward	**7,350**	**844**	**3,482**	**-**	**11,676**
Provided during the year	2,766	55	173	-	**2,994**
Reclassifications	932	(899)	-	-	**33**
Amortisation at 31 March 2022	**11,048**	**-**	**3,655**	**-**	**14,703**
Net book value at 31 March 2022	**29,035**	**-**	**1,133**	**-**	**30,168**
Net book value at 1 April 2021	**25,346**	**283**	**1,306**	**9**	**26,944**

Note 14.2 Intangible assets - 2020/21

Trust	Software licences £000	Licences & trademarks £000	Internally generated assets £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2020 - as previously stated	**28,700**	**1,020**	**6,012**	**-**	**35,732**
Additions	3,378	218	-	618	**4,214**
Reclassifications	618	-	-	(609)	**9**
Disposals / derecognition	-	(111)	(1,224)	-	**(1,335)**
Valuation / gross cost at 31 March 2021	**32,696**	**1,127**	**4,788**	**9**	**38,620**
Amortisation at 1 April 2020 - as previously stated	**5,148**	**866**	**3,642**	**-**	**9,656**
Provided during the year	2,202	31	338	-	**2,571**
Disposals / derecognition	-	(53)	(498)	-	**(551)**
Amortisation at 31 March 2021	**7,350**	**844**	**3,482**	**-**	**11,676**
Net book value at 31 March 2021	**25,346**	**283**	**1,306**	**9**	**26,944**
Net book value at 1 April 2020	**23,552**	**154**	**2,370**	**-**	**26,076**

Note 15.1 Property, plant and equipment - 2021/22

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**26,060**	**142,529**	**8,937**	**52,352**	**11,735**	**2,643**	**244,256**
Additions	-	2,257	17,228	9,367	2,599	3	**31,454**
Impairments	-	(2,610)	-	-	-	-	**(2,610)**
Reversals of impairments	-	2,423	-	-	-	-	**2,423**
Revaluations	7,108	(1,359)	-	-	-	-	**5,749**
Reclassifications	-	16,112	(18,918)	1,703	764	-	**(339)**
Disposals / derecognition	-	-	-	(602)	-	-	**(602)**
Valuation/gross cost at 31 March 2022	**33,168**	**159,352**	**7,247**	**62,820**	**15,098**	**2,646**	**280,331**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**876**	**-**	**32,668**	**8,997**	**2,071**	**44,612**
Provided during the year	-	6,168	-	2,908	977	102	**10,155**
Impairments	-	6,427	-	-	-	-	**6,427**
Reversals of impairments	-	(6,272)	-	-	-	-	**(6,272)**
Revaluations	-	(5,869)	-	-	-	-	**(5,869)**
Reclassifications	-	-	-	(43)	10	-	**(33)**
Disposals / derecognition	-	-	-	(123)	-	-	**(123)**
Accumulated depreciation at 31 March 2022	**-**	**1,330**	**-**	**35,410**	**9,984**	**2,173**	**48,897**
Net book value at 31 March 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,114**	**473**	**231,434**
Net book value at 1 April 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,738**	**572**	**199,644**

Note 15.2 Property, plant and equipment - 2020/21

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**22,055**	**136,592**	**1,951**	**48,285**	**11,253**	**2,641**	**222,777**
Additions	-	9,243	9,062	9,207	792	2	**28,306**
Impairments	-	(2,682)	-	-	-	-	**(2,682)**
Revaluations	4,005	(2,700)	-	-	-	-	**1,305**
Reclassifications	-	2,076	(2,076)	(9)	-	-	**(9)**
Disposals / derecognition	-	-	-	(5,131)	(310)	-	**(5,441)**
Valuation/gross cost at 31 March 2021	**26,060**	**142,529**	**8,937**	**52,352**	**11,735**	**2,643**	**244,256**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**433**	**-**	**34,474**	**8,292**	**1,967**	**45,166**
Provided during the year	-	5,599	-	2,664	900	104	**9,267**
Impairments	-	4,342	-	-	-	-	**4,342**
Reversals of impairments	-	(2,743)	-	-	-	-	**(2,743)**
Revaluations	-	(6,755)	-	-	-	-	**(6,755)**
Disposals / derecognition	-	-	-	(4,470)	(195)	-	**(4,665)**
Accumulated depreciation at 31 March 2021	**-**	**876**	**-**	**32,668**	**8,997**	**2,071**	**44,612**
Net book value at 31 March 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,738**	**572**	**199,644**
Net book value at 1 April 2020	**22,055**	**136,159**	**1,951**	**13,811**	**2,961**	**674**	**177,611**

