East and North Hertfordshire NHS Trust

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2015/16 annual report and accounts

2 JUNE 2016

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Trust overview

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 16% of the population in east and north Hertfordshire.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic and minor treatment services – including 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 £375 million.

Chair and chief executive's report

The Trust's longer term ambition is to become amongst the best performing organisations in the English health service. In drafting our introduction to the Trust's annual report and accounts for 2015/16, it seemed sensible to reflect upon performance over these 12 months against our key objectives relating to patient experience, clinical outcomes, patient safety and financial sustainability.

Before we do that, however, it is important to stress that our staff are at the heart of everything we do. There are over 5,000 people working in our hospital and community-based services. Every day we see great examples of how, working together, they put their patients first in providing high quality services. We see this in the many letters and emails that we receive directly from patients and their carers, as well as the very large numbers of postings made on our online NHS Choices and Patient Opinion pages, as well as through Facebook and Twitter.

Our staff are dedicated to providing high quality care – something that has been reflected in the 2015 national staff survey, where our results have shown significant improvement on previous years. Our overall staff engagement score has improved dramatically since last year and we are now above average compared to other NHS hospital groups. The biggest improvement has been the number of staff who said they felt able to contribute to improvements at work.

We are proud to be amongst the top 20% of acute trusts in the following areas: the ability of an individual to make a difference to patients; and the way in which we use all feedback from patients to make decisions about how we work. Our results show real improvement and are in the top 20% in the quality of appraisals and non-mandatory training, learning or development. Our percentage of staff experiencing physical violence from patients, relatives or the public is amongst the lowest 20% of acute trusts.

The areas where further improvement needs to be made are around staff experiencing and reporting violence, bullying, harassment or abuse in the last 12 months and those working extra hours. Although the percentage of staff reporting work-related stress has improved compared to last year's results, this is still a cause for concern.

A key area for the Trust has been a focus on *improving patient experience*. This starts long before our patients come near any of our hospitals. We know that our appointment systems require significant change and we have begun that process, although investment in new information management systems will take time to come through. We have made changes and this year saw the number of people failing to turn up for their outpatient appointment at an all-time low, but as ever there is always much more for us to do in streamlining our processes and making use easier to use from a patient-perspective.

We've also placed a great deal of emphasis on ensuring that our patients feel welcome when they attend any of our services. One example is the new external and colour-co-ordinated internal signage introduced at the Lister last year, which makes it much easier for people to find their way around the hospital.

We've seen some great innovations on our wards, with a new system of information posters now available just inside their main entrances. These help our patients and the improvements we have been making. It is not just our staff who think this has been a great thing to do – the team behind the initiative has also won a national award recently from the Patient Experience Network.

In terms of *clinical outcomes* and *patient safety*, there is much to point to in terms of successful performance – infection rates in our hospitals continue to be at an all-time low, as are levels of inpatient falls and hospital-acquired pressure ulcers. Perhaps the most telling statistic underlining the quality of the Trust's services, however, has been the steady fall in the Trust's mortality rates. Since all the changes were made to Lister and QEII – a process that concluded back in October 2014, our crude mortality rate – the number of patients who die for every 100 admitted – has reduced from an average rate of 1.72% for the three years to March 2016 to 1.6% for the most recent rolling 12 months. Although a very small change at first glance, it equates to over 100 people surviving their illness or injury than otherwise could have been the case.

Looking at our operational performance, we have experienced more of a mixed year. We have good performance in most areas, such as the 18-week and nearly all cancer waiting times standards. Like virtually every hospital group across the country, however, we have struggled to meet the 95% A&E waiting time standard. A plan has been agreed with the NHS Trust Development Authority that will see this position recovered during 2016/17. Again like the rest of the NHS, our 62-day cancer waiting time to first treatment has also been an area where performance was not as good as it should have been – our cancer services colleagues have been working hard to make the necessary improvements. An area where we have bucked the national trend, however, is how we have recovered our 18-weeks waiting time performance, where we now meet the national standard at a time when nationally this is not the case for the NHS as a whole.

Turning to the Trust's *financial sustainability*, there is no doubt that 2015/16 saw the NHS face one of the most challenging years ever in its history. The Trust was no exception and finished the year with a deficit of £16.226 million – the position that had been shared with our regulator, the NHS Trust Development Authority. Although only 4.2% of our overall budget, it represented the starting point for planning the current financial year (2016/17).

Keeping our finances under control has meant that our staff have worked very hard to stay within spending limits. One of the biggest pressures that we have faced is managing our use of temporary staff, especially nurses and doctors. Recent caps on agency spend will help drive these costs down, but this has to be managed in a way that ensures our patients continue to receive safe, high-quality care.

Increasing demand for our services means that we now employ more nurses and doctors today than we did a year ago; we also will continue to recruit to substantive vacancies to lessen reliance on more expensive agency staff.

The Trust has a particularly strong track record in delivering its cost improvement programme every year, with 94% of the £18.128 million of savings planned for 2015/16 delivered – which we expect to be one of the highest in the NHS in percentage terms. For the coming year, we are engaging with the Carter Review to ensure that we continue to drive our costs down as we look to ensure the agreed budget for 2016/17 is achieved.

The final area we would like to cover is the Trust's inspection report from the Care Quality Commission, whose inspectors visited our hospitals back in October 2015. Some six months later, our report was published and the Trust was rated overall as requiring improvement. The report's findings showed that whilst there were areas where further work was needed, many of our services were rated as being good already. The report also underlined the fact that where services came together earlier during the Trust's *Our changing hospitals* programme that concluded in October 2014 – such as surgery, critical care and children's community services – they achieved better ratings than those who changed more recently. It is also important to highlight that in publishing the Trust's report, the CQC noted 19 separate areas of outstanding practice and just six where improvement was required.

This finding reflects the fact that services such as surgery and critical care have had the time to build their teams, make the most of some great new facilities and develop new ways of working that have real benefits for our patients. We expect that some of other services – such as our emergency department at the Lister, along with some aspects of our children's, maternity, cancer and end-of-life services – will now use the experience and feedback from our CQC report to make the improvements needed to ensure that they too can achieve a good overall rating when the inspectors return at some point in the next few years.

There is no question that undertaking the CQC inspection was a very valuable experience, bringing some lasting changes that already has brought further benefits for our patients. At our last meeting with the lead inspector when their team was onsite at our hospitals, their parting comment was that the Trust was clearly an organisation on an upward trajectory.

Whilst heartening to hear, the challenge now is to work to deliver an organisation that can be rated good or better in every aspect of its work. It is with that in mind, that we extend a warm welcome to the Trust's new chair – Ellen Schroder – who took up her four-year term on 1 April 2016.

Ian Morfett
Chairman (to 31 March 2016)

Nick Carver
Chief Executive

Strategies, objectives and principle risks

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

- 2015/16 performance
- Looking forward to 2016/17
- Sustainability

2015/16 performance

Delivery of the 2015/16 annual plan

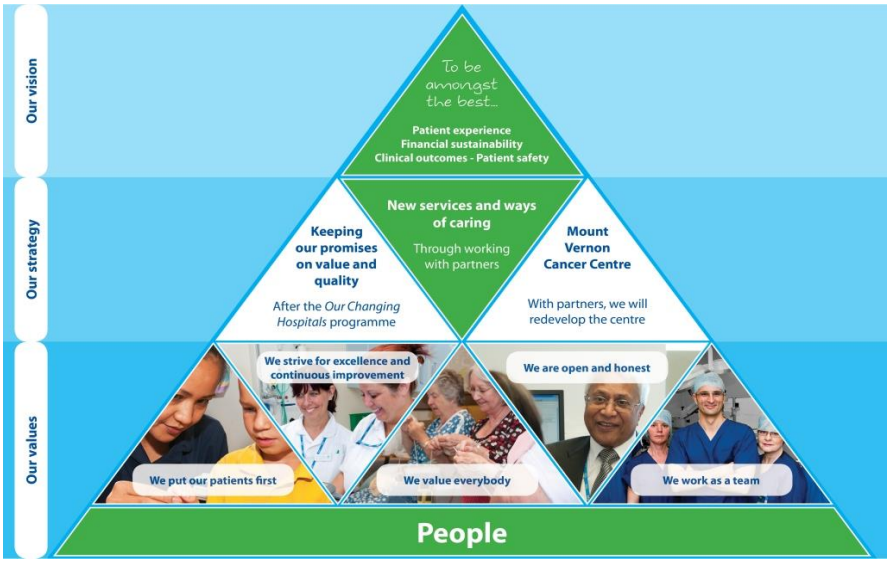
Following the successful delivery of the £150 million *Our changing hospitals* programme by October 2014, the Trust refreshed its strategic aims, in the context of local commissioners' priorities and the national *Five Year Forward View*.

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 2015/16 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.

Delivery of 2015/16 objectives

Review of performance against Trust objectives 2015/16 (as of May 2016)

The tables below, between them, set out the Trust's in-year performance and progress in terms of achieving the objectives agreed by the Board at the start of 2015/16. The Board recognises that even where a milestone set in-year has been achieved, often there will still be further work to do – as set out in the objectives for 2016/17, which support the Trust's vision to become amongst the best performing NHS organisations in the English health service.

Strategic objective 1: Keeping our promises about quality and value – embedding the changes resulting from delivery of *Our changing hospitals* programme.				
Maps to the objective set under the previous strategic aims as follows: – ***Aim 4: To consolidate services and enhance local access to specialist services in order to deliver high quality, safe, seamless, innovative and integrated services which are sustainable.*** – ***Aim 6: To improve our staff engagement and organisational culture to be amongst the best nationally***				
Our two-year objective 2014 - 2016	**Our 2015/16 milestones**	**2015/16 measures of success/metric**	**RAG rating**	**Year-end summary**
1.1 We will reduce mortality	1.1 Achieve HSMR and SHMI within the *'as expected' range or better*.	As for milestone**.**		Partly Achieved: HSMR: Achieved, 94.51 - 'better than expected' SHMI: Not achieved – Most recent data to September 2015 was 'higher than expected' 111.25.
1.2 We will minimise hospital-acquired infections in our patients	1.2.1 Sustain a zero tolerance approach to hospital acquired avoidable infections.	C. difficile < ceiling		Achieved: MRSA = no cases(year to date) - Achieved C. Diff = 16 cases against a ceiling of 11; however of these only 2 cases were considered preventable, 14 cases were unpreventable and not associated with any lapses of care
	1.2.2 Ensure full compliance with the hygiene code	Audit evidence of full compliance		Achieved: Complaint with the code
1.3 We will further improve the safety and clinical	1.3.1 Develop and then Implement	Initial priorities from strategy implemented		Partly achieved. Full year review in progress and will

outcomes for our patients by : ➢ **Implementing the Improving Patient Outcomes strategy** ➢ **providing 7 day services across 5 clinical standards** ➢ **reducing clinical variation in order to improve outcomes for our high risk patients** ➢ **ensuring a zero tolerance approach to avoidable falls and hospital acquired pressure ulcers** ➢ **delivering the Quality Account Key Priorities**	initial priorities set out in the Improving Patient Outcomes strategy 2015 to 2018			be reported to RAQC.
	1.3.2 We will implement the agreed 5 standards to deliver 7 day working (of the 10 standards)	Progress vs project plan		Not achieved. Examples of progress made within the Divisions on developing 7 day services in specific areas. Business cases developed but have not been funded by Commissioners. If the additional £2.4m becomes available the Trust aims to deliver these standards by March 2017.
	1.3.3 Deliver agreed pathways to improve patient outcomes and ensure achievement of agreed CQUIN targets	Min. 85% delivery		Achieved. Quarter 3 achieved 91%. Quarter 4 performance currently being finalised- on trajectory.
	1.3.4 Develop and implement plans to reduce clinical variation and improve outcomes for high risk patients. In Respiratory we will establish a 7 day service in conjunction with CCG and HCT and a community respiratory service. We will seek to establish a joint interface Geriatrics strategy with CCGs and community partners that builds on the current service.	Respiratory: Reduction in mortality and readmission rates in line with CQUIN target. Joint strategy agreed and implementation commenced. Establish frailty unit.		Achieved.
	1.3.5 Further reduce falls following 50% reduction in year. Ensure a zero-tolerance approach to avoidable falls.	Minimum 5% reduction in avoidable falls vs 14/15		Achieved. We are amongst the 10% best preforming Trust's
	1.3.6 Ensure a zero tolerance approach to hospital acquired avoidable pressure ulcers	Minimum 5% reduction in hospital acquired avoidable pressure ulcers		Achieved.
	1.3.7 To increase our research activity in those CRN research divisions where traditionally the Trust has not contributed	15/16 research activity outturn shows increases in number of patients in trials across the research divisions		Achieved**.** Achieved increased number recruited to NIHR studies. New Research and Development Strategy approved by Board in April 2016.
	1.3.8 Design safe clinical processes	Care bundles in place for three key		Achieved: Three care bundles have been

		diagnostic groups		written in 2015/16: Pneumonia, COPD, heart failure.
	1.3.9 Deliver key priorities agreed within the Quality Account.	Achievement of Quality Account key priorities		Partly achieved. Refer to the Trust's Quality Account 2015/16 for further details on achievements.
1.4 We will implement an interim EPR , in line with the Trust's IM&T strategy, to allow modern safe clinical note taking and recording of clinical observations.	We will implement EObs across the Trust and an EPR initially within the Emergency Department and within the Trust's Acute Units - AAU, SSU, SAU. (Subject to confirmed funding in 15/16 capital programme)	ED EPR implemented in Q1 2015/16. Roll out to acute units in year. Roll out of EObs by June 2016		Partly achieved. Pilot in progress.
1.6 **We will continuously improve and sustain high levels of operational performance across all Trust service.**	We will demonstrate progress towards achieving upper quartile performance on national and contractual targets We will demonstrate compliance with the CQC fundamental standards	Achievement of DH & Monitor performance indicators Achieve TDA governance risk rating of 'green' Maintain CQC registration without compliance conditions Maintain CQC IMR band 5 or better Achieve an overall 'good' CQC inspection rating		Partly achieved. Met DH & Monitor performance indicators with the exception of ED performance and 62 day cancer standard which have also been challenging nationally as well as locally. TDA risk rating 2-3 during 2015/16 CQC – Inspection outcome – overall requires improvement, IMR banding 4. Registration compliance without conditions during 2015/16.
4.1 We will complete our programme of acute consolidation and achieve the clinical and efficiency benefits expected from the Our Changing Hospitals (OCH) programme of investment.	4.1.1Complete delivery of the pathology Hot Lab Safe and efficient transfer of services into the new QE2. Development of an efficient, integrated Urgent Care Centre	Delivery of the Hot Lab by July 2015 Services transitioned. Integrated IT strategy agreed by end Q3. UCC GP service tendered. Project evaluation.		Achieved. Evaluating quality benefits which is due to be reported to Board in July 2016.
4.2 We will enhance the provision of a range of specialist and hyper acute services: ➢ **Robotic surgery** ➢ **Cardiology (PPCI)** ➢ **Renal services** ➢ **Stroke care (hyper acute)** ➢ **Vascular surgery** ➢ **Paediatrics**	4.2.1 We will consolidate the enhanced catchment base and consistently meet related Cancer waiting time targets.	Demand for service remains relatively stable. Urology CWT standards achieved.		Partly achieved: Increased demand, action plans in place to support delivery
	4.2.2 We will further consolidate the PPCI service which commenced in 14-15, and consider the further development	PPCI demand and performance. Business cases considered for CMR and Complex Device		Achieved

	of CMR (cardiovascular magnetic resonance imaging) repatriation and the establishment of a Complex Device service.	service.		
	4.2.3 We will develop the service via: - Developing a business case for replacement of the L&D dialysis unit - developing a business case for the decant of the Lister dialysis unit into a community location and development of the ENHT space as 'shared care/home training centre' - develop a business case for the replacement of St.Albans unit	Business cases developed and considered.		Achieved: Business cases developed and approved. Funding to be agreed.
	4.2.4 We will achieve further improvements in our acute stroke service and make progress towards the development of a Hyper Acute Stroke Unit at the Lister through the production of a Medical Division Business Case.	Business Case considered by Trust. Plans ready for implementation in 2016/17.		Achieved.
	4.2.5 We will effectively input into a revised network plan for Vascular surgery consolidation	Produce and consider an outline business case for consolidation of Vascular surgery at the Lister .		Partly achieved: In progress.
4.3 We will provide and enhance local access to specialist services within the New QEII and Hertford County Hospital, developing services which support local access to specialist care.	We will consider the development of an enhanced obesity service and enhanced Diabetes Centre. We will assess the need for, and then the location options, for a Comprehensive Elderly Assessments base.	Services commenced. Performance vs business case benefits. Case developed and considered		Not achieved: conflicting Trust priorities
4.4 We will positively promote the Trust's maternity service and be increasingly chosen by	We will increase the number of births from expected 14-15 outturn of 5450 to	Deliveries as per plan		Achieved.

local women as the provider that they choose to care for them and their babies.	5700 in 15-16 and [produce a business case for any additional capacity required to achieve this. We will deliver a minimum 5% increase in NeoNatal work via repatriation of some activity from Bedford and other areas.	Min 5% increase in neonatal activity vs 14/15 outturn.		
4.5 We will improve the financial efficiency and sustainability of the Trust. (see page 22 for further commentary)	We will deliver the financial forecast and the cost improvement programme across the Trust for 2015/16. We will implement Service Line Reporting, ensuring that it is used to inform decision making at all levels of the Trust and support service improvements.	We will seek to achieve continuity of services risk rating of two Financial forecast and CIPs achieved Service Line Reporting implemented and in use by operational and clinical teams to identify service improvements.		Achieved year end continuity of services rating of 2 and CIP delivery of 94%%. We delivered a deficit of £16.226m in 2015/16 which was an adverse variance from a planned deficit of £8m and revised forecast of £12m. Implementation of service line reporting delayed until 2016/17.
4.6 We will make progress towards becoming an NHS Foundation Trust.	We will agree a timeline with the TDA and progress along a pathway for the Trust to achieve authorisation as an NHS Foundation Trust. We will discuss our organisation TDA rating and respond to any system opportunities that arise.	Timeline agreed with TDA. Progress vs timeline. System opportunities identified and considered.		Criteria for FT updated to achieve a CQC 'good' rating prior to agreement of timeline.
6.1 We will embed an organisational culture that embraces innovation, lean systems and ways of working and is customer focused	**6.1.1** We will continue to embed a performance culture, where staff are clear about their objectives, appraised regularly and performance is linked to the reward systems in the organisation. We will seek to identify funding to enable development of the appraisal to include Nurse	Local Recognition schemes in place. Appraisal process fully aligned to incremental pay progression. Improved annual staff appraisal rate and statutory/ mandatory training compliance levels. See 2.2		Achieved

	revalidation with the review of the appraisal documentation. An on-line appraisal solution is being investigated. We will seek to identify funding to enable the launch the next stage of our Culture Change programme building on the success of ARC including initiatives that improve customer experience such as a JUICE+, 15 Steps, 'My Name is', Charter, Recognition schemes, LEAN, and a revised Corporate Induction Launch Leadership and Talent Strategy including the building of a coaching culture (subject to confirmation of resourcing).			
	6.1.2. To launch the next stage of our Culture Change programme building on the success of ARC including initiatives that improve customer experience such as a JUICE+, 15 Steps, 'My Name is', Charter, Recognition schemes, LEAN, and a revised Corporate Induction Launch Leadership and Talent Strategy including the building of a coaching culture Fully embed values based recruitment for all staff groups and levels of roles within the organisation.	Min 80% participants to attend ARC and evaluate the programme content as being relevant and meaningful. % staff accessing national programmes % staff receiving coaching training		Achieved
6.2 We will develop strategies that support effective staff recruitment, retention and	6.2.1: We will deliver the key operational performance requirements in relation to vacancy	Vacancy rate - <5% Sickness rate 3.0% 85% consultants job planned Employee Relations		Partly achieved: See workforce section for further detail.

