East and North Hertfordshire NHS Trust

East and North Hertfordshire NHS Trust

2016/17 annual report and accounts

31 May 2017

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Performance section

Trust overview

This section of the annual report provides an overview of the Trust itself, its performance during 2016/17, along with the key risks and challenges that it faces going forward.

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

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

The Trust owns the freehold for each of the Lister and Hertford County; the New QEII is operated on behalf of the NHS by Community Health Partnerships and the Mount Vernon Cancer centre operates out of facilities that the Trust leases from the Hillingdon Hospitals NHS Foundation Trust.

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

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

The birth rate is slightly above the England average, with the Trust's core catchment population forecast to rise by just under 10% over the 10 years to 2026); the most significant growth is expected in people aged 45 to 74 years (although rates of increase in those aged 75 and over are likely to have the greatest impact in terms of health needs). Black and minority ethnic groups (i.e. non-white British) make up approximately 10% of the population in east and north Hertfordshire, including Stevenage and Welwyn Hatfield.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Some 5,000 staff are employed by the Trust and its annual budget is approximately £425 million.

Chair and chief executive's report

The NHS has experienced a time of great challenge in the last 12 months. Notwithstanding these challenges, the Trust has used the last year as an opportunity to sow the seeds of recovery and improvement for 2017/18 and beyond. Part of this work has been delivered through the Trust's involvement in the new and evolving Hertfordshire and West Essex Sustainability and Transformation Partnership (STP), with the remainder coming from improvements being made to the Trust's clinical, operational and financial performance.

Through this report, we would like to focus on six areas:

- Clinical quality of care and outcomes for patients
- Feedback from and the experience of our patients
- The Trust's staff and organisational culture
- Follow-up inspection visits from the Care Quality Commission
- The Trust's financial recovery position
- The STP

When the Trust embarked upon the *Our changing hospitals* programme, which completed in early 2015, one of the key promises made to local people was that the changes would lead to improvements in the quality of care. Today across a range of quality indicators, the Trust can show that it has been delivering on that promise.

Some of the key indicators used across the country to measure and compare the quality of nursing provided to patents include such important areas as: inpatient falls; hospital-associated infections; pressure ulcers; mixed sex accommodation; and safe staffing levels. Traditionally the Trust has performed well against these measures, but it is also clear that this good performance has accelerated over the last couple of years.

Today levels of inpatient falls, infections and pressure ulcers on the Trust's wards have fallen to historical lows, which in many cases places it amongst the best performing organisations in the East of England, if not the country. The Trust is also amongst a handful of NHS trusts nationally to deliver routinely its commitments around avoiding mixed sex accommodation and delivering safe nurse staffing levels.

Perhaps the ultimate measure of clinical quality and patient outcomes, however, is mortality. There are several measures used nationally to measure mortality and allow comparisons to be made between hospitals – most notably the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indictor (SHMI). Whichever measure is used, the Trust now provides services that are either within or below the *as expected* range – something that was not the case historically.

This improvement in the clinical quality of the Trust's services has been reflected in how patients rate their experience of the care received. The measure used most commonly in the NHS to rate patient feedback is the Friends and Family Test (FFT). It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism capable of highlighting both good and poor patient experience.

Since its introduction in April 2013, the FFT has been rolled out in a phased way to cover most aspects of NHS experience, including inpatient, day case, outpatient, maternity and A&E services. Today, the Trust scores well across all areas. This high level of positive patient experience feedback is also reflected in what patients say about the Trust's staff and services online – for example through NHS Choices, or via social media outlets like Facebook and Twitter. Again, the vast majority of comments received are positive, with those raising concerns always offered the opportunity for follow-up by the teams involved in their care.

Improving clinical quality and patient feedback is linked directly to the quality of the Trust's staff, especially those working in frontline areas, and staffing levels. The NHS is facing significant challenges when it comes to recruiting and retaining sufficient staff, most notably doctors, nurses and some specialist healthcare professionals. The Trust has not been immune to these pressures, but a combination of close collaboration with its local universities, a very proactive recruitment programme and a focus on retaining its staff means that the level of vacancies and turnover has not only reduced over the last 12 months, but also is better than many of the Trust's neighbouring organisations. The recruitment challenge remains significant, however, with uncertainties over the status of European Union nationals under the Brexit negotiations and the changing nature of nurse training being significant issues.

Whilst part of the challenge has been to fill the Trust's vacancies, retaining existing staff has received equal attention. Changing the organisation's culture through the LEND (*Listen*, *Empower*, *Nurture* and *Develop*) programme has been key to helping to deliver a supportive, coaching environment across all areas. The Trust's results from the 2016 national staff survey showed that real improvements have been made over the last couple of years, with the ratings for staff engagement above the national average for the second year running. The engagement score comprises three elements: staff motivation at work; staff ability to contribute to improvements; and staff recommending the Trust as a place to work or receive treatment. For the first two, the Trust's staff rated their experience such that the Trust's scores were in the top 20% in the NHS; the Trust was rated at the national average when it came to being recommended as a place to work or be treated.

More work, of course, needs to be done on the Trust's recruitment, retention and cultural change programmes, but clear evidence is emerging that a positive course is being charted that feeds in to better clinical quality outcomes and the experience of patients. These factors are also important to how the Trust and its performance is viewed by NHS regulators such as the Care Quality Commission (CQC).

In last year's annual report, the outcome of the Trust's 2015 comprehensive CQC inspection was discussed in detail. Although rated overall as *requiring improvement*, there was much to be positive about in the CQC's report. There were also areas that needed further work, especially children's acute and emergency care services. During 2016, teams from the CQC undertook follow-up inspections of both these services, with inspectors' feedback confirming that the expected improvements were being made. The Trust is now gearing up for its next set of inspections over the coming year, with the ambition of seeing its rating improve to *good* overall.

These improvements in how services are being managed have also been reflected in the Trust's operational performance. Like the rest of the NHS, the Trust has faced significant pressures over the last 12 months in delivering the national 18-week referral to treatment (RTT), four-hour A&E and cancer waiting times standards. During 2016/17, the Trust delivered the 18-week RTT standard in 10 of 12 months, has seen steady improvement in its A&E performance and has begun the implementation of an agreed recovery programme for improving cancer waiting times.

Traditionally the winter months, especially from early January through to March, are amongst the busiest in the health service – especially for emergency care. This year the Trust, along with its partners in community and social care, were better prepared than ever before. That, along with improvements made in the Trust's emergency care pathway, resulted in better performance this winter compared to the experience in 2015 – and this was despite significant rises in the number of patients requiring emergency admission. More work is being undertaken to improve performance further, especially around A&E and cancer waiting times, but the overall direction of travel is positive.

The area where the Trust had the greatest challenge during 2016/17, however, was around its finances. In agreeing the *Our changing hospitals* programme, the NHS locally set out expectations around reducing the growth in hospital referrals, attendances and admissions. During recent years, the levels of referrals and admissions, both emergency and non-emergency, to the Trust's services have grown overall and exceeded the plan agreed by the local health system. In the past, the Trust has responded to these incremental, unplanned rises in activity by increasing capacity in stages, often through using higher-cost services – including expensive agency staff and waiting list initiatives involving independent sector partners.

On reflection, the Trust should have acted sooner to challenge the planning assumptions being made locally around hospital services. Not doing so has led the Trust to making a series of decisions around capacity planning that tended to be reactive, rather than strategic, in nature.

The development of the local Hertfordshire and West Essex STP has enabled these matters to be addressed positively by the NHS locally. The Trust's contract for 2017/18 now reflects more accurately the true cost of providing the current level of activity going through its hospitals. The STP should also, in turn, set in place a more robust framework that will see levels of hospital activity reduce over time in a planned manner – which represents a core element in providing sustainable health services by 2020.

The Trust's financial performance over the last 12 months saw it fail to meet the agreed outturn deficit position (£8.2 million) for the year that was agreed with NHS Improvement. Whilst much of the financial pressures faced by the Trust during 2016/17 were one-off and non-recurrent, a detailed plan was put in place during the final quarter to ensure that the challenges for 2017/18 and beyond were met. This plan, which will also support the changes that will be made to wider NHS services through the local STP, was developed with input and support from NHS Improvement.

A key focus in improving financial performance has been to ensure that the Trust and its staff spend money more effectively. Our staff have been reviewing all services to make improvements in their efficiency and effectiveness – making them easier to manage and better from a patient experience point-of-view.

In delivering its *Transforming our hospitals* programme, the Trust has engaged the services of external specialists from PricewaterhouseCoopers and Four Eyes Insight. These teams bring with them not only an important external perspective gained from working in other NHS organisations that have achieved successful recovery and transformation programmes, but also the additional capacity needed to allow the Trust's staff to deliver the work involved. At the same time, they will gain the skills and expertise to ensure that the programme continues to evolve and grow over time.

Although still at the beginning of its evolution, the programme's early signs have been encouraging. Key to its success is engaging the Trust's staff, as many of the answers and ideas to the challenges faced rest with them. Involving staff in ways that are consistent with, and support, the Trust's values will be key to the programme's success – something we look forward to reporting on in next year's annual report.

In summary, therefore, there has been much to be proud of in the Trust's performance during 2016/17, especially the quality of care provided to patients and their experience of the services they have used over the last 12 months. Whilst operational performance broadly has been good, the rise in demand for the Trust's services has brought special challenges – something that the new STP planning processes should help to address.

The Trust has responded to these challenges in the short to medium term by developing its own recovery and transformation programme that will help to bring its operational and financial performance back in to line. The 12 months to March 2017, therefore, have been about sowing the seeds for recovery, thus placing the Trust in a better position for 2017/18 and beyond.

Whilst the Trust has been working hard to ensure that its own finances are brought back in to balance, it has also played its part in developing the Hertfordshire and West Essex Sustainability and Transformation Partnership (STP). This is the setting where more system-wide initiatives are being developed that will lead to patients receiving more joined-up and innovative services, which make effective uses of the resources available.

Although the STP is still in the early days of its development and implementation, the Trust has been involved in several projects working with partner NHS trusts to develop joint clinical pathways that not only use available resources more efficiently, they also ensure that patients get high quality, joined-up care.

Examples include the work between the Trust and colleagues at the Princess Alexandra Hospital NHS Trust in developing a hyper-acute stroke unit at the Lister that services people from across East and North Hertfordshire and West Essex. This means that local people receive their specialist care in a dedicated unit, which means that more patients survive their stroke and can move on to the next stage in their recovery closer to where they live. Another project in development is the creation of a specialist vascular surgery hub across both hospital groups that meets emerging national guidance.

The Trust has also been working with its colleagues in the community to redesign its clinical pathways for frail, elderly patients. This work has focussed not only on making the Trust's own services much more responsive to the clinical needs of this vulnerable group of patients, but working with community partners to ensure that they can move on to their next stage of care smoothly and quickly. The project also involves outreach work to care homes and other facilities to help people needing to come in to hospital in the first place.

Over the coming months and years, the Trust looks forward to continuing to support the work of the local STP. One major enabling project will be the launch, over the summer of 2017, of the Trust's replacement patient administration computer system (Lorenzo) and a new electronic service (Nervecentre) for taking patients clinical observations in clinical areas. The Trust's staff will be trained fully in these new systems, which in turn will support new ways of working that will not only bring real improvements and benefits for both patients and staff alike, but will place the Trust in a better position when it comes to working with its STP partners.

None of the work referred to in this annual report would have been possible, of course, without the hard work and dedication of the Trust's staff and we would like to use this report to place on record our appreciation and support for everything that they do to ensure that local people continue to have timely access to consistently high quality care.

Finally, it is important to note that in March 2017, the respective boards of the University of Hertfordshire and the Trust approved a memorandum of understanding relating to the Trust being awarded university status. A very important milestone in the Trust's development, we look forward to discussing this important matter in next year's annual report.

Ellen Schroder
Chair

Nick Carver
Chief Executive

Strategies, objectives and principal risks

This part of the annual report looks at the following areas of the Trust's activities:

- 2016/17 performance
- Looking forward to 2017/18
- Sustainability

2016/17 performance

Delivery of the 2016/17 annual plan

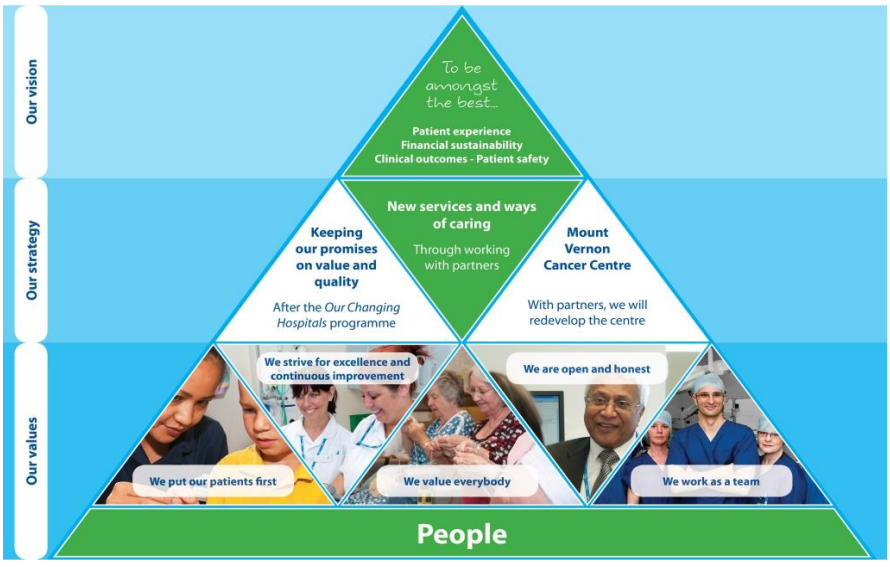
Following the successful delivery of the £150 million *Our changing hospitals* programme by October 2014, the Trust refreshed its strategic aims, in the context of local commissioners' priorities and the national *Five Year Forward View*.

The Trust's new strategic aims are:

1. **Keeping our promises on value and quality** – after the our changing hospitals programme
2. **New services and ways of caring –** through working with partners
3. **Mount Vernon Cancer Centre** – with partners, we will redevelop the cancer centre

Our vision, strategy and values

The Trust's vision, strategy and values has been summarised in a simple graphic device (see below) that has been shared with all staff through a variety of different means during the year.



Trust objectives, strategies and principles risks

The Trust's ambitions are set high to ensure continuous improvement in the quality and safety of care for patients and ensure long term financial sustainability. Key strategies are developed that support the delivery of the Trust's annual objectives and strategic aims (see diagram above).

These key corporate strategies include the following:

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

The Trust's Board recognised 2016/17 as being a challenging year, with increasing demand leading to capacity challenges. Other key risks included staff recruitment, delivery of performance targets and financial pressures and the delivery of service pathway changes across organisations.

Summary delivery against the Trust's 2016/17 objectives

Strategic aims	**1. Keeping promises on value and quality – after the *Our Changing Hospitals* Programme 2. New series and ways of caring - through working with partners 3. Mount Vernon Cancer Centre - with partners, redevelop the centre**	
	Objectives	**Assessment of achievement**
Keeping promises on value and quality	**Improve patient experiences**	✓Achieve milestones in *Patient and carer experience* strategy *(see page 38 and Quality Account)* ✓Achieve milestones in *Engagement* strategy (see page 48)
	Improve patient outcomes	✓Achieve milestones in the *Improving outcomes patient* strategy *(see page 34 and Quality Account)* ✓ Achieve milestones in the *Research* strategy *(see page 49)*
	Further reduce costs and optimise efficiency and income	✘ Deliver financial plan *(see page 38)* ✘ Cost improvement programme *(see page 38)* ✓ Carter Review recommendations ✘ Agree new *Estates* strategy *(in development)*
	Develop organisational culture and ensure that staff are supported and engaged	✓ Achieve milestones within the *People* strategy *(see page 40)* ✓ Achieve milestones within the culture change programme and the ARC/LEND leadership and engagement plan *(see page 40)*
	Easy to use	✓ Deliver first phase IM&T strategy ✓ Deliver the *Our changing hospitals* innovation programme to budget and plan *(on track for July 2017)*
	Transform the emergency care pathway	✘ Procure single provider for Trust urgent care centres *(not met due to objective milestone changed – agreed different pathway reviews)* ✘ Achieve national emergency department standards *(see page 30)*
New ways of caring	**Develop and redesign workforce to respond to recruitment challenges and support new models of care and research**	✓Achieve milestones within *People* strategy *(see page 40)*
	Develop and deliver local integrated services	✓Further develop elderly medicine and frail elderly services including dementia pathways (see Quality Account for further details on dementia care) ✘ Develop diabetes *(funding not achieved)* ✓ Respiratory medicine services

New ways of caring (cont.)	**Further develop seven-day services**	✘ Achieve designation as a vascular surgery hub *(the Trust is working with the Princess Alexandra Hospital NHS Trust to set up a vascular network covering the eastern area of the Hertfordshire and West Essex STP footprint)* ✓Develop a hyper acute stroke unit for east and north Hertfordshire and West Essex ✘ Obtain strategic funding to deliver seven-day services plan *(funding not achieved)*
	Reconfigure renal services	✘ Obtain approvals for renal services full business case *(funding not achieved)* ✘ Deliver programme to plan and budget *(funding not achieved*
Mount Vernon Cancer Centre	**To be the provider of choice for cancer services**	✘ Meet commissioning service specifications *(targets not achieved, see page 31)* ✘ Bid successfully to secure tertiary services contracts ✓Achieve milestones in *Research* strategy
	Secure a positive future for the cancer centre	✘ Agree clinical service strategy for the Mount Vernon Cancer Centre and Trust cancer services *(under development, see page 16)* ✘ Reach agreement with Hillingdon Hospitals NHS Foundation Trust that secures the Trust's interest in the site and facilitates future development *(see page 16)*
	Work with primary care to reduce late diagnoses of cancer	✘ Review and redesign cancer pathways from primary care ✘ Redesign secondary and tertiary pathways to consistency achieve 31 & 62 day standards *(in progress and on track for delivery from June 2017 – see page 31)*

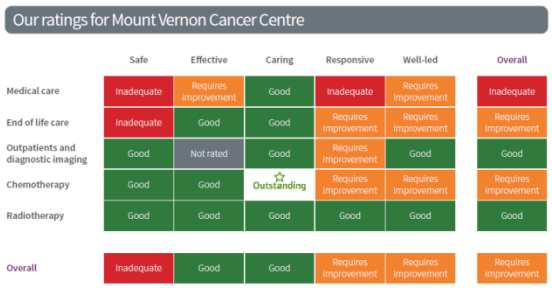
Care Quality Commission – Essential Standards of Quality and Safety

The trust is registered with the Care Quality Commission (CQC) to provide regulated activities at the specified locations set out in the table below.

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

The Trust is required to register with the CQC and its current registration status is *registered with no conditions*, but it has some regulatory actions following the October 2015 comprehensive inspection at the Lister and Mount Vernon Cancer Centre. The Trust has not participated in any special review or investigation by the CQC during 2016/17. However, it underwent a follow-up inspection as part of the overall inspection programme of all NHS trusts in May 2016.

The CQC carried out an inspection as part of its routine comprehensive inspection programme from 20 to 23 October 2015. The Commission rated the Trust as *requires improvement* overall but judged Hertford County Hospital and children's community services to be *good***.** The Bedford and Harlow renal units were inspected but not rated. The Trust was rated *good* for caring. A summary of the ratings is shown on the next page and the full reports can be viewed via the CQC website.



The areas of improvement, regulatory actions, were applied in March 2016. These are:

Lister hospital regarding compliance with regulations 12, 17 and 18. In brief, the Trust must:

- Ensure that the triage process accurately measures patient need and priority in both the emergency department and maternity services (*actions taken included the implementation of telephone triage in maternity and further review and improvements in emergency department triage – both pathways observed by CQC inspectors following an engagement meeting in February 2017, resulting in positive feedback*)
- Ensure records and assessments are completed in accordance with Trust policy (*actions taken – key messages continue to be re-enforced and internal monitoring in place*)
- Ensure that there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients (*actions taken – key messages continue to be re-enforced and internal monitoring in place*)

- Ensure that all staff in all services complete their mandatory training (*Closed – 90% target reached at the end of December 2016 and maintained – internal monitoring in place*)

Mount Vernon Cancer Centre regarding compliance with regulations 12 and 17. In brief the Trust must:

- Ensure that patients requiring urgent transfer from Mount Vernon Cancer Centre have their needs met to ensure safety and that there are effective process to handover continuing treatment (*Closed – reviewed and strengthened our systems and internal monitoring in place*)
- Ensure there is oversight and monitoring of all transfers (*Closed – reviewed and strengthened our systems and internal monitoring in place*)

The CQC carried out an unannounced, focused inspection on 17 May 2016 to review concerns found during their previous comprehensive inspection. The inspection focused on the adult emergency department (ED) and Bluebell ward, which is part of the children's and young people's service. Although services were inspected, they were not rated.

The CQC saw that significant improvements had been made since its last inspection, including:

- Staff were caring and compassionate towards patients and visitors within the emergency department; and patients and those close to them felt involved in their care
- The new triage process within the ED appeared to be efficient and safe
- There were improvements to hand hygiene and overall cleanliness
- Systems were in place to monitor patients at risk of deterioration in the ED and on Bluebell ward
- The risk assessments reviewed, including falls and pressure area risk assessments, were generally completed appropriately and reflected patients' needs
- Staffing levels met patients' needs at the time of the inspection and there had been an improvement in the number of staff that were trained to care for a child with complex needs

Further improvements were identified such as meeting targets in the ED around triage and four-hour waiting times. In addition, further improvements were required relating to the knowledge around Duty of Candour, local induction of temporary staff and training around advanced life support. The actions relating to all recommendations have been built into the action plans and monitored as above.

Throughout the year, staff have continued to progress actions to continue to improve quality and safety. Their action plans are reported and monitored via development board meetings and updates are sent routinely to the CQC. In addition to the above, some examples of improvements are given below:

- Increased awareness sessions regarding Mental Capacity Assessments
- Risk register reporting and oversight has improved
- Disability champions have been identified at Mount Vernon Cancer Centre and more appropriate seating for people with disabilities has been purchased
- Movement of paediatric clinics to ensure they are in child-appropriate environments
- Rotation of community midwives to work in the maternity unit to maintain skills and confidence
- Range of staff development and training opportunities throughout the divisions
- Implementation of safety huddles on ward areas.

This work is being monitored by the *CQC quality development board*, which reports in to the *risk and quality committee* and Trust Board. An audit of CQC actions was undertaken as part of the approved internal audit plan for 2016/17, particularly focussing on the development and monitoring of action plans following the CQC inspection. The audit concluded *substantial assurance* that the controls upon which the organisation relies to manage the identified risks are designed suitably, applied consistently and operating effectively.

The Trust continues to monitor its compliance against all CQC requirements, including the regulations – *Duty of Candour* and *Fit and Proper Persons*. It has also a programme of quality and safety audits and 15-step challenge to support embedding the standards and continuous improvement and a learning organisation.

During 2017/18, the Trust will seek to improve further upon its performance with regulators, such as the CQC, and continue a programme of self-assessment against the standards required by the CQC and NHS Improvement.

Financial pressures

The Trust agreed its financial plan for 2016/17 with NHS Improvement based on a control total of an £8.65 million deficit. In order to deliver this control total, the Trust required support from the Sustainability and Transformation Funds of £10.2 million. This support was conditional on achieving financial and operational targets, which were only met partially. The Trust has reported a deficit, after technical adjustments, including an adjustment of £4.1 million to reflect prior year issues, of £29.533 million. The main reasons for the increase in the level of deficit are:

- During 2016/17 the Trust has treated volumes of patients in excess of those anticipated in its service level agreements with commissioners. Significant elements of this demand growth have been supported through the engagement of premium cost capacity e.g. agency staffing. This has resulted in a significant cost pressure for the Trust.

- Reflecting financial pressures across the wider local health economy, some elements of funding that the Trust had planned to access were not deliverable during the course of 2016/17.

- Whilst the Trust has delivered significant levels of efficiency and cost improvement (£12.9 million), this was less than the value that the Trust had planned to achieve originally.

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

Looking forward to 2017/18

The Trust's strategic aims and annual objectives reflect the key challenges facing the organisation and wider health system over the next year and beyond. With this in mind, the Trust will continue to be guided by its vision, strategic aims and values, which underpin commitments made to patients and the community that the Trust serves.