Note 15.3 Property, plant and equipment financing - 2021/22

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	33,168	147,972	7,247	24,744	5,114	392	**218,637**
On-SoFP PFI contracts and other service concession arrangements	-	8,046	-	-	-	-	**8,046**
Owned - donated/granted	-	2,004	-	2,666	-	81	**4,751**
NBV total at 31 March 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,114**	**473**	**231,434**

Note 15.4 Property, plant and equipment financing - 2020/21

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	26,060	132,116	8,937	16,199	2,738	474	**186,524**
On-SoFP PFI contracts and other service concession arrangements	-	7,833	-	-	-	-	**7,833**
Owned - donated/granted	-	1,704	-	3,485	-	98	**5,287**
NBV total at 31 March 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,738**	**572**	**199,644**

Note 16.1 Property, plant and equipment - 2021/22

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2021 - brought forward	**26,060**	**142,529**	**8,937**	**52,352**	**11,669**	**2,490**	**244,037**
Additions	-	2,257	17,228	9,367	2,596	-	**31,448**
Impairments	-	(2,610)	-	-	-	-	**(2,610)**
Reversals of impairments	-	2,423	-	-	-	-	**2,423**
Revaluations	7,108	(1,359)	-	-	-	-	**5,749**
Reclassifications	-	16,112	(18,918)	1,703	764	-	**(339)**
Disposals / derecognition	-	-	-	(602)	-	-	**(602)**
Valuation/gross cost at 31 March 2022	**33,168**	**159,352**	**7,247**	**62,820**	**15,029**	**2,490**	**280,106**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**876**	**-**	**32,668**	**8,936**	**2,001**	**44,481**
Provided during the year	-	6,168	-	2,908	973	86	**10,135**
Impairments	-	6,427	-	-	-	-	**6,427**
Reversals of impairments	-	(6,272)	-	-	-	-	**(6,272)**
Revaluations	-	(5,869)	-	-	-	-	**(5,869)**
Reclassifications	-	-	-	(43)	10	-	**(33)**
Disposals / derecognition	-	-	-	(123)	-	-	**(123)**
Accumulated depreciation at 31 March 2022	**-**	**1,330**	**-**	**35,410**	**9,919**	**2,087**	**48,746**
Net book value at 31 March 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,110**	**403**	**231,360**
Net book value at 1 April 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,733**	**489**	**199,556**

Note 16.2 Property, plant and equipment - 2020/21

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**22,055**	**136,592**	**1,951**	**48,285**	**11,187**	**2,490**	**222,560**
Additions	-	9,243	9,062	9,207	792	-	**28,304**
Impairments	-	(2,682)	-	-	-	-	**(2,682)**
Revaluations	4,005	(2,700)	-	-	-	-	**1,305**
Reclassifications	-	2,076	(2,076)	(9)	-	-	**(9)**
Disposals / derecognition	-	-	-	(5,131)	(310)	-	**(5,441)**
Valuation/gross cost at 31 March 2021	**26,060**	**142,529**	**8,937**	**52,352**	**11,669**	**2,490**	**244,037**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**433**	**-**	**34,474**	**8,241**	**1,912**	**45,060**
Provided during the year	-	5,599	-	2,664	890	89	**9,242**
Impairments	-	4,342	-	-	-	-	**4,342**
Reversals of impairments	-	(2,743)	-	-	-	-	**(2,743)**
Revaluations	-	(6,755)	-	-	-	-	**(6,755)**
Disposals / derecognition	-	-	-	(4,470)	(195)	-	**(4,665)**
Accumulated depreciation at 31 March 2021	**-**	**876**	**-**	**32,668**	**8,936**	**2,001**	**44,481**
Net book value at 31 March 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,733**	**489**	**199,556**
Net book value at 1 April 2020	**22,055**	**136,159**	**1,951**	**13,811**	**2,946**	**578**	**177,500**

Note 16.3 Property, plant and equipment financing - 2021/22

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	33,168	147,972	7,247	24,744	5,109	323	**218,563**
On-SoFP PFI contracts and other service concession arrangements	-	8,046	-	-	-	-	**8,046**
Owned - donated / granted	-	2,004	-	2,666	-	81	**4,751**
NBV total at 31 March 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,109**	**404**	**231,360**