development.	management, rostering, sickness absence, temporary staffing efficiency, job planning (electronic) and employee relations management as set out in the FY15/16 annual priorities. (Subject to confirmation of funding) With a key focus on delivering the recruitment strategy and launching the new internal ER service. This will enable a more robust management of the ER cases with OH and the Divisional teams focusing on reducing sickness absence to 3% or below, implementing fast track services to access the Trust's services and enabling staff to return to work as timely as possible.	cases (excluding sickness) completed - 90% at < 90 days Number of rosters completed 6 weeks in advance % NHSP shifts booked via the interface Roll out of interface with NHSP to all relevant clinical areas Clinical areas will request known vacant shifts 30 days in advance		
	6.2.2: We will continue to develop and embed strategies to retain staff, ensure effective recruitment, induction, training and exit management.	Improved staff retention levels. Talent management processes in place. Grad + scheme launched.		Partly achieved. Staff retention remains an area of focus.
	6.2.3: We will deliver and embed a robust talent management and succession planning process, giving opportunities for staff development and progression.	Talent management & succession planning systems in place. Proactive measures to retain identified individuals Improved staff retention levels. Talent management processes in place. Grad + scheme launched.		Achieved
6.3 We will have a zero tolerance attitude to bullying and harassment.	We will continue to ensure that we have clearly understood and firmly established mechanisms and processes for staff to raise concerns about bullying and/or	Reduction in reports and indictors of harassment and bullying		Partly achieved. Ways in which staff can raise a concern increased. Independent research commissioned to assess the underlying reasons. This will be reported

		harassment. Launch of the new ER Service which will be open to both managers and staff seeking HR advice and support. OH is being redesigned to include reporting of any concerns at work impacting on a member of staffs' HWB			through Board.
6.4	**We will support increased engagement between operational and corporate areas across the Trust.**	We will continue to increase the visibility of the Board and senior teams in the organisation (clinical areas) to help provide strong and inspirational leadership. Up skilling programme for managers on core people management skills such as sickness, disciplinary etc.	Back to floor' sessions to be continued by all Trust Board members to include 15 steps. Completion of patient stories and consideration by Trust Board. Executive directors to attend at least 90% ARC events. Executive Directors to attend Trust Partnership.		Achieved
		We will communicate, openly, honestly, regularly and with authenticity to our staff	Regular staff communications that is informative and ensures staff are up to date with any future plans or developments within the organisation or nationally within the NHS.		Achieved
		Corporate areas will continue to support operational teams during periods of acute organisational pressure and change.	To enable corporate staff to spend time in operational area(s) as part of their appraisal process.		Achieved
6.5	**We will become the rotation of choice for trainee doctors and develop excellent multi-professional training facilities.**	Act on feedback from trainees forum and trust December trainee survey	Further improvement in GMC National Trainee survey		Achieved
		Continue to enhance the LEC library and access to online educational resources.	Improved scores for access to Educational resources in GMC National Trainee survey		Achieved

Strategic objective 2: Developing new services and ways of working – delivered through working with our partner organisations

Maps to the objectives set under the previous strategic aims as follows:

- *Aim 2: To excel at customer service, achieving outstanding levels of communication and patient, carer and GP satisfaction.*
- *Aim 3: To provide and support the best standards of integrated care for the elderly and those with long term conditions by developing key partnerships and services.*

Our two-year objective 2014-2016	Our 2015/16 milestones	2015/16 Measures of success/metrics	RAG rating	Year-end summary
2.1 We will build a reputation as a hospital which is "easy to use" and improve levels of patient, carer and customer satisfaction.	2.1.1 We will seek external support to resource TOMP and improve the experience and efficiency of our outpatient services. 2.1.2 We will improve patients' experience of our outpatient pharmacy services. 2.1.3 We will increase the amount of correspondence with GPs that is sent electronically. 2.1.4 We will implement the new Way finding Strategy and develop a signposting strategy and investment case	Confirmation of funding Delivery of TOMP metrics. Improvement in pharmacy waiting times vs KPIs. Increase in electronic communication with GPs. Achievement of Discharge Summary CQUIN. Strategy implemented. Investment case produced. 50% reduction in Complaints regarding wayfinding and 50% reduction in PALS concerns re wayfinding.		Partly achieved. TOMP project did not receive funding. Clinical Support Services progressed developing areas within their control - including improvements with contact centre and availability of records. Significant improvements with outpatient pharmacy waiting times delivered through the Trust's Pharmacy subsidiary. Electronic discharge summaries remain a priority.
2.2 We will provide development programmes that enable the organisation to become even more customer focused.	To continuously review the revised values based customer service programme and Charter for Juice+ to ensure the programme delivers improved customer care linked to patient satisfaction survey results. Linked to the Streamlining project – to fully embed values based recruitment for all staff groups and levels of roles within the organisation.	Improved patient survey results. Improved organisational capability.		Achieved
2.3 We will build a reputation as a hospital which is "easy to use" and improve levels of patient, carer and customer	We will review and develop a new 3 year Patient and Carer Experience Strategy.	New strategy approved and implementation commenced.		Achieved Strategy reviewed and approved by Board.

satisfaction.				
	2.3.1 We will improve patients and GPs experiences of the Contact Centre (CC), making it easier to use and significantly improving our responsiveness to telephone calls	Significant improvement in average CC call waiting times and reduction in abandoned calls		Achieved improvements set for 2015/16, although further improvements need to be made going forward.
	2.3.2 We will Implement and review the new meal service and finalise a FBC for the replacement of kitchen equipment coupled with the introduction of a 'Family' service.	Evaluate new meals service/patient experience surveys. FBC produced by end Q2		Partly achieved New meal service and menus introduced. Business case not yet finalised. Options under consideration.
	2.3.3 We will consistently meet health records performance targets regarding records availability in Outpatients and for electives. We will significantly improve health records tracking and repatriation back to GWR via a rollout of RFID detectors	i) Improve health records tracking on iFit. Baseline 30%, Q1 40%, Q2 60% Q3 75% Q4 90% ii) Improve repatriation of notes to main store at GWR - sign off 15-16 trajectory in Q1 and then deliver iii) Increase provision of health records for emergency admissions. Baseline 55% within 24hrs. Q1 60% Q2 65% Q3 70% Q4 75%		Achieved: Significant improvements seen. Ongoing programme to sustain and continue improvement.
3.1 We will provide responsive specialist input to primary care, developing and embedding services and models which help GPs to provide high quality care for their patients in the community, reducing emergency admissions for patients with acute conditions and long term conditions.	To play a lead role in the development of a fully Integrated Frailty strategy and to then deliver the agreed elements within that set for completion by end of 15-16.	Strategy agreed Q2 Implementation as per plan Q3&4		Partly achieved. Strategy agreed with Integrated Care Programme Board. Delay in implementation due to difficulties in recruiting into the posts.
	Implement 7-day service model for respiratory. Provide Consultant support to emerging Community respiratory service.	Achievement of CQUIN Reduced readmissions for patients with COPD.		Achieved
	Roll out rapid access service piloting to new specialties	Roll out of pilots as per plan and evaluation vs agreed criteria		Partly achieved. Rapid access available to diagnostics.
	We will work in partnership with social care to roll out Home to Assess	Piloted in 2 wards.		Partly achieved: Piloted but practice embedded and not sustained. Review of priorities and resources required.
3.2 We will play a leading role in clinical and academic	We will develop integrated care pathways which support improved	Establishment of evidence of improved patient outcome/quality of life. Integrated		Partly achieved. Executive and clinical engagement on the work streams.

networks in order to develop innovative, effective ways of providing high quality integrated care	outcomes and quality of life for: a) the frail elderly b) people with dementia c) patients approaching the end of their lives We will participate in AHSN projects relevant to these pathways. We will support the successful delivery of the ENH system Vanguard pilot focusing on support into Nursing and Residential homes to help commissioners reduce emergency admissions.	pathways designed and implemented to support frail elderly, people with dementia and end of life care. Trust input to model agreed and in place. Evaluation of the Vanguard pilot vs bid criteria		

Strategic objective 3: Delivering a positive and proactive approach to the redevelopment of the Mount Vernon Cancer Centre.

Maps to the objectives set under the previous strategic aims as follows:

- ***Aim 5: We will provide leading local and tertiary cancer services and support the continued development of the Mount Vernon Cancer Centre***

Our two-year objective 2014-2016	Our 2015/16 milestones	2015/16 measures of success/metrics	RAG rating	Year-end summary
5.1 We will develop a medium-long term vision for cancer services including the Mount Vernon Cancer Centre (MVCC) and a supporting strategy to achieve delivery.	5.1.2 We will agree a Memorandum of Understanding with Hillingdon Hospital NHSFT following resolution of the contractual dispute, regarding the Mount Vernon site development plan which will enable the development of a business case to address the cancer centre infrastructure including re-provision of the wards and clinical areas.	Memorandum of Understanding agreed		Partly achieved Memorandum of Understanding in draft. Negotiations continue.
5.2 We will further improve the quality and efficiency of cancer services provided by the Trust.	5.2.1 We will continue to meet the Cancer commissioning specification	Compliance vs specification		Partly achieved. We have not delivered the 62 day pathway and have clear recovery action plans in place.
	5.2.3 We will audit the acute oncology service -in Q1 and use this to develop a business case to enhance the service and present this before close of Q2. Depending on agreement and funding, to then	Audit completed Q1 Business Case considered Q2 Agreed implementation Q4		Not achieved due to conflicting priorities.

	implement across Q3&4.			
	5.2.4 We will implement timed pathways monitoring based on EoE recommendations and develop action plans (and agreed investment plans where required) for all tumour sites to meet these. In conjunction with the Information Department we will ensure effective development and submission of the COSD database which can then be subject to audit.	To commence the monitoring by Q2, and to have signed off action plans by Q4. 75% uploaded in Q1. Action plans developed during Q2&3		Partly achieved.

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	Registered	Registered	Registered	Registered	Registered
Surgical procedures	Registered	Registered	Registered			
Diagnostic and screening procedures	Registered	Registered	Registered	Registered	Registered	
Maternity and midwifery services	Registered	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's registration status was set at *registered without conditions* until March 2016. The CQC carried out a comprehensive announced inspection between 20 and 23 October 2015, which was followed up with two subsequent unannounced visits as part of the same overall inspection process. The Trust received its final inspection report on 2 March 2016, with its quality summit held on 1 April 2016. The overall rating for the Trust was *requires improvement*, with *good* for *caring*. The full reports can be viewed via the CQC website.

In terms of its CQC inspection report, the Trust has much to be proud of:

- *Good* ratings were received for surgery, critical care, outpatients and diagnostics (all hospital sites), children and young persons community services and radiotherapy at the Mount Vernon Cancer centre
- In total, the CQC identified 19 areas of outstanding practice across the Trust and just six where improvement had to be made

Building on the inspection report, the Trust also has nothing to hide:

- The Lister's urgent and emergency services, along with the medical care pathway at the Mount Vernon Cancer Centre were rated as *inadequate* – actions were taken in October 2015 in to address the concerns raised by the CQC, including the development of an emergency services pathway steering board

The outcome of the inspection included the requirement to address regulator actions under regulation 12, 17 and 19. These are:

Lister

- *Regulation 12, safe care and treatment* – ensure effective triage processes embedded within the emergency department and maternity service
- *Regulation 17, good governance* – risks not always identified and all mitigating actions taken in all services. Records not always completed and stored in accordance with Trust requirements
- *Regulation 18, staffing* – ensure all staff have mandatory training in accordance with Trust requirements

Mount Vernon Cancer Centre

- *Regulation 12, safe care and treatment* – ensure process in place to ensure the continuing treatment for patients requiring urgent transfer
- *Regulation 17, good governance* – recognition of risks of transferring acutely unwell patients out of the hospital via an ambulance and recording of these

The Trust has developed – and is implementing – a detailed action plan to address the areas of concern raised by the CQC and to ensure continual improvement. This work is being monitored by the *CQC quality development board*, which reports in to the *risk and quality committee* and the Trust Board.

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 an established programme of quality and safety audits to support embedding the standards and continuous improvement and a learning organisation.

During 2016/17, 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 (the new regulatory body replacing the NHS Trust Development Authority and Monitor).

Financial pressures

The Trust's original planned deficit was set at £8.0 million at the start of 2015/16. This was reviewed and revised by the Board at month nine to a forecast year-end position of £12.0 million. The actual year end deficit was £16.226 million. The major reasons for the change to the Trust's planned deficit position for 2015/16 were:

- Reduction in anticipated income from commissioners (£4.0 million)
- Additional costs relating to the Care Quality Commission inspection, affecting principally the Lister's emergency department (£1.3 million)
- Extra costs associated with capacity issues and an increase in elective cancellations caused by winter pressures and industrial action (£1.5 million)

Looking forward to 2016/17

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.

Alignment with the emerging System and Transformation Plan (STP)

During 2016/17, the Trust will work with the East and North Hertfordshire Clinical Commissioning Group and other partners to focus on further improving the quality, efficiency and sustainability of 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 This work will include focusing on patient pathways through our emergency department as well as the Care Homes Vanguard, frail elderly, dementia, diabetes, cancer, stroke and respiratory medicine pathways.

This system-wide and pathway work will be complemented by the planned positive impact on patient flow and emergency department performance standards that the Trust's emergency pathway project is beginning to deliver, in conjunction with key partners.

Following the development of a satellite renal dialysis unit in 2014/15 at the Princess Alexandra hospital in Harlow, Essex and – following commissioning changes made locally – a hyper acute stroke unit in 2015/16 at the Lister that also serves people in parts of west Essex, the Trust is planning to explore the extension of its clinical relationship with the West Essex Clinical Commissioning Group and the Princess Alexandra hospital in order to support the mutual development of more sustainable services including seven days service for interventional radiology and the development of a vascular surgery hub and spoke.

Trust annual objectives align with the emerging System and Transformation Plan (STP)

The local health system, which includes the Trust, has a strong track record of engaging and working actively with external stakeholders and welcomes the development of a place-based approach to sustainability and transformation to support delivery of the triple aim.

The Trust has a well-established relationship with its lead clinical commissioning group – the East and North Hertfordshire CCG. The organisation's objectives for 2016/17 have been developed in the light of the CCG's emerging priorities and have been shared at an early stage of development.

Objectives for 2016/17 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 Trust Development Authority covering the financial year 2016/17, with the organisation's objectives set out in the diagram below.

Key challenges for 2016/17

Capacity and demand challenges

One of the most significant strategic risks facing the Trust is that demand for services, notably emergency attendances and admissions, is exceeding the capacity available. In 2015/16 the Trust has sought to mitigate this in a range of ways including enhancing internal processes in the Lister's emergency department, along with creating additional bed capacity in the hospital.

The local CCG has developed a number of schemes designed to reduce emergency demand but the latter has continued to exceed the Trust's capacity and the actions outlined above collectively have not been sufficient to sustain the quality of services provided to the communities served by the Trust – for example in meeting the four-hour A&E waiting time standard. As a result, the Trust has experienced significant financial and operational pressures.

Based on the activity changes that took place during 2015/16, an assessment of the Trust's operational requirements and capacity has been undertaken. In terms of physical capacity across the Trust, the assessment is that there will be insufficient capacity to deliver required levels of activity in 2016/17 without significant supporting actions in place – both within and without the Trust. Accordingly, the Trust will work actively with all local health system partners to develop and put in place solutions that bring capacity in line with demand.

Operational performance standards

Draft trajectories to deliver compliance with constitutional standards for the four-hour A&E, 18-week referral-to-treatment and 62-day cancer waiting time standards have been developed and agreed with the Trust's CCG and NHS Improvement. The Trust is forecasting that it will continue delivering the six-week diagnostic standard and, with the support of its CCG, work on continuing to improve its performance for stroke patients.

The Trust is seeking to improve stroke thrombolysis performance and is working on a pilot to commence CT perfusion scanning for patients that wake having suffered a stroke during the night. Whilst few NHS trusts offer this service currently, this development is in response to a request from the CCG who asked the Trust to explore potential benefits of this for patients

Staff recruitment

The Trust's overall vacancy rate was 9.77% in January 2016. The aim is to reduce this to 5% by August 2016, with the qualified nursing rate falling to 5% by September 2016. The approach to achieve this will be via using UK recruitment to hold staffing levels against turnover and using EU and Filipino recruitment to address vacant posts. A full workforce planning exercise is nearing completion in order to refresh assumptions regarding the recruitment pipeline and its impact on pay forecasts for 2016/17. Previously, the Trust forecast achieving the agency trajectory by February 2017; this will be refreshed following a review of the agency expenditure ceilings issued on 17 March 2016 and completion of the current workforce planning refresh with a view to accelerating this if possible.

Delivering seven-day services

The Trust's recent CQC Inspection confirmed that the Trust has good plans in place to achieve seven-day services. The Trust is confident that the level of required investment identified is in line with the gaps identified by other systems in order to achieve compliance with seven-day service standards.

The Trust has completed a detailed analysis of the first tranche of five Keogh standards and, during 2015/16, submitted business cases for a total of £2.4 million to fund the gaps that have been identified – for example to ensure compliance with the time it takes for a first consultant review (standard two). These business cases mostly cover funding to enable recruitment to extend services into weekends/evenings, including assumptions regarding use of agency recruitment where areas are known to be challenging to recruit in to. To date, these business cases have not been approved.

The value of business cases for additional funding in 2016/17, over and above the required 2015/16 funding, to support compliance with an additional five standards in the coming is being confirmed currently but is estimated to be in the region of £1.5 to £2.2 million.