During 2017/18, the Trust will continue to work actively with the East and North Hertfordshire Clinical Commissioning Group and other partners to focus on improving further the quality, efficiency and sustainability of services. The Trust's objectives reflect its key areas of focus over this two-year period. They have been designed to facilitate and drive the further transformation of the Trust into an organisation that delivers best value and high quality care consistently, whilst supporting simultaneously its STP partners to deliver system-wide transformation in models of care and back office services.

This will include continuing to work with the wider health and care system to develop more integrated services to facilitate effective joined up ways of managing emergency demand and avoiding unnecessary hospital admissions. The Trust will support the provision of sustainable acute services across the STP by adopting a patient-centred, quality driven approach to optimising patient outcomes, whilst reducing activity, optimising use of all resources and removing avoidable cost. This approach is also being adopted in reaction to the Mount Vernon Cancer Centre where the Trust will commence the implementation of a new five-year clinical strategy for the service, enabling it to respond to the challenges and opportunities faced by the centre.

Alignment with the emerging System and Transformation Plan (STP)

The Trust has a long track record of partnership working and recognises the value of working as a health and social care system to best meet the needs of the communities that we jointly service. The STP has identified some key principles and priority actions in relation to acute care, which the Trust endorses (see diagram on next page).

KEY STP PRINCIPLES

- **Development of a model of integrated clinical pathways for all three acute Trusts which places patients at the centre**
- **Right care at the right time in the right place**
- **Use evidence from the UK and around the world to develop clinical services and pathways which support optimisation of patient outcomes**
- **Supporting effective system demand management by co-designing pathways and services which enable primary and community services to access timely specialist advice and input**
- **Collaboration across providers to develop shared services which reduce the costs of non-clinical and back office functions**
- **Develop a sustainable workforce that is fit for purpose, is supported by modern technology, and can deliver evidence-based care in new ways that suit patients' and staff lifestyles**
- **Working together to drive best value solutions for investment in estates development and backlog maintenance**

PRIORITY ACTIONS

- **Elimination of unwarranted variation – appropriate standardisation of integrated clinical pathways across the STP in order to eliminate variation and optimise clinical effectiveness and efficiency**
- **Demand for acute services – application of appropriate responses according to the acuity of patients presenting in acute care and working with STP partners to reduce and better manage demand for acute care by supporting their management of patients within primary and community services**
- **Harness benefits from sharing services at scale - sharing clinical support and back office functions to reduce service costs**
- **Developing new pan-provider service models to enable fragile clinical services to continue to be provided sustainably and locally**
- **Driving best value solutions for estates development and backlog maintenance**

This system-wide and pathway work will be underpinned by work within the Trust to transform its services to further improve patient flows, clinical outcomes, patient experience and financial sustainability. Objectives for 2017/18 build upon work the Trust has started already with external partners to develop more integrated services and pathways for the community served, underpinned by work to further strengthen clinical engagement, improve further patient outcomes and invest in information management and technology.

The Trust has submitted an annual plan to the NHS Improvement covering the financial year 2017/18, with the organisation's objectives set out in the diagram on the next page.

Trust plan on a page for 2017/18 and 2018/19

Vision & Values	**Our Vision:** **To Be Among the Best...** • **Patient Experience** • **Financial Sustainability** • **Clinical Outcomes – Patient Safety**	**Our Values:** • **We put our patients first** • **We strive for excellence and continuous improvement** • **We value everybody** • **We are open and honest** • **We work as a team**	
Strategic Aims	**1. Keeping our promises on value and quality - after the *Our Changing Hospitals* Programme** **2. New services and ways of caring - through working with partners** **3. Mount Vernon Cancer Centre - with partners, we will redevelop the centre**		
	Plan Aims	**Key Objectives**	**With a specific focus on**
Delivering our Promises	Improve Patient Experiences	- achieve milestones in Patient & Carer Experience Strategy - achieve milestones in Engagement Strategy	Patients feeling involved in decisions about their care, staff explaining what will be done during operation/procedures and staff answering questions about operation/procedure. Focus on patient and community engagement in service and system transformation
	Improve Patient Outcomes	- achieve milestones in the Improving Outcomes Patient Strategy - achieve milestones in the Research Strategy	Implementation of e-Obs Expand care bundles in routine use to cover 10 common clinical conditions Increase in recruitment of patients to research studies
	Secure financial recovery – transform our services, become easy to use and optimise our efficiency & income	- deliver 17/18 and 18/19 agreed control totals - deliver underpinning CIP - Implement the Trust Lorenzo PAS system during 2016/17 Improve financial and operational decision making - deliver Phase 2 Our Changing Hospitals Transformation Programme	Development of a dynamic and flexible long term financial planning framework to support strategic decision making Development and deployment of a fit for purpose Business Intelligence Framework Deliver a programme to support improved accuracy of Trust data capture and coding Revise job planning policy and deliver e-job planning for senior medical staff Theatre efficiency, Outpatients, Inpatient Flow, Cater, Workforce Productivity
	Develop our organisational culture and ensure that our staff are supported and engaged	- achieve milestones within the People Strategy - achieve milestones within the Culture Change Programme - achieve milestones in Leadership and Management Strategy - achieve milestones in Health & Wellbeing Strategy	Embed LEND as Trust leadership model. Develop all of our managers with coaching skills. Deliver Flexible Working Project as part of Retention Strategy. Continue to embed Health & Wellbeing CQUIN with particular focus on attendance at work and supporting our staff to be well.
	Transform our services to deliver consistent improvements in access to care and quality of care that our patients receive	- achieve and sustain delivery of all constitutional standards - achieve consistent Good CQC ratings across all services and sites	Deliver 4 hour performance trajectory and sustain improved performance Redesign acute medical model to provide early senior intervention across Emergency Department and Acute Assessment areas Redesign Review and transform cancer pathways from primary care to reduce late diagnoses of cancer Transform secondary and tertiary pathways to consistency achieve 31 & 62 day standards
New Ways of Caring	Develop and redesign our workforce to respond to recruitment challenges and support new models of care and research within the Trust and STP	- achieve milestones within People Strategy - finalise and implement Multi-professional Education strategy - achieve University Trust status	Implementation of the Nursing Associate role & Paediatric Nursing Associate role Develop our UEP employment offering, branding the Trust as a flexible employer Establish pathways to support research that takes place across the STP area
	Transform our services to support and deliver STP plans	- work with partners to redesign patient-centred pathways that facilitate keeping patients out of hospital including full participation in the STP work streams - harness benefits from developing back office & support services at scale across ENHT and PAH - reduce unwarranted variation	Frailty Services to minimise admission and re-admission rates and enable patients to be cared for in the community where appropriate End of Life care to optimise outcomes and reduce acute variation Provide consultant-led ambulatory services across all major admitting specialties Support services at scale: Pharmacy, Radiology, Estates, In hospital therapies. Review, design and implement new pan provider pathways for Chest Pain, Community acquired Pneumonia, Frailty and End of Life
	Develop & Deliver Sustainable Specialist Services across the STP	- deliver the renal sustainability strategy - further develop seven day services and strengthen clinically fragile services by working collaboratively with partners - review capacity and demand and transform service models to deliver more efficient and cost effective pathways	Relocate Luton Dialysis Unit, obtain approvals for next steps in renal strategy and develop tertiary renal in-reach service at PAH Develop a vascular surgery network across Hertfordshire and W Essex with a Vascular Centre at the Lister, subject to agreement with NHSE Develop sustainable model of interventional radiology across Hertfordshire and W Essex Develop the complex Urological Surgical Cancer Service to include W Essex patients
Mount Vernon Cancer Centre	Secure a positive future for the MVCC	- commence delivery of the clinical service strategy for MVCC - secure the Trust's interest in the site to facilitate future development - deliver rolling Linac replacement programme aligned with clinical strategy - achieve milestones in Research Strategy	Confirm key delivery partner(s) and develop relationships incl. radiotherapy network Reach site agreement with THHFT Progress linac replacement including develop proposals for a satellite radiotherapy service and implement national requirements as per the outcome of the pending Modernising Radiotherapy Strategy Ensure protected research time for research active clinicians, access to research support, and collaborative working with associated local hospitals and tertiary centres

Key challenges for 2016/17

Two of the most significant strategic risks facing the Trust currently concern the ability to meet demand for services and the capacity to effectively deliver a complex service transformation programme underpinning financial and service sustainability. Demand, notably emergency attendances and admissions, has been exceeding the capacity and resources available and resulting in significant operational and financial pressures. Going forward, the STP is developing several schemes and new models of care designed to reduce demand for services and expand the provision of non-acute services within localities.

In relation to service transformation, the Trust has set up a central programme management office (PMO) function to lead the development, delivery and monitoring of its CIP and transformation programme. This function will build on best practice nationally and internationally to facilitate the effective transformation of Trust services.

Risk	Mitigating factors
Demand for services exceed capacity/is more than plan	Emergency pathway work programme and implementation of action plan/development of clinical pathways with community partners/review and develop effective capacity and demand model.
Shortfall in Trust CIP programme compromising financial plan delivery	We are working to set up a central programme management office (PMO) function to lead the development, delivery and monitoring Trust's CIP and transformation programme. This will be supported by a refresh of the business intelligence and business reporting systems.
Adverse impact of CIP programme on service quality and improvement	Quality and impact assessment process led by the medical director and director of nursing. In addition, the clinical governance strategy committee reviews all clinical schemes to consider any potential impact across divisions
Workforce – ability to recruit and retain workforce required to deliver plan	Comprehensive workforce recruitment and retention plans in place. Leadership development programmes.
Organisational capacity and resilience to transform services, implement Lorenzo (IT) and deliver *business as usual*	The establishment of a PMO and team to provide capacity and skills to support service transformation. Delivery of the people and leadership and management strategy to strengthen leadership and support resilience building and a coaching culture.
Limited access to funding to implement service developments	All business cases should demonstrate clear cost and quality benefit analysis. Alternative funding opportunities identified where possible. The establishment of a PMO will support responsiveness to opportunities

Sustainability

Accountability

Over the past six years, the Trust has made great progress in delivering the sustainability agenda within the organisation, meeting reduction targets set for 2015 four years early. By 2014, the Trust had reduced its carbon emissions by 17.4% against a target of a 10% reduction.

The target of reducing our carbon emissions by 34% by 2020 is challenging; from extensive stakeholder engagement with the community, however, it is clear they expect the Trust to continue to be a leader on the sustainability agenda.

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

Progress is managed, monitored and reported through the Trust's *sustainable development committee*, along with the annual implementation of a sustainable development management plan and bi-annual adaptation plan. The *Good Corporate Citizen* tool is also used to track progress and compare performance to other similar organisations around the country.

Context

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

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

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

Foundations

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

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

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

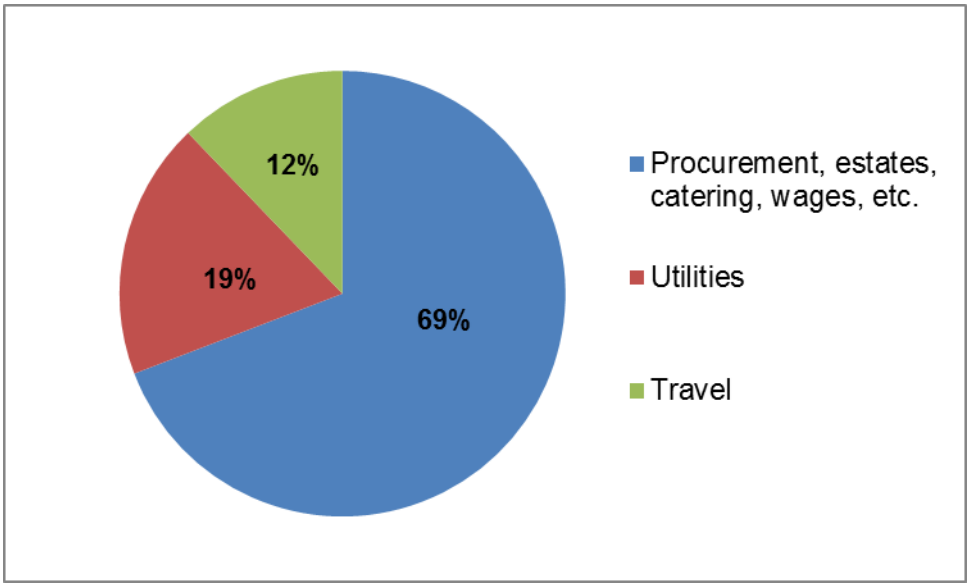
The goals and target for achieving the 2020 reduction of carbon emissions by 34% is expected to be challenging, albeit one that the Trust expects to achieve. The Trust is committed to meeting the target, which will be delivered through a combination of specific carbon reduction schemes, behavioural change,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

Measurements

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

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

The chart below breaks down The Trust's 2016/17 carbon emissions by scope:



Overall in 2016/17, the Trust's carbon emissions have seen a 22% reduction on the 2007 baseline and are now just 16.6 % above the 2020 expected position. Emissions from utilities have reduced as the total energy used in 2016/17 decreased due to the disposal of the old QEII site and its associated utilities, along with the vacation of a storage facility previously used by the Trust as part of the *Our changing hospitals* project.

Business travel and fleet performance reflects the consolidation of services on to the Lister hospital site, and the reduction in cross–site working. The Trust's inter-site bus service now includes a *dial a ride*-type option to improve accessibility and convenience of inter-site travel.

Overall waste production has increased as a direct result of the increase in patient numbers across the organisation. However, within the total waste produced, the Trust has recycled less and this is an area targeted for improvement in 2017/18.

The Trust also uses the *Good Corporate Citizen* tool to benchmark and monitor progress internally, which is completed and submitted twice a year. Progress has been consistent with the most recent score generated in April 2017 of 70% rising from 62% at the end of 2014/15.

Extensive work has taken place with local community groups, including local schools, Irish Network Stevenage and Hertfordshire County Council's public health and children's services, to improve partnership working. In this regard, the Trust is considered as leaders in engagement and community work in relation to the sustainable agenda within the NHS. This was recognised at the NHS Sustainability Awards 2015, when the Trust won the *public health* and *community* awards, as well as being the *overall winner* for the event. The Trust was also shortlisted for the national HSJ Awards 2015 in the social and environmental sustainability category.

In 2016/17 a number of initiatives have been implemented aimed at improving the general health and well-being of all staff members across the organisation. This work included increasing the number of staff members receiving 'flu jabs across the winter period, a refresh of food and drink items offered in all catering outlets across the Trust's sites, and availability of activity classes such as walking groups, mindfulness sessions and discounts at local gyms to improve overall general health.

Investment has also taken place using interest-free Salix funding to replace the steam traps across the Lister site. The investment, which leads to a reduction in both utility usage and the associated carbon emission reductions, was implemented over the winter of 2017. In just one year this will save c. 1,000 tonnes of carbon, bringing the Trust closer to the target reductions required by 2020.

A more detailed breakdown of the Trust carbon emissions and progress can be found on the Trust's website.

Trust's performance in 2016/17

The part of the annual report looks at the following areas of the Trust's performance:

- Operational
- Clinical
- Financial
- Workforce
- External engagement
- Research and development

Operational performance

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

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

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

The 2016/17 year represented a challenging period for the Trust, characterised by further growth in emergency activity.

Despite meeting many of the standards set nationally and locally for the Trust, there were three areas where additional work was required in-year to drive improved performance:

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

A&E four-hour waiting time standard

The Trust had a particularly challenging year in 2016/17, experiencing growth in emergency admissions and in the volume of ambulance conveyances. As a result, the level of demand has been in excess of planned growth, in particular demand from out of area.

Extensive programmes of work have taken place and are continuing into 2017/18, such as the *emergency care pathway* project, to deliver a trajectory of continuing improvement on the A&E waiting time standard. There has been a lot of attention on improving hospital flow this year, with a keen focus on discharge management. The trust also commenced the roll-out of the *Red/Green* initiative which identifies the status of each patient, with respect to their ongoing care plan and discharge.

The Trust engaged with an external company this year to investigate capacity and patient flow, and this work is continuing into 2017/18.

Controlling emergency demand will be the most critical challenge as the Trust cannot create any additional bed capacity and is working closely with system partners. At the same time, the Trust will need to continue to protect elective bed capacity in order to deliver the levels of activity required to achieve national referral to treatment standards.

18-weeks referral to treatment standard

This is a performance measure that the trust has achieved historically. During 2016/17, the Trust achieved the standard (92%) for 10 out of the 12 months. There are multiple contributing factors that the Trust did not achieve for two months, the main reason being that referral levels where a lot higher than expected, up approximately 7% from the previous year.

An extensive demand and capacity review in currently is in progress using external expertise to ensure sufficient bed, theatres and outpatient capacity is in place during 2017/18 to meet the commissioned levels of activity.

62-day urgent GP cancer referral to treatment standard

2016/17 saw under-performance against this target, a trend that started in 2015/16, with the average performance range – against the 85% target – being 69.8%. The reasons for the under-performance continue to be multi-factorial, but there is now a better understanding of the key drivers. A revised action plan has been agreed with the commissioners and regulators, and progress is now under way to resolving the underlying issues. This focuses predominantly on rectifying a broad range of issues within the cancer service, from data capture and improved availability of management information available to influence cancer performance within the Trust.

The second phase of this plan is to manage cancer pathways robustly. The evidence shows that the majority of long wait cancer patients have delays in the diagnostic phase of their pathway. Through tumour site pathway mapping, common themes are emerging and being addressed. In addition the Trust is committed to reducing cancer diagnostic turnaround times to seven days.

The final part of the plan is to start to measure capacity and demand for cancer pathways. Two-week wait referrals have risen undoubtedly over the last two years and the Trust maintains a 62-day waiting list size of between 1,000 and 1,200 patients.

There are now signs of a clear recovery of the 62-day standard. Although current performance remains below the standard, the profile of the waiting list demonstrates a more sustainable position.

Activity planning

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

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

Although the Trust has developed longer-term activity plans through its integrated business plan, for the purposes of this annual report, the information available on activity plans is limited to the year ahead (i.e. 2017/18). This information, along with comparisons against the previous year's performance, is set out below.

Activity	2016/17 actual	2017/18 planned
A&E attendances (including the eye casualty service)	159,134	162,071
Outpatients – first appointments	126,534	138,986
Outpatients – follow-up appointments	261,924	267,173
Elective inpatients (i.e. planned admissions)	9,353	10,538
Elective day cases	30,673	29,938
Non-elective inpatients (i.e. emergency admissions)	46,124	45,629
Births	5,600	5,730

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

Emergency preparedness

During the past year, all of the Trust's policies and plans (including the major incident and mass casualty plan) have been revised and updated to reflect the consolidation of acute and emergency services onto the Lister hospital site. These documents have been written in accordance with Department of Health guidelines and relevant legislation (Civil Contingencies Act 2004 (CCA) and the Health and Social Care Act 2015).

Over the past twelve months the work programme has focused strengthening its compliance with standards to ensure the Trust meets it's legal and statutory obligations as a category one responder under the Civil Contingencies Act 2004. During the year, an independent peer review has been carried out covering all Trust policies and processes relating to emergency preparedness, resilience and business continuity. The review also detailed the resources required to maintain compliance with regulations.

During late 2016, the Trust made its annual core standards submission to NHS England clarifying its levels of competency. Whilst clearly there are some areas needing improvement, the Trust was able to demonstrate areas of success, as well as action plans moving forward.

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

Two desk-top exercises have taken place during this period, which were attended by various staff groups from across the Trust as well as attendees from external agencies. These were carried out to test staff readiness in the event of an incident occurring. Several key staff have also attended external multi-agency exercises and several administrative staff have received *loggist* training to provide a bank of staff should they be required.

The key priorities identified for the forthcoming year include:

- Continuing to raise emergency preparedness profile amongst all Trust staff
- Continued progression of the on-going training strategy for all staff
- Continuing to develop the working relationships with NHS Midlands and East
- Maintain and review of the risk register in relation to emergency and business continuity planning
- Continuing to identify key risks and appropriate actions to mitigate

For further information, please contact:

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Clinical performance

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

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

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

Infection prevention and control

During the 12 months to the end of March 2017, the Trust recorded two Trust-associated blood infections (bacteraemia) caused by Methicillin-resistant *Staphylococcus aureus* (MRSA) bacterial strains. Over the same period, 22 cases of Trust-associated infections due to *Clostridium difficile* were reported. The targets for these two significant causes of Trust-associated infections were zero and 11 cases respectively.

Although the target for *Clostridium difficile* was missed, the Trust remains amongst the best performing NHS organisations in the country. Every case of *Clostridium difficile* infection is investigated to identify any learning. In a high proportion of the cases reported in 2016/17, no lapses in care that contributed to the acquisition of infection were identified. These figures demonstrate that the Trust's infection prevention measures and rolling programme of staff training are effective. As a result, patients remain at low risk of acquiring a healthcare-associated infection at the Trust's hospitals.

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

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

Mortality rates

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

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

- Average rate over the last three years (April 2014 to March 2017) – 1.67%
- Average for the last rolling 12 months (April 2016 to March 2017) – 1.68%

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

The two main mortality measures used are:

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

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

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

- *HSMR* – the most recently published data, for the rolling annual 12-month period to December 2016, is 95.2. Statistically speaking, this falls within the *as expected* range, though at 54th out of 154 acute providers the Trust is still well placed nationally;

- *SHMI* – the most recently published score, for the 12 months to September 2016, is 105.61 and is in the *as expected band 2* range. This is a significant improvement on the Trust's position last year (111.25). Adjusted for palliative care, the rating drops to 95.37 for the same time period, which falls within the *better than expected* range.

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

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

Reducing pressure ulcers

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

The Trust is committed to reducing this form of harm to its lowest level possible. For 2016/17, the total number of avoidable hospital-acquired pressure ulcers, including SDTIs (suspected deep tissue injuries), has reduced from last year by one to 44, which equates to 27 grades 2-4 and 17 STDI.

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

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

Preventing inpatient falls

Inpatient falls remain the most commonly recorded patient safety incident in the NHS. Annually more than 240,000 patient falls are reported from hospitals and mental health units across England and Wales (approximately 657 incidents per day).

Nationally, 30% of people aged between 65 and 79 years of age, as well as 50% of those over the age of 80, will fall every year. It is well researched that people over the age of 65 who are admitted to hospital during an episode of acute illness are at a significantly higher risk of falling. During 2015, a total of 3,222 people over the age of 65 attended the Trust's emergency department following a fall in the community; this figure reduced to 2,774 attendances in 2016.

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

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

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

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

Adult and children's safeguarding services

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

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

The Trust continues to support the adult safeguarding systems and processes in Hertfordshire by raising concerns, or supporting families to raise concerns, about neglect or abuse and to work with adults *at risk* to provide personalised protection plans. During 2016/17, the Trust has continued to work closely with the IDVA (Independent Domestic Abuse Advisor) service developing the role of the Hospital IDVA.

In October 2016, the Hertfordshire IDVA service changed management from Victim Support to Refuge and this has seen some changes in personnel whilst the new services become embedded. During 2016/17, the Trust has participated in four of the Domestic Homicide Reviews (DHR) for Hertfordshire residents. The number of DHR in Hertfordshire shows the importance of being able to offer early intervention for domestic abuse victims to reduce the risks for people at high risk of injury or death.

The Trust has established networks with the Stevenage Borough Council Domestic Abuse services during 2016. It is also working in collaboration with the Multi-Agency Risk Assessment Conferences (MARAC) in Hertfordshire to share information to help safeguard victims of Domestic Abuse. The county as a whole has seen the number of safeguarding alerts for domestic abuse increase during 2016/17.

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

During 2016/17, the Trust's diabetic eye screening programme was successful in being awarded *Purple Star* accreditation by Hertfordshire County Council in recognition of the work the team has done to develop learning disability-friendly services. Staff at the New QEII hospital and in ophthalmology services at the Lister's Treatment Centre are also progressing the project work for their services to receive similar accreditation.

The Trust established an enhanced care team during 2016/17, which provides enhanced support on the wards for patients who need extra supervision or assistance whilst they are in hospital; this can include patients with confusion, delirium, dementia, learning disability or physical disability. The team works with patients to reduce agitation or distress and help to keep patients safe from harm.

Other initiatives that have enhanced the quality of care for patients have included the introduction of the *Stay with me – John's campaign* to support carers of patients with dementia being able to stay with them whilst they are in hospital; this can help to reduce agitation, disorientation or distress experienced by some patients with dementia if they do not see people who are most familiar to them. The Trust has also introduced Butterfly volunteers who are able to stay with patients at the end of their lives, where the person does not have family or friends who can stay with them in hospital.

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

Staff compliance with adult safeguarding training has achieved the target set at 90%.

The East and North Hertfordshire CCG has undertaken annual assurance visits to the Trust in 2016 and 2017, with the Trust able to provide assurance that systems and processes are in place for adult safeguarding.