Note 16.4 Property, plant and equipment financing - 2020/21

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	26,060	132,116	8,937	16,199	2,733	391	**186,436**
On-SoFP PFI contracts and other service concession arrangements	-	7,833	-	-	-	-	**7,833**
Owned - donated / granted	-	1,704	-	3,485	-	98	**5,287**
NBV total at 31 March 2021	**26,060**	**141,653**	**8,937**	**19,684**	**2,733**	**489**	**199,556**

Note 17 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 Hertfordshire NHS Trust Charitable Funds. The amount received in 2021-22 was £405k (2020-21 £371k).

The Trust has not received any donation of equipment as part of the coronavirus pandemic response in 2021/22 from NHS England and Improvement. The amount received in 2020-21 was £2,178k.

Note 18 Revaluations of property, plant and equipment

The Trust's land and buildings valuations were reviewed at 31 March 2022 by an independent, qualified valuer, using the Modern Equivalent Asset (MEA) methodology for specialised assets, in accordance with DH guidance and the NHS Group Accounting Manual. Where refurbishment work is carried out on a leased property, these are not revalued.

A full 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.

Current Value in Existing Use 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. The DRC method is a form of cost approach that is defined in the RICS Valuation – Global Standards 2017 (RB Global) Glossary as: 'The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation. '

For non-specialised properties, the Current Value in Existing Use has been derived from comparable market transactions of arm's length terms. The existing use value is not materially different from its open market value.

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 MEA has been determined based upon a single build programme on a cleared site to modern design and arrangement.

The value of land has been assessed on the basis of the construction of a modern equivalent asset in an alternative site, over a number of storeys, with the associated footprint that such a construction would require. The modern equivalent asset may not require a site as extensive as the actual site. The Trust has applied a concept of single build of an integrated moultistorey hospital incorporating all clinical provision and ancillary accomodation and services.

Lister hospital will require 62% of its current land size and this equates to a single 5 storey building, utilising 25% site density. Similarly, Hertford County Hospital will require 75% of its current land size with a 3 storey single build facility.

Net increase in the valuation of property, plant and equipment which was transferred to revaluation reserve during the year was £11,431k, whilst impairment of £155k was charged to statement of comprehensive income.

Note 19 Other investments (current)

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 subsidiary's accounts are prepared as at 31 March 2022 and for the period then ended.

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 2022, the subsidiary's total profit for the year was £1,192k (2020/21: £991k), with gross assets of £5,498k (2020/21: £4,867k) and net assets of £3,266k (2020/21: £2,576k).

Note 20 Inventories

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Drugs	3,630	3,489	2,360	2,139
Consumables	4,114	4,437	4,113	4,437
Energy	152	161	152	161
Total inventories	**7,896**	**8,087**	**6,625**	**6,737**
of which:				
Held at fair value less costs to sell	-	-		

Inventories recognised in expenses for the year were £64,034k (2020/21: £64,632k). Write-down of inventories recognised as expenses for the year were £317k (2020/21: £434k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,688k of items purchased by DHSC (2020/21: £7,983k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above. The closing balance of inventory included in Consumables was £165k (2020/21: £318k).

Note 21.1 Receivables

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Current				
Contract receivables	15,981	13,958	15,939	13,936
Allowance for impaired contract receivables	(1,342)	(1,440)	(1,342)	(1,440)
Prepayments (non-PFI)	4,493	4,535	4,493	4,535
PDC dividend receivable	218	1,484	218	1,484
VAT receivable	3,297	3,343	2,645	2,711
Other receivables	1,980	1,611	1,980	1,611
Total current receivables	**24,627**	**23,491**	**23,933**	**22,837**
Non-current				
Contract receivables	569	1,833	569	1,833
Allowance for other impaired receivables	(404)	(404)	(404)	(404)
Prepayments (non-PFI)	949	997	949	997
Other receivables	467	59	467	59
Total non-current receivables	**1,581**	**2,485**	**1,581**	**2,485**
Of which receivable from NHS and DHSC group bodies:				
Current	11,055	12,297	11,055	12,297
Non-current	467	59	467	59