Sustainability

Accountability

Over the past five 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%

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 new sustainability strategy for 2015 to 2020 focusses the work undertaken by the Trust, with consistent leadership and accountability at director level from the deputy chief executive.

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.

A questionnaire was also circulated to all staff to gauge feeling across the organisation. Responses to the survey highlighted the strength of positive views and expectations from staff in relation to sustainability targets and requirements.

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's travel plan is under review currently as the Trust recognises that the desired impacts on reduction in usage and travel has not materialised to expected levels. As a result, more work needs to be done in this area over the next five years.

The Trust adaptation plan is also reviewed bi-annually to incorporate plans for events such as heatwave, extreme cold spells, etc.

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 has been enhanced by the Trust's participation in the annual NHS sustainability day, a comprehensive communications campaign and by implementing specific initiatives throughout the year.

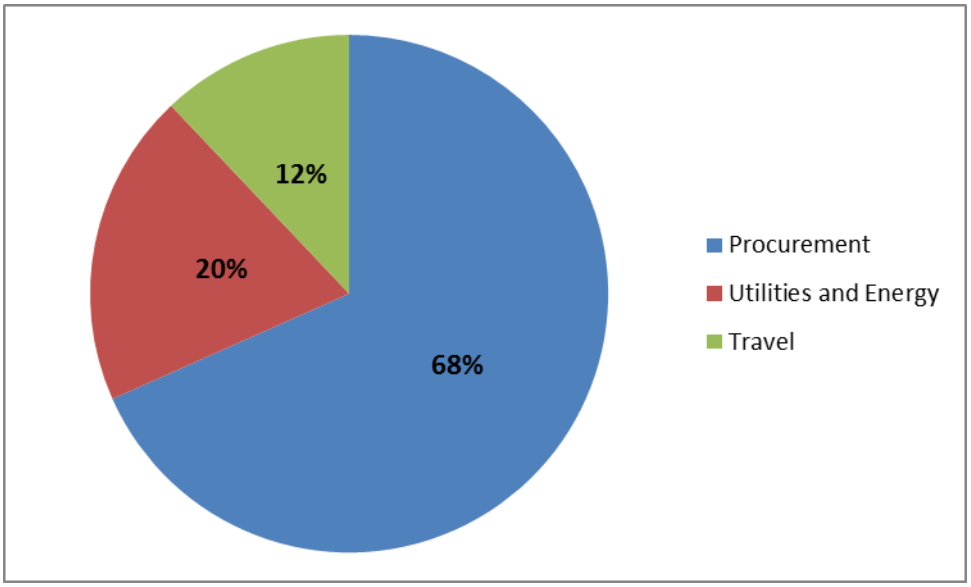
The goals and target for achieving the 2020 reduction of carbon emissions by 34% is expected to be challenging, albeit one that the Trust expects to achieve. The Trust is committed to meeting the target, which will be delivered through a combination of specific carbon reduction schemes, behavioural change,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

Measurements

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

Scope	2007 baseline	2013/14	2014/15	*2015 target*	2015/16	*2020 target*
Procurement, estates, catering, wages, etc.	58,231	45,170	44,819	*52,407*	44,814	*38,432*
Utilities	16,382	15,106	15,498	*14,743*	12,765	*10,812*
Travel	8,309	8,261	8,174	*7,479*	7,966	*5,484*
Total footprint	**82,922**	**68,537**	**68,491**	***74,629***	**65,545**	***54,728***

The chart below breaks down The Trust's 2015/16 carbon emissions by scope:



Overall in 2015/16 our carbon emissions are 21% reduction on the 2007 baseline and 19.7 % above the overall 2020 expected position. Emissions from utilities has reduced as the total energy used in 2015/16 decreased due the completion of the final stage of the *Our Changing Hospitals* programme and the closure of the Old QEII site from the end June 2015. This is also includes utility reductions due to the completion of major construction projects on the Lister site. Our reporting this year also includes sites previously unreported such as offsite office accommodation and our satellite dialysis units due to national changes in reporting requirements.

Spend and usage on water and sewerage has increased as a direct result of including previously unreported sites, in particular our off site renal dialysis units which are heavy users of water.

Business travel and fleet reflects the first full year post the Our Changing Hospitals programme and the consolidation of services on to the Lister Hospital site. The Trust's inter-site bus service now includes a "dial a ride" type service to improve accessibility and convenience of inter-site travel.

Overall waste production has increased as a direct result of the decommissioning of the old QEII Hospital site. However, within the total waste produced we have as a Trust recycled less and this is an area targeted for improvement in 2016/17.

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 March 2016 of 69% 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.

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

Trust's performance in 2015/16

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 the NHS Trust Development Authority.

The 2015/16 year represented a challenging period for the Trust, characterised by further growth in emergency activity – including higher than usual volumes of patients being brought to the Lister's emergency department by ambulance.

Despite meeting many of the standards set nationally and locally for the Trust, there were four 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 referral to treatment standard
- Stroke-related treatment waiting time standards

A&E four-hour waiting time standard

The Trust had a particularly challenging year in 2015/16, again experiencing significant growth in emergency admissions and an unprecedented growth in the volume of ambulance conveyances to the Lister's emergency department. As a result, the level of demand has been in excess of planned growth.

For 2016/17, the Trust is forecasting that no patient will wait over 12 hours for admissions. Extensive programmes of work are in place, under the auspices of the *emergency care pathway* project, to deliver a trajectory of continuing improvement on the A&E waiting time standard for which compliance is expected before the end of the year.

The latter achievement, however, is subject to identifying funding for the additional capacity required at the Lister, along with the delivery of out-of-hospital care initiatives by partner organisations working in the community.

There is a joint Trust and System Resilience Group (SRG) plan to ensure A&E and ambulance handover performance meets the required levels. This focuses on the recommended eight high impact interventions, three of which are largely internal to the Trust; the remaining five are focused on the role of the Trust's system partners.

Controlling emergency demand will be the most critical challenge as the Trust cannot create any additional bed capacity before late 2015/16 at the earliest. At the same time, the Trust will need to protect surgical bed capacity in order to deliver the levels of activity required to achieve national referral to treatment standards (see below) and income to deliver the budgeted plan.

18-weeks referral to treatment standard

The Trust consistently has achieved the aggregated performance against all three referral-to-treatment (RTT) standards (non-admitted, admitted and open) during 2015/16. At the end of the summer 2015, the rules changed resulting in the admitted and non-admitted performances no longer forming part of the national standards.

The Trust has achieved overall the 92% target for the open pathways standard for 2015/16, despite increased referral volumes and higher than typical cancellation rates due partly to bed pressures experienced during the year. Industrial action taken by junior doctors during 2015/16 (which has continued in 2016/17), had limited effect on the admitted pathways, but impacted on non-admitted services - over 700 appointments were cancelled and had to be rebooked as a result of the strike action taken by junior doctors.

Capacity planning for 2016/17 is being finalised; it is likely, once again, that there will be an average growth of 3% for the Trust to accommodate within its services.

62-day urgent GP referral to treatment standard

Performance against the 62-day standard came under particular pressure at Trust in 2015/16, although an improvement trajectory has now been agreed for the coming year.

The reasons for this under-performance are multi-factorial, but a contributing factor has been the increase in late referrals from other NHS trusts to the Trust's tertiary cancer centre at Mount Vernon, resulting in breaches that counted against the Trust. Addressing this particular challenge, as well as implementing a series of improvements that can be made within the Trust's processes, are being pursued in order to recover the position by the end of the first quarter of 2016/17.

There has also been growth in referrals, which is a further pressure in terms of delivering the 62-day treatment standard. Perhaps a more risk-adverse approach being adopted within primary care community has seen more people being referred to the Trust using the two-week urgent referral pathway. This means that the Trust not only has to put on greater capacity to deal with this specific group of patients, doing so may in turn put pressure on more routine appointments. It also represents a further challenge to the Trust's aspiration to see all patients referred in on the two-week waiting pathway by day eight following their referral.

Stroke-related treatment waiting time standards

Over the year, the Trust continued to focus on improving performance and developed a robust action plan to drive performance, utilising advice from external experts. Actions included the introduction of stroke nurse specialists to ensure that all patients receive stroke specialist input from admission to discharge. A pilot was also run to provide CT perfusion scanning for those patients who wake having suffered a stroke during the night. Whilst few NHS hospitals offer this service currently, the Trust is exploring, with the support of its local clinical commissioning group, the potential benefits of this new service for patients.

The Trust opened its designated hyper-acute stroke unit earlier than had been planned in the year in order to support the fragile stroke service at the neighbouring Princess Alexandra hospital in Harlow, Essex. This had the consequence of diverting some of the Trust's clinical resource, which in turn will slow down the improvement trajectory for some of the services key performance indicators over the coming year.

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 the integrated business plan required as part of the application process to become a NHS foundation trust, for the purposes of this annual report, the information available on activity plans is limited to the year ahead (i.e. 2016/17). This information, along with comparisons against the previous year's performance, is set out below.

Activity	2015/16 actual	2016/17 planned
A&E attendances (including the eye casualty service)	141,260	146,829
Outpatients – first appointments	137,350	150,530
Outpatients – follow-up appointments	264,362	321,242
Elective inpatients (i.e. planned admissions)	9,814	11,726
Elective day cases	23,024	25,334
Non-elective inpatients (i.e. emergency admissions)	44,433	41,405
Births	5,607	5,887

Notes

Please note that births are counted as the mother giving birth, not the number of babies. A&E attendances excludes the urgent eye clinic.

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).

The entire suite of emergency preparedness documents have been made accessible to all staff via a one-click process on the Trust's staff intranet, called the *Knowledge Centre*, which is in line with the aim of raising staff awareness and increasing accessibility to current processes and procedures. To embed awareness, an emergency preparedness overview is now incorporated into all fire training – both at induction and annual mandatory training refresher courses.

A programme of training has begun, starting with senior and on-call staff and then rolling out via training and desktop exercises during the coming year. Additionally, key staff participate in multi-agency resilience exercises to enable testing of policies and ensure readiness for events and incidents. There is also an on-going process of debriefing and lessons learned following any incidents, whether planned or unexpected.

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

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 Hertfordshire and South Midlands
- 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

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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 the NHS Trust Development Authority (known as NHS Improvement from the 1st April 2016)

Infection prevention and control

During the 12 months to the end of March 2016, the Trust recorded no Trust-associated blood infections (bacteraemias) caused by Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteria strains.

Over the same period, 16 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 2015/16, 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 (viral gastroenteritis) on a number of the Trust's inpatient wards during the year. When Norovirus 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 2013 to March 2016) – 1.72%
- Average for the last rolling 12 months (April 2015 to March 2016) – 1.60%

Although relatively small changes in percentage terms, these changes are significant – as they represent year-on-year decreases in the numbers of people dying in our hospitals thanks to advances in medicine, but also in the quality of care provided.

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 a better indication of likely performance.

- *HSMR* – the most recently published data, for the rolling annual 12-month period to December 2015, is 94.51. Statistically speaking, this rating is better than the national position;
- *SHMI* – the most recently published score, which was for the 12 months to September 2015, was 111.25 and in the *higher than expected* range. Adjusted for palliative care, the rating drops to 99.56 for the same time period.

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 is developing 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 and has achieved a reduction year-on-year since 2011 that equates to an overall reduction of 93%. For 2015/16, the total number of avoidable hospital-acquired pressure ulcers fell again, with a total of 42 compared to last year's figure of 52.

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 patient falls

Inpatient falls are 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 significantly higher risk of falling. During 2014 a total of 2,564 people attended the Trust's emergency department at the Lister following a fall in the community; this figure increased to 3,222 attendances in 2015.

In 2015/16, the Trust took part in the national audit of inpatient falls. The official audit report acknowledges that the Trust has the eighth lowest number of inpatient falls per 1,000 bed days out of the 136 NHS trusts with inpatient beds who participated in the study.

The aim of the Trust's falls prevention strategy is to reduce continually the number of falls incidents and since March 2011, there has been a reduction of 57.5% in the number of inpatients who have had a fall in the Trust (from 2,058 falls in 2010/11 to 861 falls last year). Furthermore 2015/16 saw a 6% decrease in inpatient falls when compared to the previous year. Although this was an improved situation, clearly this is still too many patients experiencing falls in the Trust and thus a further reduction target has been set for 2016/17.

Adult and children's safeguarding services

Adult safeguarding is an important part of patient care within the Trust, reflecting the new statutory framework for adult safeguarding under the Care Act 2014 that was implemented in April 2015. The Act defines the statutory requirements for local authorities, the police and NHS; it replaces the previous guidance issued by the Department of Health.

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 lead nurse 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 Hertfordshire Safeguarding Adults Board. The changes in the legislative frameworks for adult safeguarding in recent years, along with improved awareness generally about the abuse of adults, has highlighted how important adult safeguarding is to care in the NHS and the wider community.

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. An important development in 2015 has been the introduction of an independent domestic violence advisor (IDVA), who works with Trust staff to support victims of domestic abuse – including honour-based violence and forced marriage. Early access to an IDVA is vital for people who are at risk of serious harm or death.

Providing support to vulnerable 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 newly developed dementia team.

During 2015 the day surgery unit at the Lister was awarded a *Purple Star* 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 have started on a programme of work to achieve similar *Purple Star* accreditation.

The Trust's new dementia team has developed services and ward environments to enhance the care of people with dementia. Examples of initiatives now in place include *reminisce rooms* in the elderly care wards at the Lister and therapeutic activities that help to reduce anxiety and agitation. The team works innovatively with their voluntary services colleagues and local charities to provide positive interventions such as afternoon teas, music and singing, beauty sessions, pet therapy, activity events and fidget blankets.

The work of the adult safeguarding team has included awareness training for staff around the statutory duty for *Prevent* (the Government's anti-radicalisation strategy), as well as developing knowledge and skills in relation to use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. The Trust continues to see an increase in the number of urgent authorisations for Deprivation of Liberty Safeguards since the changes made by the Supreme Court in 2014; there has been a year-on-year increase in the number of such applications since 2013.

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 colleagues in clinical teams across the Trust to achieve much improved safeguarding training compliance, which stood at 90% of staff by the end of 2015.

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.

In 2016 the Trust worked closely with patients, carers and staff to develop a new *patient and carer experience strategy* for the five-year period to 2019. This strategy 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 2015/16, the Trust consistently was among the better performing NHS organisations for the Friends and Family test response rate, as well as for the percentage of inpatients who would recommend the Trust to friends and family.

2015/16 CQUIN performance

The Trust agreed nine CQUIN schemes with the East and North Hertfordshire Clinical Commissioning Group in 2015/16. Of these, three were national schemes involving care for patients:

- With acute kidney injury (AKI)
- Presenting with sepsis in the emergency department
- With dementia and delirium and their carers

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

- Reducing the proportion of avoidable admissions to hospital
- Implementing a ward accreditation programme
- Improving the stroke pathway
- Implementing an acute chest team in respiratory care
- Promoting safer discharge
- Implementation of a rostered seven-day pharmacy service

At the end of quarter three of 2015/16, the Trust was achieving 91% compliance against these CQUIN schemes.

Financial performance

The Trust's financial 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 the NHS Trust Development Authority.

As with most other NHS providers of patient care, the Trust experienced a challenging year financially and ended 2015/16 with a £16.226 million income and expenditure deficit. As mentioned above, the main issues experienced were:

- Reduction in anticipated income from commissioners (£4.0 million)
- Additional costs relating to the Care Quality Commission inspection, affecting principally the Lister's emergency department (£1.3 million)
- Extra costs associated with capacity issues and an increase in elective cancellations caused by winter pressures and industrial action (£1.5 million)

External financing limit

The Trust received £28.4 million of cash support in 2015/16 through revolving working capital loan and revenue support loan in order to address the cash issues resulting from its underlying liquidity position, its 2015/16 deficit and a cash call by the Pathology Partnership, of which the Trust is a partner. However, the Trust undershot against its external financing limit by £0.5 million and thus achieved this financial duty.

Capital spending

The Trust undershot against its capital resource limit by £0.1 million and, therefore, achieved this financial duty. During 2015/16, the Trust spent £9.8 million on capital projects, including:

- Medical equipment £1.1 million
- IM&T £1.8 million
- Backlog maintenance £0.4 million
- Increased bed capacity £1.6 million
- Quality schemes £1.0 million

Looking to the future

The forecast deficit for 2016/17 is £23.8 million. The Trust will require additional cash support from Department of Health to cover the impact of the deficit.

Going concern

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

Better payment practice code

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

The Trust has adopted the national *NHS Better payment practice code*. The target set is that 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 more challenging financial environment, the Trust's overall performance in relation to the code has reduced significantly to 44.3% of non-NHS trade invoices paid within target in 2015/16.

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.

Our culture

The Trust launched two key workforce strategies in 2015/16 to support the delivery of the *people strategy* for 2014 to 2019. The *ARC – Next Steps* strategy outlines a programme of work to deliver large-scale and long-term cultural change within the organisation, including improved staff engagement, better patient and staff experience and the embedding of a continuous improvement culture led by frontline staff.

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 has now begun, starting at Board and senior level. It will then be cascaded down to further layers of leadership and management.

NHS national staff survey for 2015

The 2015 national staff survey results showed considerable improvements on the findings from the previous year. The Trust is now in the top 20% of acute trusts in five key findings – this compares to just one area achieving this performance in 2014. At the other end of the scale the Trust was in the worst 20% of acute trusts in four key findings, compared to 11 in 2014.

Strong areas of performance included: staff feeling their role makes a difference to patients; effective use of patient feedback; the quality of appraisals; and quality of non-mandatory training. Other areas where the Trust has improved significantly were: overall staff engagement; staff feeling able to contribute to improvements; and those witnessing potential errors, incidents or near misses.

Areas that still require improvement include: staff experiencing work-related stress and working extra hours; and staff experiencing and reporting bullying or harassment. In February 2016, the Trust commissioned Duncan Lewis, who specialises in research into bullying and harassment, to conduct an independent review to determine the scale of the problem, followed by putting a plan of action in place. The research included an online survey, open to all staff for four weeks, and focus groups run across the main Trust sites. The findings of this research will be detailed in April 2016 and will be made available to all staff and employee representative groups.

In September 2015 the Trust introduced the anonymous *Speak in Confidence* platform, which allows staff to select a manager that they can contact anonymously if they wish to raise concerns. From there the manager will investigate and continue to communicate with the member of staff until the concerns are addressed.

Staff health and well-being

In June 2015 the Trust's occupational health service was re-positioned as the *Health@Work* service, to reflect a more proactive approach to staff health and well-being. The increased focus on the health and well-being of the workforce, rather than just their ill-health, has proven links to overall organisational performance and supports the wider public health agenda at the same time.