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

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

The Trust has excellent working relationships with other agencies across Hertfordshire to safeguard children who access its services. An example of this work came in July 2015, when Hertfordshire county council introduced a multi-agency safeguarding hub (MASH) – the aim of which is for different agencies to work in partnership in order to:

- Assess referrals
- Share information
- Make collective decisions to safeguard children

The safeguarding children's team has worked closely with their clinical colleagues across the Trust to achieve a vast improvement on safeguarding training compliance, which has increased the figures to 91% of staff compliant during the last three months of 2016.

Improving patient experience

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

The Trust's *patient and carer experience strategy 2016/19* was developed with patients, carers and staff and sets out three clear ambitions for improving patient experience as follows:

- *Ambition 1: we want to improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care.*

- *Ambition 2: we want to improve the information we provide to enhance communication between our staff, patients and carers.*

- *Ambition 3: we want to meet our patients' physical, emotional and spiritual needs while they are using our services, recognising that every patient is unique.*

The Trust continues to strive to improve patient and carer experience and encourages feedback actively, which enables good practice to be shared and changes made to improve services.

In 2016/17, consistently the Trust was among the better performing NHS organisations for the Friends and Family test response rate, as well as for the percentage of inpatient/day case patients who would recommend the Trust to their friends and family.

2016/17 CQUIN performance

The Trust agreed eight CQUIN schemes with the East and North Hertfordshire Clinical Commissioning Group in 2016/17. Of these, three were national schemes:

- Staff health and wellbeing
- Patients with sepsis
- Antimicrobial resistance and stewardship

Five further schemes were agreed with the CCG that focussed on local priorities for improving patient care:

- Seven-day pharmacy
- Improving outpatients experience
- Ambulatory care
- Improved turnaround for urgent radiology diagnostics
- Renal telemedicine

At the end of quarter three of 2016/17, the Trust was achieving 87.9% compliance against these CQUIN schemes.

Financial performance

The Trust experienced an extremely challenging financial year in 2016/17.

Operational pressures, under delivery in planned savings and failure to secure planned levels of Sustainability and Transformation funding were exacerbated by some underlying financial issues. The Trust's pre-audited reported financial performance was an adjusted retained deficit of £29.5 million, a significant deterioration in the organisation's financial performance.

The Trust is required to meet a number of statutory and administrative duties in its financial performance, these are outlined below. As with other NHS trusts and foundation trusts, the Trust is held to account by its external oversight body, NHS Improvement, for both financial and operational performance.

Breakeven duty

The Trust has a duty to *breakeven* i.e. to ensure that any cumulative deficits between income and expenditure do not exceed 0.5% of turnover over a period to be agreed with its oversight body, NHSI. In 2016/17, the Trust agreed that its financial performance, its *control total*, would be a deficit of £8.65 million.

However, as stated, the Trust's pre-audited reported financial performance was an adjusted retained deficit of £29.5 million. (This includes the consolidated profits of the Trust's wholly owned subsidiary, ENH Pharma of £0.3 million.) The breakeven position was -7.11% in year, which contributed to the cumulative position of -9.11%. *Therefore, the Trust has not met its financial duty in this respect*.

External Financing Limit

The Trust is given an External Financing Limit (EFL) each year, which it is permitted to undershoot. In 2016/17, the Trust's EFL was £56.9 million, of which it utilised £54.8 million, leading to an undershoot of £2.1 million (*financial duty achieved*). Included in this *undershoot* is £0.7 million cash balance relating to ENH Pharma.

Incorporated within the EFL cash flow financing, was £45.1 million of Revenue Support Loans and Working Capital Support, together with £4.2 million Capital Investment Loans, necessitated by the Trust's increased deficit position. The Trust has repaid £11.2 million of its borrowings in-year.

Capital Resource Limit

The Trust is required to keep its investment in capital assets within its internally generated resources, together with approved sources of financing from the Department of Health. The Trust's Capital Resource Limit for 2016/17 was £11.5 million, against which it expended £10.8 million – an undershoot of £0.7 million (*financial duty achieved*).

Going Concern

The Trust Board has a requirement to consider whether it is appropriate to adopt the *Going Concern* basis in the preparation of its financial statements i.e. that it is not expected that the Trust is to be *wound up* in the immediate future. Guidance from the Department of Health gives a number of criteria that suggest this basis is appropriate, including commissions for future services that are in place. The guidance also states that the Board should consider the *Going Concern* basis to be appropriate in the absence of confirmation to the contrary from the Trust's main oversight body, NHS Improvement. No such confirmation has been received.

Better payment practice code

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

The Trust's detailed performance against this target for non-NHS creditors is set out in note 9.1 in the annual accounts section of this annual report. Due to the challenging financial environment and liquidity issues the Trust has experienced, the Trust's overall performance in relation to the code has been 39.1% (2015/16 – 44.3%) of non-NHS trade invoices paid within target during 2016/17.

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

Losses and special payments/gifts

The Trust is required to declare if it has had any loss, made any special payment or made a gift in excess of £300,000. No such single payment has been made. The Trust has included information on losses and special payments in Note 35 of the financial statements. No gifts have been made using Trust monies.

Financial outlook

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

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

Workforce performance

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

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

Trust's culture

The Trust embedded four key workforce priority areas in 2016/17 to support the delivery of the *people strategy* for 2014 to 2019. ARC – next steps outlined a programme of work to deliver large-scale and long-term cultural change within the organisation which has developed into LEND, to improve staff engagement, better patient and staff experience and the embedding of a continuous improvement culture led by frontline staff.

The LEND - *Listen, Empower, Nurture, Develop* - leadership model was developed in consultation with staff and was launched in the organisation in Summer 2016, followed by the Leadership and Management Development Pathway (LMDP), the Trust's first comprehensive leadership education and training programme.

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

The three-year (2016 to 2019) Health and Wellbeing CQUIN aims to improve the support available to our staff to help promote health and wellbeing in order for them to remain healthy and well at work. Some of the initiatives implemented within the Trust are listed below:

- Health and Wellbeing Events
- Health at Work advice line was launched
- A fast track Physio service was offered to staff
- An early service was launched to support staff's mental health and wellbeing
- Healthier Food available to staff
- Exercise classes and walking groups
- Lister *Any Voice* choir
- Annual staff flu vaccination programme
- Encourage staff to take healthy lunch breaks away from their work place/desks and keep hydrated

NHS national staff survey for 2016

The 2016 national staff survey results showed an upward trend on the findings from the previous year.

Overall the results continue to show an upward trend. Of the 32 key findings, the Trust scores are above average or in the best 20% for 14, average for 11 and below average or in the worst 20% for 7. The Trust results now have the highest number of positive and lowest number of negative key findings since 2012

The Trust is ranked eighth best non-foundation acute trust and 27th best when compared to all acute trusts. This is an improvement of 14 places on the ranking against all acute Trusts achieved in 2016. The Trust shows positive results in areas related to the staff experience of working at the Trust and improvements have been made, particularly in relation to staff health and well-being and job satisfaction.

The Trust score for overall engagement was *above average* for the second consecutive year and also improved slightly on last year's score. Of the three factors contributing to the engagement score, the Trust moved from *above average* to the *best-performing 20%* for both *Staff motivation* and *Staff ability to contribute towards improvements at work.* The third factor, *Recommendation of the Trust as a place to work or receive treatment* remained average.

The Trust was also among the *best-performing 20%* for the following key findings, a repeat of our performance last year:

- Quality of non-mandatory training, learning or development
- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months

The Trust showed the most significant improvement on last year's results in the following key findings:

- *Staff feeling unwell due to work-related stress in the last 12 months*, where we moved from *worst-performing 20%* to *above average*
- *Staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves*, where we moved from *worse than average* to *above average*
- *Organisational and management interest in and action on health and wellbeing,* where we moved from *worse than average* to *above average*
- *Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse.* Although the Trust remains in the *worst-performing 20%,* the score shows a significant improvement from 22% in 2015 to 42% this year.

Staff working extra hours and staff experiencing bullying from other staff recorded a slight percentage improvement on the 2015 results, while staff reporting violence and staff experiencing physical violence from staff showed a slightly worse percentage. It should be noted that the percentages of staff reporting physical violence from other staff are very low overall and the Trust score increased from 2% in the 2015 survey to 3% in the 2016 survey.

Areas that still require improvement include: staff working extra hours; and staff experiencing bullying, harassment and violence.

People performance

Recruitment and retention

The Trust has continued to work to reduce vacancy rates and improve the time to hire during 2016/17, with a particular focus on recruitment to band two clinical support worker (CSW) and band five staff nurse vacancies. The aim of this work was to achieve a CSW vacancy rate and a qualified nursing vacancy rate of 5% by the end of 2017. There has been a blended approach that has been taken during the year is to use UK nursing recruitment to hold staffing levels against turnover, with wider EU and international recruitment – for example from the Philippines – to address vacant posts and those that arise from the approval of any new business cases.

Local recruitment has been increased in 2016/17, including advertising in local media, developing a streamlined recruitment process for student nurses who have had their placements at the Trust and also streamlining the process for NHS Professionals staff to transfer to permanent posts within the Trust. The cohort recruitment day programme for band five nurses and band two clinical support workers was also continued to be further developed during the year.

The time to hire has changed from 8.6 weeks in April 2016 to 9.3 weeks in March 2017, due to the changes in NMC requirements and immigration rules. An increase in offers was made in April 2016 (117) compared to March 2017 (186) of around 58%; there was an increase of candidates in the pipeline in April 2016 (235) compared to March 2017 (409) of around 74%.

The Trust is the lead host for the *streamlining* programme in the Midlands and East of England regions, which sets out to improve the efficiency and cost of human resources processes by working together to find a consistent and efficient way for these functions to operate. It also enables organisations to compare performance, share best practices, overcome issues and work collectively to drive change that leads to improved efficiency and patient safety. Current benefits of the programme include the reduction of regional *time-to-hire*, the automation of occupational health information for NHS-to-NHS staff transfers and the streamlining of localised induction programmes.

The Trust has put actions in place during 2016/17 to address staff turnover, which continues to be a concern - although they are amongst the lowest locally. A more structured process of exit interviews was implemented at the start of 2016 to gain more insight into why staff leave the Trust and views have also been sought from staff who are employed currently to understand the main challenges to their work.

As well as other initiatives outlined elsewhere that will have a positive impact on retention, other actions taken include: centralised flexible working requests and a Trust-wide flexible working review; enhanced pension offering for band five nurses, increased opportunities for training and development as well as the introduction of a clinical director's mentorship and development programme. Each of the Trust's five clinical divisions has also developed specific retention plans. Current work includes a review and refresh of the corporate induction programme to improve the focus on the Trust values and patient care, as well as a more structured local induction.

Temporary staffing

The Trust has taken significant steps during 2016/17 to reduce reliance on bank and agency staff, along with the associated costs. On-going work includes leading the regional hub across Hertfordshire and Bedfordshire to implement the national agency price cap, while a *Return to Bank* initiative has continued to promote the benefits of working at the Trust via the bank through NHS Professionals, rather than through an agency. Tighter centralised controls and a revised process has been embedded with executive director sign off required for all agency shifts. The usage of temporary staffing across the Trust is reviewed on a weekly basis for all clinical Divisions.

Work has also taken place throughout the year to ensure that all Trust agencies are on the national NHS framework, as well as ensuring that they have completed the required pre-employments checks before staff are placed here, thus providing additional reassurance. As part of the agency reduction plan work has been implemented to remove the requirement for tier three nursing agency staff across the Trust. In addition, a revised process has been applied to all non-clinical administration workers in order not to permit any non-clinical administration agency shifts.

Employee relations advisory service (ERAS)

The ERAS team takes calls and correspondence from both staff and managers on any employee relations query. The team's approach is to identify concerns and provide early intervention before a situation escalates. During 2016 staff from the Workforce team undertook specialist mediation and facilitated conversation training to support the early intervention service. Those using ERAS rate the service highly, with a feedback score of 4.2 out of 5 achieved in March 2016.

As well as providing advice and support, the ERAS team also provide employee training for managers, working in conjunction with the organisational development team on the development and delivery of the Trust's core management skills programme.

Medical HR

The first quarter of the year 2016/2017 saw the continuation of strike action by the doctor in training workforce due to breakdowns in the national negotiation process for a new doctor in training contract. The BMA commended the Trust on its professional approach and good working relationships during these difficult periods. The Trust managed its F1 shadowing and August 2016 offers safely, and starters, to the backdrop of a suspension of Trust activity on the contract by NHS Improvement and a BMA referendum *no vote* in July 2016. In quarter three, preparations were made for the further commencement of week-long periods of full walkouts in each ensuing month though these did not occur. The Trust then focused on the first transition of its 61 F1 posts in December 2016 and has maintained a project implementation group inclusive of doctor in training representation. By March 2017 the Trust had revised 22 out of 41 rotas to *mixed economy* and transitioned 89 doctors.

The Trust was successful in July 2016 in appointing Dr Stephen Bates as the Guardian of Safe Working Hours. Between first transition in December 2016 and March 2017 the Trust has received 63 exception reports.

The peak of transition will take place next financial year in August 2017 with 225 posts to be offered 2016 terms by the beginning of June 2017, accompanied by work schedules, and a further 13 rotas revised to mixed economy.

Appraisals

A key factor in supporting and enabling good staff performance is through appraisal. Since November 2015, incremental pay awards have been dependent on the completion of an annual appraisal, along with statutory and mandatory training compliance. This has had a demonstrable effect on both, with appraisal rates improving from 80.45% in March 2016 to 81.75% in March 2017, and full statutory and mandatory compliance rates increasing from 62.50% in March 2016 to 68.50% in March 2017.

The quality of appraisals is also continuing to improve; this has been demonstrated both by the findings of the regular divisional appraisal quality audits and by the 2016 national staff survey results, where the Trust ranks among the top 20% of acute trusts for quality of appraisal.

This year nursing and midwifery validation has been integrated into the appraisal process as part of the national NMC revalidation process that started in April 2016.

Developing our people

Trust staff have access to a range of leadership, management and personal development training, and the 2016 staff survey results show that the Trust is in the top 20% of acute Trusts for the quality of non-mandatory training, learning and development.

The *excellence in management* and *excellence in supervision* programmes, both of which are endorsed by the Institute of Leadership and Management, have been refreshed this year, with increased numbers of places available.

Over 400 line managers have received core management skills training since April 2016. This new programme is a collaboration between the Trust's organisational development and ERAS teams, providing managers with a comprehensive training programme – including: emotional intelligence; communication skills; time management and delegation; dignity and respect at work; the role of a leader; assertiveness training; and appraisal skills training.

The Trust continues to run its quarterly LEND briefings for leaders and line managers. A revised and extensive multi-disciplinary programme of leadership courses and master classes, which are open to all staff, has also launched this year. They have been well-attended and the initiative is developing a good reputation across the Trust.

Making a difference to our communities

The *Community Hub*, opened at the Lister site in 2015, is a collaboration between the resourcing, carers' support, voluntary services and Trust membership teams. The Hub acts as a key contact point for staff, patients and visitors, providing information on a range of subjects including jobs, apprenticeships and volunteering opportunities, as well as on the Trust's charity and carers' support. It is also used as the Trust's annual staff flu campaign hub.

Statutory training

The Trust monitors compliance for nine statutory competencies and is 68.5% compliant for overall coverage and 89.7% for staff compliant with all nine.

Non-medical and medical education quality performance review

The Trust was visited for its yearly quality performance review for non-medical training by Health Education East of England. The non-medical education team was rated green for all key performance indicators (KPIs) and commended, amongst a number of things, for its engagement with student nurses.

Medical education

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

Over the course of the year there has been progress in trainee engagement and the Trust's trainee survey for 2016 has shown year-on-year improvement. The GMC Trainee Survey 2016 showed consistent improvement across clinical specialities in the Trust. Robust processes for student and trainee feedback are in place, which strengthen trainee engagement with the education faculty.

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

For undergraduate education, the Trust has links with Cambridge Medical School and University College London. The number of students from UCL is increasing and there is substantial increase in the number of Cambridge students from the next academic year.

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

The phased implementation of the new Junior Doctors Contract 2016 is progressing well. The first changeover point was October 2016 and other changeover points were February and April 2017. The contract will be implemented fully by November 2017. To date no exception report has been submitted to the Director of Medical Education relating to education and training. The Guardian of Safe Working Hours has been receiving exception reports relating to trainees working over and above their contractual hours. Formal reports by the Guardian are submitted to the Trust Board.

Medical education faces several challenges. Rota gaps continue to be an issue in many specialities. With substantial increase in undergraduate numbers and the establishment of the physician associate programme with the University of Hertfordshire, the pressure on educational space has increased. Work is likely to start on a new training room at Lister Education Centre, but more training space is required – particularly for expansion of skills and simulation facilities.

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

Non-medical education

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

International recruitment

A three-day bespoke programme has been implemented to support international nurses who already have their NMC PIN and who obtain their NMC PIN following a successful objective structured clinical exam (OSCE).

The programme of assessment, co-designed with the University of Hertfordshire to prepare overseas nurses for their OSCE, was delivered successfully throughout the year to support and prepare overseas nurses.

Currently 90 nurses have been recruited successfully. There has been a 91.5% pass rate with NMC OSCE, compared to the 56% national average pass rate.

Ward development

The Trust's ward development and improvement programme has been rolled out to eight wards, with clear evidence of improvement in quality and patient experience resulting. The programme identifies expected outcomes based on the Care Quality Commission's five key lines of enquiry that it uses when carrying out its inspections.

The ward development programme has been developed to recognise and produce high standards of care throughout the Trust and reduce variation of practice within departments. It is promoting a culture of continuous improvement, including strong leadership, team culture and the use of evidence based and supported practice in all areas.

The programme is used to encourage shared decision-making and responsibility by ward and department teams to achieve identified and expected outcomes. It also provides assurance that regulatory requirements and essential standards are being met and to identify where any improvements in practice and care are required. This is monitored by sustainability action plans, nursing quality indicators and patient experience data.

Continuing professional development (CPD)

In 2016/17, the Trust received £286,236 funding from the Bedfordshire and Hertfordshire Workforce Partnership for funding CPD commissioning. The resulting training reflected the Trust's priorities, including courses for service improvement, diabetes, advanced nurse practitioners and Allied Health Professional speciality courses. Simulation training for band one to four staff on *Recognition of the deteriorating patient* was again evaluated very highly.

The challenge of providing CPD for the non-medical workforce on a decreasing budget led to commissioning of individual study days (infection prevention and control, wound care, dementia and respiratory care) to increase access to education for the non-medical workforce. New innovative ways of delivering education in-house were explored and will be built upon in the coming year.

Nursing and midwifery revalidation

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

Pre-registration students

There continues to be a comprehensive programme of learning and support offered to the student population. Multi-professional forums and surgeries are well attended, and a student induction programme for all new non-medical students was run successfully in December 2016, with over 100 students attending.

This year has seen the introduction of nursing students to the Trust's e-roster system, which enables the Trust and the University to monitor student attendance and compliance with mentor supervision. The mentorship database has also been re-designed to link with ESR, providing live information of mentor profiles in line with expectations of the NMC.

A recruitment process for third year student nurses on qualification has been implemented, with all graduates offered a substantive post in the Trust and supported subsequently with a preceptorship programme.

For the third year in a row, one of the Trust's adult nursing students has won the University of Hertfordshire's *Elaine Andrews prize* for the most caring student nurse. A student on the flexible nursing pathway at the University of Bedfordshire has been shortlisted for the Nursing Times *Student of the Year* award.

Bands one to four nursing and midwifery staff

An 18-month flexible nursing pathway at the University of Bedfordshire developed to bridge the gap between the band four role with a foundation degree and the registered nurse role has three Trust employees on the programme currently.

The Trust in conjunction with other local partners within the Sustainability Transformation Plan (STP) footprint has been successful in becoming a *fast follower* pilot site for the new national nursing associate role, which has been designed to support registered nurses in the delivery of patient care. On successful completion of their training, nursing associates will be registered with the NMC.

Apprenticeship levy/apprenticeships

With the introduction of the national apprenticeship levy in May 2017, work has been ongoing in collaboration with STP partners to prepare for its implementation. Apprenticeships for bands one to four will continue, with *trailblazing* processes commenced to support the transition of CPD delivery to the apprenticeship standards, funded by the levy. This will provide educational opportunities through an apprenticeship framework for all bands of staff, from a level two qualification through to Masters level (higher apprenticeships).

170 staff have completed their level two apprenticeship, 45 staff completed level three and seven have commenced the level five apprenticeship in leadership. Work also continues with The Princes Trust – six young people were given work trainee placements in the Trust during 2016/17, with two now employed in band two clinical support worker posts.

The nurse education team employed an apprentice on a business and administration apprenticeship; she has now gained substantive employment in the Trust's workforce team in a band four position. A development progression route also has been implemented through employing apprentices in the Trust's finance service.

External engagement performance

The Trust has a strong track record of being committed to engaging proactively with all external stakeholders. The aim of this work is put the Trust's hospitals at the heart of local communities by providing practical help and support across a range of health and care related issues that are important to public constituents.

Engaging with local communities to encourage involvement through public membership, the Trust has seen its public membership increase by 33% over the last five years. The Trust's involvement programme for members delivers satisfaction ratings consistently of 90% and over for events and activities.

Further improvements were made in 2016/17, in both the quality and diversity of the Trust's involvement through public membership.

Membership development highlights

- Net increase of 535 public members over the year
- Net increase of 111 young members aged 14 to 16 over the 12 months
- CQC described the Trust's youth engagement programme *#theFUTUREismembership* as "outstanding practice"
- First annual work experience week at the Lister held in June 2016
- Trust's member-led new engagement strategy published
- Launch of new youth forum for the Trust – *Lister Young Voices* – hosted a Christmas party for the Lister's children's ward
- Key member event delivered to support Trust's successful university status bid
- First public engagement event in support of the Hertfordshire and West Essex STP delivered in March 2017
- Public member involvement in executive director appointments

Partnership working highlights

- The Trust held a successful annual general meeting (AGM) in July 2016, which attracted over 300 delegates returning a 90% satisfaction rating
- On-going and proactive support and partnership working with both Healthwatch Hertfordshire (for example securing independent lay involvement in PLACE visits) and Hertfordshire County Council's Health Scrutiny Committee (such as the March 2017 annual scrutiny meeting focussing on the Trust's Quality Account)
- On-going and proactive support for local council health and wellbeing projects, including the Public Health Board
- Collaboration with Health Education East of England to deliver the Trust's second annual work experience week at the Lister hospital for 74 local school pupils

Clinical engagement and primary care

- Supported the third annual Hertfordshire diabetes conference in autumn 2016
- Support engagement between GPs and hospital clinicians through a clinical forum
- Published regular editions of the Trust's *GP Update* newsletter, providing practical access and pathways information that GPs say they want
- Continued to promote and deliver the Trust's dedicated GP helpline service, as well as visiting GPs and practice managers to discuss matters of importance to them

Research and development performance

The Trust seeks to *enhance patient experience and outcome through research and innovation* and is an important part of the National Institute for Health Research (NIHR). As such, the Trust supports health and care research and translate discoveries into practical products, treatments, devices and procedures, involving patients and the public in all its work. This ensures that the Trust can support research from a wide range of funders to encourage broader investment in, and economic growth from, health research. It works with charities and the life sciences industry to help patients gain earlier access to breakthrough treatments and the Trust trains and develops researchers to keep the nation at the forefront of international research.

During 2016/17, the Trust's research and development strategy was launched. It was devised through extensive internal communication, two public engagement events and an analysis of detailed feedback from a survey to which there was 499 respondents – including staff, members of the public, patients, various stakeholders (such as university staff, people from other NHS organisations, industry, the Department of Health and NHS England).

The strategy is based around the recognition that a *research-active* organisation provides a better care environment than an organisation with little or no research. This is why the Trust has introduced measures to increase the numbers of patients entered into research. For the period April 2016 to Mar 2017, the Trust entered 2,715 patients into research (see details below). Of these there were 2,247 participants to research studies adopted to the NIHR Portfolio. This represents an increase of 39% from the 1,612 recruited in 2015/16. The Trust's sees this improvement as a strong sign that its research strategy is delivering immediate benefits in its first year.

The number of research studies open and number of research participants for April 2016 to March 2017 broken down by area of research and proportion of randomised controlled trials (RCT).