Note 21.2 Allowances for credit losses - 2021/22

	Group and Trust	
	Contract receivables	All other receivables
	£000	£000
Allowances as at 1 Apr 2021 - brought forward	**1,844**	**-**
New allowances arising	30	-
Utilisation of allowances (write offs)	(128)	-
Allowances as at 31 Mar 2022	**1,746**	**-**

Note 21.3 Allowances for credit losses - 2020/21

	Group and Trust	
	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2020 - as previously stated	**1,938**	**-**
Changes in existing allowances	7	-
Utilisation of allowances (write offs)	(101)	-
Allowances as at 31 Mar 2021	**1,844**	**-**

Note 22.1 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	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
At 1 April	**52,459**	**11,389**	**51,574**	**10,823**
Net change in year	32,488	41,070	31,749	40,751
At 31 March	**84,947**	**52,459**	**83,323**	**51,574**
Broken down into:				
Cash at commercial banks and in hand	1,657	905	33	20
Cash with the Government Banking Service	83,290	51,554	83,290	51,554
Total cash and cash equivalents as in SoFP	**84,947**	**52,459**	**83,323**	**51,574**

Note 22.2 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 2022	31 March 2021
	£000	£000
Monies on deposit	8	5
Total third party assets	**8**	**5**

Note 23.1 Trade and other payables

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Trade payables	25,274	27,160	24,866	26,765
Capital payables	1,388	3,154	1,388	3,154
Accruals	45,080	26,148	45,080	26,148
Social security costs	3,854	3,452	3,854	3,425
Other taxes payable	3,797	3,080	3,797	3,080
Total current trade and other payables	**79,393**	**62,994**	**78,985**	**62,572**
Non-current				
Other payables	3,799	4,004	3,799	4,004
Total non-current trade and other payables	**3,799**	**4,004**	**3,799**	**4,004**
Of which payables from NHS and DHSC group bodies:				
Current	5,745	9,460	5,745	9,460
Non-current	-	-	-	-

Note 24 Other liabilities

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Current		
Deferred income: contract liabilities	7,542	3,299
Total other current liabilities	**7,542**	**3,299**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 25 Borrowings

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Current		
Loans from DHSC	2,638	2,641
Other loans	-	63
Obligations under PFI or other service concession contracts (excl. lifecycle)	335	263
Total current borrowings	**2,973**	**2,967**
Non-current		
Loans from DHSC	35,449	38,037
Obligations under PFI or other service concession contracts	5,411	5,745
Total non-current borrowings	**40,860**	**43,782**

Note 25.1 Reconciliation of liabilities arising from financing activities

Group and Trust - 2021/22	Loans from DHSC	Other loans	PFI scheme	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	**40,678**	**63**	**6,008**	**46,749**
Cash movements:				
Financing cash flows - payments of principal	(2,588)	(63)	(262)	**(2,913)**
Financing cash flows - payments of interest	(1,177)	-	(447)	**(1,624)**
Non-cash movements:				
Application of effective interest rate	1,174	-	447	**1,621**
Carrying value at 31 March 2022	**38,087**	**-**	**5,746**	**43,833**

Group and Trust - 2020/21	Loans from DHSC	Other loans	PFI scheme	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**190,487**	**126**	**6,227**	**196,840**
Cash movements:				
Financing cash flows - payments of principal	(149,474)	(63)	(219)	**(149,756)**
Financing cash flows - payments of interest	(1,589)	-	(464)	**(2,053)**
Non-cash movements:				
Application of effective interest rate	1,254	-	464	**1,718**
Carrying value at 31 March 2021	**40,678**	**63**	**6,008**	**46,749**

Note 26.1 Provisions for liabilities and charges analysis

Group and Trust	Pensions: early departure costs	Legal claims	Redundancy	Dilapidation	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2021	**971**	**80**	**376**	**610**	**58**	**2,095**
Change in the discount rate	18	-	-	-	-	**18**
Arising during the year	46	37	297	12,577	409	**13,366**
Utilised during the year	(101)	(42)	(376)	-	-	**(519)**
Reversed unused	(5)	-	-	-	-	**(5)**
Unwinding of discount	(10)	-	-	-	-	**(10)**
At 31 March 2022	**919**	**75**	**297**	**13,187**	**467**	**14,945**
Expected timing of cash flows:						
- not later than one year;	107	74	297	218	-	**696**
- later than one year and not later than five years;	321	-	-	8,330	-	**8,651**
- later than five years.	491	1	-	4,639	467	**5,598**
Total	**919**	**75**	**297**	**13,187**	**467**	**14,945**

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.