People performance

Recruitment and retention

The Trust has continued to work to reduce vacancy rates and improve the time to hire during 2015/16, 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 of 5% by April 2016 and a qualified nursing vacancy rate of 5% by September 2016. The approach that has been taken is to use UK nursing recruitment to hold staffing levels against turnover, with wider EU and overseas 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 2015/16, 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 expanded during the year.

The time to hire has improved from 12 weeks in 2014/15 to 8.5 weeks in March 2016, despite overall recruitment activity increasing by 22% during the same time period.

The Trust is leading on 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 2015/16 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 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; an estates programme of maintenance to improve the working environment; and the introduction of a nurse education mentorship 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.

A retention strategy is being developed currently and future work will focus on shift patterns and roster planning, as well as increased opportunities for training and development.

Temporary staffing

The Trust has taken significant steps during 2015/16 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 also been introduced to promote the benefits of working at the Trust through NHS Professionals, rather than through an agency.

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.

Employee relations advisory service (ERAS)

The Trust introduced an in-house employee relations advisory service – known as ERAS – in April 2015, which replaced the previous service provided by an external contractor. 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. Those using ERAS rate the service highly, with a feedback score of 4.2 out of 5 achieved in February 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.

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 68% in March 2015 to 80% in March 2016, and full statutory and mandatory compliance rates increasing from 56% in March 2015 to 62.5% in March 2016.

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 2015 national staff survey results, where the Trust ranks among the top 20% of acute trusts for quality of appraisal.

Work has also taken place this year to integrate nursing and midwifery validation into the appraisal process in time for the introduction of 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 2015 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.

A total of 400 hundred line managers have received core management skills training since June 2015. 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 ARC briefings for leaders and line managers. The subjects covered in 2015/16 included: setting the strategic direction following the completion of the *Our changing hospitals* programme in October 2014; launching the leadership and culture change strategies; and CQC inspection preparation, with debrief and feedback immediately following the inspection.

A programme of leadership masterclasses, 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*, which opened at the Lister site in Summer 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.

Statutory training

The Trust monitors compliance for nine statutory competencies and is 62.5% compliant for overall coverage and 86.5% for staff compliant with all nine.

Non-medical and medical education quality performance review

The Trust was visited for its three-yearly quality performance review (QPR) for both medical and non-medical training by Health Education East of England. The Trust was commended amongst a number of things for its governance structure and engagement from the executive team.

Medical education

The Trust's medical education team provides excellent facilities, with extensive educational opportunities for all medical staff. Trainees are valued and there is commitment to education and active involvement at every level of the organisation. There are processes for gaining student and trainee feedback.

Over the past year the Trust has been visited by the General Medical Council (GMC), Health Education East of England and most of the speciality schools. The Trust has been commended for demonstrating continuous improvements and developing a supportive environment for education and training. Good governance systems and processes for trainee engagement ensured that no patient safety concerns were raised by the GMC or by Health Education East of England during their respective visits.

Results of the Trust trainee survey for 2015 have shown consistent improvement in nearly every aspect of medical education across the organisation. Notably there was significant improvement in trainee satisfaction and educational standards. This is as a result of establishing educational faculty groups in specialities, which resulted in improved engagement between trainees and trainers.

There is a comprehensive induction programme for medical trainees in the Trust. Compliance with Trust and departmental induction is 100% and there is handover in all clinical areas. The GMC framework for medical educators has been implemented and a process for annual educational appraisal introduced. The Trust's simulation skills laboratory is well developed and providing multi-disciplinary skills training for staff.

There are strong academic and training links with two medical schools. For undergraduate education, those with the Cambridge Medical School have been strengthened and student numbers visiting the Trust look set to increase. Historic links with University College London have been maintained, with continued medical student intake.

Going forward, the Trust faces several challenges in relation to medical education. The impact of reduction in training space in the Trust following transfer of clinical, educational and library services to the Lister is being assessed. Expansion of training space is being explored to accommodate increasing demands on educational services.

A second challenge is that the repatriation of training posts from London to the East of England is progressing, but there is little information available to the Trust. The repatriation process is accompanied by a review and redistribution of speciality posts in the East of England. There has been a reduction to the training numbers over the past year as part of redistribution of posts in Eastern England and there is risk of further loss of training posts following the repatriation programme. In addition, a national shortage of trainees in frontline specialities has led to rota gaps in several specialities. As a result, the workload for trainees has increased and any loss of clinical posts may exert further pressure on hard pressed specialities.

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; preparing staff for last year's CQC inspection and the quality performance review visit by Health Education England QPR; supporting international recruitment; developing pre-registration students; delivering statutory and mandatory training for all staff; and learning and development for all non-medical staff. A large number of new initiatives and projects have been developed over the year, some of which are detailed below.

International recruitment

The education team has developed bespoke programmes of education for the wider European recruitment, as well as more recently for nurses recruited from the Philippine. The Trust and Bedfordshire and Hertfordshire Workforce Partnership have invested in resources to support the transition for this group of staff, including dedicated nurse support and English language assessments and teaching. An innovative programme of assessment has been co-designed with the University of Hertfordshire to prepare Philippine nurses for their objective structured clinical examination (OCSE); currently 19 staff have been recruited from the Philippines, 11 of whom have attained their NMC PIN, with others in the process of so doing. There has been an 81% pass rate on NMC OCSE, compared to the 49% national pass rate on first attempt. As a result, other NHS organisations are interested in the process that the Trust has been using.

Ward development

The Trust's ward development and improvement programme has been rolled out to five 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.

Continuing professional development (CPD)

In 2015/16, the Trust received £393,309 funding from the Bedfordshire and Hertfordshire Workforce Partnership for funding of CPD commissioning. The resulting training reflected the Trust's priorities, including courses for leadership, stroke care, advanced nurse practitioners and Recognising the deteriorating patient simulation study days for band one to four nursing staff. The challenge of providing CPD for the whole workforce led to commissioning of individual study days and to an increase of education provided within the Trust.

Nursing and midwifery revalidation

In October 2015 the NMC announced the implementation of revalidation in April 2016. The team has been part of a project to prepare the workforce for revalidation, which includes delivery of monthly workshops.

Pre-registration students

There has continued to be a comprehensive programme of learning and support offer to the student population. Multi-professional forums and surgeries are well attended, with feedback identifying the Trust as a good experience for students (who along with their mentors receive regular newsletters).

Band one to four nursing and midwifery staff

A new 18-month flexible nursing pathway has been developed by the University of Bedfordshire; the Trust has four band four staff that started on this programme during 2015/16.

Apprenticeships

A total of 184 staff completed their level two apprenticeships, including 18 in customer care. In April 2015 it became mandatory for all care staff to complete a *care certificate*; the Trust was instrumental in developing this across Bedfordshire and Hertfordshire and to date 166 staff have achieved this qualification within the Trust. Work also continues with The Princes Trust – six young people were given work placements in the Trust during 2015/16, with two now applying for clinical support worker apprenticeships.

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 over 25% in the last three years – including over 1,000 young members aged between 14 and 18. The Trust's involvement programme for members delivers satisfaction ratings consistently of 90% and over for events and activities.

Further improvements have been made in 2015/16 in both the quality and diversity of the Trust's involvement through public membership.

Membership development highlights

- Net increase of 710 public members over the year
- Net increase of 354 young members aged 14 to 16 over the 12 months
- The Trust won NHS Sustainability Awards in April 2015 for community, public health and overall project (#theFUTUREismembership)
- Young members designed and delivered a successful #NHSTakeoverDay in November 2015
- Public members Fiona Loud and Hannah Price confirmed on first list of 50 NHS England / Health Service Journal national patient leaders
- New member update newsletter launched in August 2015

Partnership working highlights

- The Trust held a successful annual general meeting (AGM) in July 2015, which attracted over 300 delegates returning a 90% satisfaction rating
- Opening of the Community Hub at the Lister to help patients, carers, visitors and staff better connect with opportunities for jobs, apprenticeships, volunteering, public membership, carer support and charitable giving
- Piloted successfully a listening event for children and young people as part of the Trust's Care Quality Commission inspection process in October 2015
- Filmed on location at the Lister highlighting national good practice for engagement and membership development work for NHS England's Participation Academy
- Ongoing 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 in January 2016, a topic group visit to the Trust's stroke and diabetes services)
- Staff from all of the Trust's sites donated around 40 large boxes of food and personal care items to seven local food banks across Hertfordshire in December 2015
- Worked with *Healthy Hub Stevenage* to promote NHS Sustainability Day in March 2016

Clinical engagement and primary care

- Supported the second annual Hertfordshire diabetes conference in September 2015
- Support engagement between GPs and hospital clinicians through a clinical forum
- Worked with the local clinical commissioning group to deliver public engagement events on the development of local stroke services
- 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 recognises the benefit of having a research culture as this enhances patient care and outcomes. It also provides an opportunity for patients to help others – for example through a statement made by a research participant recently:

> "*I have just joined the* Add Aspirin *[cancer] research project as it could significantly help other patients in years to come*."

During 2015/16, the Trust strengthened significantly its leadership through the appointment of an associate director of research and development who reports directly to the Trust's medical director and is supported by a highly professional team. The new appointment provides a single point of contact for all research matters across the organisation.

The Trust has a long history of being research active, with particular strengths in: cancer (via the Mount Vernon Cancer Centre, which serves a population of some two million people); renal medicine (as part of a sub-regional renal service that provides care to around 1.4 million people); cardiovascular disease; and diabetes.

The research activity at the Trust is a mixture of studies that staff have gained though external funding, via both commercial and non-commercial sources, along with studies that support the development of staff.

The Trust continues to be research active and produces a large number of research publications; for 2015 calendar year, more than 130 were produced in a number of key journals. These publications covered a wide range of areas, including patient care and patient experience, and were often part of collaborations.

For 2015/16 the external research income is expected to total £2.924 million. The majority of the research at the Trust is eligible for financial support via the Department of Health and this is provided via the National Institute for Health Research (NIHR) Clinical Research Network (CRN).

The Trust is a partner organisation of the NIHR and falls within its Eastern region. Together with other local NHS organisations that form part of the NIHR, the Trust has the following aims:

- Help increase the opportunities for patients to take part in clinical research
- Ensure that studies are carried out efficiently
- Improve the environment for commercial contract clinical research in the NHS

Research activity for the period from April 2015 to January 2016, for studies supported by the NIHR, is set out below (it is worth noting that an additional 377 patients were recruited to other research studies):

Research area	Recruits	Recruiting studies
Cancer	602	60
Renal disorders	310	14
Cardiovascular disease	114	13
Diabetes	45	6
Children	42	1
Ear, nose and throat	33	4
Mental Health	15	1
Stroke	10	3
Other	35	10
Grand Total	**1,199**	**111**

Particular highlights have included:

Prostate cancer

The Trust has recruited 135 patients to the STAMPEDE trial, which is evaluating the treatment of prostate cancer. Out of 107 national centres, the Trust was ranked 14th highest overall in terms of entering patients and the best of the five NHS trusts involved in the East of England. The results of the trial were published in the Lancet and concluded that:

> *"Docetaxel treatment should become part of standard of care for adequately fit men commencing long-term hormone therapy for advanced prostate cancer*".

Renal research

A large number of projects are devised, supported and delivered by this team. For example, external funding was obtained from the NIHR's *Research for patient benefit* scheme to study supportive care for dialysis patients. The attitudes and perceptions of 325 patients in relation to supportive and end-of-life care planning were assessed. The results were published and now inform local care arrangements.

Cardiovascular research

The Trust's cardiology team has a large portfolio of research studies involving studies on cholesterol-lowering, angioplasty, stenting, heart failure and arrhythmias. For cardiovascular research, the Trust was the highest recruiter of commercial studies in the East of England, as well as being the second highest overall in the England including both commercial and non-commercial research.

Commercial research

Of the 1199 recruits, a total of 179 (i.e. 14.9%) were to commercial studies. With the latter in mind, this year the NIHR singled out consultant medical oncologist, Dr Paul Nathan for his contribution to cancer research and development**.**

The Trust has good academic links with a number of academic organisations, including the University of Hertfordshire, University of Cambridge, Brunel University, Anglia Ruskin University and University College London. These provide opportunities for Trust staff to translate research ideas to grant applications – for example Dr Andreas Makris is a co-chief investigator for a £3.4 million Health Technology Appraisal Grant called OPTIMA (optimal personalised treatment of early breast cancer using multi-parameter analysis) that is looking into the use of a blood test to assess which patients will respond to chemotherapy.

The Trust is very grateful for the support of £200,000 in 2015/16 from local charities – including the Cancer Treatment and Research Trust, 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 the level without significant and on-going local charitable support; all involved in research at the Trust are very grateful to the many patients and relatives who continue to donate to this vital cause.

During 2015/i6, the Trust produced a research strategy for 2016 to 20199, the aim of which is to enhance patient experience and outcome by offering research opportunity for all patients and staff. To achieve this outcome, the Trust will build on its reputation as an internationally recognised centre of excellence for research and patient outcomes where patients and public are engaged with, participate in, and benefit from research and innovation.

The strategy 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).

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 2015/16, 10 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 chairman, five non-executive directors and five executive directors – the chief executive and the medical, nursing, finance and operations directors. In addition, two further executive directors – for strategic development and workforce and organisational development *(from January 2014)* – and a non-executive director designate 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 2015/16, two non-executive directors left the Board. Mr John Gilham, previously a non-executive director designate was appointed as a non-executive director and became a full Board member on 1 June 2016. Currently the Trust is reviewing the skills and experience required to fill the current vacancy for a non-executive director designate.

The term of office for the current chairman, Mr Ian Morfett, ended on 31 March 2016 and he has decided to retire. The Trust has worked with the NHS Trust Development Authority (TDA) in establishing a successor to the role and following a rigorous appointment process lead by the TDA, Mrs Ellen Schroder was appointed as the new Trust chair from 1 April 2016.

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.

The chair and non-executive directors were, until 1 October 2012, appointed by a national body – the Appointments Commission – on behalf of the Secretary of State for Health. This function was taken over by the NHS Trust Development Authority on 1 October 2012. The normal term of office served by the chair and non-executive directors is either a two or four years, renewable for a further four-year period.

The chair and non-executive directors appoint the Trust's chief executive. Together with the chief executive, the chair and non-executive directors appoint all other executive directors and determine their remuneration.

The executive directors are appointed by the Board on permanent contracts. All executive and non-executive directors undergo an annual performance evaluation and appraisal. The chair conducts the annual performance evaluation and appraisal of the chief executive and non-executive directors. The chief executive, in turn, conducts the annual performance evaluation and appraisal of the Trust's executive directors. The chair is appraised by the TDA.

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 his/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 and a half days per month. To add most value, non-executive duties should not extend into operational matters – which are the responsibility of the chief executive and 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 2015/16

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 chairman attends all Board committees regularly although he is no longer a designated member. The committee attendance figures listed below do not take into account these additional attendances; rather they reflect attendances that are *expected*.

Ian Morfett, chairman (until 31 March 2016)

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

Committee membership: RC, CTC, IC

Attendance: Trust Board 12 out of 13; FPC 9 out of 11; RAQC 8 out of 11; RC 3 out of 3; CTC 3 out of 4; IC 3 out of 3

Nick Carver, chief executive

The chief executive is the accountable officer for the Trust and carries full responsibility for its performance, forward planning and leadership of the executive team and clinical directors. Nick was appointed as the Trust's chief executive in November 2002, having been a successful chief executive of a hospital trust in the Midlands for the previous three and a half years. Nick has led the organisation through financial turnaround and major service change and has been instrumental in securing public and political support for a major reconfiguration of hospital services that will bring substantial quality and financial benefit to the local health economy. Nick started his NHS career as a qualified registered nurse in 1982, before developing his interest in health service management. In addition to holding his registered general nurse (RGN) qualification, Nick holds a BA (Hons) in political theory and government, as well as an MSc in health care management. In 2013, Nick was presented with the *Inspirational Leader of the Year* award by Health Education, East of England.

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

Attendance: Trust Board 13 out of 13; FPC 9 out of 11; RAQC 11 out of 11; AC 3 out of 5; IC 1 out of 3; RC 3 out of 3

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 9 out of 11; RC 3 out of 3

Dyan Crowther, non-executive director (until 31 December 2015)

Dyan Crowther joined Network Rail as route director for London North Eastern in December 2004, from Arriva Trains Northern where she had worked as its commercial director from March 2002 and was promoted to managing director in October 2003. Dyan took over the role of route director for Midland and Continental in May 2008. She has over 20 years' experience in the rail industry. Prior to joining Network Rail, Dyan held a number of strategic roles within the former infrastructure company, Railtrack, including executive for West Coast (South) in the Midland Zone. Dyan has a masters degree in transport and logistics from Salford University and is a member of the Chartered Institute for Marketing. Dyan was appointed as a non-executive director in July 2010. She chairs the Board's *risk and quality committee*. Originally from Wiltshire, Dyan is married and has three children.

Committee membership: RAQC, RC

Attendance: Trust Board 6 out of 9; RAQC 8 out of 8; RC 1 out of 2

Julian Nicholls, non-executive director

Julian has spent 20 years successfully managing substantial business to business services companies in the UK and Europe. He is currently 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 10 out of 11; RC 3 out of 3

Stuart Gavurin, non-executive director (until 31 May 2015)

Stuart spent over 20 years in private practice as a qualified accountant but more recently has been a commercial director with particular experience in finance, property development, investment, management and contract negotiation in the commercial, health and residential sectors. He has specialist knowledge of commercial legal affairs and has been responsible for setting up legal partnership working arrangements between NHS bodies and the private sector. Stuart has been a board member for a wide range of both public and private organisations, including several NHS partnership companies, in both executive and non-executive capacities. He is an experienced executive and non-executive company chair and director. Stuart lives in Bushey Heath, was first appointed a non-executive director designate in August 2012 and was then appointed as a non-executive director in June 2013. Stuart chaired the Board's *Charity Trustee Committee.*

Committee membership: FPC, RAQC, RC, CTC

Attendance: Trust Board 2 out of 2; FPC 2 out of 2; RAQC 1 out of 2; CTC 1 out of 1; RC 1 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.

Bob Niven, non-executive director (contd.)

Committee membership: RAQC, RC, AC, CTC, RC,

Attendance: Trust Board 13 out of 13; RAQC 10 out of 11; FPC 6 out of 11, AC 4 out of 5; CTC 4 out of 4; IC 1 out of 3; RC 3 out of 3

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 masters 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 work for the NHS. John recognises the importance of staff engagement and the role it plays in providing high quality of services for patients.