Trust specialty area	Number of studies	% RCT	Research participants	% RCT
Cardiology	14	57.1%	414	33.3%
Critical Care	4	0.0%	293	0.0%
Dementia	1	0.0%	10	0.0%
Diabetes	10	90.0%	22	95.5%
ENT	5	20.0%	239	32.6%
Gastroenterology	2	0.0%	5	0.0%
Health services research	1	0.0%	92	0.0%
Mental health	1	0.0%	36	0.0%
Musculoskeletal	7	14.3%	47	14.9%
Orthopaedics	1	100.0%	3	100.0%
Paediatrics	3	0.0%	16	0.0%
Renal	30	16.7%	727	2.8%
Respiratory disorders	4	50.0%	62	11.3%
Stroke	1	100.0%	10	100.0%
Surgery	1	0.0%	16	0.0%
Urology	3	100.0%	42	100.0%
Cancer	66	69.7%	523	34.8%
Supportive oncology	7	28.6%	158	19.6%
Grand total	**161**	**49.1%**	**2715**	**19.9%**

The Trust is an important contributor to national research

The Trust has a long history of being research-active with particular strengths in cancer, renal, cardiovascular disease, diabetes, ENT (ear, nose and throat) and health services research. Based on numbers of research participants for April 2016 to February 2017, the Trust had the highest national recruitment for a total of 11 multi-trust studies adopted to the NIHR Portfolio. Furthermore, it was the highest recruiting NHS trust to 30 multi-trust studies in the East of England; the Trust is also the fourth highest recruiting organisation in the region and the second highest, after Cambridge University Hospitals NHS Foundation Trust, for cancer research trials.

It is worth pointing out that randomised clinical trials (RCT) comprise 49% of the Trust's studies and 20% of its research participation. These RCTs are considered to provide the most robust evidence of the efficacy of therapeutic options. The design of effective treatment, however, tends to rely on a mixture of RCTs and other studies.

Gaining external funding for research and capacity development

The Trust supports its staff to apply for external research funding, working closely with the NIHR East of England Research Design Service to develop high quality research grant applications. Recent successes include:

- The renal team has worked with Keel University, and others, to gain a NIHR Health Research Health Technology Assessment (HTA) Programme grant "*BioImpedance Spectroscopy To Maintain Renal Output: The BISTRO Trial*" that aims to determine if incorporation of bioimpedance into the setting of the post dialytic weight reduces loss of residual kidney function.
- The gynae cancer team has been granted an award to study "*CICATRIX - Sample collection study to explore circulating tumour cells and leucocytes with ImagesTReam analysis in patients with various cancers*". This study, which was developed with Brunel University, aims to demonstrate that circulating tumour cells (CTCs) and lymphocytes in various solid tumours can be identified, quantified and used to monitor ongoing metastatic disease.
- The cardiology team has been awarded a grant for a project "*Assessing the effect of apixaban on endogenous fibrinolysis in patients with nonvalvularatrial fibrillation*". The award is from the Bristol-Myers Squibb / Pfizer European Thrombosis Investigator-Initiated Research Program, which was established in 2013 to fund innovative medical research by European investigators.
- One of the Trust's urology/haematology research nurses won a place on the Clinical Academic Internship Programme, funded by Health Education England, which will provide a practical skills to undertake a research project.

Supporting commercial research as part of the national research strategy

Nationally it is important for the NHS to support commercially-funded research. This promotes the health and the wealth of the nation**.** The Trust has an effective and productive working relationship with the commercial team of the NIHR Clinical Research network based in the Eastern region. During 2016/17, the Trust recruited 350 participants to 53 commercially-funded research studies that represented 33% of all recruiting studies and 13% of research participants.

So that the UK can compete in a globally-competitive market it is important that NHS organisations can quickly:

a) Set-up i.e. complete research feasibility and the necessary governance checks and
b) Deliver i.e. enter an agreed number of patients within a specified time period.

These measures are measured nationally through a scheme called *Performance in initiating and delivering clinical research*. Based on first nine months of 2016/17, the Trust was ranked first out of 20 for set-up and fifteenth out of 22 for delivery. The Trust introduced a *Key studies* initiative to improve its ability to deliver studies, with early signs of this working being evident – although it will take time for this to be reflected fully in the Trust's national ranking.

Of particular note are the following examples of entering patients quickly into commercially-funded research:

- First global site, from nine countries, to enter a patient into a study relating to a study looking into treatments for iron-deficient patients admitted for acute heart failure.
- First global site, from five countries, to confirm ability to start a funded cancer study to look at a new way of treating patients with skin cancer.
- First national site, of 10, to randomise a patient into a commercially funded cancer study which seeks to to determine how patients with ovarian, fallopian tube, and primary peritoneal cancer will best respond to two types of treatment (rucaparib versus chemotherapy).
- First national site to randomise a commercial trial by the cardiology research team for a phase III randomized controlled trial study to evaluate cardiovascular risk in a genetically defined population with a recent Acute Coronary Syndrome.

Working with other organisations

Much of the Trust's research activity has arisen from working in partnership with other organisations. The Trust has a long and successful history of working with universities – including the University of Hertfordshire, University of Cambridge, University College London, Brunel University, Anglia Ruskin University and Buckinghamshire New University. During 2016/17, the Trust also gained *University* status from the University of Hertfordshire and a significant contributor to this was the Trust's track record in research excellence, as well as supporting workforce development and other areas.

The Trust and the University of Hertfordshire have been given the opportunity to offer a joint appointment of a Florence Nightingale Chair in Clinical Nursing Practice Research. This will consolidate the links between the two organisations and promote the development of research.

Research publication and impact on patient care

The Trust publishes research and for the period January to December 2016 produced at least 199 publications in peer-reviewed journals. Examples of how research and innovation at the Trust has had a positive benefit for patients are:

- The renal team has established a shared care space in haemodialysis. Some patients were trained to set up their own dialysis machines in the renal unit, self-needle, put themselves on the machine and take themselves off.
- The respiratory team contributed to the cancer diagnosis in the acute setting (CaDiAS) lung and colorectal research study. This study is important because a high proportion of lung and colorectal cancer patients are diagnosed after presenting as an emergency, rather than after primary care referral.
- The radiotherapy team, with support from its bioengineering colleagues, has developed an innovative *fixation template device* for the delivery of high dose radiation (brachytherapy) in prostate cancer treatment. The Trust has worked with Health Enterprise East to review options to make this available on a commercial basis to other organisations.
- Patients who have robot-assisted radical prostatectomy were found to have better treatment when compared with patients undergoing open radical prostatectomy and that the cost of treatment was less.

Working with others both regionally, nationally and internationally

The Trust plays an important part in providing leadership to the NHS research community. This is delivered locally by working closely with others, including the Eastern Academic Health Science Network (AHSN), the Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC), Health Enterprise East (HEE) and the Stevenage Bioscience Catalyst (SBC). The Trust's associate director of research co-chairs the regional Hertfordshire Health and Wellbeing and Social Care Research Strategy Group and co-chairs the national NHS RD Forum Research Strategy Group.

Working with local charities

The Trust is very grateful for the support of more than £200,000 in 2016/17 from local charities – including the Cancer Treatment and Research Trust, the Marie Curie Research Wing at Mount Vernon Cancer Centre, local fundraising for the Trust Charity and support to the Lee Haynes Research Institute at the Lister hospital. It would be very hard for the Trust to continue supporting research at its current level without significant and on-going local charitable support. The Trust is very grateful to the many patients and relatives who continue to donate to support research.

Public and patient engagement and involvement

Patients are involved actively with developing the Trust's research and its research culture, with numerous focus groups and surveys undertaken to gain valuable insight into how research is viewed at the Trust. There are also specific patient work groups that contribute to the development of research.

The Trust also conducts research participant surveys. Between November and December 2016, a survey was completed at both the Lister and Mount Vernon Cancer Centre, with a total of 100 research participants providing their views. When asked "*Overall, how would you rate your experience of taking part in research on a scale of 1 to 10 – with 1 being very poor and 10 excellent?"* 69 responded with a score of 10 as excellent, 29 responded with a score of 9 and the remainder responded with 7 or more.

Example comments from the research participant survey include:

- *"I am happy to take part in the research so that the study can help future treatments. I am completely satisfied with the care and support provided to me by the staff."*
- *"The nurses were absolutely lovely, they listened and explained everything to me and also gave very good advice on caring for myself."*
- *"Research staff would answer questions, often finding out the answers and getting straight back to me. This was very important to me to know what is going on."*
- *"My research nurse has always been supportive, kind and caring and has always listened to my thoughts, doubts and concerns and has always put my mind at ease. She makes my two week treatments bearable."*

The Trust seeks to improve further the experience of patients when offered entry into a research study. It has worked with patients to create videos that share their research experience. The Trust will use these as part of its training for research and other staff as part of the wider ambition to "*enhance patient experience and outcome through research and innovation*".

Accountability section

Corporate governance report

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

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

Directors' report

The Trust Board

The Trust's Board operates according to the highest corporate governance standards. It is a unitary Board with collective responsibility for the leadership of the Trust, setting its strategic direction and all aspects of the performance of the trust, including financial performance, clinical and service quality, management and governance.

The Board is accountable legally for the services provided by the Trust and its key responsibilities include:

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

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

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

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

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

The Board met in formal session on 13 occasions during 2016/17, eight of which were held in public followed by a private session to consider matters of a confidential nature.

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

The Board consists of a non-executive chair, five non-executive directors and five executive directors – the chief executive and the medical, nursing, finance and operations directors. In addition, two further executive directors – for strategy and workforce and organisational development – and a non-executive director designate (until end January 2017) 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 2016/17, one non-executive director and the non-executive director designate left the Board. Following a recruitment process with NHS Improvement, Ms Val Moore joined the Board in September 2016. Currently the Trust is reviewing the skills and experience required for the challenges ahead – in particular with regard to the vice chair, Ms Alison Bexfield ending her maximum 10 year term in January 2018 and the vacant designate non-executive director role.

During 2016/17 there have been four changes to the executive team. The director of operations left the Trust in February 2016 and the recruitment process for a new chief operating officer got underway at the same time. Mr Nigel Kee joined the Trust as chief operating officer on 7 January 2017. During the intervening period Mr Brian Owens was acting director of operations until August 2016 and Ms Bernie Bluhm, interim chief operating officer from August 2016 to 6 January 2017.

The director of finance, Mr Tony Ollis, retired at the end of June 2016 and Mr Martin Armstrong joined the Trust on 31 October 2016. During the intervening period, Mr Brian Steven was the interim director of finance from July 2016 to 30 October 2016.

The Trust's deputy chief executive/director of strategic development successfully gained a chief executive post elsewhere in the NHS and left the Trust on 31 October 2016. Ms Kate Lancaster joined as the Trust's director of strategy on 1 February 2017. During the intervening period, Ms Sarah Brierley was the acting director of strategy.

The director of nursing joined NHS Improvement on secondment from 7 November 2016 and since this time, Ms Liz Lees has acted as the Trust's director of nursing.

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

The chair and non-executive directors appoint the Trust's chief executive. Together with the chief executive, the chair and non-executive directors appoint all other executive directors and determine their remuneration. Specialist recruitment consultants have been used to support the recruitment process during 2016/17.

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

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

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

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

The role of the NHS trust chair

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

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

The role of non-executive directors

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

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

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

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

The Trust Board 2016/17

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

Key to principal committee membership

AC – audit committee
EC – executive committee
FPC – finance and performance committee
RAQC – risk and quality committee
RC – remuneration committee
CTC – charity trustee committee
IC – involvement committee

Notes to committee attendance

1. The *executive committee* (EC) is a weekly meeting that is attended by all executive directors, unless absent from the Trust.
2. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. In particular, the Trust chair attends the *finance and performance* and *risk and quality committees* although she is not a designated member. The committee attendance figures listed below do not take into account these additional attendances; rather they reflect attendances that are *expected*.

Ellen Schroder, chair

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

Committee membership: RC, IC

Attendance: Trust Board 12 out of 13; FPC 7 out of 11; RAQC 7 out of 11; RC 1 out of 1; IC 3 out of 4

Nick Carver, chief executive

After initially working as a hospital porter, Nick qualified as a Registered Nurse before developing his interest in health service management. In addition to his registered general nurse qualification, he holds a BA (Hons) in political theory and government, as well as an MSc in health care management.

Nick was appointed as Chief Executive in November 2002, having previously been Chief Executive of the George Eliot Hospital NHS Trust in Warwickshire, prior to which he held senior roles in the West Country and South Wales. He has led the East and North Hertfordshire NHS Trust through major service change and delivered public and political support for a major reconfiguration of hospital services that delivered substantial quality and financial benefit to the local health economy. In 2013, Nick was presented with the *Inspirational Leader of the Year* award by Health Education, East of England. Nick is passionately committed to leadership development and is the Chief Executive lead for the widely praised Bedfordshire and Hertfordshire Aspiring Directors Development Scheme and also chairs the Midlands and East Regional Talent Board.

Committee membership: EC, FPC (core attendee), RAQC (core attendee), AC (attendee), RC (attendee), IC
Attendance: Trust Board 13 out of 13; FPC 10 out of 11; RAQC 2 out of 11 (due to required attendance at system wide STP meetings); AC 2 out of 5; IC 1 out of 4; RC 1 out of 1

Alison Bexfield, vice-chair

Alison, who lives in Letchworth, started her career as a chartered accountant in public practice. She spent several years with KPMG, where she provided audit services across a number of healthcare organisations. She held a variety of senior finance and governance roles at the BBC, most recently as head of internal audit, and currently is director of internal audit at HMRC. Alison has also served as an independent audit committee member on a number of audit committees across the public sector. Alison was appointed a non-executive director on 1 February 2008. She was re-appointed in 2012 and again in 2016; she will serve on the Trust Board until 31 January 2018. Alison is vice-chair of the Trust Board. She chairs the *audit* and *remuneration committees*.
Committee membership: AC, FPC, RC,
Attendance: Trust Board 10 out of 13; AC 5 out of 5; FPC 6 out of 11; RC 1 out of 1

Julian Nicholls, non-executive director

Julian has spent 20 years successfully managing substantial business to business services companies in the UK and Europe. Currently he is chairman of Whitehill Pelham Ltd and advisor to a number of private equity-owned companies. During his early career he had senior roles in sales, marketing and business development in the computer industry. He spent parts of his early career working in Africa, the Middle East and South East Asia. Julian was appointed as a non-executive director in July 2010 and chairs the Board's *finance and performance committee*.
Committee membership: AC, FPC, RC
Attendance: Trust Board 11 out of 13; AC 4 out of 5; FPC 11 out of 11; RC 0 out of 1

Bob Niven, non-executive director

Mr Niven, who lives in Hatfield, is a retired senior civil servant. He joined the civil service in 1974, having graduated from Oxford University with a BA in politics, philosophy and economics, followed by an MA in Political Science from Michigan State University and a B. Phil in Management Studies from Oxford University. His final post on retirement in 1999 was director of equal opportunities legislation policy at the then Department for Education and Employment. Following his departure from the civil service, Mr Niven became the chief executive of the Disability Rights Commission until September 2007. After a number of board appointments, including as chair of the Mental Health Helplines Partnership and at the Office of the Public Guardian, Mr Niven served as the resident independent adviser to the Israeli Equal Employment Opportunities Commission under a two-year, EU-supported capacity-building project until February 2012. Bob was appointed a designate non-executive director on 1 September 2013 and a full non-executive director from 6 January 2014 and chairs the *charity trustee committee*.
Committee membership: RAQC, RC, AC, CTC, RC,
Attendance: Trust Board 9 out of 13; RAQC 11 out of 11; AC 5 out of 5; CTC 4 out of 4; IC 1 out of 4; RC 1 out of 1

John Gilham, non-executive director

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

Committee membership: RAQC, RC

Attendance: Trust Board 12 out of 13; RAQC 9 out of 11; RC1 out of1

Val Moore, non-executive director (from November 2016)

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

Committee membership: RAQC, RC, IC, CTC

Attendance: Trust Board 6 out of 8; RAQC 7 out of 7; RC 0 out of 1; IC 2 out of 2.

Vijay Patel, non-executive director (designate) (until 31 January 2017)

Vijay joined the Trust on 1 November 2015 as a designate non-executive director. Vijay, who lives in Hemel Hempstead, is an ACCA graduate accountant. He started his career in the private sector, working for the Rank Group, British Telecom and John Laing before moving to the public sector in 1994 to head up the internal audit and risk management function at the William Sutton Trust and the Affinity Sutton Group (both housing associations). Since 2007, Vijay has held a number of non-executive directorships in the public sector and currently chairs the audit and risk committees at two of these organisations.

Committee membership: FPC, RC

Attendance: Trust Board 10 out of 11; FPC 9 out of 9, RC 1 out of 2

Jane McCue, medical director

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

Committee membership: EC, RAQC (core attendee)
Attendance: Trust Board 11 out of 13; RAQC 8 out of 11

Angela Thompson, director of nursing (on secondment from 7 November 2016)

Angela took up the post of director of nursing, patient experience, and infection prevention and control at the Trust in August 2011. Previously, she was assistant and then deputy chief nurse at Cambridge University Hospitals NHS Foundation Trust from 2007 to 2011, and lead for infection prevention and control from 2006 to 2010. She was also an advisor to Waikato District Health Board, Hamilton, New Zealand from 2006 until 2010. Angela is a registered general nurse (adult) and a registered sick children's nurse specialising in neonatal intensive care and care of the newborn. Her previous experience includes multi-disciplinary education, research, governance, patient safety and patient experience.
Committee membership: EC, RAQC (core attendee), FPC (attendee)
Attendance: Trust Board 4 out of 8; RAQC 4 out of 6; FPC 3 out of 6

Tony Ollis, director of finance (until end-June 2016)

Tony joined the Trust in November 2014 as finance director responsible for the Trust's strategic financial planning, maintaining and developing its financial systems and ensuring strong financial controls. He has been working in the NHS for a number of years, most recently as the finance director at the former Barnet and Chase Farm NHS Trust, where he provided the financial leadership for a major site redevelopment and significant clinical reconfiguration together with the subsequent integration with the Royal Free NHS Foundation Trust. Prior to this role, Tony had been the finance director of Buckinghamshire PCT where he was a key player in delivering a significant financial turnaround. He also brings significant experience from the private sector, most recently with GE and Schering Plough. Tony is a member of the Chartered Institute of Management Accountants.
Committee membership: EC, CTC, FPC (core attendee), AC (core attendee)
Attendance: Trust Board 4 out of 4; CTC 1 out of 1; FPC 3 out of 4; AC 1 out of 1

Stephen Posey, deputy chief executive (until end-October 2016)

Stephen joined the Trust as its director of strategic development in 2008 from the East of England strategic health authority (SHA), where he had been its provider development and foundation trust lead. Prior to his time at the SHA, Stephen undertook a number of senior management roles across both primary and secondary care. Stephen was responsible for the delivery of the Trust's acute consolidation programme, which completed in 2014. Called *Our changing hospitals*, it was a £150 million investment programme to reconfigure the Trust's acute services across east and north Hertfordshire. Appointed deputy chief executive in 2014, Stephen's executive lead responsibilities include: involvement and engagement; the Trust's NHS foundation trust application; major strategic projects; IM&T; business development; and the leadership of the Trust's transformation programme office.
Committee membership: EC, CTC, FPC (core attendee), RAQC (attendee)
Attendance: Trust Board 5 out of 7; CTC 2 out of 2; FPC 6 out of 6; IC 2 out of 3

Tom Simons, director of workforce and organisation development

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

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

Attendance: Trust Board 11 out of 13; FPC 9 out of 11; RAQC 6 out of 11; RC 3 out of 3

Martin Armstrong, director of finance (from 31 October 2016)

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

Committee membership: EC, FPC (core attendee)

Attendance: Trust Board 6 out of 6; FPC 5 out of 5

Nigel Kee, chief operating officer (from 7 January 2017)

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

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

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

Kate Lancaster, director of strategy

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

Committee membership: EC, FPC (attendee), CTC

Attendance: Trust Board 2 out of 2; FPC 1 out of 2; CTC 1 out of 1

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

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

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

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

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

Board members' terms of office 2016/17

	Title	Appointment date	Term(s) of office	Term of office ends
Ellen Schroder	Chair	1 April 2016	Four years	31 March 2020
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chair	1 February 2008	Four years plus four years Plus two year s	31 January 2018
Julian Nicholls	Non-executive director	1 July 2010	Four years plus two years	30 June 2018
Bob Niven	Non-executive director designate*	1 September 2013	n/a	n/a
	Non-executive director	6 January 2014	Four Years	5 January 2018
John Gilham	Non-executive director designate*	1 December 2014	n/a	n/a
	Non-executive director	1 June 2015	two years + 6 months	30 November 2017
Val Moore	Non-executive director	1 September 2016	Four Years	31 August 2020
Vijay Patel	Non-executive director designate*	1 November 2015	n/a	Finished 31 January 2017
Jane McCue	Medical director	1 April 2012	n/a	n/a
Angela Thompson	Director of nursing	30 August 2011	n/a	On secondment to NHSI from 7 November 2016
Liz Lees	Acting director of nursing	7 November 2016	n/a	n/a
Tony Ollis	Director of finance	20 October 2014	n/a	n/a
Brian Steven	Interim director of finance	July 2016	n/a	Until November 2016
Martin Armstrong	Director of finance	31 October 2016	n/a	n/a
Brian Owens	Acting director of operations	September 2015	n/a	Acting director of operations from Sept 2015 to August 2016
Bernie Bluhm	Interim chief operating officer	August 2016	n/a	Until 13 January 2017
Nigel Kee	Chief operating officer	9 January 2017		n/a
Tom Simons*	Director of workforce and OD	January 2014	n/a	n/a
Stephen Posey*	Director of strategic development deputy CEO	21 January 2008	n/a	Deputy CEO from 1 October 2014. Left the Trust end-October 2016
Sarah Brierley *	Acting director of strategy	31 October 2016	n/a	Until 31 January 2017
Kate Lancaster *	Director of strategy	1 February 2017	n/a	n/a

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

Remuneration and declaration of interests

The remuneration of individual directors can be found within the accountability section of this annual report. All the Trust's directors – both executive and non-executive – make annual declarations of directorships and/or other interests they hold that are relevant and material to NHS business matters. At each meeting of the Board and its committees a standing agenda item also requires all executive and non-executive directors to make known any interest in relation to the agenda and any changes to their declared interests. This register of directors' interests, along with expenses incurred by directors in pursuing Trust work, is published on the Trust's website.

For further information, please contact:

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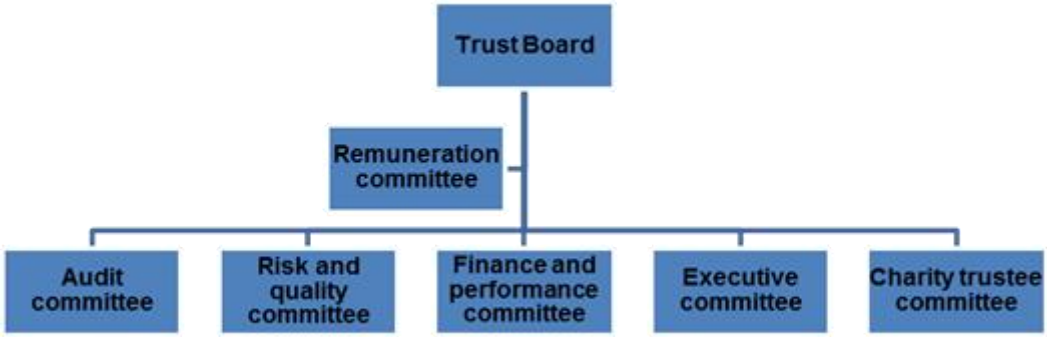
Governance structure

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



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

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

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

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

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

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

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

- *Division of surgery* (divisional chair, Dr Michael Chilvers and divisional director, John Fitzmaurice)
- *Division of medicine* (divisional chair, Dr Jon Baker and divisional director Bridget Sanders)
- *Division of clinical support services* (divisional chair, Dr Tim Walker and divisional director, Eilish Midlane)
- *Division of cancer services* (divisional chair, Dr Catherine Lemon and divisional director, currently vacant, supported by deputy director of operations, Brian Owens)
- *Division of women's and children's services* (divisional chairs, Mr Douglas Salvesen /Dr Linda Struthers and divisional director, Christine Bell)

The divisional structure is being reviewed currently for 2017/18 to ensure it continues to meet the needs of the organisation.

Information governance

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

For 2016/17, the Trust achieved 75%, which is a *satisfactory* rating. The Trust has reported two information governance serious incidents due to *breach of confidentiality* during the year to the Information Commissioner's Office (ICO), both of which related to handover sheets being found and handed in by a member of the public. The two incidents were investigated fully and the root cause was identified as human error. The handover sheets in question contained three personal identifiers, but very limited clinical information.