Redundancy provision relates to costs that are likely to be paid as a result of transfer of service.

Dilapidation provision relates to contractual and constructive obligation to reinstate leased buildings to the original state at the time the Trust surrenders the building back to the Landlord.

Other provision relates to clinician pension costs.

The discount rate applied to provisions above is -1.3%.

Note 26.2 Clinical negligence liabilities

At 31 March 2022, £540,945k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire NHS Trust (31 March 2021: £336,302k).

Note 27 Contingent assets and liabilities

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(28)	(53)
Gross value of contingent liabilities	**(28)**	**(53)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(28)**	**(53)**
Net value of contingent assets	**-**	**-**

Contingent liabilities relate to claims under the Trust's Employer Liability and Public Liability Schemes, where the probability of success has been assessed as being between 20% and 50%.

Note 28 Contractual capital commitments

	Group	
	31 March 2022	31 March 2021
	£000	£000
Property, plant and equipment	3,612	5,204
Intangible assets	-	-
Total	**3,612**	**5,204**

Note 29 On-SoFP PFI

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 29.1 On-SoFP PFI

The following obligations in respect of the PFI are recognised in the statement of financial position:

	Group and Trust	
	31 March 2022 £000	31 March 2021 £000
Gross PFI liabilities	**8,674**	**9,383**
Of which liabilities are due		
- not later than one year;	761	710
- later than one year and not later than five years;	2,996	2,981
- later than five years.	4,917	5,692
Finance charges allocated to future periods	(2,928)	(3,375)
Net PFI obligation	**5,746**	**6,008**
- not later than one year;	335	263
- later than one year and not later than five years;	1,560	1,434
- later than five years.	3,851	4,311

Note 29.2 Total on-SoFP PFI commitments

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

	Group and Trust	
	31 March 2022 £000	31 March 2021 £000
Total future payments committed in respect of the PFI	**20,680**	**22,520**
Of which payments are due:		
- not later than one year;	1,635	1,613
- later than one year and not later than five years;	6,960	6,865
- later than five years.	12,085	14,042

Note 29.3 Analysis of amounts payable to PFI operator

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

	Group and Trust	
	2021/22	2020/21
	£000	£000
Unitary payment payable to service concession operator	**1,595**	**1,574**
Consisting of:		
- Interest charge	447	464
- Repayment of balance sheet obligation	263	219
- Service element and other charges to operating expenditure	121	120
- Capital lifecycle maintenance	338	375
- Contingent rent	426	396
Total amount paid to service concession operator	**1,595**	**1,574**

Note 30 Financial instruments

Note 30.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking these activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the 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 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 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 2022 are in receivables from customers, as disclosed in the trade and other receivables note. The Trust has assessed this risk against the impact of Covid-19 and has come to the same conclusion.

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 30.2 Carrying values of financial assets

	Group
Carrying values of financial assets as at 31 March 2022	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	17,250
Cash and cash equivalents	84,947
Total at 31 March 2022	**102,197**

Carrying values of financial assets as at 31 March 2021	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	15,617
Cash and cash equivalents	52,459
Total at 31 March 2021	**68,076**

Note 30.3 Carrying values of financial assets **Trust**

Carrying values of financial assets as at 31 March 2022	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	16,556
Cash and cash equivalents	83,323
Total at 31 March 2022	**99,879**

Carrying values of financial assets as at 31 March 2021	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	15,595
Cash and cash equivalents	51,574
Total at 31 March 2021	**67,169**

All financial assets are held at amortised cost

Note 30.4 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Group Held at amortised cost £000
Loans from the Department of Health and Social Care	38,087
Obligations under PFI, LIFT and other service concessions	5,746
Trade and other payables excluding non financial liabilities	75,540
Other financial liabilities	1,750
Total at 31 March 2022	**121,123**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000
Loans from the Department of Health and Social Care	40,678
Obligations under PFI, LIFT and other service concessions	6,008
Other borrowings	63
Trade and other payables excluding non financial liabilities	58,960
Other financial liabilities	1,927
Total at 31 March 2021	**107,636**

Note 30.5 Carrying values of financial liabilities	Trust
Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	38,087
Obligations under PFI, LIFT and other service concessions	5,746
Trade and other payables excluding non financial liabilities	75,132
Other financial liabilities	1,750
Total at 31 March 2022	**120,715**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost
	£000
Loans from the Department of Health and Social Care	40,678
Obligations under PFI, LIFT and other service concessions	6,008
Other borrowings	63
Trade and other payables excluding non financial liabilities	58,565
Other financial liabilities	1,927
Total at 31 March 2021	**107,241**

All financial liabilities are held at amortised cost.