Committee membership: RAQC

Attendance: Trust Board 12 out of 13; RAQC 10 out of 11; RC 3 out of 3

Vijay Patel, non-executive director (designate)

Vijay joined the Trust on 1 November 2015 as a designate non-executive director and became a full non-executive director on 1 January 2016. 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 7 out of 13; FPC 5 out of 11, RC 1 out of 2

John Watson, director of operations (until February 2016)

The Trust's director of operations is responsible for the day-to-day running of hospital operations, its divisions and divisional management teams. John joined the Trust at the start of February 2013, having previously been the director of operations at Ipswich Hospital NHS Trust for three years. Prior to this role, he held acting director of operations and divisional manager posts at Kings College Hospital in central London. John has also completed the Public Service Leaders scheme, which included a two-day a week secondment to the Department of Health. Having started his NHS career in 1990, John has a BSc in social policy and economics and MSc in health policy, planning and financing – both from the London School of Economics.

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

Attendance: Trust Board 4 out of 13; FPC 4 out of 11; RAQC 4 out of 11,

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 10 out of 13; RAQC 10 out of 11

Angela Thompson, director of nursing

Angela took up the post of director of nursing, patient experience, and infection prevention and control at the Trust in 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 12 out of 13; RAQC 9 out of 11; FPC 9 out of 11

Tony Ollis, director of finance

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 10 out of 13; CTC 3 out of 4; FPC 9 out of 11; AC 4 out of 5

Stephen Posey, deputy chief executive

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.

Stephen Posey, deputy chief executive (contd.)
Committee membership: EC, CTC, FPC (core attendee), RAQC (attendee)
Attendance: Trust Board 7 out of 13; CTC 2 out of 4; FPC 10 out of 11; 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 9 out of 13; FPC 9 out of 11; RAQC 7 out of 11; RC 3 out of 3

Board members terms of office 2015/16

	Title	Appointment date	Term(s) of office	Term of office ends
Ian Morfett	Chairman	1 April 2012	Four years	31 March 2016
Ellen Schroder	Chair	1 April 2016	Four years	31 March 2020
Nick Carver	Chief executive	18 November 2002	n/a	n/a
Alison Bexfield	Vice chairman	1 February 2008	Four years plus four years Plus two year s	31 January 2018
Dyan Crowther	Non-executive director	1 July 2010	Four years plus two years	30 June 2016 Term ended 31 December 2015
Julian Nicholls	Non-executive director	1 July 2010	Four years plus two years	30 June 2016
Stuart Gavurin	Non-executive director designate*	15 August 2012	n/a	Ended 31 May 2013
	Non-executive director	1 June 2013	Two years	Ended 31 May 2015 (retired)
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	
	Non-executive director	1 June 2015	two years	31 May 2017
Vijay Patel	Non-executive director designate*	1 November 2015	n/a	n/a
John Watson	Director of operations	4 February 2013	n/a	16 February 2016
Jane McCue	Medical director	1 April 2012	n/a	n/a
Angela Thompson	Director of nursing	30 August 2011	n/a	n/a
Tony Ollis	Director of finance	20 October 2014	n/a	n/a
Stephen Posey*	Director of strategic development Deputy CEO	21 January 2008	n/a	n/a
Tom Simons*	Director of Workforce & OD	January 2014	n/a	n/a

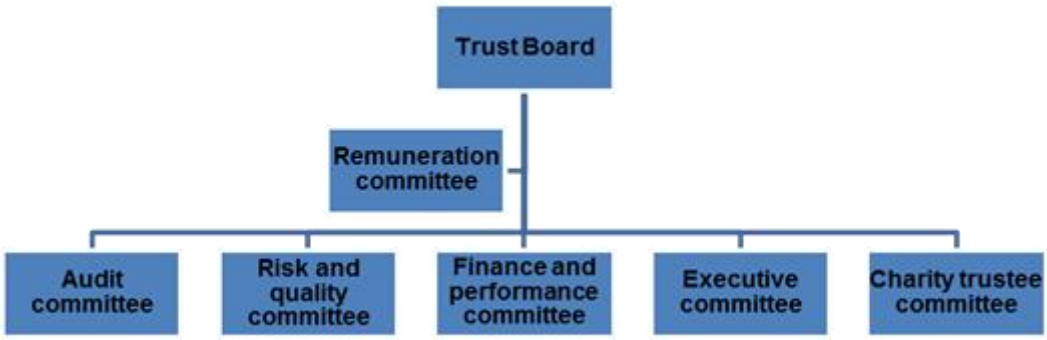
*Attend and participate in Trust Board meetings, but without voting rights.

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

Governance structure

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



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

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

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

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

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

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

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

- *Division of surgery* (divisional chair, Dr Michael Chilvers and divisional director, John Fitzmaurice)
- *Division of medicine* (divisional chair, Dr Jon Baker and deputy director of operations – medicine and integration, Barbara Harrison)
- *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, Ella Stracey)
- *Division of women's and children's services* (divisional chairs, Mr Rob Sattin/Dr Linda Struthers and divisional director, Christine Bell)

External auditor

Owing to the special accountabilities attached to public money and the conduct of public business, the Audit Commission – independently of the Trust – appoints external auditors. The *Audit Commission Act 1998* sets out the role of the Audit Commission Board in the appointment of external auditors for NHS bodies. It appoints auditors from its own staff, as well as from private firms of auditors.

For 2015/16, the Trust was appointed a new external auditor - BDO LLP. The Trust's existing external auditor service contract will remain in place up until 2016/17 and 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 promptly discuss audit and other issues. 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. The Trust has established an auditor panel and process to enable the selection and appointment of the external auditors for 2017/18 by the end of December 2016.

Statement of accountable officer's responsibilities

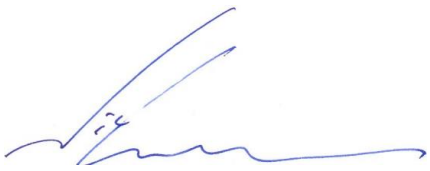
The chief executive of the NHS Trust Development Authority has designated that the chief executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the chief executive of the NHS Trust Development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

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

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

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: 2 June 2016

Governance statement

Executive summary

My annual governance review of 2015/16 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 have been identified that would impact on the delivery of the Trust's strategic and annual objectives. The Trust recognises that the internal control environment can always be strengthened and this work will continue in 2016/17. 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 the NHS Trust Development Authority, 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 the East and North Hertfordshire NHS Trust,
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in East and North Hertfordshire NHS Trust for the year ended 31 March 2016 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 2015 to 31 March 2016, 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 risks to the director of finance, operational, facilities, estates and security management, emergency planning to the director of operations, and sustainability management and IT and information management to the director of strategic development, and workforce and organisational development (OD) to the director of workforce and OD.

Further detail on the individual director accountabilities are set out in the Trust's quality governance and risk management strategy, corporate governance assurance map, the Trust's annual plan and board assurance framework.

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 mitigated against effectively, 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 accountable jointly for risk and governance. A process of review and challenge of divisional risks, as contained in the risk register, is conducted through divisional performance review meetings. Areas of high risk are escalated to the *risk and quality committee* (RAQC) and the Trust Board. In addition each of the divisions attends RAQC on an annual basis for further scrutiny of their risk and governance processes.

The operational risk management team provides support and training to staff on risk management and the risk register. The health, safety and security team provides mandatory training on health and safety to all staff across the organisation. The company secretary ensures the Board 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. 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).

3. Risk assessment

3.1 Risk profile

Risk assessment is 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.

A full comprehensive record of the principle risks identified in 2015/16 and how these have been mitigated and reviewed is discussed at RAQC and Trust Board. The greater impact of the external environment is evident in the risk ratings for 2015/16 and the controls and actions to mitigate these risks will be a focus for 2016/17. These risks are set out on the next page.

Capacity and demand:

- Risk that sudden and unforeseen changes to referral pathways impact on the delivery of our quality and financial outcomes. This risk was reviewed and increased to *red* in January 2016 due to the potential changes identified to pathways from a number of providers.
- Risk that excess demand on services impacts on the delivery of our national performance targets and quality measures. This risk has remained *red* due to impact on the cancer waits and emergency department performance (see section 5 of this statement for more information).
- Risk that the health and social care system wide plans do not deliver the outcomes expected and further impact on capacity and demand. This risk was increased to *red* in March 2016 to reflect the cumulative impact on capacity and demand.

Risk that the clinical and non-clinical benefits or our changing hospitals are not fully realised. This has remained at amber throughout the year. Improvements in hospital mortality and patient safety and outcomes have been demonstrated. This is covered further in section 5 and will be formally evaluated in July 2016. It is anticipated that this risk will then close.

Linked to the above risk is the risk that the NHS Trust Development Authority (TDA), clinical commissioning group (CCG) and public lose confidence in our plan to deliver sustainable improvements (specifically mortality, patient survey, staff survey, emergency department and finance), leading to loss of reputation, increased regulation and scrutiny, and financial penalties. The risk increased to reflect the increased levels of emergency activity experienced requiring additional ward capacity to be opened. This impacted on the ability to deliver some key performance targets including the emergency department, cancer and stroke. The Trust is working jointly with its commissioners and partners; this will be an on-going focus in 2016/17.

The risk that if we do not fully embed a value based culture we will fail to attract and retain high performing workforce and deliver our objectives. Improvements in culture are evidenced through the staff survey results and some workforce indicators, however recruitment remains challenging. Actions are in place and updates are provided in Workforce report to Board.

The risk that if we do not 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 *finance and performance committee* and Trust Board (see section 5).

The risk that the Pathology Partnership (TPP) fails to perform effectively and does not deliver the operation and financial commitments, impacting on the quality outcomes for patients. This has remained a high risk and monitoring through RAQC and Board to support delivery and minimise impact on the organisation.

Other operational key risks, including infection control, mortality and performance, that have been managed during 2015/16 are discussed in section five.

***Assurance framework rating is based on the 5 x 5 matrix of likelihood and consequence.**

Red: *A significant failure to mitigate a risk either through lack of controls identified (or poorly framed controls), with a high likelihood of the risk being realised in the short term.*

Amber: *On course to be mitigated, given the controls identified, but further work required in delivering the agreed actions.*

Green: *Risk has been mitigated as defined by the controls and actions identified. These risks will continue to be displayed on the framework so that assurances received can be kept up to date.*

4. The risk and control framework

Quality governance and risk management is central to the effective running of the organisation and the Trust's ambition *to be amongst the best*.

The objectives of this strategy are:

- To achieve the Trust's strategic and operational objectives as defined in the integrated business and annual plans
- To maintain registration with CQC registration without compliance conditions
- To strengthen compliance with the quality governance framework and achieve a score of 0.5 or better *(now within the well-led framework)*
- To strengthen compliance with the Board governance assurance framework and maintain a green rating *(now within the well-led framework)*

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 truly reflective of the risks faced
- Support compliance with regulatory bodies including, registration with the Care Quality Commission, Monitor (on gaining NHS foundation trust status), Health and Safety Executive and maintaining and improving compliance with NHS Litigation Authority's risk management standards and achieve year-on-year improvement in compliance with national standards, regulation requirements and accreditation schemes
- Provide and maintain a safe and secure environment for patients, staff and visitors
- Encourage and support innovation and service developments within a framework for risk management
- Protect the services, finances and reputation of the Trust through risk evaluation, control, elimination or transfer of risk. Otherwise ensure the organisation openly accepts the remaining risks.

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

4.1 Board assurance and reporting

The Trust Board has established three committees to discharge its responsibilities on Board assurance. These are the *audit*, *risk and quality* and *finance and performance* committees. These are constituted as key assurance committees under Monitor's Code of Governance and an annual review of each of the committees is undertaken to ensure they continue to meet their terms of reference and requirements of the code.

In addition, the Board has established the *charity trustee* committee to provide assurance and support for its responsibility as a corporate trustee.

The assurance process as described below is reviewed by the Trust's *audit committee* (AC), 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 major projects (including the consolidation programme), and ensure it is prepared for the forthcoming major changes.

The *risk and quality committee* (RQC), a formal committee of the Board, is chaired by a non-executive director. The purpose of the committee is to ensure that the Board has a sound assessment of risk and that the Trust has adequate plans, processes and systems for managing risk. It is inclusive of clinical and corporate risk, clinical governance, clinical effectiveness, research governance, information governance, health and safety, staff governance and patient and public safety. The committee also ensures that the Trust has an effective management and clinical governance framework that includes the assessment and monitoring of quality indicators, which drive forward the development of quality of services and care, patient safety and patient experience. The Trust's *finance and performance committee* will ensure the monitoring of financial risk, unless there is potential impact or actual risk to quality identified; in these circumstances RAQC will provide scrutiny.

The principal objectives of the RAQC are to:

- Provide assurance to the Board that the services the Trust provides meet all national standards and are safe, effective, high quality and patient-focused
- Review and monitor the Board assurance framework and the corporate risk register, ensuring appropriate action is taken to mitigate risks where possible and advising the Board where acceptance of risk may need to be considered
- Monitor the standards and reviews from external bodies through receiving development plans, outcome reports and associated action plans, e.g. Care Quality Commission, NHS Litigation Authority (NHSLA), Clinical Negligence Scheme for Trusts (CNST), Health and Safety Executive (HSE), NHS Trust Development Authority (TDA) and ensure action is taken for compliance

- Monitor and advise the Board on compliance with the Hygiene Code
- Endorse, monitor and receive reports on the implementation of the Trust's key quality, clinical outcome, patient safety and patient experience strategies and indicators
- Provide regular risk management reports to the Trust Board
- Liaise with the audit committee and finance and performance committee
- Receive, annually, divisional presentations on progress with divisional objectives, governance structures, quality, safety and risk
- Review the quality risk assessment of the cost improvement programme (CIP)
- Work with the audit committee when appropriate, and specifically in agreeing the annual internal audit plan and providing a review of effectiveness on clinical audit

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

- Clinical governance strategy committee
- Patient safety committee
- Patient experience committee
- Health and safety committee
- Emergency planning committee
- 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 2015/16 has not highlighted any issues. These are reported in full in the Trust's annual report.

4.2 Board development

During 2015/16 the Board had a series of development sessions to consider key areas of strategic significance and risk, including our strategic plan, models of care, procurement, quality and safety, the Trust's operating plan, care quality commission and developing a coaching culture and leadership style. The Board have continued to increase their time out in the Trust.

The expectation is that the 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.

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.

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

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

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

Our registration status has been - *registered without conditions*- until March 2016. CQC Comprehensive announced inspection from 20-23 October 2015 with 3 unannounced visits. The Trust received the final report 2 March 2016 and the quality summit was held on 1 April 2016. The overall rating for the Trust was *requires improvement* with *good* for *caring*. The full reports can be seen via the Trust's website.

We have much to be proud of:

- Good ratings were received for surgery, critical care, outpatients and diagnostics (all sites), children and young persons community services and MVCC radiotherapy.
- 19 areas of outstanding practice being recognised.

We have nothing to hide:

- Lister urgent and emergency services and MVCC medical care pathway were rated as inadequate and we have actions in place to address the concerns raised. This includes the development of an Emergency Services Pathway Steering Board.
- The outcome of the inspection included the requirement to address regulator actions under regulation 12, 17 and 19. These are:

Lister hospital:

- **regulation 12, safe care and treatment** – ensure effective triage processes are embedded within the emergency department and maternity service
- **regulation 17, good governance –** risk were not always identified and all mitigating actions taken in all services. Records were not always completed and stored in accordance with Trust requirements.
- **regulation 18, staffing** – ensure all staff have mandatory training in accordance with Trust requirements.

Mount Vernon Cancer Centre:

- **regulation 12, safe care and treatment –** ensure process in place to ensure the continuing treatment for patients requiring urgent transfer
- **regulation 17, good governance –** recognition of risks of transferring acutely unwell patients out of the hospital via an ambulance and recording of these.

We have developed an action plan to address the areas of concern and to ensure continual improvement. This is being monitored by our CQC quality development board, risk and quality committee and Board.

We continue to monitor its compliance against all CQC requirements, including the regulations – *Duty of Candour* and *Fit and Proper Persons*. It has also an established programme of quality and safety audits to support embedding the standards and continuous improvement and a learning organisation.

During 2016/17, we will seek to address the regulatory actions and improve further upon our performance with regulators such as the Care Quality Commission and continue a programme of self-assessment against the standards required by CQC and NHS Improvement (previously the NHS Trust Development Authority and Monitor).

Clinical audit

The risk and quality committee and audit committee considered the clinical audit assurance following an evidence-based self-assessment against the Audit Committee Handbook 2010 criteria. The self-assessment 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.

It is clear that processes and monitoring have led to a continued improvement in clinical audit activity across the Trust. Approximately 457 (88%) of the audits included in the Trust's clinical audit forward plan due for completion in 2015/16, and an additional 99 (97%) of those that were approved in year, have been completed or are in progress for 2015/16. This is an improving performance that the previous year and the outcome 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 2016/17.

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 2015/16 the Trust achieved 75%, not satisfactory rating. This was due to two measures assessed as a level 1, coding and clinical information assurance, business continuity management. Action plans are in place to deliver a minimum of a level 2 for all measures. The Trust has reported one information governance serious incident where it had been identified that 898 documents were paused in the print queue and, therefore, the patients had not received these appointment letters. All patients were followed up and a full investigation has been completed and actions implemented to mitigate the risk of reoccurrence. Information governance 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.

Performance

A&E performance – the pressures on the A&E standard have continued in 2015/16 and we failed to deliver the 95% target to be seen within 4 hours, achieving 85.05%. We had a particularly challenging year experiencing significant growth in emergency admissions from other areas, a higher acuity of patients and difficulties in recruiting to an increased staffing establishment. The level of demand has been in excess of planned growth. The local health system resilience group (HSRG) has acknowledged that A&E performance is a system wide responsibility and has developed a system wide recovery plan. In November we introduced an emergency pathway steering group supported by seven workstreams to improve bed capacity and flow across the organisation. Action plans are in place to ensure a sustained recovery in performance during 2016/17.

18-week referral to treatment time (RTT) – we have achieved consistently the aggregated performance against the RTT open pathways standard and we are expecting to deliver the aggregated performance going forward. Performance has deteriorated for the non-admitted and admitted pathways but plans are in place to improve performance and these are internally monitored monthly.

Cancer waits – cancer targets have been met with the exception of the 62-day wait from referral to first definitive treatment. A full breach analysis has been completed for all patients and evidences an increase in patients breaching the standards within skin surgery, lung and patient choice delays. In addition we have received higher volumes of later referrals from other NHS trusts. Pathways are being reviewed and actions are being implemented and a recovery trajectory has been agreed.

Infection control – we have a zero tolerance approach to avoidable hospital acquired infections and continue to remain compliant with the requirements of the Hygiene Code. During 2015/16 we have not had any cases of MRSA bacteraemia and we have had 16 cases of *Clostridium difficile* against a target of 11. Root cause analysis has been completed on all cases and actions taken. Two of the 16 cases were considered preventable and 14 were unpreventable, with no associated lapses of care identified. Within the acute NHS trusts in East of England, we have the second lowest rate of *C. difficile*.