Actions have been taken to mitigate the risk of reoccurrence, including: a new poster and communications campaign to remind staff on safe disposal of confidential waste at the end of their shift; the number of personal identifiers used on handover notes reduced to two; and longer term a commitment to the implementation of digital technology to reduce the requirement for printed handover sheets.

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

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

External auditor

BDO LLP was appointed as the Trust's external auditor for 2015/16 and 2016/17 by the Audit Commission. As the Audit Commission closed on 1 April 2015, this contract is managed by a *transitional body* – Public Sector Audit Appointments Ltd. The external auditors have regular dialogue and meetings to discuss audit and other issues promptly. BDO LLP does not provide non-audit services to the Trust.

The *Local Audit and Accountability Act 2014* (the 2014 Act) brings in significant changes to the local public audit regime in England by replacing centralised arrangements for appointing external auditors to local authorities and health service bodies (clinical commissioning groups and NHS trusts, but *not* NHS foundation trusts) with a system that allows each body to make its own appointment. During 2016/17 the Trust established an auditor panel and following a tender process and approval by Trust Board in December 2016, appointed BDO as the Trust's external auditors commencing 1 April 2017; the contract award is for two years, with an option to extend for one further year.

Internal auditors

RSM, the Trust's internal auditors, is responsible for undertaking the internal audit functions on behalf of the Trust. The head of internal audit reports to each meeting of the Trust's *audit committee* on the audit activity undertaken. The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives; therefore, it can only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The summary of the internal audit work is included in the annual governance statement.

Modern Slavery Act

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.

Statement of accountable officer's responsibilities

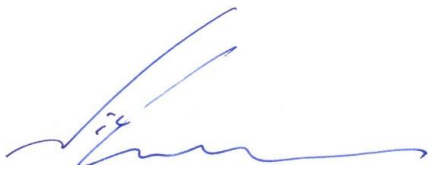
The chief executive of NHS Improvement has designated that the chief executive should be the accountable officer to the Trust. The relevant responsibilities of accountable officers are set out in the Accountable Officers Memorandum issued by the chief executive of NHS Improvement. These include ensuring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

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

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

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Signed  **Nick Carver, chief executive**

Date: 31 May 2017

Governance statement

Executive summary

My annual governance review of 2016/17 confirms that East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust has a programme that regularly monitors and tests various aspects of its governance and risk management structures to ensure they remain fit for purpose. Overall, no significant internal control issues (i.e. issues where the risk could not be effectively controlled) have been identified that would impact on the delivery of the Trust's strategic objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2017/18 with a focus on financial governance. The document below summarises the key areas that informed this opinion.

1. Scope of responsibility

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

In undertaking this role I, and my team, have developed strong links with NHS Improvement, local Clinical Commissioning Groups, and partner organisations.

2. The governance framework of the organisation

2.1 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an 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,
- 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 2017 and up to the date of approval of the annual report and accounts.

2.2 Capacity to handle risk

We have an established leadership and accountability framework and from 1 April 2016 to 31 March 2017 the responsibility for ensuring that there is a comprehensive risk management and corporate governance systems in place has been delegated to the Company Secretary.

In addition, I have delegated clinical governance and health and safety to the Director of Nursing, clinical governance and the co-ordination of the management of all clinical risks to the Medical Director, financial and information management and technology risks to the Director of Finance, operational, facilities, estates and security management, emergency planning to the Chief Operating Officer, and strategy and sustainability management to the Director of Strategy, and workforce and organisational development (OD) to the Chief People Officer and Director of Workforce.

Further detail on the individual director accountabilities are set out in the Corporate Governance Assurance map, the Trust's Annual Plan and Board Assurance Framework.

We have an approved an Assurance Framework and Quality Governance and Risk Management Strategy that ensures that:

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

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

Each of the Trust's clinical divisions has a Divisional (clinical) Chair and a Divisional Director, who are jointly accountable for risk and governance. A process of review and challenge of Divisional risks, as contained in the Risk Register, is conducted through the monthly Divisional Performance Review meetings. Areas of high risk are escalated to the Risk and Quality Committee (RAQC) and the Trust Board. In addition each of the Divisions attends RAQC on an annual basis for further scrutiny of their risk and governance processes. Plans are in place for divisions / specialities to attend Finance and Performance Committee (FPC) for a deep dive into their financial governance in 2017/18 and a quarterly discussion on the financial risks on the BAF.

The operational risk management team provides support and training to staff on risk management and the risk register. The Health, Safety and Security Team provide mandatory training on Health and Safety to all staff across the organisation. The Company Secretary ensures the Board receive support and training on risk management and in February 2016 the Board reviewed the key areas of strategic significance and potential risks facing the Trust in the future as part of developing the future operating plan. A Board development session on strategic risk management and risk appetite will be held in 2017/18. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff though governance half days, patient safety newsletter, trust bulletin and the organisational development programme (ARC/LEND).

I confirm that arrangements are in place for the discharge of statutory functions have been checked for any irregularities, and that they are legally compliant.

2.3 Board composition and Board development

During 2016/17, the Board had a series of facilitated development sessions on developing as a high performing board, supporting a coaching culture and reflections on our leadership style. Other key sessions have included the STP, financial recovery and transformation and sustainability. The Board has continued to increased its time out in the Trust and during 2017/18 we will link each non-executive director with a division.

The expectation is that the Board development sessions provide strategic focus to the organisation, enabling it to proactively respond to and support the achievement of strategic priorities for the local health economy in ways which are commercially and clinically effective for the Trust and support visibility and engagement across the Trust. To support the dedicated time required for board development we have reviewed the frequency of our public board meetings to alternate months.

Although we are not formally required to meet the Corporate Governance Code and Monitor's Code of Governance we have developed our corporate governance structures in line with the principles and best practice.

There have been a number of changes to the Board during 2016/17. One non-executive director and the non-executive director designate left the Board. Following a recruitment process with NHS Improvement, Ms Val Moore joined the Board in September 2016. Currently the Trust is reviewing the skills and experience required for the challenges ahead – in particular with regard to the vice-chair, ending her maximum 10 year term in January 2018 and the vacant designate non-executive director role.

There have been four changes to the executive team – the director of finance, director of strategy and director of nursing; the director of operations post was reviewed and a chief operating officer was recruited. The financial position of the Trust is such that considerable additional executive capacity needs deploying to its financial turnaround and transformation. As such, the *remuneration committee* approved that a new role of chief people officer was created to support the *model hospital* programme and ensure that culture change in the organisation is supported appropriately during a period of significant change.

2.4 Highlights of Board reports

The Board committee structure is outlined in section four of this governance statement. The Board receives a written report from each of its Board Committees – Audit Committee, Finance and Performance Committee (FPC), Risk and Quality Committee (RAQC) and Charity Trustee Committee (CTC) – after each meeting. The reports to Board highlight key decisions, assurance and areas for escalation or referrals to other Board Committees to provide further scrutiny on an area. During 2016/17 examples escalated from RAQC have included the management of estates strategic risk and capacity and demand. The Pathology Partnership has been monitored and escalated to Board by both the FPC and RAQC. The Audit Committee has considered the Internal Audit reports and sought greater assurance that all actions are implemented in a timely manner to mitigate the identified risks and sought further assurance on areas such as financial controls.

2.5 Annual Quality Account

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

The production of the Quality Account for 2016/17 has been led by the Trust's head of quality and patient safety on behalf of the medical director and was designed to meet all relevant Department of Health and NHS Improvement requirements. It provides a *look-back* against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a *look forward* to future priorities that have been developed with input from a range of local stakeholders. The account includes a section on mandated topics, for example clinical audits, and reports against the achievement of national standards.

The 2016/17 priorities for improvement were identified for a range of reasons including feedback on survey data, CQC Inspection report, a review of clinical outcomes and following input from staff, key external stakeholders, key internal quality, patient safety and patient experience committees and the Involvement Committee. For 2016/17 these were:

- Improve safety – introduce human factors
- Improve safety – medications management
- Improve outcomes – reduce mortality
- Improve clinical outcomes – further improve stroke standards
- Improve experiences – communication
- Improve experiences – nutrition and hydration

The review of the priorities for 2017/18 concluded:

- Patient safety – improve medication management
- Patient safety – progress *deteriorating patient* work
- Clinical effectiveness – further reduce mortality
- Clinical effectiveness – further improve stroke standards
- Patient experiences – improve communication
- Patient experiences – improve nutrition and hydration

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

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

Clinical audit

The RAQC and Audit Committee considered the clinical audit assurance following an evidence-based self-assessment against the Audit Committee Handbook 2010 criteria. The clinical audit year end summary report demonstrates that the Trust's clinical audit systems and processes are compliant with requirements, and that there are plans in place to continue to strengthen these.

Streamlining processes and monitoring have led to a continued improvement in clinical audit activity across the Trust. There has been a significant increase in recorded clinical audit activity during 2016/17 with the inclusion of the nursing audits for the first time. Approximately 81% of the audits included in the Trust's Clinical Audit Forward Plan were completed in 2016/17 and a further 16% in progress. The outcomes and learning from the Clinical Audits are discussed in the Trust's Quality Account. Ensuring the follow up of the action plans and learning is a focus for 2017/18.

Never events

We had two *never events* in 2016/17. One wrong implant or prosthesis and one fall from a restricted window. In the first case the patient involved came to no clinical harm. The second case resulted in the patient suffering harm from a fall; appropriate treatment was given. The incidents were identified and dealt with quickly; the patients were also informed about what had happened and a full apology given. Each incident has been investigated fully and root cause analysis undertaken and actions implemented.

Serious incidents

The Trust's incident management system has been tailored to capture themes common within serious incidents. Such themes include patient factors, staff/ team factors, education, equipment or organisational factors to support greater learning. One aspect relates to poor escalation – where a patient shows signs of deterioration but this has not been escalated to a more appropriate or senior member of staff in a timely way. Human factors is now included in our serious incident investigations.

The Trust uses the National Early Warning Score (NEWS) and is in the process of implementing an electronic observations system is which will support an automatic escalation function. This means that any concerns will be communicated automatically to relevant doctors and critical care outreach staff. Each serious incident has been fully investigated and root cause analysis undertaken and actions implemented and reported though to RAQC and Board.

3. Risk assessment

3.1 Risk profile

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

The Board Assurance framework risks were reviewed in July 2016 with the lead directors. The three previous risks on capacity and demand were consolidated into one strategic risk and it was recommended that strategic risk eight – the risk that the clinical and non-clinical benefits of the *Our changing hospitals* programme were not realised fully leading to the Trust reviewing its strategy (previously strategic risk four in 2015/16) could now be closed as evidence supported the outcomes were being achieved.

Since September 2016, RAQC has undertaken a deep dive into a strategic risk at each meeting to gain assurance on the actions taken to mitigate a risk and identification of emerging and external risks. They have considered and made recommendations for capacity and demand, the pathology Partnership and workforce and organisational development. The impact of the external environment continues to be evident in the risk ratings for 2016/17 and the controls and actions to mitigate these risks will be a focus and greater Board discussion in 2017/18.

These principle strategic risks include:

Strategic risk one: The risk that demand for services is in excess of plan exceeds capacity impacting on the delivery of our quality and financial outcomes.

Strategic risk two: The risk that the reduced available funding for the Trust estate is not sufficient to deliver the strategic outcomes for patients

Strategic risk three: The risk that the Pathology Partnership fails to perform effectively and does not deliver the operation and financial commitments, impacting on the quality outcomes for patients.

Strategic risk four: The risk of failure to maintain effective strategic relationships with partners in order to deliver integrated pathways (previously strategic risk eight in 2015/16).

Strategic risk five: The risk that the NHS Improvement, clinical commissioning group and public lose confidence in our plan to deliver sustainable improvements (specifically - mortality, patient survey, staff survey, A&E, finance), leading to loss of reputation, increased regulation and scrutiny, and financial penalties.

Strategic risk six: The risk if we don't deliver our approved financial plan we will not be able to access further funding and invest in service developments. This has been a high risk for the year. Actions in place and scrutinised by FPC and the Board (see section five of this governance statement).

Strategic risk seven: The risk that if we do not embed fully a value-based culture, we will fail to attract and retain high performing workforce and deliver our objectives.

Information governance

The Assurance Framework and Risk Register include the risks associated with the management and control of information. In this respect the Trust also has an Information Governance Statement of Compliance (IGSoC) agreement that supports the confidentiality, integrity, security and accuracy of personal data. The agreement includes independent review of systems and access to ensure authorised usage.

For 2016/17 the Trust achieved 75%, satisfactory rating. The Trust has reported two information governance serious incidents due to *breach of confidentiality*; both of these related to handover sheets being found and handed in by a member of the public. These have been fully investigated and the root cause was identified as human error. The handover sheets contained three personal identifiers, but very limited clinical information.

Actions have been taken to mitigate the risk reoccurrence including a new poster and communications campaign to remind staff on safe disposal of confidential waste at the end of the shift, the number of personal identifiers has been reduced to two, and long term we are committed to the implementation of digital technology to reduce the requirement of printed handover sheets. IG Training remains a priority for the Trust and the e-learning package is supported by an increased number of face to face training sessions delivered on the Trust's Statutory and Mandatory training day and a number of other training and awareness activities across the organisation.

On 12 May 2017 the Trust experienced a cyber-attack resulting in complete loss of IT systems and some telephony systems. The major incident plans were initiated and recovery process undertaken over a number of days reintroducing systems with normal activity resuming 19 May 2017. No patient data has been compromised and there has not been any patient harm reported as a consequence of the major incident. A full serious incident review will be undertaken to ensure lessons are learnt and actions are taken to mitigate a reoccurrence.

Other operational key risks, including infection control, mortality and performance, that have been managed during 2016/17 are discussed in section five of this governance statement.

4. The risk and control framework

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

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

Through a process of risk identification, assessment, learning and control, the organization maintains a corporate risk register that informs the board assurance framework and, thereby, provides assurance both to the Board and to the community we serve.

4.1 Board assurance and reporting

The Trust Board has established three committees to discharge its responsibilities on Board assurance. These are the Audit Committee, Risk and Quality Committee and the Finance and Performance Committee. These are constituted as key assurance committees and an annual review of each of the committees is undertaken to ensure they remain effective, continue to meet their terms of reference and requirements of the corporate governance code.

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

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

The Finance and Performance Committee (FPC) supports the governance structures and its main roles are to support the further development of the financial strategy of the Trust, to review the strategy as appropriate and monitor progress against it to ensure the achievement of financial targets and business objectives and the financial stability of the Trust. This includes:

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

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

The Risk and Quality Committee, a formal committee of the Board, is chaired by a non-executive director. The purpose of the committee is to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, information governance, health and safety, staff governance and patient and public safety. The committee also ensures that the Trust has an effective management and clinical governance framework that includes the assessment and monitoring of quality indicators, which drive forward the development of quality of services and care, patient safety and patient experience.

The RAQC will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny.

Each executive director is accountable to RAQC for their defined areas of responsibility and has clear assurance systems and structures in place; these are reviewed annually with each director.

Key committees supporting this process include:

- Clinical governance strategy committee
- Patient safety committee
- Patient experience committee
- Health and safety committee
- Emergency planning committee
- Infection control committee

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

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

This is a delegated duty carried out on behalf of the East and North Hertfordshire NHS Trust, which is the sole *Corporate Trustee* of the charity, *enhance herts* (registered charity no 1053338). Directors' attendance at the Board and its Committees is recorded and monitored. A review of attendance during 2016/17 has not highlighted any issues. These are reported in full in the Trust's annual report.

4.2 Assurance framework and risk register

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

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

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

- Business and service delivery plans
- Adverse incident forms
- Health and safety risk assessments
- Local risk assessments
- External assessment/audit
- External guidance/alerts
- Results of feedback

Where appropriate, through consultation and direct involvement with the Trust, public stakeholders are involved in managing risks which impact on them. The Trust has in place established risk assessment tools for all identified risks. These enable staff to quantify risks in their respective areas and decide what action, if any, needs to be taken with a view to reducing or eliminating those risks. A common risk score matrix is used by the Trust, with risks logged onto *local* and *corporate* risk registers.

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

Care Quality Commission

The trust is required to register with the Care Quality Commission (CQC) and its current registration status is *registered with no conditions*, but had some regulatory actions following the October 2015 comprehensive inspection at the Lister and Mount Vernon Cancer Centre. The Trust has not participated in any special review or investigation by the CQC during 2016/17. However. It underwent a follow-up inspection as part of the overall inspection programme of all NHS trusts in May 2016.

The Care Quality Commission (CQC) carried out an inspection as part of its routine comprehensive inspection programme from 20-23 October 2015. The Commission rated the Trust as *requires improvement* overall but judged Hertford County Hospital and children's community services to be *good*. The Bedford and Harlow renal units were inspected but not rated. The Trust was rated *good* for caring. A summary of the ratings are included in the trust annual report and the full reports can be viewed via the CQC website.

The areas of improvement, regulatory actions, were applied in March 2016. These are:

Lister hospital regarding compliance with regulations 12, 17 and 18. In brief the Trust must:

- Ensure that the triage process accurately measures patient need and priority in both the emergency department and maternity services (*actions taken include the implementation of telephone triage in maternity and further review and improvements in emergency department triage – both pathways observed by CQC Inspectors following the engagement meeting in February 2017, with positive feedback received*).
- Ensure records and assessments are completed in accordance with Trust Policy (*actions taken – key messages continue to be re-enforced and internal monitoring in place*).
- Ensure that there are effective governance systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients (*actions taken – key messages continue to be re-enforced and internal monitoring in place*).
- Ensure that all staff in all services complete their mandatory training (*closed – 90% target reached at end December 2016 and maintained – internal monitoring in place*).

Mount Vernon Cancer Centre regarding compliance with regulations 12 and 17. In brief, Trust must:

- Ensure patients requiring urgent transfer from Mount Vernon Cancer Centre have their needs met to ensure safety and that there are effective processes to handover continuing treatment (*closed – reviewed and strengthened systems and internal monitoring in place*).
- Ensure there is oversight and monitoring of all transfers (*closed – reviewed and strengthened our systems and internal monitoring in place*).

The CQC carried out an unannounced, focused inspection on 17 May 2016 to review concerns found during their previous comprehensive inspection. The inspection focused on the Lisgter's adult emergency department (ED) and Bluebell ward (part of the children's and young people's service). Although these services were inspected, they were not rated.

The CQC inspectors saw that significant improvements had been made since their last inspection, including:

- Staff were caring and compassionate towards patients and visitors within the emergency department; and patients and those close to them felt involved in their care
- The new triage process within the ED appeared to be efficient and safe
- There were improvements to hand hygiene and overall cleanliness
- Systems were in place to monitor patients at risk of deterioration in the ED and on Bluebell ward
- The risk assessments reviewed, including falls and pressure area risk assessments, were generally completed appropriately and reflected patients' needs
- Staffing levels met patients' needs at the time of the inspection and there had been an improvement in the number of staff that were trained to care for a child with complex needs

Further improvements were identified, such as meeting targets in the ED around triage and four-hour waiting times. In addition, further improvements were required relating to the knowledge around Duty of Candour, local induction of temporary staff and training around advanced life support. The actions relating to all recommendations have been built into the action plans.

Throughout the year, staff have continued to progress actions to continue to improve quality and safety. Their action plans are reported and monitored via development board meetings and updates are sent routinely to the CQC.

This work is being monitored by the CQC quality development board, which reports in to the Risk and Quality Committee and the Trust Board. An audit of Care Quality Commission (CQC) work was undertaken as part of the approved internal audit plan for 2016/17, particularly focussing on the development and monitoring of action plans following the CQC inspection. The audit concluded *substantial assurance* that the controls upon which the organisation relies to manage the identified risks are designed suitably, applied consistently and operating effectively.

The Trust continues to monitor its compliance against all CQC requirements, including the regulations – *Duty of Candour* and *Fit and Proper Persons*. It also has a programme of quality and safety audits and 15-step challenge to support embedding the standards and continuous improvement and a learning organisation. During 2017/18, the Trust will seek to improve further upon its performance with regulators, such as the CQC, and continue a programme of self-assessment against the standards required by the CQC and NHS Improvement.

Performance

A&E performance – the Trust had a particularly challenging year experiencing growth in emergency admissions and a high volume of ambulance conveyances. As a result, the level of demand has been in excess of planned growth, in particular demand from out of area. We have a number of work streams, including with external partners to improve capacity, bed flow and performance. The Trust did not deliver the 95% target to be seen within four hours, achieving 85.17% in March 2017.

18 week -referral to treatment time – this is a performance measure that the Trust has achieved historically. During 2016/17, the Trust achieved the standard (92%) for 10 out of the 12 months. There are multiple contributing factors that the Trust did not achieve for two months, the main reason being that referral levels were a lot higher than expected (up approximately 7% from the previous year). An extensive demand and capacity review currently is currently in progress using external expertise to ensure sufficient bed, theatres and outpatient capacity is in place during 2017/18 to meet the commissioned levels of activity.

Cancer waits – 2016/17 saw under-performance against this target, a trend that started in 2015/16, with the average performance range – against the 85% target – being 69.8%. The reasons for the under-performance continue to be multi-factorial, but there is now a better understanding of the key drivers. A revised action plan has been agreed with the commissioners and regulators, and progress is now under way to resolving the underlying issues. This focuses predominantly on rectifying a broad range of issues within the cancer service, from data capture and improved availability of management information available to influence cancer performance within the Trust. There are now signs of a clear recovery of the 62-day standard. Although current performance remains below the standard, the profile of the waiting list demonstrates a more sustainable position.

Infection control – the Trust has a zero tolerance approach to avoidable hospital-acquired infections and continues to remain compliant with the requirements of the Hygiene Code. During 2016/17, there were two cases of MRSA bacteraemia – root cause analysis has been completed and actions taken. One case was unavoidable – no gaps in practice identified. Over the same period there were 22 cases of *C. difficile* infections against a ceiling target of 11. Root cause analysis has been completed on all cases and actions taken. Eleven of the 22 cases were considered unpreventable, with no associated lapses of care identified. Within the acute NHS trusts in East of England, the Trust had the second lowest rate of *C. difficile* infections.

Data quality – overall the Trust's data quality national position makes it one of the highest performing NHS organisations in England. However, local data quality issues across the Trust are impacting on a number of key areas, including performance targets, theatres, outpatients, inpatients and clinical coding. Our programme of internal audit has provided assurance and identified where we need to strengthen our processes, including quality and accuracy of reporting accuracy of elective waiting time data and the risks to the quality and accuracy of this data. We have a data quality improvement programme that takes into account findings from an external review and our internal audits. We have supported an additional resource to ensure progress in line with our digital transformation programme. This is reported through our executive and Board committees. This will continue to be a priority for 2017/18.

Safer staffing

We are committed to ensuring that levels of nursing staff, which includes registered nurses, midwives and clinical support workers (CSWs), match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care. We undertake a formal review of the nursing establishment twice a year and report this to RAQC and Board. We manage nurse staffing proactively to support patient safety; in addition, safer staffing is reported each month to RAQC and Board.

Mortality

We have continued to reduce mortality and the year-to-date performance shows HSMR for the 12 month period (January to December 2016) is 95.18 and statistically is *as expected*. The latest SHMI data available (October 2015 to September 2016) shows this has improved to 105.61 and is considered *as expected band two*. We have continued to see a reduction in the number of people dying in hospital and in particular across the respiratory pathway and have further improvements to make. This includes supporting ways to reduce the number of deaths in the community.

We have an established mortality review process supported by 32 trained reviewers. By the end of April, we are aiming to achieve reviewing over 90% of recorded deaths against our target of 95%. We also continue to monitor any *alerts* that show higher than expected mortality with certain diagnoses. We have not received any CQC mortality outlier alerts during the last three years.

Reducing mortality remains an improvement priority for the Trust in 2017/18 and the Trust's operating plan and improving patient outcomes strategy set out the priorities and actions, including progress towards seven-day services.

Pensions

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

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. An assessment against the criteria stated in the Equality Delivery Scheme (EDS) has been undertaken, with EDS objectives agreed and published. The Workforce Reporting Equality Standard (WRES) was produced first in June 2015; it has been reviewed and updated and published through our Board.

Sustainability

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

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

The Trust experienced an extremely challenging financial year in 2016/17. Operational pressures, under-delivery of planned savings and failure to secure planned levels of sustainability and transformation funding were exacerbated by some underlying financial issues. The Trust's pre-audited reported financial performance was an adjusted retained deficit of £29.5 million, which was a significant deterioration in the organisation's financial performance.