Note 30.6 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 30.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
In one year or less	76,422	63,757	76,014	63,364
In more than one year but not more than five years	18,606	18,087	18,606	18,087
In more than five years	37,461	38,804	37,461	38,804
Total	**132,489**	**120,648**	**132,081**	**120,255**

Note 31 Losses and special payments

	2021/22		2020/21	
Group and trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Cash losses	-	-	1	-
Bad debts and claims abandoned	70	129	357	100
Stores losses and damage to property	50	329	57	414
Total losses	**120**	**458**	**415**	**514**
Special payments				
Ex-gratia payments	36	267	38	147
Total special payments	**36**	**267**	**38**	**147**
Total losses and special payments	**156**	**725**	**453**	**661**
Compensation payments received		-		-

Included in the Ex-gratia payaments is overtime corrective payment (flowers legal case) as nationally agreed and funded.

Cases over £300,000

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

Note 32 Gifts

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

Note 33 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 Care 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, West Essex CCG, 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 2021-22 the Trust received £1,446k (2020-21 £1,417k) 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 £375k (2020-21 £155k) receivable balance from the charity at the end of the financial year.

Note 34 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 35 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	68,930	219,118	64,775	204,423
Total non-NHS trade invoices paid within target	64,278	195,991	61,832	188,874
Percentage of non-NHS trade invoices paid within target	93.3%	89.4%	95.5%	92.4%
NHS Payables				
Total NHS trade invoices paid in the year	2,470	33,700	2,565	32,920
Total NHS trade invoices paid within target	1,683	24,894	1,715	25,861
Percentage of NHS trade invoices paid within target	68.1%	73.9%	66.9%	78.6%

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 11.

Note 36 External financing

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

	2021/22 £000	2020/21 £000
Cash flow financing	(8,883)	(21,693)
Finance leases taken out in year		
Other capital receipts	-	-
External financing requirement	**(8,883)**	**(21,693)**
External financing limit (EFL)	(8,883)	15,957
Under spend against EFL	**-**	**37,650**

Note 37 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	37,366	32,520
Less: Disposals	(479)	(1,560)
Less: Donated and granted capital additions	(405)	(2,549)
Plus: Loss on disposal from capital grants in kind	479	-
Charge against Capital Resource Limit	**36,961**	**28,411**
Capital Resource Limit	37,082	30,800
Under spend against CRL	**121**	**2,389**

Note 38 Breakeven duty financial performance

	2021/22 £000
Adjusted financial performance surplus (control total basis)	361
Remove impairments scoring to Departmental Expenditure Limit	-
Breakeven duty financial performance surplus	**361**

Note 39 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,500	3,328	3,568	532	109	(3,613)
Breakeven duty cumulative position	1,825	4,325	7,653	11,221	11,753	11,862	8,249
Operating income		331,312	340,309	346,402	350,543	365,313	376,050
Cumulative breakeven position as a percentage of operating income		1.3%	2.2%	3.2%	3.4%	3.2%	2.2%

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(16,226)	(29,533)	(24,424)	(13,543)	1,452	2,528	361
Breakeven duty cumulative position	(7,977)	(37,510)	(61,934)	(75,477)	(74,025)	(71,497)	(71,136)
Operating income	384,712	411,870	420,968	444,903	498,597	540,900	578,461
Cumulative breakeven position as a percentage of operating income	(2.1%)	(9.1%)	(14.7%)	(17.0%)	(14.8%)	(13.2%)	(12.3%)

The Trust first reported cumulative deficit in 2015-16 of £7,977k (-2.1% of operating income). The Trust is in the seventh year of consecutive break-even duty breach achieving a cumulative deficit of £71,136k (-12.3% of operating income) above the -0.5% permitted. The Trust achieved surplus of £361k in 2021-22 and is working with NHS England & Improvement to develop a plan to achieve cumulative breakeven duty in future years.