Data quality – we have continued to review our data quality both internally and with the support of external experts and our 2015/16 internal audit programme undertaken has included a focus on data quality – specifically we have reviewed our coding, data quality, capture and validation for RTT, stroke care services, financial reporting, income recovery and cancer waiting times. This will continue to be a priority for 2016/17.

Safer staffing

Ensuring safe staffing levels remains a priority and we have continued to invest in nursing and medical posts. We undertake a formal review of the nursing establishment twice a year and report this to the risk and quality committee and Board. In addition safer staffing is reported each month to risk and quality committee and Board.

Mortality

We have continued to reduce mortality and the year-to-date performance shows HSMR improved to the *better than expected* range (94.15). The latest SHMI data available (October 2014-September 2015) shows there are further improvements to be made to reduce this from the *higher than expected* range (111.3) and this is expected to improve in 2016/17. 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.

Mortality monitoring includes reviewing all deaths and *alerts*, which show higher than expected mortality with certain diagnoses. We did not receive any CQC mortality outlier alerts during 2015/16. Reducing mortality remains an improvement priority for the Trust in 2016/17 and the Trust's operating plan and improving patient outcomes strategy set out the priorities and actions, including progress towards seven-day services.

Never events

We had four never events in 2015/16. One wrong route administration of medication, one wrong site surgery and two retained swabs. In each case, the patients involved came to no clinical harm and 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 and root cause analysis undertaken and actions implemented.

Pensions

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

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. An assessment against the criteria stated in the equality delivery scheme (EDS) has been undertaken and the EDS objectives have been agreed and published. The workforce reporting equality standard (WRES) was first produced 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

We have a clear framework ensuring the effective monitoring and control of the use of Trust resources. Financial monitoring, performance monitoring and workforce information is scrutinised through the Trust's performance monitoring framework. Internal and external audit provide scrutiny to the key processes that have been applied to ensure that resources are used economically, efficiently and effectively. The finance and performance committee and Board provide scrutiny and challenge to ensure the Trust mitigates and manages the risks effectively to deliver the Trust's strategic and annual objectives.

We delivered a deficit of £16.226 million in 2015/16 which was an adverse variance from a planned deficit of £8 million and revised forecast of £12 million. At year-end the Trust delivered an improved continuity of services rating of two and delivered 94% of its cost improvement programme (CIP). This is the second year of deficit against the previous seven years in a surplus position. The major reasons for change to the planned deficit were due to additional CQC costs, (relating to emergency department staffing and triage - £1.3 million), capacity issues/increase elective cancellations and reduction in support/transformation funding from commissioners (£3.9 million).

Income recovery – during 2015/16 we identified a reduction to our expected income position. Investigation identified the current process of capturing information on activity was faulty with inconsistencies, duplications and omissions within billing. It appeared to be a consequence of weak and an insufficient control environment potentially compounded by the implementation of a software update which was put in place in November 2014. To address this - an income assurance group was established between IM&T and finance to review the manual process and automate income recovery fully; this programme of work has now been addressed. Further work and monitoring will continue in 2016/17 to ensure this is effective.

Annual quality report

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

The formulation of the 2015/16 quality account has been led by the head of quality and patient safety on behalf of the medical director and was designed to meet all relevant Department of Health and Monitor requirements. It provides a *look-back* against identified priorities and overall progress with improving quality (safety, effectiveness and experiences). It also provides a look forward to future priorities. The account includes a section on mandated topics, for example clinical audits, and reports against the achievement of national standards.

The 2015/16 and 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 2015/16 these were:

- Improve safety: safety thermometer
- Improve safety: medications
- Improve outcomes: mortality
- Improve clinical outcomes: stroke
- Improve experiences: communication
- Improve experiences: reduce delays

The review of the priorities for 2016/17 concluded:

- Maintain three of last year's priorities – medication management; mortality; stroke standards
- Retire the safety thermometer scores as the most significant improvements have been made over previous years and the processes are embedded. These indicators are routinely monitored as part of the director of nursing reports to the risk and quality committee
- Retire delays because of the reductions noted via the complaints and PALS concerns. This will continue to be monitored in the same way as the safety thermometer
- Maintain communication as a priority but adjust the way this is measured. The existing indicators will continue to be monitored by the patient experience committee or via the director of nursing reports to the risk and quality committee
- Introduce *Human Factors* as a new safety priority and Improve nutrition and hydration as a new experiences priority

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.

In addition to the improvements noted above, an overview of 2015/16 shows that we have made progress on the current priorities including:

- Reducing in-hospital deaths
- Reducing avoidable pressure ulcers
- Reducing falls

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

6. Significant issues

There no significant control issues to report.

Review of effectiveness

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

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

As 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 2015 to 31 March 2016 overall opinion is:

The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Factors and findings that have informed our opinion:

- One Red (no assurance) opinion was provided to the Trust during the year in respect of our audit entitled *Temporary medical staffing ED and AMU*. Our opinion was based primarily on significant inadequacies in the design of and compliance with the temporary staff shift booking processes being followed in practice within the emergency department and acute medical unit, in combination with a lack of adequate information being reported that would allow effective oversight of the process by senior management. In addition, the processes placed large reliance on individuals for the booking and monitoring functions for temporary medical staff. This increased the risk of single points of failure, inefficiencies through dual processes, increased workloads on individuals and has increased the potential for fraud due to a lack of a robust control framework.

Following our audit, management developed an action plan to rectify the issues raised. These have subsequently been incorporated into a wider review of the emergency department and acute medical unit.

- An *amber red* (partial assurance) opinion was provided as part of our audit on CQC compliance into the area of medicines management. Our audit was undertaken prior to the CQC inspection and found a number of issues around the storage of drugs stocks within wards. Management acted upon our findings at the time of our audit and undertook an internally led re-audit which confirmed a number of the issues identified had been addressed.
- All of the remaining internal work undertaken for the year resulted in either green (substantial assurance) or amber green (reasonable assurance) opinions being provided.

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 above areas identified as high risk have an action plan in place which has been implemented or is on track for delivery. The CQC inspection demonstrated that the issues raised had been addressed with the exception of a few areas.

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.

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 regularly reviews the Trust's objectives and receives reports on key matters of concern
- the audit committee provides an independent and objective review of the Trust's system of internal control and comments where appropriate on the overall risk management process
- the risk and quality committee provides assurance on the progress of all areas of risk management
- the finance and performance committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the Risk and Quality Committee for further scrutiny, while providing proactive risk management within the areas of activity covered by its own remit
- internal audit, through its annual audit plan, provides assurance and comment on matters related to internal control
- the Board has appointed a senior information risk owner, who is supported by an information governance steering group, to provide information governance assurance via the information governance toolkit submission and information governance statement of compliance

- the Board ensures that all senior staff, clinical and other, through various meetings and review processes, including bi-monthly performance reviews with each clinical division, are held to account in all areas for delivery against finance, performance, quality, governance and risk issues
- I am confident that executive directors, senior managers of the Trust and identified risk leads are engaged fully in maintaining and reviewing the effectiveness of the system of internal control. This is supported by the positive CQC engagement and recent internal audit reports

Conclusion

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

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

Accounting Officer: **Nick Carver**

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

Signature: 

Date: **2 June 2016**

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 2015/16)
- 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 2015/16. 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 principals:

- 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
- Pay keeps track with inflation – an underlying rate of 1% in the last quarter of this financial year
- 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. The Trust has not had any new executive director appointments during 2015/16. 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 2015/16

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 2015/16 was £187,500 (2014/15 – £182,500). This was 6.7 times (2014/15 – 6.5 times) the median remuneration of the workforce, which was £28,076 (2014/15 – £28,076). The slightly increased multiple is due to an increase in the remuneration of the highest paid director, while the median was unchanged.

In 2015/16, 19 employees (2014/15 – 20 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £14,320 to £248,835 (2014/15 – £13,076 to £249,906).The lowest paid employee is part of a salary sacrifice scheme, which has had the effect of reducing pay; otherwise the lowest paid employee would have received £15,100, which is the bottom of the *Agenda for Change* pay scales.

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	2015/16						2014/15					
	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	2.5-5	190-195	180-185	4	0	0	22.5-25	205-210
Chief executive												
Paul Traynor (to 31/10/14)	n/a	n/a	n/a	n/a	n/a	n/a	80-85	67	0	0	12.5-15	100-105
Director of finance												
Anthony Ollis (from 1/11/14)	140-145	2	0	0	32.5-35	175-180	60-65	0	0	0	20-22.5	80-85
Director of finance												
Angela Thompson	120-125	1	0	0	50-52.5	170-175	115-120	1	0	0	35-37.5	150-155
Director of nursing												
John Watson (to 16/2/16)	105-110	0	0	0	100-102.5	205-210	105-110	0	0	0	30-32.5	135-140
Director of operations												
Jane McCue*	160-165	1	0	0	222.5-225	385-390	135-140	2	0	0	105-107.5	240-245
Medical director												
Stephen Posey	125-130	21	0	0	72.5-75.0	200-205	115-120	62	0	0	45-47.5	165-170
Deputy CEO/director of strategic development												
Tom Simons	100-105	50	0	0	47.5-50	155-160	85-90	45	0	0	35-37.5	130-135
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 2015/16 (14% in 2014/15). 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.
- The change in Jane McCue's salary reflects partly the change in role from part-time to full time, as well as the Clinical Excellence Award.

Name and title	2015/16						2014/15					
	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												
Ian Morfett (term ended 31/03/16)	20-25	0	0	0	0	20-25	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)	0-5	0	0	0	0	0-5	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)	0-5	0	0	0	0	0-5	5-10	0	0	0	0	5-10
Bob Niven	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
John Gilham (from 1/12/14)	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0
Vijay Patel (from01/11/15)	0-5	0	0	0	0	0-5	0	0	0	0	0	0

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 2014/15 and 2015/16.

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 2016	Lump sum at pension age related to accrued pension at 31 March 2016	Cash equivalent transfer value at 1 April 2015	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2016	Employer's contribution to stakeholder pension
	(bands of £2500)	(bands of £2500)	(bands of £5000)	(bands of £5000)	£000	£000	£000	£000
Nick Carver	0-2.5	2.5-5	65-70	200-205	1,272	35	1,323	0
Chief executive								
Anthony Ollis (from 1/11/14)	2.5-5	n/a	15-20	n/a	185	42	230	0
Director of finance								
John Watson	5-7.5	5-7.5	35-40	105-110	577	64	657	0
Director of operations (to 16/02/16)								
Stephen Posey	2.5-5	5-7.5	25-30	80-85	327	44	375	0
Director of strategic development								
Angela Thompson	2.5-5	7.5-10	45-50	145-150	876	68	954	0
Director of nursing								
Jane McCue	10-12.5	30-32.5	70-75	210-215	1,251	270	1,536	0
Medical director								
Tom Simons	2.5-5	n/a	10-15	n/a	86	27	114	0
Director of workforce and organisation development								

Notes to pensions table

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

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

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

On 16th Match 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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.

Compensation for loss of office

There is nothing to disclose for 2015/16

Staff report

This section covers:

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

Staff numbers

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

Average staff numbers	2015/16			2014/15
	Total	Employed permanently	Other	Total
Medical and dental	788	729	59	720
Ambulance staff	0	0	0	0
Administration and estates	1,417	1,282	135	985
Healthcare assistants and other support staff	775	652	123	381
Nursing, midwifery and health visiting staff	1,795	1,515	280	2,279
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	524	473	51	601
Social care staff	0	0	0	0
Healthcare science staff	0	0	0	0
Other	0	0	0	0
Total	**5,299**	**4,651**	**648**	**4,969**

NB: The analysis of staff numbers in the table above have been audited by the Trust's auditors, BDO LLP.

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).

2015/16	Male	Female	Total
Executive directors	5	2	7
Employees	1,186	4,271	5,457
Total	**1,191**	**4,273**	**5,464**

Workforce data

In the table below, a summary of workforce-related statistics is provided for 2015/16, alongside figures provided for the previous three years. The figures are the average for the years ending 31 March and are expressed full time equivalents (FTEs).

Activity	31 March 2016	31 March 2015	31 March 2014	31 March 2013
Staff employed	4,651.92	4,540.63	4,797.40	4,703.04
Vacancy rate	9.72%	7.11%	5.64%	8.0%
Turnover rate	12.80%	12.91%	10.63%	10.3%
Sickness absence rate	4.30%	4.12%	3.90%	3.81%

An additional 250 FTE posts (102 FTE qualified nursing and 25 FTE nursing support) were added to the Trust's establishment in May 2015. As a result the *Drive to 5* recruitment campaign was reforecast and nursing support vacancies are now expected to reduce to 5% by April 2016, with qualified nursing vacancies reduced to 5% by September 2016.

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

Sickness absence data

The Trust has taken a number of steps to reduce sickness absence during 2015/16. A key action has been the introduction of *Absence Assist*, 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 six months.

Equality and diversity – staff in post

Ethnicity

The Trust's workforce continues to be more diverse than the population served; 25.9% 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, 74% 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 46% are female and 54% are male. By way of comparison, the male population of Hertfordshire is 547,110 compared to females at 568,952 (49% compared to 51%). Just under 38% of all Trust employees work part-time, with the highest percentage in nursing and midwifery (46%) and nursing unqualified (45.5%).

Disability

14.32% of people in the 2011 census for Hertfordshire reported they had a disability. Of the Trust's 5,464 staff, 228 did not disclose whether they have a disability and 2,890 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 40% Christian, however 30% have not disclosed any religion and 9% do not want to disclose their religion. The next largest group is atheist at 7.85%.

Sexual orientation

59.5% of the Trust's workforce state they are heterosexual, with 32.7% giving undefined responses; furthermore, 6.8% 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 2015/16 include the stress at work, raising concerns and appraisal policies, 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 2015/16, £321,000 was spent on consultancy.

Off-payroll engagements

The table below looks at all off-payroll engagements as of 31 March 2016 (more than £220 per day and last longer than six months).

Category	Number
Number of existing engagements as of 31 March 2016	15
Of which, the number that have existed:	
- for less than one year at the time of reporting	8
- for between one and two years at the time of reporting	5
- for between two and three years at the time of reporting	1
- for between three and four years at the time of reporting	0
- for four or more years at the time of reporting	1

NB: These figures include high-value agency workers, as well as independent contractors.

All recent off-payroll engagements for independent contractors have been subject to a risk-based assessment as to whether or not assurance was required that the individual is paying the right amount of tax and, where necessary, that assurance was sought. Work is in hand to establish a similar process in respect of high-value agency workers.

The two tables below between them set out all new off-payroll engagements between 1 April 2015 and 31 March 2016, where pay is more than £220 per day and that last longer than six months.

Category	Number
Number of new engagements between 1 April 2015 and 31 March 2016	8
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.	3
Number for whom assurance has been requested	2
Of which:	
- assurance has been received	1
- assurance has not been received	1
- engagements terminated as a result of assurance not being received	0

NB: These figures include high-value agency workers, as well as independent contractors.

Category	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	0
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	7

The majority of the Trust's off-payroll engagements are with NHS Professionals or other long-standing reputable agencies. The Trust does not have any more information outside of its existing processes to confirm that it has not captured all of these engagements.

Exit packages

No exit packages were agreed in 2015/16. There were eight exit packages agreed in 2014/15 at a total cost of £362,379 and these were all in relation to the *Our Changing Hospitals* programme. Further details are disclosed in note 8.4 to the accounts.

Financial statements

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 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the combined group and single entity Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015-16 Government Financial Reporting Manual (the 2015-16 FReM) as contained in the Department of Health Group Manual for Accounts 2015-16 (the 2015-16 MfA) 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 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 2015, 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 2016.

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 Tust 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 2016 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.

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 2016. 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 reported a deficit of £16 million for 2015/16 against an original plan of £8 million deficit, although this was revised during the year to approximately £12 million with risk factors increasing this to up to £20 million. The deterioration in the Trust's financial outturn was due to issues relating to agency costs, the failure to secure £4 million of additional funding from Commissioners that had been agreed during the year and additional spending on Accident and Emergency services;
- the Trust has budgeted for a deficit £23.8 million in 2016/17;
- Cost reductions of £15.5 million are required in 2016/17 to deliver the forecast deficit; and
- No recovery plan to bring spending back within the available resources has been produced and the Trust's medium term financial plan is still being developed in conjuction with partner organisations in the regional Sustainability and Transformation footprint.

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 2015, 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 2016.

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

Auditor's responsibilities

We report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the

Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

Basis for reporting

The Trust's deficit for the year of £19.5 million continues a continues a cumulative three-years deficit gainst a duty to break even, with no immediate prospect of returning to break even. This breach is a matter that needs to be referred to the Secretary of State.

Exercise of powers

The referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 was issued on 30 May 2016.

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 Authority's 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

2 June 2016

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 2015 to 31 March 2016

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Consolidated 2014-15 £000s
Gross employee benefits	8.1	**(242,253)**	(229,396)	**(242,813)**	(229,396)
Other operating costs	6	**(166,044)**	(163,148)	**(166,689)**	(166,222)
Revenue from patient care activities	3	**345,586**	337,555	**345,586**	337,555
Other operating revenue	4	**39,126**	38,495	**40,312**	40,966
Operating surplus/(deficit)		**(23,585)**	(16,494)	**(23,604)**	**(17,097)**
Investment revenue	10	**37**	26	**37**	106
Other gains and (losses)	11	**4,153**	-	**4,153**	-
Finance costs	12	**(3,421)**	(2,758)	**(3,423)**	(2,758)
Surplus/(deficit) for the financial year		**(22,816)**	(19,226)	**(22,837)**	(19,749)
Public dividend capital dividends payable		**(2,878)**	(3,430)	**(2,878)**	(3,430)
Retained surplus/(deficit) for the year		**(25,694)**	(22,656)	**(25,715)**	(23,179)

Other Comprehensive Income

	2015-16 £000s	2014-15 £000s	2015-16 £000s	2014-15 £000s
Impairments and reversals taken to the revaluation reserve	**5,041**	(691)	**5,041**	(691)
Net gain/(loss) on revaluation of property, plant & equipment	**767**	7,273	**767**	7,273
Net gain/(loss) on revaluation of financial assets			**(139)**	148
Total Other Comprehensive Income	**5,808**	6,582	**5,669**	6,730
Total comprehensive income for the year	**(19,886)**	(16,074)	**(20,046)**	(16,449)

Financial performance for the year- Department of Health

Retained surplus/(deficit) for the year	**(25,694)**	(22,656)
Impairments (excluding IFRIC 12 impairments)	**8,996**	19,297
Adjustments in respect of donated gov't grant asset reserve elimination	**472**	(254)
Adjusted retained surplus/(deficit)	**(16,226)**	(3,613)

The impairments of £8,996k comprises £6,624k (2014-15 19,297k) due to the revaluation of the Trust's Estate and £2,372k due to the change in the value of the investment in tPP.