The Trust Board is committed to ensuring that the Trust has a secure financial future, to enable us to deliver great care to our patients. Through improved financial control the Trust will aim to deliver service improvements and cost improvement programmes in 2017/18 that will lead to the better use of resources, including our estate. The financial recovery plan focuses on two scopes of work on financial control and transformation and productivity improvement across clinical processes.

2017/18 is likely to be another challenging year but the Trust will be looking to improve its financial performance through the delivery of its financial recovery plan, delivered through the on-going dedication and commitment of the Trust's staff, as a key step to returning to financial balance.

We have also undertaken a review of our business intelligence framework and have deployed a product to significantly enhance the quality and effectiveness of financial reporting and decision making capabilities and to improve its data quality environment.

6. Significant issues

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Risk and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

The Head of Internal Audit, 1 April 2016 to 31 March 2017 overall opinion is:

The organisation has an adequate and effective framework for risk management, governance and internal control, although our work has identified weaknesses with the design and application of internal control in specific areas.

Our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective. Actions have been identified which the Trust has either implemented or is in the process of implementing to close these gaps.

The Trust's internal audit programme is directed to areas of perceived high risk and where individual weaknesses have been identified the executive director lead has ensured comprehensive action plans have been put in place to address these and evidence collated to support implementation. The areas identified as high risk including capacity planning, divisional governance, data quality, GP helpline handling and responses, discharge management and corporate risk register, complaints management and application of audit control framework have an action plan in place which has been implemented or is on track for delivery.

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

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the external auditors, the Care Quality Commission inspections, the quality risk profile and intelligence monitoring report, the self-assessment against the CQC essential standards of quality and safety. I have also taken into account the Trust wide response to the recent major incident – cyber-attack, where our business continuity plans have been tested over a sustained period, no data was compromised and staff continued to deliver high quality care.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, the Risk and Quality Committee and the Finance and Performance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

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

- Internal Audit, through its annual audit plan, provides assurance and comment on matters related to internal control
- the Board has appointed a senior information risk owner, who is supported by an information governance steering group, to provide information governance assurance via the IG toolkit submission and IGSoC
- the Board ensures that all senior staff, clinical and other, through various meetings and review processes, including bi-monthly performance reviews with each Clinical Division, are held to account in all areas for delivery against finance, performance, quality, governance and risk issues
- I am confident that executive directors, senior managers of the Trust and identified risk leads are engaged fully in maintaining and reviewing the effectiveness of the system of internal control. This is supported by the positive CQC engagement and recent Internal Audit reports

Conclusion

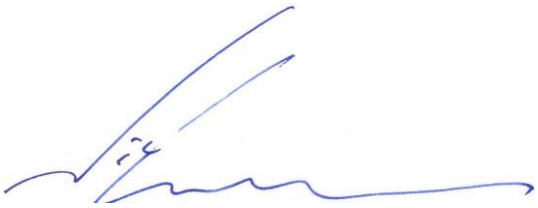
Capacity and demand remains a strategic risk and control issue for the Trust, which impacts on its ability to deliver its targets, the quality of patient care and its financial position.

Conclusion: There are no significant control issues (i.e. issues where the risk could not be controlled effectively) that have been identified in respect of 2016/17.

My review confirms that the East and North Hertfordshire NHS Trust has a generally sound system of internal control that supports the achievement of its organisation's objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2016/17, with a focus on financial governance.

Accounting Officer: **Nick Carver**

Organisation: **East and North Hertfordshire NHS Trust**

Signature: 

Date: **31 May 2017**

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 2016/17)
- Remuneration table
- Pensions entitlement table
- Pensions benefits table

Remuneration policy

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

The remuneration committee is a committee of the Trust Board, consisting of the chairman and all the non-executive directors. It is chaired by the vice chairman. The committee is supported by the chief executive, director of workforce and organisational development and the company secretary. The remuneration committee aims to meet quarterly to fulfil its duties and it met twice during 2016/17. Details of directors' remuneration are given in the annual accounts.

Every year, the Board's remuneration committee considers the performance and contribution of each director against the functions. This is carried out in parallel with a detailed review at least every two years of remuneration for individual posts within regional and national markets. In March 2016, the committee took into account a benchmarking report prepared by an external body.

Executive director and chief executive pay is then set based on the following principles:

- What they bring to the role – their experience and capability
- Their marketability and importance to the organisation – their previous salary history, how in demand are they by other organisations and how important are they to the Trust
- The *going rate* for the job and what it means for the person the Trust wishes to appoint or retain
- Performance against objectives and delivery in year

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

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

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

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate and involvement of a non-executive director. All the Trust's executive directors hold permanent contracts. The notice period for executive directors is six months. There are no arrangements for termination payments or compensation for early termination of contract. The Trust is also not liable for any compensation payments to former senior managers or amounts payable to third parties for the services of a senior manager.

The remuneration and terms of office of non-executive directors are those set out by the NHS Trust Development Authority (now part of NHS Improvement). The level of remuneration is paid for a minimum of two and a half days per month for non-executive directors and three and half days per week for the Trust's chair. Pay awards agreed nationally for other staff groups working at the Trust and the wider NHS, including staff on *Agenda for Change* contracts, medical and dental staff and very senior managers are determined by the Senior Salaries Review Body, which looks at senior salaries and pay conditions across the public sector.

Pay multiples (fair pay disclosure) for 2016/17

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 2016/17 was £187,500 (2015/16 – £187,500). This was 6.2 times (2015/16 – 6.7 times) the median remuneration of the workforce, which was £30,357 (2015/16 – £28,076). Median pay has increased due to the pay rise awarded in 2016/17, together with a change in the profile of staff, due to the temporarily increased number of contractors who are providing support to strategic capital projects. As the pay of the highest paid director has remained static and the median salary increased, the multiple has fallen.

In 2016/17, there were 21 employees who received remuneration in excess of the highest paid director (in 2015/16, the figure reported was 19 employees). The remuneration received by Trust staff in 2016/17 ranged from £15,251 to £264,925 per annum (for 2015/16 – the reported range was £14,320 to £248,835).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. The salaries and allowances of directors in tabular format, table of pension benefits of directors and the pay multiples information have been audited by the Trust's auditors BDO LLP.

Remuneration tables

Name and title	2016/17						2015/16					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Executive directors												
Nick Carver	185-190	8	0	0	0	185-190	185-190	8	0	0	2.5-5	190-195
Chief executive												
Anthony Ollis (to 30/06/16)	40-45	0	0	0	0	40-45	140-145	2	0	0	32.5-35	175-180
Director of finance												
Brian Steven (20/06/16-30/10/16)	115-120	0	0	0	0	115-120	n/a	n/a	n/a	n/a	n/a	n/a
Director of finance												
Martin Armstrong (from 31/10/16)	55-60	0	0	0	42.5-45	95-100	n/a	n/a	n/a	n/a	n/a	n/a
Director of finance												
Angela Thompson (to 06/11/16)	70-75	0	0	0	30-32.5	105-110	120-125	1	0	0	50-52.5	170-175
Director of nursing												
Liz Lees (from 07/11/16)	40-45	21	0	0	45-47.5	85-90	n/a	n/a	n/a	n/a	n/a	n/a
Acting Director of Nursing												
John Watson (to 16/2/16)	n/a	n/a	n/a	n/a	n/a	n/a	105-110	0	0	0	100-102.5	205-210
Director of operations												
Brian Owens (01/04/16-01/08/16)	35-40	0	0	0	12.5-15	50-55	n/a	n/a	n/a	n/a	n/a	n/a
Acting director of operations												

Executive directors												
Bernie Bluhm (02/08/16-08/01/17)	140-145	0	0	0	0	140-145	n/a	n/a	n/a	n/a	n/a	n/a
Interim chief operating officer												
Nigel Kee (from 09/01/17)	30-35	0	0	0	7.5-10	35-40	n/a	n/a	n/a	n/a	n/a	n/a
Chief operating officer												
Jane McCue*	160-165	2	0	0	27.5-30	190-195	160-165	1	0	0	222.5-225	385-390
Medical director												
Stephen Posey (to 31/10/16)	80-85	1	0	0	40-42.5	120-125	125-130	21	0	0	72.5-75	200-205
Deputy CEO/director of strategic development												
Sarah Brierley (01/11/16-31/01/17)	20-25	6	0	0	47.5-50	70-75	n/a	n/a	n/a	n/a	n/a	n/a
Acting director of strategy												
Kate Lancaster (from 01/02/17)	20-25	0	0	0	7.5-10	30-35	n/a	n/a	n/a	n/a	n/a	n/a
Director of strategy												
Tom Simons	115-120	59	0	0	57.5-60	180-185	100-105	50	0	0	47.5-50	155-160
Director of workforce and OD												

Notes:

The table above includes an amount in respect of the increase in pension entitlements of each executive director. It compares the projected pension and lump sum at the end of the financial year with the equivalent figures at the start of the year, adjusted for inflation and deducting employees' pension contributions. The pension element of the calculation is based on the assumption that the individual will receive a pension for a twenty-year period. The figures for all pension-related benefits do not constitute a charge to the Trust's Statement of Comprehensive Income or a taxable benefit for the directors. The Trust's contribution to directors' pensions was 14.3% of salary for 2016/17 (14.3% in 2015/16). 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.

Name and title	2016/17						2015/16					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)	(bands of £5000)	Rounded to the nearest £100	(bands of £5000)	(bands of £5000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ellen Schroder (from 01/01/17)	35-40	0	0	0	0	35-40	n/a	n/a	n/a	n/a	n/a	n/a
Chair												
Ian Morfett (term ended 31/03/16)	n/a	n/a	n/a	n/a	n/a	n/a	20-25	0	0	0	0	20-25
Chair												
Alison Bexfield	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Vice-chair												
Dyan Crowther (retired 31/12/15)	n/a	n/a	n/a	n/a	n/a	n/a	0-5	0	0	0	0	0-5
Julian Nicholls	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Stuart Gavurin (retired 31/05/15)	n/a	n/a	n/a	n/a	n/a	n/a	0-5	0	0	0	0	0-5
Bob Niven	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
John Gilham	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Vijay Patel (from 01/11/15 to 31/01/17)	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Val Moore (from 01/09/16)	0-5	0	0	0	0	0-5	n/a	n/a	n/a	n/a	n/a	n/a

Notes:
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 2015/16 and 2016/17.

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 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash equivalent transfer value at 1 April 2016	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2017	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver*	n/a	n/a	n/a	n/a	1,323	n/a	n/a	n/a
Chief executive								
Anthony Ollis (to 30/06/16)	0-2.5	n/a	15-20	n/a	230	48	248	0
Director of finance								
Martin Armstrong (from 31/10/16)	5-7.5	2.5-5	30-35	120-125	415	73	488	0
Director of finance								
Brian Owens (01/04/16-01/08/16)	2.5-5	0-2.5	30-35	45-50	361	41	402	0
Acting director of operations								
Nigel Kee (from 09/01/17)	2.5-5	7.5-10	30-35	90-95	508	75	583	0
Chief operating officer								
Stephen Posey (to 31/10/16)	2.5-5	5-7.5	30-35	85-90	375	57	432	0
Director of strategic development								
Sarah Brierley (01/11/16 -31/01/17)	7.5-10	22.5-25	25-27.5	70-75	323	154	477	0
Acting director of strategy								
Kate Lancaster (from 01/02/17)	2.5-5	2.5-5	30-35	80-85	434	34	468	0
Director of strategy								
Angela Thompson (to 06/11/16)	2.5-5	7.5-10	50-55	150-155	954	88	1,042	0
Director of nursing								
Liz Lees (from 07/11/16)	5-7.5	15-17.5	30-35	90-95	427	92	519	0
Acting director of nursing								
Jane McCue	0-2.5	5-7.5	70-75	220-225	1,536	120	1,656	0
Medical director								
Tom Simons	2.5-5	n/a	15-20	n/a	114	36	150	0
Director of workforce and OD								

Notes to pensions table

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

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.

Notes to pensions table (contd.)

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

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

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

Compensation for loss of office

There was one compulsory redundancy below £10,000 in 2016/17. There was nothing to disclose in respect of 2015/16.

Staff report

This section covers:

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

Staff numbers and costs

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

Average staff numbers	2016/17		2015/16
	Total	Employed permanently	Total
Medical and dental	800	735	788
Ambulance staff	0	0	0
Administration and estates	1,525	1,395	1,417
Healthcare assistants and other support staff	816	678	775
Nursing, midwifery and health visiting staff	1,826	1,527	1,795
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	407	359	524
Social care staff	0	0	0
Healthcare science staff	135	135	0
Total	**5,509**	**4,829**	**5,299**

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

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

Staff costs	2016/17	2015/16
	£000s	£000s
Employee benefits excluding Board members	255,746	241,596
Board members	1,400	1,217
Total employee benefits	**257,146**	**242,813**

Staff composition (by gender)

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

2016/17	Male	Female	Total
Executive directors	3	2	5
Employees	1,250	4,419	5,669
Total	**1,253**	**4,421**	**5,674**

Workforce data

In the table below, a summary of workforce-related statistics is provided for 2016/17, alongside figures provided for the previous three years. The figures are the average for the years ending 31 March and are expressed as full time equivalents (FTEs).

Activity	31 March 2017	31 March 2016	31 March 2015	31 March 2014
Staff employed	4,828.71	4,651.92	4,540.63	4,797.40
Vacancy rate	12.06%	9.72%	7.11%	5.64%
Turnover rate	12.96%	12.80%	12.91%	10.63%
Sickness absence rate	4.06%	4.30%	4.12%	3.90%

The Trust has increased the overall establishment by circa 300 wte in the financial year 2016/17 which has subsequently increased the vacancy factor. As a result of variety of recruitment campaigns launched in 2016/17 the current pipeline has increased significantly and in March 2017 reached 346 wte of external candidates. The trust is on trajectory to reach a vacancy rate of 6% in September 2017.

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

Sickness absence data

The Trust has taken a number of steps to reduce sickness absence during 2016/17. A key action has been the continuation of *Absence Assist* for a full year, an external centralised sickness reporting and advisory service that has helped to address the variance in reporting and managing sickness absence across the Trust. During the initial six-month pilot, there was a demonstrable reduction in short-term sickness absence, as well as an increase in management referrals to the Health@Work (occupational health) service. More effective reporting and management of short-term sickness has also enabled managers to focus more time on the management of long-term sickness absence cases; as a result, the pilot was extended for a further twelve months.

Equality and diversity – staff in post

Ethnicity

The Trust's workforce continues to be more diverse than the population served; 32.88% of the workforce is from ethnic minority groups in comparison to the local community, which is 16.9% (based on 2011 Census data).

Age

In Hertfordshire, 41% of the population is aged between 30 and 59; within the Trust, 72.91% of staff fall within this age bracket. Staff are employed from all age bands across all staff grades, however the Trust appears to have a lower representation of staff aged 60 years plus across most bands and a lower representation of staff aged 29 years or less working at bands 7, 8 and 9.

Gender

Females continue to make up the majority of the workforce at 78%; they outnumber males in all staff groups with the exception of medical and dental, where 45.99% are female and 54.01% are male. By way of comparison, the male population of Hertfordshire is 547,110 compared to females at 568,952 (49% compared to 51%). Just under 37% of all Trust employees work part-time, with the highest percentage in nursing and midwifery (47%) and nursing unqualified (46.00%).

Disability

14.32% of people in the 2011 census for Hertfordshire reported they had a disability. Of the Trust's 5,674 staff, 233 did not disclose whether they have a disability and 2,493 were undefined. It is not clear why staff are unwilling to share their status, so it is difficult to draw any definitive conclusions based on these figures.

Religion

54.4%% of Hertfordshire's population state they are Christian, with the next highest group at 33.6% stating they follow no religion. The Trust's workforce is 42.19% Christian, however 25.20% have not disclosed any religion and 9% do not want to disclose their religion. The next largest group is atheist at 9.62%.

Sexual orientation

59.4% of the Trust's workforce state they are heterosexual, with 32.70% giving undefined responses; furthermore, 6.79% do not wish to disclose their orientation. It has not been possible to find any localised census data with which to compare these figures.

Policy overview

A policy review process is in place, with a schedule of work planned for the year to ensure that workforce-related policies are reviewed in a timely fashion. Key policies that have been reviewed and updated during 2016/17, were the Retirement Policy; Trust Smoke Free Policy; Trust Induction Policy, Temporary Staffing Policy; Family Leave Policy; Adverse Weather Conditions, Prevention and management of natural rubber latex allergy and the Dress Code Policy, as well as the core employee relations policies and procedures. The Trust has specific policies in place to prevent staff with a disability from being discriminated against, including during the recruitment process. The Trust's workforce and organisational development team has also reviewed and refreshed its internal standard operating procedures during the year.

Policies applied to support disabled people

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

For staff who become disabled in service or may suffer from a condition that may be considered as disabled under the Equality Act, the Trust seeks to retain their service and make reasonable adjustments to their role. The Trust's occupational health team supports this process by providing recommendations on adjustments and suitability of the post, based on the member of staff's condition. If this is not feasible, the Trust will seek to redeploy the member of staff into a suitable alternative post; this process is in line with the Trust's absence management policy.

Full training is provided as part of the redeployment process and a trial period can be put in place, where applicable. The Trust's equality and diversity policy covers the fair treatment of staff that have a *protected characteristic* in training, career development and promotion.

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

Equality impact assessments

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

Expenditure on consultancy

In 2016/17, £973,000 was spent on consultancy.

Off-payroll engagements

The table below looks at all off-payroll engagements as of 31 March 2017 (more than £220 per day and last longer than six months).

Category	Number
Number of existing engagements as of 31 March 2017	44*
Of which, the number that have existed:	
- for less than one year at the time of reporting	32
- for between one and two years at the time of reporting	6
- for between two and three years at the time of reporting	3
- for between three and four years at the time of reporting	1
- for four or more years at the time of reporting	2

*These figures include high-value agency workers, as well as independent contractors. 26 of these were high value agency workers, engaged on an IT project.

All recent off-payroll engagements for independent contractors were subject to a risk-based assessment as to whether or not to request assurance that the individual was paying the right amount of tax. Assurance was sought in two cases.

The table on the next page sets out all new off-payroll engagements between 1 April 2016 and 31 March 2017, where pay is more than £220 per day and that last longer than six months.

Category	Number
Number of new engagements between 1 April 2016 and 31 March 2017	33*
Of which:	
Number of new engagements that include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations.	10
Number for whom assurance has been requested	2
Of which:	
- assurance has been received	0
- assurance has not been received	2**
- engagements terminated as a result of assurance not being received	0

*These figures include high-value agency workers, as well as independent contractors, and 22 of these were agency workers engaged on an IT project.

**The Trust is still within the requested timescale for response. However, both contractors have already ended their engagements with the Trust.

The table below sets out the number of off-payroll engagements for board members or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Category	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	2
Number of individuals that have been deemed *board members, and/or senior officers with significant financial responsibility* during the financial year. This figure includes both off-payroll and on-payroll engagements	14

Exit packages

No exit packages were agreed in 2016/17.

Financial statements

Statement of directors' responsibilities in respect of the accounts

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

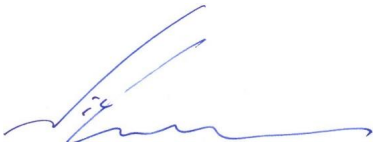
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent; and
- state whether applicable accounting standards have been followed, subject to any material departures disclosed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

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

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

By order of the Board

Date: 31 May 2017 **Nick Carver, Chief Executive**



Date: 31 May 2017 **Martin Armstrong, Finance Director**

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

We have audited the financial statements of East and North Hertfordshire NHS Trust (the Trust) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements comprise the combined group and single entity Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, and Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016-17 Government Financial Reporting Manual (the 2016-17 FReM) as contained in the Department of Health Group Accounting Manual 2016-17 (the 2016-17 GAM) and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

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

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 Public Sector Audit Appointments Limited. 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.

Respective responsibilities of Directors, the Accountable Officer and auditor

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

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountabilty Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Trust's and the group's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Directors; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of East and North Hertfordshire NHS Trust as at 31 March 2017 and of its expenditure and income for the year then ended; and
- give a true and fair view of the financial position of the Group as at 31 March 2017 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Direction issued thereunder.

Emphasis of Matter – Going Concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosures made in Note 1.1.1 to the financial statements concerning the Trust's ability to continue as a going concern. The ability of the Trust to continue as a going concern in maintaining operational and financial stability is dependent upon cash support which is not currently formally approved. As explained in Note 1.1.1, this matter indicates the existence of material uncertainties that may cast significant doubt on the ability of the Trust to continue as a going concern.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

Auditor's responsibilities

We 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 2017. Our assessment of arrangements is made by reference to the overall criterion: *In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people*.

Basis for qualified conclusion – use of resources

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

- The Trust recorded a deficit for 2016/17 of £37.2 million (£29.5 million after adjusting for technical issues to arrive at the deficit used to judge financial performance), this being a deterioration compared to 2015/16 (£25.7 million and £16.2 million respectively) and a significant deterioration in year.
- The Trust had agreed a Cost Improvement Programme (CIP) target of £15.5 million for 2016/17, with the CIP profile assuming greater levels of delivery in the latter part of the year. Some 31% of the CIP programme was forecast to be delivered in the first six months of the year, with 69% of the £15.5 million total profiled for the second half of the year.
- As early as July 2016 the CIP forecast showed a likely £3.2 million under-delivery, with a number of CIP schemes, particularly cross-cutting schemes, still in development. Outturn CIP achievement was approximately £3 million down on the annual target.
- Other key reasons for financial deterioration included not qualifying for Sustainability and Transformation Funding after quarter two (approximately £5 million impact) and reduced levels of income from CCGs compared to that anticipated and budgeted for (approximately £5 million).

- The Trust has set a challenging CIP target for 2017/18. To help address issues encountered in 2016/17, the Trust is setting up a central programme management office (PMO) function to lead the development, delivery and monitoring Trust's CIP and transformation programme.
- The pursuit of a long-term sustainable solution to bring the Trust back to financial balance is dependent upon the Sustainability and Transformation Plan (STP) collaboration, but an agreed recovery plan to bring spending back within the available resources has not yet been produced.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects East and North Hertfordshire NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014

Exercise of powers

A referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 relating to breach of rolling breakeven financial duties was issued on 30 May 2016 in respect of the 2015/16 audit and the issues referred remain in 2016/17.

Other matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Trust Development Agency (operating as NHS Improvement) guidance; 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.

We have nothing to report in these respects.

Certificate

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

David Eagles
For and on behalf of BDO LLP, Appointed Auditor
Ipswich, UK
31 May 2017

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

East and North Hertfordshire NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

Statement of Comprehensive Income for year ended 31 March 2017

		Group		Trust Only	
	NOTE	**2016-17 £000s**	2015-16 £000s	**2016-17 £000s**	2015-16 £000s
Gross employee benefits	8.1	**(257,146)**	(242,813)	**(256,903)**	(242,253)
Other operating costs	6	**(185,925)**	(166,689)	**(185,643)**	(166,044)
Revenue from patient care activities	3	**372,704**	345,586	**371,684**	345,586
Other operating revenue	4	**39,166**	40,312	**39,353**	39,126
Operating surplus/(deficit)		**(31,201)**	(23,604)	**(31,509)**	(23,585)
Investment revenue	10	**31**	37	**31**	37
Other gains and (losses)	11	**0**	4,153	**0**	4,153
Finance costs	12	**(4,142)**	(3,423)	**(4,137)**	(3,421)
Surplus/(deficit) for the financial year		**(35,312)**	(22,837)	**(35,615)**	(22,816)
Public dividend capital dividends payable		**(1,852)**	(2,878)	**(1,852)**	(2,878)
Retained surplus/(deficit) for the year		**(37,164)**	(25,715)	**(37,467)**	(25,694)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s	**2016-17 £000s**	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**(907)**	5,041	**(907)**	5,041
Net gain/(loss) on revaluation of property, plant & equipment	**3,319**	767	**3,319**	767
Other gain /(loss) (explain in footnote below)	**0**	(139)	**0**	0
Total comprehensive income for the year	**(34,752)**	(20,046)	**(35,055)**	(19,886)

Financial performance for the year

Retained surplus/(deficit) for the year	**(37,164)**	(25,694)
Prior period adjustment to correct errors and other performance adjustments	**4,099**	0
Impairments	**3,466**	8,996
Adjustments in respect of donated asset reserve elimination	**66**	472
Adjusted retained surplus/(deficit)	**(29,533)**	(16,226)

The Trust has a wholly-owned subsidiary, ENH Pharma, which dispenses Outpatient Pharmaceutical prescriptions, principally to the Trust's patients. The Trust is required to incorporate the financial results of its subsidiary with its own as a single entity in the assessment of financial performance for 2016/17. However, performance of the Trust has also been provided alongside, and this was the basis for assessment of financial performance in 2015/16.

The Notes in the Accounts support the consolidated results above.

The Trust has recorded some significant adjustments, totalling £4,099,000, in its 2016/17 retained deficit for issues relating to prior years. The impact of these has been removed from its financial performance for the year as agreed with NHSI .

The Trust's financial performance in year is adjusted for the value of impairments to the value of its assets (see Note 16). The impairments recorded within the Accounts are a net figure and relate to:

- The Impairment of the Trust's investment in The Pathology Partnership of £6,294,000 (2015/16 £2,372,000)
- The reversal of impairments in prior years to the value of the Trust's Property, Plant and Equipment of -£2,828,000 (2015/16 £6,624,000)

The Trust is required to remove the impact of the difference between the income recorded from the receipt of donated assets and the expenditure relating to the depreciation on donated assets from the assessment of its financial performance.

The notes on pages 102 to 138 form part of this account.

Statement of Financial Position as at 31 March 2017

		Group		Trust Only	
		31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	NOTE	**£000s**	£000s	**£000s**	£000s
Non-current assets:					
Property, plant and equipment	14	**185,953**	179,563	**185,698**	179,310
Intangible assets	15	**12,860**	8,491	**12,720**	8,491
Other Investments - Charitable*			2,298	**0**	0
Other financial assets		**0**	1,505	**1,000**	2,505
Trade and other receivables	19.1	**3,125**	2,562	**3,125**	2,562
Total non-current assets		**201,938**	194,419	**202,543**	192,868
Current assets:					
Inventories	18	**5,535**	6,006	**4,943**	5,264
Trade and other receivables	19.1	**46,810**	42,094	**45,716**	41,513
Cash and cash equivalents	21	**2,064**	17,516	**1,369**	15,863
Sub-total current assets		**54,409**	65,616	**52,028**	62,640
Non-current assets held for sale	22	**0**	1,700	**0**	1,700
Total current assets		**54,409**	67,316	**52,028**	64,340
Total assets		**256,347**	261,735	**254,571**	257,208
Current liabilities					
Trade and other payables	23	**(56,453)**	(67,205)	**(55,223)**	(65,373)
Other liabilities	24	**(203)**	(203)	**(203)**	(203)
Provisions	28	**(2,669)**	(288)	**(2,669)**	(288)
Borrowings	25	**(437)**	(289)	**(437)**	(289)
Other financial liabilities	26	**(157)**	(150)	**(157)**	(150)
DH capital loan	25	**(3,043)**	(8,493)	**(3,043)**	(8,493)
Total current liabilities		**(62,962)**	(76,628)	**(61,732)**	(74,796)
Net current assets/(liabilities)		**(8,553)**	(9,312)	**(9,704)**	(10,456)
Total assets less current liablilities		**193,385**	185,107	**192,839**	182,412
Non-current liabilities					
Other liabilities	24	**(4,813)**	(5,015)	**(4,813)**	(5,015)
Provisions	28	**(1,143)**	(770)	**(1,143)**	(770)
Borrowings	25	**(7,001)**	(7,115)	**(7,001)**	(7,115)
Other financial liabilities	26	**(2,437)**	(2,595)	**(2,437)**	(2,595)
DH revenue support loan	25	**(71,062)**	(28,369)	**(71,062)**	(28,369)
DH capital loan	25	**(52,175)**	(50,987)	**(52,175)**	(50,987)
Total non-current liabilities		**(138,631)**	(94,851)	**(138,631)**	(94,851)
Total assets employed:		**54,754**	90,256	**54,208**	87,561
FINANCED BY:					
Public Dividend Capital		**171,652**	169,950	**171,652**	169,950
Retained earnings		**(163,753)**	(127,458)	**(163,753)**	(127,458)
Revaluation reserve		**46,309**	45,069	**46,309**	45,069
Charitable Funds Reserve			2,452	**0**	0
Other reserves		**546**	243	**0**	0
Total Taxpayers' Equity:		**54,754**	90,256	**54,208**	87,561

* The Trust has not consolidated the results of its associated Charity for 2016/17 (see Note 1.3)

The notes on pages 102 to 138 form part of this account.

The financial statements on pages 97 to 101 were approved by the Board on 31st May 2017 and signed on its behalf by

Chief Executive:  Date: 31st May 2017

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Group					
	Public Dividend capital	Retained earnings	Revaluation reserve	Charitable Funds Reserves	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**169,950**	**(127,458)**	**45,069**		**243**	**87,804**
Changes in taxpayers' equity for 2016-17						
Retained surplus/(deficit) for the year		(37,164)				**(37,164)**
Net gain / (loss) on revaluation of property, plant, equipment			3,319			**3,319**
Impairments and reversals			(907)			**(907)**
Transfers between reserves		1,172	(1,172)		0	**0**
Temporary and permanent PDC received - cash	1,702					**1,702**
Other movements	0	(303)	0		303	**0**
Net recognised revenue/(expense) for the year	**1,702**	**(36,295)**	**1,240**		**303**	**(33,050)**
Balance at 31 March 2017	**171,652**	**(163,753)**	**46,309**		**546**	**54,754**
Balance at 1 April 2015	**169,916**	**(106,292)**	**43,789**	**2,848**	**13**	**110,274**
Changes in taxpayers' equity for 2015-16						
Retained surplus/(deficit) for the year		(25,694)			230	(25,464)
Net gain / (loss) on revaluation of property, plant, equipment			767			767
Impairments and reversals			5,041			5,041
Transfers between reserves		4,528	(4,528)		0	0
New PDC received - cash	34					34
Charitable Funds Adjustment				(396)	0	(396)
Net recognised revenue/(expense) for the year	**34**	**(21,166)**	**1,280**	**(396)**	**230**	**(20,018)**
Balance at 31 March 2016	**169,950**	**(127,458)**	**45,069**	**2,452**	**243**	**90,256**

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Trust Only			
	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**169,950**	**(127,458)**	**45,069**	**87,561**
Changes in taxpayers' equity for 2016-17				
Retained surplus/(deficit) for the year		(37,467)		**(37,467)**
Net gain / (loss) on revaluation of property, plant, equipment			3,319	**3,319**
Impairments and reversals			(907)	**(907)**
Transfers between reserves		1,172	(1,172)	**0**
Temporary and permanent PDC received - cash	1,702			**1,702**
Net recognised revenue/(expense) for the year	**1,702**	**(36,295)**	**1,240**	**(33,353)**
Balance at 31 March 2017	**171,652**	**(163,753)**	**46,309**	**54,208**
Balance at 1 April 2015	**169,916**	**(106,292)**	**43,789**	**107,413**
Changes in taxpayers' equity for 2015-16				
Retained surplus/(deficit) for the year		(25,694)		(25,694)
Net gain / (loss) on revaluation of property, plant, equipment			767	767
Impairments and reversals			5,041	5,041
Transfers between reserves		4,528	(4,528)	0
New PDC received - cash	34			34
Net recognised revenue/(expense) for the year	**34**	**(21,166)**	**1,280**	**(19,852)**
Balance at 31 March 2016	**169,950**	**(127,458)**	**45,069**	**87,561**

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Trust is payable to the Department of Health as the public dividend capital dividend.

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

3 **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.

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

5 **Charitable Funds Reserve**
This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

Statement of Cash Flows for the Year ended 31 March 2017

		Group		Trust Only	
		2016-17	2015-16	**2016-17**	2015-16
	NOTE	**£000s**	£000s	**£000s**	£000s
Cash Flows from Operating Activities					
Operating surplus/(deficit)		**(31,201)**	(23,604)	**(31,538)**	(23,585)
Depreciation and amortisation	6	**7,285**	7,604	**7,246**	7,593
Impairments and reversals	16	**3,466**	8,996	**3,466**	8,996
Donated Assets received credited to revenue but non-cash		**(148)**	0	**(148)**	0
(Increase)/Decrease in Inventories		**471**	(1,352)	**321**	(1,020)
(Increase)/Decrease in Trade and Other Receivables		**(5,024)**	(1,466)	**(5,169)**	(1,478)
Increase/(Decrease) in Trade and Other Payables		**(11,941)**	4,532	**(11,302)**	5,461
(Increase)/Decrease in Other Current Liabilities		**(272)**	1,200	**(272)**	(203)
Provisions utilised		**(161)**	(106)	**(161)**	(106)
Increase/(Decrease) in movement in non cash provisions		**2,843**	36	**2,843**	36
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows			600	**0**	0
Net Cash Inflow/(Outflow) from Operating Activities		**(34,682)**	(3,560)	**(34,714)**	(4,306)
Cash Flows from Investing Activities					
Interest Received		**31**	37	**31**	37
(Payments) for Property, Plant and Equipment		**(6,785)**	(7,946)	**(6,646)**	(7,872)
(Payments) for Intangible Assets		**(4,980)**	(3,419)	**(4,950)**	(3,419)
(Payments) for Other Financial Assets		**(4,788)**	(2,584)	**(4,788)**	(2,584)
Proceeds of disposal of assets held for sale (PPE)		**1,700**	14,705	**1,700**	14,705
Net Cash Inflow/(Outflow) from Investing Activities		**(14,822)**	793	**(14,653)**	867
Net Cash Inform / (outflow) before Financing		**(49,504)**	(2,767)	**(49,367)**	(3,439)
Cash Flows from Financing Activities					
Gross Temporary and Permanent PDC Received		**1,702**	34	**1,702**	34
Loans received from DH - New Capital Investment Loans		**4,231**	0	**4,231**	0
Loans received from DH - New Revenue Support Loans		**45,138**	28,369	**45,138**	28,369
Other Loans Received		**323**	0	**323**	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(8,493)**	(2,588)	**(8,493)**	(2,588)
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(2,445)**	0	**(2,445)**	0
Capital element of payments in respect of finance leases and on-SOFP PFI		**(289)**	(307)	**(289)**	(307)
Interest paid		**(3,849)**	(3,410)	**(3,845)**	(3,408)
PDC Dividend (paid)/refunded		**(1,449)**	(3,398)	**(1,449)**	(3,398)
Net Cash Inflow/(Outflow) from Financing Activities		**34,869**	18,700	**34,873**	18,702
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**(14,635)**	15,933	**(14,494)**	15,263
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period*		**16,699**	1,583	**15,863**	600
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**2,064**	17,516	**1,369**	15,863

* The balance at year end for 2015/16 for the Group results includes cash held by the Charity (see Note 1.3).

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.1.1 Going Concern

IAS1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. As outlined in the Group Accounting Manual for the NHS, in the context of a non-trading entity within the Department of Health Group, the anticipation of the continuation of the provision of services is normally sufficient evidence of the appropriateness of the going concern basis, especially in the absence of any instruction to the contrary from with NHS Improvement or the Department of Health. In the event of the winding up of the Trust, in its current form, its services, and assets and liabilities, would pass to another public sector entity.

The Trust has submitted to its sponsoring body, NHSI, and has had accepted, its Operating Plans for the next two financial years. These financial plans show that the Trust is expecting to report a deficit of income over expenditure and, as a result, will require further cash support, which is not currently formally approved, in order to maintain operational and financial stability. The guidance issued from the Department of Health states that this would indicate a material uncertainty that may cast significant doubt on the ability of the Trust to continue to operate as a going concern.

However, the Directors have assessed the likelihood of the Trust being wound up in the foreseeable future, which would require the adoption of a different accounting convention and valuation of the Trust's assets and liabilities. It has been concluded that it is reasonable to anticipate the continuing support of NHSI and the Department of Health under its constitution as an NHS Trust. Therefore the going concern basis has been adopted.

1.2 Acquisitions and discontinued operations

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

1.3 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements, where the consolidation of such results would be material to the results of the overall Group. The income, assets and liabilities of the Trust's associated Charity are not material when considered with those of the Trust, so consolidated financial statements have not been prepared for 2016/17, nor will be for future years. However, the Trust decided to produce overall 'Group' accounts for 2015/16, so 'Group' comparative numbers include the results of the Charity. This will not be an issue in future years.

1.4 Pooled Budgets

The Trust has no pooled budgets.

1.5 Critical accounting judgements and key sources of estimation uncertainty

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

NOTES TO THE ACCOUNTS

1.5.1 Critical judgements in applying accounting policies

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

The Trust judges that it is unlikely that it will recover any of the value of its investment in tPP in future years, so has impaired the value of this financial asset to zero. This includes the opening balance at the start of the financial year, together with further 'cash calls' in 2016/17.

The 'cash calls' have been treated as an investment in the joint venture under IAS 39, Financial Instruments. This requires a critical judgement on the nature of the payments made to tPP in 2016/17 as Investments. This treatment is supported by tPP's mirrored accounting treatment as a capital injection.

The Trust has also reflected a provision in its Financial Statements for its potential share of the negative net assets in the Balance Sheet of TPP at 31st March 2017. This requires a judgement on the probability of this payment being required under IAS 37, Provisions, Contingent Liabiities and Contingent Assets.

As in 2015/16, the Trust has charged the tPP impairment to Annually Managed Expenditure (AME) rather than the Departmental Expenditure Limit (DEL). As in the prior year, the definitions in the NHS Group Accounting Manual do not specifically apply to the TPP scenario, but the definition of an AME impairment has been judged to be the best fit.

The Trust has made a voluntary disclosure regarding the potential over-recovery of VAT that it has been charged in prior years. However, it has provided a full explanation of the rationale for the recovery to HMRC and is awaiting a decision on whether it is repayable. A provision has been made in the Financial Statements for the full value of the disclosure under IAS 37, Provisions, Contingent Liabilities and Contingent Assets.

The Trust has prepared consolidated 'Group' Accounts to include the financial performance and position of its subsidiary, ENH Pharma, for 2016/17, which has been assessed as being under the common control of the Trust Board, as defined in IAS 27. The results of the Trust as a single entity are provided for information purposes only. All supporting Notes are prepared under the consolidated basis.
In 2015/16, the Trust consolidated its associated Charity into its Group Accounts. As the results are not material, the decision has been made not to consolidate the Charity for 2016/17.

1.5.2 Key sources of estimation uncertainty

Estimation techniques are explained in more detail under the relevant notes. Particular transactions that are the source of estimation uncertainty include:
Pension valuations - note 8.3
Valuation of Property, Plant and Equipment - note 14
Provision for the Impairment of Receivables - note 19
Expenditure accruals - note 23
The likelihood, amount and timing of provisions and contingent liabilities - note 28
Liabilities under Private Finance Initiative Scheme - note 25

1.6 Revenue

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

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

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

NOTES TO THE ACCOUNTS

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

1.7 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. There has been no allowance made in the financial statements for the cost of leave earned but not taken by employees at the end of the period. Employees, in the normal course of employment are not allowed to carry leave forward into the following period.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

A very small number of employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. Although the scheme assets and liabilities attributable to those employees could be identified, they are not recognised in the NHS trust's accounts on the grounds of immateriality.

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

NOTES TO THE ACCOUNTS

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

1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

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

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

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

Subsequent expenditure

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

NOTES TO THE ACCOUNTS

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

1.10 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:
- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.11 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 Donated assets

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

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

1.13 Non-current assets held for sale

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

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

1.14 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 NHS Trust as lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

NOTES TO THE ACCOUNTS

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

1.15 Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The NHS trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the initial value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term accrual or prepayment is recognised respectively.

NOTES TO THE ACCOUNTS

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

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

Other assets contributed by the NHS trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.16 Inventories
Inventories are valued at the lower of cost and net realisable value using the *first-in first-out* cost formula, as per IAS 2. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.18 Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates.

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years
• A medium term rate of negative 1.95% (2015-16: negative 1.00%) for expected cash flows over 5 years up to and including 10 years
• A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the NHS trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

NOTES TO THE ACCOUNTS

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

1.19 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 28.

1.20 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.21 Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS trust makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.22 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.23 Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the NHS trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

NOTES TO THE ACCOUNTS

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

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques [specify – see IAS 39 AG 76]

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.24 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
The Trust does not have any of these liabilities

Financial liabilities at fair value through profit and loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the NHS trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.25 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.26 Foreign currencies
The NHS trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.27 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

NOTES TO THE ACCOUNTS

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

1.28 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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

1.29 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 Subsidiaries

Material entities over which the NHS trust has the power to exercise control are classified as subsidiaries and are consolidated. The NHS trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the NHS trust or where the subsidiary's accounting date is not co-terminus.

The Trust has a wholly-owned subsidiary, ENH Pharma. This subsidiary provides services to the patients of the Trust and hence its activities are considered to be those of the Trust for the purposes of the preparation of these financial statements. The results of this subsidiary are therefore included within these financial statements.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The Trust has an associated Charity, the Trustees of which are the Board of the NHS Trust. Although the Trust could be seen to exercise control of the Charity under IAS 27, Consolidated Financial Statements, the financial position and performance of the Charity are not considered material to the Trust and hence have not been consolidated.

NOTES TO THE ACCOUNTS

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

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.32 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.33 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.

2. Income generation activities

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

3. Revenue from patient care activities

	2016-17 £000s	2015-16 £000s
NHS Trusts	**(304)**	923
NHS England	**93,270**	89,694
Clinical Commissioning Groups	**267,820**	249,473
Foundation Trusts	**3,317**	135
Department of Health	**2,197**	0
NHS Other (including Public Health England and Prop Co)	**179**	0
Non-NHS:		
Local Authorities	**351**	220
Private patients	**3,448**	3,646
Overseas patients (non-reciprocal)	**747**	439
Injury costs recovery	**589**	1,056
Other Non-NHS patient care income	**1,090**	0
Total Revenue from patient care activities	**372,704**	345,586

The Trust issued credit notes to two NHS Trusts against income that had been recognised in 2015/16, which has led to the negative balance.

4. Other operating revenue

	2016-17 £000s	2015-16 £000s
Education, training and research	**18,313**	17,213
Charitable and other contributions to revenue expenditure -non- NHS	**5**	0
Receipt of charitable donations for capital acquisitions	**258**	0
Non-patient care services to other bodies	**7,884**	18,297
Sustainability & Transformation Fund Income	**5,216**	0
Income generation (Other fees and charges)	**2,293**	2,426
Rental revenue from operating leases	**740**	452
Other revenue	**4,457**	1,924
Total Other Operating Revenue	**39,166**	40,312
Total operating revenue	**411,870**	385,898

Revenue includes £1,020,000 in respect of ENH Pharma (2015-16 £247,000)
Other revenue includes support from NHS Digital for the Lorenzo Digital Innovation Project of £2.2m and Winter Pressures funding of £1m.

5. Overseas Visitors Disclosure

	2016-17 £000s	2015-16 £000s
Income recognised during 2016-17 (invoiced amounts and accruals)	**747**	**439**
Cash payments received in-year (re receivables at 31 March 2016)	**18**	**22**
Cash payments received in-year (iro invoices issued 2016-17)	**239**	**108**
Amounts added to provision for impairment of receivables (re receivables at 31 March 2016)	**362**	**0**
Amounts added to provision for impairment of receivables (iro invoices issued 2016-17)	**91**	**0**
Amounts written off in-year (irrespective of year of recognition)	**0**	**47**

6. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**6,987**	5,975
Services from CCGs/NHS England	**97**	0
Services from other NHS bodies	**5,254**	3
Services from NHS Foundation Trusts	**12,198**	11,579
Total Services from NHS bodies	**24,536**	17,557
Purchase of healthcare from non-NHS bodies	**13,122**	6,242
Trust Chair and Non-executive Directors	**79**	59
Supplies and services - clinical	**77,906**	65,748
Supplies and services - general	**11,590**	12,701
Consultancy services	**973**	321
Establishment	**4,311**	5,981
Transport	**511**	519
Service charges - ON-SOFP PFIs and other service concession arrangements	**130**	100
Business rates paid to local authorities	**1,639**	1746
Premises	**19,425**	15,012
Hospitality	**73**	0
Insurance	**289**	0
Legal Fees	**179**	0
Impairments and Reversals of Receivables	**41**	520
Inventories write down	**136**	0
Depreciation	**5,943**	6,216
Amortisation	**1,342**	1,377
Impairments and reversals of property, plant and equipment	**(2,828)**	6,309
Impairments and reversals of financial assets	**6,294**	2,372
Impairments and reversals of non current assets held for sale	**0**	315
Internal Audit Fees	**149**	155
Audit fees	**87**	79
Other auditor's remuneration	**10**	14
Clinical negligence	**13,486**	11,632
Education and Training	**1,028**	1,171
Other	**5,474**	10,543
Total Operating expenses (excluding employee benefits)	**185,925**	166,689
Employee Benefits		
Employee benefits excluding Board members	**255,746**	241,596
Board members	**1,400**	1,217
Total Employee Benefits	**257,146**	242,813
Total Operating Expenses	**443,071**	409,502

7. Operating Leases

The Trust's operating leases relate to medical equipment and motor vehicles.

7.1. East and North Hertfordshire NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016-17 Total £000s	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**3,788**	4,898
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**3,788**	4,898
Payable:					
No later than one year		0	4,408	**4,408**	4,565
Between one and five years	0	0	12,064	**12,064**	13,717
After five years	0	0	247	**247**	1,246
Total	**0**	**0**	**16,719**	**16,719**	19,528
Total future sublease payments expected to be received:				0	0

7.2. East and North Hertfordshire NHS Trust as lessor

	2016-17 £000s	2015-16 £000s
Recognised as revenue		
Rental revenue	740	452
Contingent rents	0	0
Total	**740**	452
Receivable:		
No later than one year	238	307
Between one and five years	0	0
After five years	0	0
Total	**238**	307

Rental income includes that from The Pathology Partnership in respect of facilties at the QEII hospital, income from retail space, telephone masts and staff accommodation.

8. Employee benefits

8.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**221,633**	211,580
Social security costs	**17,774**	13,689
Employer Contributions to NHS BSA - Pensions Division	**20,490**	19,819
Other pension costs	**6**	0
Termination benefits	**5**	0
Total employee benefits	**259,908**	245,088
Employee costs capitalised	**2,762**	2,275
Gross Employee Benefits excluding capitalised costs	**257,146**	242,813

8.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**6**	5
	£000s	£000s
Total additional pensions liabilities accrued in the year	**350**	136

8.3. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

9. Better Payment Practice Code

9.1. Measure of compliance

	2016-17 Number	2016-17 £000s	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**68,173**	**212,051**	61,593	183,477
Total Non-NHS Trade Invoices Paid Within Target	**26,670**	**67,407**	27,261	73,309
Percentage of NHS Trade Invoices Paid Within Target	**39.12%**	**31.79%**	44.26%	39.96%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,886**	**33,827**	2,220	**26,934**
Total NHS Trade Invoices Paid Within Target	**1,269**	**8,273**	1,139	**15,497**
Percentage of NHS Trade Invoices Paid Within Target	**67.29%**	**24.46%**	51.31%	57.54%

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 a valid invoice. Performance in 2016/17, particularly for NHS invoices, has been impacted by a change in methodology on invoices that were paid on account.