The notes on pages 95 to 136 form part of this account.

Statement of Financial Position as at 31 March 2016

	NOTE	**31 March 2016** £000s	31 March 2015 restated £000s	31 March 2015 £000s	**Consolidated 31 March 2016** £000s	Consolidated 31 March 2015 restated £000s	Consolidated 31 March 2015 £000s
Non-current assets:							
Property, plant and equipment	13	**179,310**	179,111	179,172	**179,563**	179,407	179,407
Intangible assets	14	**8,491**	6,449	6,388	**8,491**	6,392	6,392
Other Investments- Charity					**2,298**	2,738	2,738
Other financial assets	20.1	**2,505**	2,293	2,293	**1,505**	1,293	1,293
Trade and other receivables	19.1	**2,562**	1,352	1,352	**2,562**	1,352	1,352
Total non-current assets		**192,868**	189,205	189,205	**194,419**	191,182	191,182
Current assets:							
Inventories	18	**5,264**	4,244	4,244	**6,006**	4,653	4,653
Trade and other receivables	19.1	**41,513**	40,725	40,725	**42,094**	41,647	41,647
Other financial assets	20	**-**	-	-	**-**	-	-
Other current assets		**-**	-	-	**-**	-	-
Cash and cash equivalents	21	**15,863**	600	600	**17,516**	1,583	1,583
Sub-total current assets		**62,640**	45,569	**45,569**	**65,616**	**47,883**	**47,883**
Non-current assets held for sale	22	**1,700**	11,913	11,913	**1,700**	11,913	11,913
Total current assets		**64,340**	57,482	57,482	**67,316**	59,796	59,796
Total assets		**257,208**	246,687	246,687	**261,735**	250,978	250,978
Current liabilities							
Trade and other payables	23	**(65,373)**	(60,069)	(60,069)	**(67,205)**	(61,493)	(61,493)
Other liabilities	24	**(203)**	(203)	(203)	**(203)**	(203)	(203)
Provisions	30	**(288)**	(284)	(284)	**(288)**	(284)	(284)
Borrowings	25	**(289)**	(307)	(307)	**(289)**	(307)	(307)
Other financial liabilities	26	**(150)**	(145)	(145)	**(150)**	(145)	(145)
DH revenue support loan	25	**0**	0	0	**0**	0	0
DH capital loan	25	**(8,493)**	(8,488)	(8,488)	**(8,493)**	(8,488)	(8,488)
Total current liabilities		**(74,796)**	(69,496)	(69,496)	**(76,628)**	(70,920)	(70,920)
Net current assets/(liabilities)		**(10,456)**	(12,014)	(12,014)	**(9,312)**	(11,124)	(11,124)
Total assets less current liablilities		**182,412**	177,191	177,191	**185,107**	180,058	180,058
Non-current liabilities							
Trade and other payables	23	**-**	-	-	**-**	-	-
Other liabilities	24	**(5,015)**	(5,218)	(5,218)	**(5,015)**	(5,218)	(5,218)
Provisions	30	**(770)**	(831)	(831)	**(770)**	(831)	(831)
Borrowings	25	**(7,115)**	(7,404)	(7,404)	**(7,115)**	(7,404)	(7,404)
Other financial liabilities	26	**(2,595)**	(2,745)	(2,745)	**(2,595)**	(2,745)	(2,745)
DH revenue support loan	25	**(28,369)**	0	0	**(28,369)**	0	0
DH capital loan	25	**(50,987)**	(53,580)	(53,580)	**(50,987)**	(53,580)	(53,580)
Total non-current liabilities		**(94,851)**	(69,778)	(69,778)	**(94,851)**	(69,778)	(69,778)
Total assets employed:		**87,561**	107,413	107,413	**90,256**	110,280	110,280
FINANCED BY:							
Public Dividend Capital		**169,950**	169,915	169,915	**169,950**	169,916	169,916
Retained earnings		**(127,458)**	(106,291)	(106,291)	**(127,458)**	(106,292)	(106,292)
Revaluation reserve		**45,069**	43,789	43,789	**45,069**	43,789	43,789
Charitable Funds Reserve					**2,452**	2,848	2,848
Other Reserves					**243**	19	19
Total Taxpayers' Equity:		**87,561**	107,413	107,413	**90,256**	110,280	110,280

The accounts for 2014-15 had an immaterial mis-stated split of property, plant and equipment and intangible assets. A restated Statement of Financial Position has been produced to reflect the change, the value of which was £61k.

The notes on pages 95 to 136 form part of this account.

The financial statements on pages 91 to 94 were approved by the Board on *2 June 2016* and signed on its behalf by

Chief Executive: 2 June 2016

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2016

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
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**
Other gains/(loss) (provide details below)	-	-	-	-	**0**
Transfers between reserves	-	4,528	(4,528)	-	**0**
Reclassification Adjustments					
Permanent 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**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**161,980**	**(83,636)**	**37,207**	**-**	**115,551**
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year	-	(22,656)	-	-	(22,656)
Net gain / (loss) on revaluation of property, plant, equipment	-	-	7,273	-	7,273
Impairments and reversals	-	-	(691)	-	(691)
New temporary and permanent PDC received - cash	13,936	-	-	-	13,936
New temporary and permanent PDC repaid in year	(6,000)	-	-	-	(6,000)
Net recognised revenue/(expense) for the year	**7,936**	**(22,656)**	**6,582**	**-**	**(8,138)**
Balance at 31 March 2015	**169,916**	**(106,292)**	**43,789**	**-**	**107,413**

Consolidated- (as restated)

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Charitable Funds Reserve	Total reserves
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**169,916**	**(106,292)**	**43,789**	**19**	2848	**110,280**
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**
Permanent PDC received - cash	34	-	-	-		**34**
Other movements	-	-	-	224		**224**
Charitable Funds Adjustment	-	-	-	-	(396)	**(396)**
Net recognised revenue/(expense) for the year	**34**	**(21,166)**	**1,280**	**224**	**(396)**	**(20,024)**
Balance at 31 March 2016	**169,950**	**(127,458)**	**45,069**	**243**	**2,452**	**90,256**

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Charitable Funds Reserve	Total reserves
	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2014	**161,980**	**(83,636)**	**37,207**	**0**	0	**115,551**
Changes in taxpayers' equity for the year ended 31 March 2015						
Retained surplus/(deficit) for the year	-	(22,656)	-	-	-	(22,656)
Net gain / (loss) on revaluation of property, plant, equipment	-	-	7,273	-	-	7,273
Impairments and reversals	-	-	(691)	-	-	(691)
New temporary and permanent PDC received - cash	13,936	-	-	-	-	13,936
Charitable Funds Adjustment		-	-	-	2848	2,848
Other movements	-	-	-	19	-	19
New temporary and permanent PDC repaid in year	(6,000)	-	-	-	-	(6,000)
Net recognised revenue/(expense) for the year	**7,936**	**(22,656)**	**6,582**	**19**	**2,848**	**(5,271)**
Balance at 31 March 2015	**169,916**	**(106,292)**	**43,789**	**19**	**2,848**	**110,280**

Statement of Cash Flows for the Year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s	Consolidated 2015-16 £000s	Restated Consolidated 2014-15 £000s	Consolidated 2014-15 £000s
Cash Flows from Operating Activities						
Operating surplus/(deficit)		**(23,585)**	(16,494)	**(23,604)**	(16,494)	(16,494)
Depreciation and amortisation	6	**7,593**	7,361	**7,604**	7,361	7,361
Impairments and reversals	15	**8,996**	19,297	**8,996**	19,297	19,297
Donated Assets received credited to revenue but non-cash		**-**	(219)	**-**	(219)	(219)
Interest paid		**(3,408)**	(2,729)	**(3,410)**	(2,729)	(2,729)
PDC Dividend (paid)/refunded		**(3,398)**	(3,399)	**(3,398)**	(3,399)	(3,399)
(Increase)/Decrease in Inventories		**(1,020)**	646	**(1,352)**	646	646
(Increase)/Decrease in Trade and Other Receivables		**(1,478)**	(568)	**(1,466)**	(568)	(568)
Increase/(Decrease) in Trade and Other Payables		**5,461**	14,045	**4,532**	14,045	14,045
(Increase)/Decrease in Other Current Liabilities		**(203)**	(202)	**1,200**	(202)	(202)
Provisions utilised		**(106)**	(216)	**(106)**	(216)	(216)
Increase/(Decrease) in movement in non cash provisions		**36**	51	**36**	51	51
NHS Charitable Funds - net adjustments for working capital movements				**600**	(469)	(469)
Net Cash Inflow/(Outflow) from Operating Activities		**(11,112)**	17,573	**(10,368)**	17,104	17,104
Cash Flows from Investing Activities						
Interest Received		**37**	26	**37**	26	26
(Payments) for Property, Plant and Equipment		**(7,872)**	(29,133)	**(7,946)**	(28,133)	(29,133)
(Payments) for Intangible Assets		**(3,419)**	(2,729)	**(3,419)**	(2,729)	(2,729)
(Payments) for Other Financial Assets		**(2,584)**	(2,293)	**(2,584)**	(2,293)	(2,293)
Proceeds of disposal of assets held for sale (PPE)		**14,705**	-	**14,705**	-	-
Net Cash Inflow/(Outflow) from Investing Activities		**867**	(34,129)	**793**	(33,129)	(34,129)
Net Cash Inform / (outflow) before Financing		**(10,245)**	(16,556)	**(9,575)**	(16,025)	(17,025)
Cash Flows from Financing Activities						
Gross Temporary (2014/15 only) and Permanent PDC Received		**34**	13,936	**34**	13,936	13,936
Gross Temporary (2014/15 only) and Permanent PDC Repaid		**-**	(6,000)	**-**	(6,000)	(6,000)
Loans received from DH - New Capital Investment Loans		**-**	7,794	**-**	7,794	7,794
Loans received from DH - New Revenue Support Loans		**28,369**	-	**28,369**	-	-
Loans repaid to DH - Capital Investment Loans Repayment of Principal		**(2,588)**	(2,588)	**(2,588)**	(2,588)	(2,588)
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(307)**	(275)	**(307)**	(275)	(275)
Net Cash Inflow/(Outflow) from Financing Activities		**25,508**	12,867	**25,508**	12,867	12,867
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**15,263**	(3,689)	**15,933**	(3,158)	(4,158)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**600**	4,289	**1,583**	4,741	4,289
Cash and Cash Equivalents (and Bank Overdraft) at year end	**21**	**15,863**	600	**17,516**	1,583	131

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 Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.11 Going Concern

IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust its services to another entity within the public sector.

The Directors have received confirmation from the NHS TDA that they will make sufficient cash financing available to the organisation up to the period of 12 months from the date the board will approve the accounts such that the organisation is able to meet its current liabilities.

1.2 Acquisitions and discontinued operations

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

1.3 Charitable Funds

Under the provisions of IFRS10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. The results have been included in the consolidated balances.

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

1.5.1 Critical judgements in applying accounting policies

The Trust believes there is no probable liability for a share of the losses of The Pathology Partnership (tPP), on the basis of a letter from the Director of Finance confirming that partners will not be recharged for the losses and a recovery plan approved by partners is being implemented to bring the organisation back into a normalised surplus from 2016-17.

The Trust has impaired the value of its investment in tPP by £2,372k (Note 15) after a revaluation exercise using a discounted future cash flow model covering the period from 2016-17 to 2020-21. The critical judgements relate to both the basis of the valuation estimate and to the accounting treatment for the resulting impairment.

The cash flows are derived from operational profitability included within the tPP business plans, after making a number of prudent assumptions relating to income and expenditure growth rates and potential future cash calls from investors. The discount rate used is the Treasury-determined rate of 3.5%. The profit projections period reflects that set out in the tPP business plan and reflects the point at which a significant contract re-tendering is due.

The accounting treatment judgements relate to whether the impairment should be charged against the Departmental Expenditure Limit (DEL) or against Annually Managed Expenditure (AME). The definitions set out in the Manual for Accounts do not directly apply to the tPP scenario, but the Trust considers that key factors in support of charging against AME include:

- The impairment is not within the Trust's control - the Trust is a minority shareholder of tPP and does not exercise management control. A DEL impairment is typically one within management's control. Impairments charged to DEL can also relate to normal operations, and the issue does not relate to the normal operations of the Trust.
- The impairment is a write-down of an investment in a specialised operation to a discounted value which excludes any market premium – there are close parallels to an example in the Manual for Accounts defined as AME.

The impairment of the tPP investment value is therefore judged to be more appropriately classified as an AME because it is the best fit.

NOTES TO THE ACCOUNTS

1.5.2 Key sources of estimation uncertainty

Estimation techniques in the following areas are explained in more detail under the relevant note:

Provision for impairment of receivables - note 19.3
The valuation of property, plant and equipment - note 13.3
The calculation of provisions - note 29
Public Finance Initiative - note 31
Pensions - note 8.6
Accruals - note 23

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

NOTES TO THE ACCOUNTS

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, except for bonuses earned but not yet taken which is not accrued for at the year end, on the grounds of immateriality. No accrual is necessary in respect of annual leave earned but not taken as staff have not been permitted to carry forward annual leave since 2011-12.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.8 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.

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 Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

NOTES TO THE ACCOUNTS

Revaluations 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. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

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

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

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

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

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

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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

NOTES TO THE ACCOUNTS

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

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

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

1.12 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 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.

1.15 Leases

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

NOTES TO THE ACCOUNTS

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

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

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

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

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

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

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

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

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

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

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

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

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

NOTES TO THE ACCOUNTS

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

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

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

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

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

Assets contributed by the 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 Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator
Assets contributed (e.g. cash payments, surplus property) by the 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 Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

NOTES TO THE ACCOUNTS

1.17 Inventories

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

1.18 Cash and cash equivalents

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

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

1.19 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate at 1.37% pa.

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

1.20 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 29.

1.21 Non-clinical risk pooling

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

1.22 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 body 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.

NOTES TO THE ACCOUNTS

1.23 Contingencies

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

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

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

1.24 Financial assets

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

Financial assets are 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.

1.25 Financial liabilities

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

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

NOTES TO THE ACCOUNTS

Financial guarantee contract liabilities
The Trust currently has no guarantee contract liabilities.

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.

1.26 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.

1.27 Foreign currencies
The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. 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.

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

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 *[amend as appropriate].*

1.28 Public Dividend Capital (PDC) and PDC dividend
Public dividend capital represents taxpayers' equity in the 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 of 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.30 Subsidiaries
The Trust has a subsidiary company, ENH Pharma Limited. The results have been included as part of the consolidated accounts together with the Charity (East and North Hertfordshire NHS Trust Charitable Fund). Under IAS 27 the Trust has the power to exercise control over both bodies.

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.

NOTES TO THE ACCOUNTS

There are no associates and joint arrangements.

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 2015-16. 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 for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, 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.

2. Income generation activities

Not relevant for the Trust

3. Revenue from patient care activities

			Consolidated	
	2015-16 £000s	2014-15 £000s	**2015-16 £000s**	2014-15 £000s
NHS Trusts	**923**	2,864	**923**	2,864
NHS England	**89,694**	85,645	**89,694**	85,645
Clinical Commissioning Groups	**249,473**	238,465	**249,473**	238,465
Foundation Trusts	**135**	3,062	**135**	3,062
Department of Health	**-**	763	**-**	763
NHS Other (including Public Health England and Prop Co)	**-**	803	**-**	803
Non-NHS:				
Local Authorities	**220**	288	**220**	288
Private patients	**3,646**	3,648	**3,646**	3,648
Overseas patients (non-reciprocal)	**439**	236	**439**	236
Injury costs recovery	**1,056**	1,781	**1,056**	1,781
Total Revenue from patient care activities	**345,586**	337,555	**345,586**	337,555

4. Other operating revenue

			Consolidated	
	2015-16 £000s	2014-15 £000s	**2015-16 £000s**	2014-15 £000s
Education, training and research	**17,213**	16,018	**17,213**	16,018
Receipt of donations for capital acquisitions - Charity	**0**	768	**0**	768
Non-patient care services to other bodies	**18,297**	17,848	**18,297**	17,848
Income generation (Other fees and charges)	**2,426**	2,351	**2,426**	2,351
Rental revenue from finance leases	**0**	0	**0**	0
Rental revenue from operating leases	**452**	410	**452**	410
Other revenue	**738**	1,100	**1,924**	3,571
Total Other Operating Revenue	**39,126**	38,495	**40,312**	40,966
Total operating revenue	**384,712**	376,050	**385,898**	378,521

The consolidated comparatives under other revenue include £939k for the Charity (2014-15 £634K) and net £247k for ENH Pharma (2014-15 £1,837k)

5. Overseas Visitors Disclosure

	2015-16 £000	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	**439**	236
Cash payments received in-year (re receivables at 31 March 2015)	**22**	15
Cash payments received in-year (iro invoices issued 2014-15)	**108**	88
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	**-**	-
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	**-**	124
Amounts written off in-year (irrespective of year of recognition)	**47**	264

6. Operating expenses

			Consolidated	
	2015-16 £000s	2014-15 £000s	**2015-16 £000s**	2014-15 £000s
Services from other NHS Trusts	**5,975**	4,746	**5,975**	4,746
Services from CCGs/NHS England	**-**	-	**-**	-
Services from other NHS bodies	**3**	196	**3**	196
Services from NHS Foundation Trusts	**11,579**	9,246	**11,579**	9,246
Total Services from NHS bodies	**17,557**	14,188	**17,557**	14,188
Purchase of healthcare from non-NHS bodies	**6,242**	5,325	**6,242**	5,325
Purchase of Social Care	**0**		**0**	
Trust Chair and Non-executive Directors	**59**	57	**59**	57
Supplies and services - clinical	**73,945**	71,066	**65,748**	71,066
Supplies and services - general	**12,701**	12,504	**12,701**	12,504
Consultancy services	**321**	692	**321**	692
Establishment	**5,981**	5,019	**5,981**	5,019
Transport	**519**	631	**519**	631
Service charges - ON-SOFP PFIs and other service concession arrangements	**100**	98	**100**	98
Business rates paid to local authorities	**1,746**	1,540	**1,746**	1,540
Premises	**15,012**	13,856	**15,012**	13,856
Impairments and Reversals of Receivables	**520**	221	**520**	221
Depreciation	**6,216**	6,312	**6,216**	6,312
Amortisation	**1,377**	1,049	**1,377**	1,049
Impairments and reversals of property, plant and equipment	**6,309**	19,297	**6,309**	19,297
Impairments and reversals of financial assets [by class]	**2,372**	-	**2,372**	-
Impairments and reversals of non current assets held for sale	**315**	-	**315**	-
Audit fees	**79**	130	**79**	130
Other auditor's remuneration - Quality Accounts and Independent Examination of Charity	**10**	12	**14**	12
Clinical negligence	**11,632**	7,505	**11,632**	7,505
Education and Training	**1,171**	907	**1,171**	907
Other	**1,860**	2,739	**10,698**	5,813
Total Operating expenses (excluding employee benefits)	**166,044**	163,148	**166,689**	166,222

The consolidated comparatives under other includes £841k for the Charity (2014-15 £1,259K) and £7,997k for ENH Pharma (2014-15 £1,815k). Supplies and Services- clinical have been reduced by £8,197k to account for intercompany sales with ENH Pharma

			Consolidated	
Employee Benefits				
Employee benefits excluding Board members	**241,036**	228,253	**241,596**	228,253
Board members	**1,217**	1,143	**1,217**	1,143
Total Employee Benefits	**242,253**	229,396	**242,813**	229,396

The consolidated results includes £345k (£319k 2014-15) for the Charity and £215k for ENH Pharma.