9.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**196**	332
Total	**196**	332

10. Investment Revenue

	2016-17 £000s	2015-16 £000s
Rental revenue		
Bank interest	**31**	37
Subtotal	**31**	37
	31	37

11. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**0**	10
Gain (Loss) on disposal of assets held for sale	**0**	4,143
Total	**0**	4,153

12. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**3,030**	2,219
Interest on obligations under PFI contracts:		
- main finance cost	**546**	569
- contingent finance cost	**304**	290
Interest on late payment of commercial debt	**196**	332
Total interest expense	**4,076**	3,410
Other finance costs	**64**	0
Provisions - unwinding of discount	**2**	13
Total	**4,142**	3,423

13. Auditor Remuneration

13.1. Other auditor remuneration

The Trust did not pay the external auditors for services other than the audit of the Financial Statements and Quality Accounts

14.1. Property, plant and equipment

2016-17	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
Brought forward from 2015-16	32,750	132,137	0	55,632	0	12,883	3,960	**237,362**
Adjustment to recognise Group configuration	0	0	0	(264)	0	0	153	**(111)**
At 1 April 2016	32,750	132,137	0	55,368	0	12,883	4,113	**237,251**
Additions of Assets Under Construction			0					**0**
Additions Purchased	0	1,871		3,622	0	1,448	153	**7,094**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	0	0	110	**110**
Revaluation	0	880	0	0	0	0	0	**880**
Impairments/reversals charged to operating expenses	0	841	0	0	0	0	0	**841**
Impairments/reversals charged to reserves	693	(1,600)	0	0	0	0	0	**(907)**
At 31 March 2017	**33,443**	**134,129**	**0**	**58,990**	**0**	**14,331**	**4,376**	**245,269**
Depreciation								
Brought forward from 2015-16	0	2,191	0	41,517	0	11,052	3,039	**57,799**
Adjustment to recognise Group configuration	0	0	0	(11)	0	0	11	**0**
At 1 April 2016	0	2,191		41,506	0	11,052	3,050	**57,799**
Revaluation	0	(2,439)		0	0	0	0	**(2,439)**
Impairments/reversals charged to operating expenses	0	(1,987)		0	0	0	0	**(1,987)**
Charged During the Year	0	2,247		2,802	0	711	183	**5,943**
At 31 March 2017	**0**	**12**	**0**	**44,308**	**0**	**11,763**	**3,233**	**59,316**
Net Book Value at 31 March 2017	**33,443**	**134,117**	**0**	**14,682**	**0**	**2,568**	**1,143**	**185,953**
Asset financing:								
Owned - Purchased	33,443	125,646	0	13,528	0	2,527	983	**176,127**
Owned - Donated	0	1,414	0	1,154	0	41	160	**2,769**
On-SOFP PFI contracts	0	7,057	0	0	0	0	0	**7,057**
	33,443	**134,117**	**0**	**14,682**	**0**	**2,568**	**1,143**	**185,953**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1st April 2016	18,369	26,076	0	615	0	0	9	**45,069**
Movements (revaluation or depreciation of previous revaluations)	42	1,200	0	(1)	0	0	(1)	**1,240**
At 31 March 2017	**18,411**	**27,276**	**0**	**614**	**0**	**0**	**8**	**46,309**

14.2. Property, plant and equipment prior-year

2015-16	Land	Buildings excluding dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:								
At 1 April 2015	26,967	134,250	1,311	56,728	113	12,883	3,960	**236,212**
Additions of Assets Under Construction			0					**0**
Additions Purchased	0	4,492		1,987	0	0	0	**6,479**
Reclassifications	0	1,311	(1,311)	0	0	0	0	**0**
Reclassifications as Held for Sale and Reversals	637	0	0	0	0	0	0	**637**
Disposals other than for sale	0	0	0	(3,083)	(113)	0	0	**(3,196)**
Revaluation	0	(7,811)	0	0	0	0	0	**(7,811)**
Impairments/reversals charged to operating expenses	5,146	(105)	0	0	0	0	0	**5,041**
At 31 March 2016	**32,750**	**132,137**	**0**	**55,632**	**0**	**12,883**	**3,960**	**237,362**
Depreciation								
At 1 April 2015	0	2,332		41,504	113	10,171	2,869	**56,989**
Disposals other than for sale	0	0		(3,035)	(113)	0	0	**(3,148)**
Revaluation	0	(8,578)		0	0	0	0	**(8,578)**
Impairments/reversals charged to operating expenses	0	6,309		0	0	0	0	**6,309**
Charged During the Year	0	2,128		3,048	0	881	170	**6,227**
At 31 March 2016	**0**	**2,191**	**0**	**41,517**	**0**	**11,052**	**3,039**	**57,799**
Net Book Value at 31 March 2016	**32,750**	**129,946**	**0**	**14,115**	**0**	**1,831**	**921**	**179,563**
Asset financing:								
Owned - Purchased	32,750	122,060	0	12,582	0	1,748	857	**169,997**
Owned - Donated	0	1,336	0	1,533	0	83	64	**3,016**
On-SOFP PFI contracts	0	6,550	0	0	0	0	0	**6,550**
Total at 31 March 2016	**32,750**	**129,946**	**0**	**14,115**	**0**	**1,831**	**921**	**179,563**

14.3. (cont). Property, plant and equipment

The Trust has received a donation from East and North Herts Charitable Fund for the refurbishment of space in the Renal Department for the benefit of patients, visitors and carers.

The Trust's land and buildings were revalued at 31 March 2017 by an independent qualified valuer, using the Modern Equivalent Asset methodology, in accordance with DH guidance and the NHS Group Accounting Manual.

The professional valuation was carried out by Bilfinger GVA, 3 Brindleyplace, Birmingham, B1 2JB. The valuation was carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Existing Use Value of the properties has been primarily derived using the Depreciated Replacement Cost (DRC) approach because the specialised nature of the asset means that there are no market transactions for this type of asset except as part of the entity.

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

The Existing Use Value is defined in UKPS 1.3 of the Red Book and, in undertaking the valuations, our surveyors have applied the conceptual framework of Market Value, which is detailed in PS3.2, together with the supplementary commentary which is included in items 2-5 of UKPS 1.3. Under UKPS1.3 the term "Existing Use Value" is defined as follows:
"The estimated amount for which as property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost".

The definition of MEA

Modern Equivalent Assets - a structure similar to an existing structure with an equivalent, productive capacity, which coud be built using modern materials, techniques and designs. Replacement cost is the basis used to estimate the cost of constructing a modern equivalent asset.

The economic lives of tangible fixed assets range from:	**Min life (years)**	**Max life (years)**
Buildings exc dwellings	19	90
Plant and machinery	5	20
Information Technology	5	8
Furniture and Fittings	7	10

There have been no changes to asset lives/residual values other than those advised by the independent valuer during the review on a MEA basis.

There have been no write-downs to recoverable amounts or reversals of write-downs.

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

15. Intangible non-current assets

15.1. Intangible non-current assets

2016-17	Computer Licenses	Licenses and Trademarks	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's
Brought forward from 2015-16	**2,650**	**1,217**	**13,134**	**0**	**17,001**
Adjustment to recognise Group configuration	**123**	**0**	**0**	**0**	**123**
At 1 April 2016	**2,773**	**1,217**	**13,134**	**0**	**17,124**
Additions of Assets Under Construction				4,564	**4,564**
Additions Purchased	639	249	0	0	**888**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	148	**148**
Reclassifications	0	0	0	0	**0**
At 31 March 2017	**3,412**	**1,466**	**13,134**	**4,712**	**22,724**
Amortisation					
Brought forward from 2015-16	**1,411**	**893**	**6,206**	**0**	**8,510**
Adjustment to recognise Group configuration	**12**	**0**	**0**	**0**	**12**
At 1 April 2016	**1,423**	**893**	**6,206**		**8,522**
Charged During the Year	**263**	**101**	**978**		**1,342**
At 31 March 2017	**1,686**	**994**	**7,184**	**0**	**9,864**
Net Book Value at 31 March 2017	**1,726**	**472**	**5,950**	**4,712**	**12,860**
Asset Financing: Net book value at 31 March 2017 comprises:					
Purchased	1,678	472	5,950	4,564	**12,664**
Donated	48	0	0	148	**196**
Total at 31 March 2017	**1,726**	**472**	**5,950**	**4,712**	**12,860**

15.2. Intangible non-current assets prior year

2015-16	Computer Licenses £000's	Licenses and Trademarks £000's	Development Expenditure - Internally Generated £000's	**Total £000's**
Cost or valuation:				
At 1 April 2015	2,650	1,217	9,715	**13,582**
Additions - internally generated	0	0	3,419	**3,419**
At 31 March 2016	2,650	1,217	13,134	**17,001**
Amortisation				
At 1 April 2015	1,156	775	5,202	**7,133**
Charged during the year	255	118	1,004	**1,377**
At 31 March 2016	1,411	893	6,206	**8,510**
Net book value at 31 March 2016	1,239	324	6,928	**8,491**
Net book value at 31 March 2016 comprises:				
Purchased	1,185	322	6,928	**8,435**
Donated	54	2	0	**56**
Total at 31 March 2016	1,239	324	6,928	**8,491**

15.3. Intangible non-current assets

The Trust accounts for intangible non-current assets in accordance with IAS 38. All intangible non-current assets with an initial cost of over £5,000 are amortised on a quarterly basis over its economic useful life. The Trust does not consider that its intangible non-current assets have an active market, and therefore uses book value as a prudent indicator of the fair value of the intangible non-current assets.

The Trust does not hold intangible non-current assets with an indefinite economic life.

The economic lives of intangible non-current assets range from:	**Min life (years)**	**Max life (years)**
Software purchased	3	8
Licences and trademarks	2	8
Development Expenditure	5	8

16. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	(2,828)
Total charged to Annually Managed Expenditure	**(2,828)**
Total Impairments of Property, Plant and Equipment changed to SoCI	**(2,828)**
Financial Assets charged to SoCI	
Other-Change to Fair Value	6,294
Total charged to Annually Managed Expenditure	**6,294**
Total Impairments of Financial Assets charged to SoCI	**6,294**
Total Impairments charged to SoCI - DEL	**0**
Total Impairments charged to SoCI - AME	**3,466**
Overall Total Impairments	**3,466**

The reversal of impairments to Property, Plant and Equipment has arisen as a result of the revaluation of the Trust's properties by the professional valuer. Reductions in value in previous years resulting from changes to market value have been reversed by an upward movement in 2016/17.

The impairment to Financial Assets results from the Trust's evaluation of the value of its investment in The Pathology Partnership. This investment has been impaired to zero.

16.1. Analysis of impairments and reversals recognised in 2016-17

	Property Plant and Equipment £000s	Financial Assets £000s	Total £000s
Impairments and reversals taken to SoCI			
Other	0	6,294	**6,294**
Changes in market price	(2,828)	0	**(2,828)**
Total charged to Annually Managed Expenditure	**(2,828)**	**6,294**	**3,466**
Total Impairments charged to SoCI	**(2,828)**	**6,294**	**3,466**

17. Commitments

17.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**0**	50
Intangible assets	**2,584**	0
Total	**2,584**	50

18. Inventories

	Drugs	Consumables	Energy	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**2,663**	**3,183**	**160**	**6,006**	0
Additions	47,361	48	34	**47,443**	0
Inventories recognised as an expense in the period	(47,678)	(100)	0	**(47,778)**	0
Write-down of inventories (including losses)	(88)	(48)	0	**(136)**	0
Balance at 31 March 2017	**2,258**	**3,083**	**194**	**5,535**	**0**

19.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**16,488**	16,174	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**13,576**	1,870	**0**	0
Non-NHS receivables - revenue	**4,297**	5,696	**0**	0
Non-NHS prepayments and accrued income	**6,366**	10,222	**1,198**	1,256
PDC Dividend prepaid to DH	**227**	630	**0**	0
Provision for the impairment of receivables	**(620)**	(1,002)	**(404)**	(368)
VAT	**1,304**	2,183	**0**	0
Other receivables	**5,172**	6,321	**2,331**	1,674
Total	**46,810**	42,094	**3,125**	2,562
Total current and non current	**49,935**	44,656		

The great majority of trade is with Clinical Commissioning Groups (CCGs). As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

19.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**4,720**	4,328
By three to six months	**1,173**	1,961
By more than six months	**10,611**	2,791
Total	**16,504**	9,080

19.3. Provision for impairment of receivables

	2016-17 £000s	2015-16 £000s
Balance at 1 April 2016	**(1,370)**	(899)
Amount written off during the year	**387**	49
(Increase)/decrease in receivables impaired	**(41)**	(520)
Balance at 31 March 2017	**(1,024)**	(1,370)

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non-NHS debt is analysed at invoice level. Unless there is objective evidence of impairment, the debt is assumed to be recoverable. Objective evidence includes the failure to obtain payment after referral to external recovery agencies or inability to trace the debtor. Within the provision above is that relating to the Injury Cost Recovery Scheme. In the absence of evidence to the contrary, the Trust is obliged to include a provision of 22.94% (2015/16 21.99%) of the total amount of claims outstanding.

20.1. Other Financial Assets - Non Current

	31 March 2017 £000s	31 March 2016 £000s
Opening balance 1 April	**1,505**	2,293
Additions	**4,789**	2,584
Impairment/reversals taken to SoCI	**(6,294)**	(2,372)
Total Other Financial Assets - Non Current	**0**	2,505

21. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**16,699**	1,583
Net change in year	**(14,635)**	15,933
Closing balance*	**2,064**	17,516

The Closing Balance for 2015/16 includes £817,000 for the Trust's associated Charity

Made up of		
Cash with Government Banking Service	**1,343**	15,813
Commercial banks	**712**	1,694
Cash in hand	**9**	9
Cash and cash equivalents as in statement of financial position	**2,064**	17,516
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**2,064**	17,516
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	**3**	0

22. Non-current assets held for sale

	Land	Total
	£000s	£000s
Balance at 1 April 2016	1,700	**1,700**
Less assets sold in the year	(1,700)	**(1,700)**
Balance at 31 March 2017	**0**	**0**
Liabilities associated with assets held for sale at 31 March 2017	**0**	**0**
Balance at 1 April 2015	11,913	**11,913**
Less assets sold in the year	(9,261)	**(9,261)**
Less impairment of assets held for sale	(315)	**(315)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(637)	**(637)**
Balance at 31 March 2016	**1,700**	**1,700**
Liabilities associated with assets held for sale at 31 March 2016	0	0

The assets held for sale relate to parcels of land at the former QEII Hospital at Welwyn Garden City, the last of those designated as held for sale was sold in 2016/17. The Trust still has an interest in a small part of the site, but this does not currently meet the criteria of 'Asset Held for Sale'. It is therefore included within Property, Plant and Equipment.

23. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**9,639**	8,905	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**2,735**	4,137	**0**	0
Non-NHS payables - revenue	**20,712**	16,383	**0**	0
Non-NHS payables - capital	**1,864**	825	**0**	0
Non-NHS accruals and deferred income	**12,249**	27,616	**0**	0
Social security costs	**2,698**	1,819		
Accrued Interest on DH Loans	**104**	76		
Tax	**2,391**	2,334		
Other	**4,061**	5,110	**0**	0
Total	**56,453**	67,205	**0**	0
Total payables (current and non-current)	**56,453**	**67,205**		
Included above:				
outstanding Pension Contributions at the year end	**2,936**	2,862		

24. Other liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Other	**203**	203	**4,813**	5,015
Total	**203**	203	**4,813**	5,015
Total other liabilities (current and non-current)	**5,016**	**5,218**		

The Liabilities above relate to the Multi-Storey Car Park at the Lister Hospital site. The car park has been funded through a public/private partnership arrangement. The liabilities to the private partner will be amortised over a 30 year period, at the end of which ownership will transfer to the Trust.

The liability relating to the car park is split between other liabilities and other financial liabilities (Note 26)

25. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Bank overdraft - Government Banking Service	**0**	0		
Bank overdraft - commercial banks	**0**	0		
Loans from the Department of Health	**3,043**	8,493	**123,237**	79,356
Loans from other entities	**81**	0	**242**	0
PFI liabilities - main liability	**356**	289	**6,759**	7,115
Total	**3,480**	**8,782**	**130,238**	**86,471**
Total other liabilities (current and non-current)	**133,718**	**95,253**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	3,043	437	**3,480**
1 - 2 Years	9,140	388	**9,528**
2 - 5 Years	74,094	885	**74,979**
Over 5 Years	40,003	5,728	**45,731**
TOTAL	**126,280**	**7,438**	**133,718**

26. Other financial liabilities

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Financial liabilities carried at fair value through profit and loss	**157**	150	**2,437**	2,595
Total	**157**	150	**2,437**	2,595
Total other financial liabilities (current and non-current)	**2,594**	2,745		

27. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**5,380**	6,842	**0**	5,218
Deferred revenue addition	**1,610**	0	**0**	0
Transfer of deferred revenue	**(5,380)**	(1,462)	**0**	(5,218)
Current deferred Income at 31 March 2017	**1,610**	5,380	**0**	0
Total deferred income (current and non-current)	**1,610**	5,380		

28. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**1,058**	853	92	113
Arising during the year	**2,965**	31	0	2,934
Utilised during the year	**(161)**	(105)	(17)	(39)
Reversed unused	**(52)**	(52)	0	0
Unwinding of discount	**2**	2	0	0
Change in discount rate	**0**	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0
Balance at 31 March 2017	**3,812**	**729**	**75**	**3,008**
Expected Timing of Cash Flows:				
No Later than One Year	**2,669**	82	75	2,512
Later than One Year and not later than Five Years	**296**	296	0	0
Later than Five Years	**847**	351	0	496

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

	£000s
As at 31 March 2017	236,767
As at 31 March 2016	215,985

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

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

- The Trust has made a voluntary disclosure to HMRC regarding potentially over recovered VAT. There is a level of uncertainty regarding the requirement to repay this tax, together with the level of retrospection that may be applied to the claim.
- There has been a provision made for the Trust's potential share of negative net assets in the Pathology Partnership relating to prior years.
- A provision has been made for Carbon Trading units.
- The Trust is involved in a dispute regarding the proceeds from the sale of a parcel of land. Uncertainty relates to the amount and timing.

The discount rate applied to provisions above is 1.37%.

29. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(54)**	(62)
Net value of contingent liabilities	**(54)**	(62)

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

30. PFI - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

The Trust has one PFI Scheme, relating to the Hertford County Hospital. The hospital provides outpatient and therapy services to the local community. The facility became operational on 1st November 2004 with a contract period of 28.5 years. The contract is due to end on 31st March 2033.

The Trust pays a monthly contractual unitary payment, which covers the cost of facilities management services, financing and lifecycle replacement of assets components. Further information on the nature and value of these payments is included below.

Charges to operating expenditure and future commitments in respect of ON SOFP PFI

	2016-17 £000s	2015-16 £000s
Service element of on SOFP PFI charged to operating expenses in year	**130**	100
Total	**130**	100

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**105**	103
Later than One Year, No Later than Five Years	**448**	437
Later than Five Years	**1,507**	1,623
Total	**2,060**	2,163

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17 £000s	2015-16 £000s
No Later than One Year	**880**	835
Later than One Year, No Later than Five Years	**2,905**	3,080
Later than Five Years	**8,617**	9,322
Subtotal	**12,402**	13,237
Less: Interest Element	**(5,287)**	(5,833)
Total	**7,115**	7,404

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2016-17 £000s**	2015-16 £000s
No Later than One Year	**356**	289
Later than One Year, No Later than Five Years	**1,030**	1,123
Later than Five Years	**5,729**	5,992
	7,115	7,404

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	**1**
Number of on PFI contracts which individually have a total commitments value in excess of £500m	**0**

31. Impact of IFRS treatment - current year

Not relevant for trust

The information below is required by the Department of Heath for budget reconciliation purposes	2016-17 Income £000s	2016-17 Expenditure £000s	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		**104**		90
Interest Expense		**546**		569
Other Expenditure		**519**		442
Revenue Receivable from subleasing	**0**		0	
Impact on PDC dividend payable		**0**		0
Total IFRS Expenditure (IFRIC12)	**0**	**1,169**	**0**	**1,101**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**1,243**		1,383
Net IFRS change (IFRIC12)		**(74)**		**(282)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		109		52
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		135		0

	2016-17 Income/ Expenditure IFRIC 12 YTD **£000s**	**2016-17** Income/ Expenditure ESA 10 YTD **£000s**	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	2015-16 Income/ Expenditure ESA 10 YTD **£000s**
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**104**		90	
Interest Expense	**546**		569	
Other Expenditure				
Service Charge	**106**	**1,243**	100	1,383
Contingent Rent	**304**		290	
Lifecycle	**109**		52	
Impact on PDC Dividend Payable	**0**		0	
Total Revenue Cost under IFRIC12 vs ESA10	**1,169**	**1,243**	**1,101**	**1,383**
Revenue Receivable from subleasing	**0**	**0**	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**1,169**	**1,243**	**1,101**	**1,383**

32. Financial Instruments

32.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by 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 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care organisations, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

32.2. Financial Assets

	Loans and receivables	Total
	£000s	£000s
Embedded derivatives		**0**
Receivables - NHS	27,487	**27,487**
Receivables - non-NHS	6,214	**6,214**
Cash at bank and in hand	2,064	**2,064**
Other financial assets	0	**0**
Total at 31 March 2017	**35,765**	**35,765**
Embedded derivatives		0
Receivables - NHS	18,162	18,162
Receivables - non-NHS	7,044	7,044
Cash at bank and in hand	15,863	15,863
Total at 31 March 2016	41,069	41,069

32.3 Financial Liabilities

		Other	Total
	£000s	£000s	£000s
Embedded derivatives			**0**
NHS Payables		12,374	**12,374**
Non-NHS payables		32,762	**32,762**
Other borrowings		126,603	**126,603**
PFI & finance lease obligations		7,115	**7,115**
Other financial liabilities		7,610	**7,610**
Total at 31 March 2017		**186,464**	**186,464**
Embedded derivatives			0
NHS payables		10,324	10,324
Non-NHS payables		41,219	41,219
Other borrowings		87,849	87,849
PFI & finance lease obligations		7,404	7,404
Other financial liabilities		7,963	7,963
Total at 31 March 2016		154,759	154,759

33. Events after the end of the reporting period

The Trust's pathology services have been provided by the Pathology Partnership (tPP) since May 2014. This has been in partnership with:

West Suffolk Hospital NHS Foundation Trust
Ipswich Hospital NHS Trust
Colchester Hospital University NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Hinchingbrooke Health Care NHS Trust
East & North Hertfordshire NHS Trust

The Trust was assessed as being 19.1% of this structure.

From 1st May 2017, the structure of that delivery has changed and pathology services for this Trust are now provided in a smaller arrangement with Cambridge University Hospitals NHS Foundation Trust and North West Anglia NHS Trust, although the Trust us still part of a wider tPP arrangement involving all the former partner organisations.

In 2017/18 the accounting arrangements for this service delivery will be carefully considered in view of the change from May 2017, which has led to the Trust being assessed as being 38.64% of the smaller structure.

34. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with East and North Hertfordshire NHS Trust

The Department of Health is regarded as a related party. During the year East and North Hertfordshire NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

The most significant related parties are listed below:	Income £000s	Expenditure £000s	Debtors £000s	Creditors £000s
East and North Hertfordshire CCG	218,692	85	6,627	3,056
NHS England	93,692	12	5,966	18
Health Education England	12,749	11	134	0
The Hillingdon Hospitals NHS Foundation Trust	367	9,096	434	0
HMRC	0	17,774	0	5,089
NHS Pension Scheme	0	20,490	0	2,919
NHS Litigation Authority	0	13,503	0	0
Bedfordshire CCG	24,860	0	2,917	0
Herts Valleys CCG	14,209	0	0	0
NHS Professionals	0	46,403	0	6,821

In addition to the above, there were a number of transactions between the Trust and its charity, the East and North Hertfordshire NHS Trust Charitable Fund. At 31st March 2017 £201k was owed to the Trust by the Charity.

35. Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	137,969	72
Special payments	98,610	48
Gifts	0	0
Total losses and special payments and gifts	236,579	120

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	49,292	141
Special payments	6416	38
Total losses and special payments	55,708	179

Details of cases individually over £300,000

There were no such cases.

36. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

36.1. Breakeven performance

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	270,257	286,332	309,074	331,312	340,309	346,402	350,543	365,313	376,050	384,712	411,870
Retained surplus/(deficit) for the year	(1,527)	2,003	2,070	(19,220)	1,459	3,193	(12,416)	22,153	(22,656)	(25,694)	(37,164)
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	4,099
Adjustments for impairments	0	0	0	21,758	1,906	88	12,658	781	19,297	8,996	3,466
Adjustments for impact of policy change re donated/government grants assets						287	290	(414)	(254)	472	66
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				(38)	(37)	0	0	0	0	0	0
Absorption accounting adjustment							0	(22,411)	0	0	0
Other agreed adjustments	22,379	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	**20,852**	**2,003**	**2,070**	**2,500**	**3,328**	**3,568**	**532**	**109**	**(3,613)**	**(16,226)**	**(29,533)**
Break-even cumulative position	**(2,248)**	**(245)**	**1,825**	**4,325**	**7,653**	**11,221**	**11,753**	**11,862**	**8,249**	**(7,977)**	**(37,510)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	7.72	0.70	0.67	0.75	0.98	1.03	0.15	0.03	-0.96	-4.22	-7.17
Break-even cumulative position as a percentage of turnover	-0.83	-0.09	0.59	1.31	2.25	3.24	3.35	3.25	2.19	-2.07	-9.11

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

36.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

36.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	56,900	10,740
Cash flow financing	54,802	10,245
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	**54,802**	10,245
Under/(over) spend against EFL	**2,098**	**495**

36.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	12,804	9,746
Less: book value of assets disposed of	(1,700)	(9,309)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(258)	0
Charge against the capital resource limit	**10,846**	437
Capital resource limit	11,548	692
(Over)/underspend against the capital resource limit	**702**	255

37. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017 £000s	31 March 2016 £000s
Third party assets held by the Trust	**3**	0