Total Operating Expenses	**408,297**	392,544	**409,502**	395,618

7. Operating Leases

The Trust's operating leases are in respect of medical equipment and motor vehicles.

7.1. East and North Hertfordshire NHS Trust as lessee

	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense			
Minimum lease payments	4,898	**4,898**	3,735
Total	**4,898**	**4,898**	3,735
Payable:			
No later than one year	4,565	**4,565**	4,021
Between one and five years	13,717	**13,717**	12,162
After five years	1,246	**1,246**	1,574
Total	**19,528**	**19,528**	17,757

7.2. East and North Hertfordshire NHS Trust as lessor

	2015-16 £000	2014-15 £000s
Recognised as revenue		
Rental revenue	452	410
Total	**452**	410
Receivable:		
No later than one year	307	46
Between one and five years	-	184
After five years	-	1,242
Total	**307**	1,472

Rental income included amounts received from ENH Pharma Limited for facilities at the Lister Hospital and the new QE2.

There was also income from The Pathology Partnership in respect of facilities at the old QE2, together with income from retail space, telephone masts and staff accommodation. The Trust is in the process of reviewing contracts therefore cannot provide estimates for more than one year

8. Employee benefits and staff numbers

8.1. Employee benefits

Employee Benefits - Gross Expenditure 2015-16	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**211,020**	170,704	40,316
Social security costs	**13,689**	13,689	-
Employer Contributions to NHS BSA - Pensions Division	**19,819**	19,819	-
Total employee benefits	**244,528**	**204,212**	**40,316**
Employee costs capitalised	**2,275**	2,275	-
Gross Employee Benefits excluding capitalised costs	**242,253**	**201,937**	**40,316**

Employee benefits- (Consolidated)

Employee Benefits - Gross Expenditure 2015-16	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**211,580**	171,264	40,316
Social security costs	**13,689**	13,689	-
Employer Contributions to NHS BSA - Pensions Division	**19,819**	19,819	-
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
Total employee benefits	**245,088**	**204,772**	**40,316**
Employee costs capitalised	**2,275**	2,275	-
Gross Employee Benefits excluding capitalised costs	**242,813**	**202,497**	**40,316**

Included in Employee benefits is £345k (2014-15 £319k) relating to the Charity and £215k relating to ENH Pharma

Employee Benefits - Gross Expenditure 2014-15	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	199,848	170,619	29,229
Social security costs	13,701	13,701	-
Employer Contributions to NHS BSA - Pensions Division	18,974	18,974	-
TOTAL - including capitalised costs	232,523	203,294	29,229
Employee costs capitalised	3,127	2,991	136
Gross Employee Benefits excluding capitalised costs	229,396	200,303	29,093

8.2. Staff Numbers

	2015-16 Total Number	Permanently employed Number	Other Number	2014-15 Total Number
Average Staff Numbers				
Medical and dental	**788**	729	59	720
Administration and estates	**1,417**	1,282	135	985
Healthcare assistants and other support staff	**775**	652	123	381
Nursing, midwifery and health visiting staff	**1,795**	1,515	280	2,279
Scientific, therapeutic and technical staff	**524**	473	51	601
Social Care Staff	**-**	-	-	-
Healthcare Science Staff	**-**	-	-	-
Other	**-**	-	-	3
TOTAL	**5,299**	**4,651**	**648**	4,969
Of the above - staff engaged on capital projects	**56**	56	0	44

8.3. Staff Sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	44,578	42,947
Total Staff Years	4,599	4,628
Average working Days Lost	10	9

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	**5**	7
	£000s	£000s
Total additional pensions liabilities accrued in the year	**136**	319

8.4. Exit Packages agreed in 2015-16

2015-16

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	-	-	-	-	-	-	-	-
£10,000-£25,000	-	-	-	-	-	-	-	-
£25,001-£50,000	-	-	-	-	-	-	-	-
£50,001-£100,000	-	-	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	-	-	-	-	-
>£200,000	-	-	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

2014-15

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed.	Total number of exit packages	Total cost of exit packages	Number of Departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	-	-	.....	.....	.....	.....	-	-
£10,000-£25,000	-	-	.....	.....	.....	.....	-	-
£25,001-£50,000	-	-	.....	.....	.....	.....	-	-
£50,001-£100,000	-	-	.....	.....	.....	.....	-	-
£100,001 - £150,000	-	-	-	-	-	-	-	-
£150,001 - £200,000	-	-	.....	.....	.....	.....	-	-
>£200,000	-	-	-	-	-	-	-	-
Total	**-**	**-**	**8**	**362,379**	**8**	**362,379**	**-**	**-**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS terms and conditions handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

In order to protect the confidentiality of individuals, numbers less than five are represented by "...".
The exit packages disclosed in respect of 2014-15 were related to the Our Changing Hospitals programme.

8.5. Exit packages - Other Departures analysis

	2015-16 Agreements	Total value of agreements	2014-15 Agreements	Total value of agreements
	Number	£000s	Number	£000s
Contractual payments in lieu of notice	-	-	8	362
Total	-	-	8	362
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 8.4 which will be the number of individuals.

8.6. 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 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 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.

9. Better Payment Practice Code

9.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**61,593**	**183,477**	63,961	162,741
Total Non-NHS Trade Invoices Paid Within Target	**27,261**	**73,309**	45,475	91,591
Percentage of NHS Trade Invoices Paid Within Target	**44.26%**	**39.96%**	71.10%	56.28%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,220**	**26,934**	2,827	**35,938**
Total NHS Trade Invoices Paid Within Target	**1,139**	**15,497**	1,559	**16,477**
Percentage of NHS Trade Invoices Paid Within Target	**51.31%**	**57.54%**	55.15%	45.85%

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, whichever is later.

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

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	**332**	77
Total	**332**	77

10. Investment Revenue

	2015-16 £000s	2014-15 £000s
Interest revenue		
Bank interest	**37**	26
Total investment revenue	**37**	26

11. Other Gains and Losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**10**	-
Gain (Loss) on disposal of assets held for sale	**4,143**	-
Total	**4,153**	-

12. Finance Costs

			Consolidated	
	2015-16 £000s	**2014-15 £000s**	2015-16 £000s	2014-15 £000s
Interest				
Interest on loans and overdrafts	**2217**	1,815	**2219**	1,815
Interest on obligations under PFI contracts:				
- main finance cost	**569**	590	**569**	590
- contingent finance cost	**290**	258	**290**	258
Interest on late payment of commercial debt	**332**	77	**332**	77
Total interest expense	**3,408**	2,740	**3,410**	2,740
other finance costs				
Provisions - unwinding of discount	**13**	18	**13**	18
Total	**3,421**	2,758	**3,423**	2,758

13.1. Property, plant and equipment

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments	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	£000's
Cost or valuation:									
At 1 April 2015	26,967	134,250	-	1,311	56,616	113	12,883	3,960	**236,100**
Additions of Assets Under Construction	-	-	-	-	-	-	-	-	**0**
Additions Purchased	0	4,492	-	-	1,835	-	-	-	**6,327**
Additions - Non Cash Donations (i.e. physical assets)	0	0	-	-	-	-	-	-	**0**
Additions Leased (including PFI/LIFT)	0	0	-	-	-	-	-	-	**0**
Reclassifications	0	1,311	-	(1,311)	-	-	-	-	**0**
Reclassifications as Held for Sale and reversals	637	0	-	-	-	-	-	-	**637**
Disposals other than for sale	0	0	-	-	(3,083)	(113)	-	-	**(3,196)**
Devaluation	0	(7,811)	-	-	-	-	-	-	**(7,811)**
Impairments/reversals charged to reserves	5,146	(105)	-	-	-	-	-	-	**5,041**
At 31 March 2016	**32,750**	**132,137**	**-**	**-**	**55,368**	**0**	**12,883**	**3,960**	**237,098**
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)	-	-	**(3,148)**
Devaluation	0	(8,578)	-	-	0	-	-	-	**(8,578)**
Impairments/reversals charged to operating expenses	0	6,309	-	-	0	-	-	-	**6,309**
Charged During the Year	0	2,128	-	-	3,037	-	881	170	**6,216**
At 31 March 2016	**0**	**2,191**	**-**	**-**	**41,506**	**-**	**11,052**	**3,039**	**57,788**
Net Book Value at 31 March 2016	**32,750**	**129,946**	**-**	**-**	**13,862**	**-**	**1,831**	**921**	**179,310**
Asset financing:									
Owned - Purchased	32,750	122,060	-	-	12,470	-	1,748	857	**169,885**
Owned - Donated	0	1,336	-	-	1,392	-	83	64	**2,875**
On-SOFP PFI contracts	0	6,550	-	-	0	-	-	-	**6,550**
PFI residual: interests	0	0	-	-	0	-	-	-	**0**
Total at 31 March 2016	**32,750**	**129,946**	**-**	**-**	**13,862**	**-**	**1,831**	**921**	**179,310**

Property, plant and equipment- Consolidated

2015-16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments	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	£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**
Additions Purchased	0	4,492	-	-	1,987	-	-	-	**6,479**
Additions - Non Cash Donations (i.e. physical assets)	0	0	-	-	-	-	-	-	**0**
Additions Leased (including PFI/LIFT)	0	0	-	-	-	-	-	-	**0**
Reclassifications	0	1,311	-	(1,311)	-	-	-	-	**0**
Reclassifications as Held for Sale and reversals	637	0	-	-	-	-	-	-	**637**
Disposals other than for sale	0	0	-	-	(3,083)	(113)	-	-	**(3,196)**
Devaluation	0	(7,811)	-	-	-	-	-	-	**(7,811)**
Impairments/reversals charged to reserves	5,146	(105)	-	-	-	-	-	-	**5,041**
At 31 March 2016	**32,750**	**132,137**	**-**	**-**	**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)	-	-	**(3,148)**
Devaluation	0	(8,578)	-	-	0	-	-	-	**(8,578)**
Impairments/reversals charged to operating expenses	0	6,309	-	-	0	-	-	-	**6,309**
Charged During the Year	0	2,128	-	-	3,048	-	881	170	**6,227**
At 31 March 2016	**0**	**2,191**	**-**	**-**	**41,517**	**-**	**11,052**	**3,039**	**57,799**
Net Book Value at 31 March 2016	**32,750**	**129,946**	**-**	**-**	**14,115**	**-**	**1,831**	**921**	**179,563**
Asset financing:									
Owned - Purchased	32,750	122,060	-	-	12,582	-	1,748	857	**169,997**
Owned - Donated	0	1,336	-	-	1,533	-	83	64	**3,016**
On-SOFP PFI contracts	0	6,550	-	-	0	-	-	-	**6,550**
PFI residual: interests	0	0	-	-	0	-	-	-	**0**
Total at 31 March 2016	**32,750**	**129,946**	**-**	**-**	**14,115**	**-**	**1,831**	**921**	**179,563**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's		£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2015	16,952	26,191	-	-	480	143	-	23	**43,789**
Movements (specify)	1,417	(115)	-	-	135	(143)	-	(14)	**1,280**
At 31 March 2016	**18,369**	**26,076**	**-**	**-**	**615**	**-**	**-**	**9**	**45,069**

13.2. Property, plant and equipment prior-year

Not relevant for trust

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments	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	£000's
Cost or valuation:									
At 1 April 2014	36,284	86,900	-	42,805	54,406	113	11,871	3,557	**235,936**
Additions of Assets Under Construction	-	-	-	11,390	-	-	-	-	**11,390**
Additions Purchased	268	10,138	-	-	2,599	-	1,113	412	**14,530**
Additions - Non Cash Donations (i.e. Physical Assets)	-	124	-	-	24	-	60	11	**219**
Reclassifications	-	52,157	-	(52,157)	0	-	-	-	**-**
Reclassifications as Held for Sale and Reversals	(11,913)	-	-	-	0	-	-	-	**(11,913)**
Disposals other than for sale	-	-	-	(728)	0	-	-	-	**(728)**
Revaluation	2,328	4,945	-	-	0	-	-	-	**7,273**
Impairments/negative indexation charged to reserves	-	(691)	-	-	0	-	-	-	**(691)**
At 31 March 2015	**26,967**	**153,573**	**-**	**1,310**	**57,029**	**113**	**13,044**	**3,980**	**256,016**
Depreciation									
At 1 April 2014	-	-	-	-	39,064	113	9,358	2,700	**51,235**
Impairments/negative indexation charged to operating expenses	-	19,293	-	-	4	-	-	-	**19,297**
Charged During the Year	-	2,360	-	-	2,849	-	914	189	**6,312**
At 31 March 2015	**-**	**21,653**	**-**	**-**	**41,917**	**113**	**10,272**	**2,889**	**76,844**
Net Book Value at 31 March 2015	**26,967**	**131,920**	**-**	**1,310**	**15,112**	**-**	**2,772**	**1,091**	**179,172**
Asset financing:									
Owned - Purchased	26,967	123,846	-	1,310	13,338	-	2,646	1,007	**169,114**
Owned - Donated	-	1,518	-	-	1,774	-	126	84	**3,502**
On-SOFP PFI contracts	-	6,556	-	-	-	-	-	-	**6,556**
PFI residual: interests	-	-	-	-	-	-	-	-	**-**
Total at 31 March 2015	**26,967**	**131,920**	**-**	**1,310**	**15,112**	**-**	**2,772**	**1,091**	**179,172**

Property, plant and equipment prior-year (Restated)

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments	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	£000's
Cost or valuation:									
At 1 April 2014	36,284	86,900	-	42,805	54,406	113	11,871	3,557	**235,936**
Additions of Assets Under Construction	-	-	-	11,390	-	-	-	-	**11,390**
Additions Purchased	268	10,138	-	-	2,186	-	952	392	**13,936**
Additions - Non Cash Donations (i.e. Physical Assets)	-	124	-	-	24	-	60	11	**219**
Reclassifications	-	52,157	-	(52,157)	0	-	-	-	**-**
Devaluation	0	(19,323)	-	-	0	-	-	-	**(19,323)**
Reclassifications as Held for Sale and Reversals	(11,913)	-	-	-	0	-	-	-	**(11,913)**
Disposals other than for sale	-	-	-	(727)	0	-	-	-	**(727)**
Revaluation	2,328	4,945	-	-	0	-	-	-	**7,273**
Impairments/negative indexation charged to reserves	-	(691)	-	-	0	-	-	-	**(691)**
At 31 March 2015	**26,967**	**134,250**	**-**	**1,311**	**56,616**	**113**	**12,883**	**3,960**	**236,100**
Depreciation									
At 1 April 2014	-	-	-	-	39,064	113	9,358	2,700	**51,235**
Devaluation	0	- 19,321.00	-	-	0	-	-	-	**(19,321)**
Impairments/negative indexation charged to operating expenses	-	19,293	-	-	0	-	-	-	**19,293**
Charged During the Year	-	2,360	-	-	2,440	-	813	169	**5,782**
At 31 March 2015	**-**	**2,332**	**-**	**-**	**41,504**	**113**	**10,171**	**2,869**	**56,989**
Net Book Value at 31 March 2015	**26,967**	**131,918**	**-**	**1,311**	**15,112**	**-**	**2,712**	**1,091**	**179,111**
Asset financing:									
Owned - Purchased	26,967	123,846	-	1,311	13,338	-	2,485	1,007	**168,954**
Owned - Donated	-	1,516	-	-	1,774	-	227	84	**3,601**
On-SOFP PFI contracts	-	6,556	-	-	-	-	-	-	**6,556**
PFI residual: interests	-	-	-	-	-	-	-	-	**-**
Total at 31 March 2015	**26,967**	**131,918**	**-**	**1,311**	**15,112**	**-**	**2,712**	**1,091**	**179,111**

Property, plant and equipment prior-year (Consolidated)

2014-15	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments	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	£000's
Cost or valuation:									
At 1 April 2014	36,284	86,900	-	42,805	54,406	113	11,871	3,557	**235,936**
Additions of Assets Under Construction	-	-	-	11,390	-	-	-	-	**11,390**
Additions Purchased	268	10,138	-	-	2,834	-	1,113	412	**14,765**
Additions - Non Cash Donations (i.e. Physical Assets)	-	124	-	-	24	-	60	11	**219**
Reclassifications	-	52,157	-	(52,157)	0	-	-	-	**-**
Reclassifications as Held for Sale and Reversals	(11,913)	-	-	-	0	-	-	-	**(11,913)**
Disposals other than for sale	-	-	-	(728)	0	-	-	-	**(728)**
Revaluation	2,328	4,945	-	-	0	-	-	-	**7,273**
Impairments/negative indexation charged to reserves	-	(691)	-	-	0	-	-	-	**(691)**
At 31 March 2015	**26,967**	**153,573**	**-**	**1,310**	**57,264**	**113**	**13,044**	**3,980**	**256,251**
Depreciation									
At 1 April 2014	-	-	-	-	39,064	113	9,358	2,700	**51,235**
Impairments/negative indexation charged to operating expenses	-	19,293	-	-	4	-	-	-	**19,297**
Charged During the Year	-	2,360	-	-	2,849	-	914	189	**6,312**
At 31 March 2015	**-**	**21,653**	**-**	**-**	**41,917**	**113**	**10,272**	**2,889**	**76,844**
Net Book Value at 31 March 2015	**26,967**	**131,920**	**-**	**1,310**	**15,347**	**-**	**2,772**	**1,091**	**179,407**
Asset financing:									
Owned - Purchased	26,967	123,846	-	1,310	13,338	-	2,646	1,007	**169,114**
Owned - Donated	-	1,518	-	-	2,009	-	126	84	**3,737**
On-SOFP PFI contracts	-	6,556	-	-	-	-	-	-	**6,556**
PFI residual: interests	-	-	-	-	-	-	-	-	**-**
Total at 31 March 2015	**26,967**	**131,920**	**-**	**1,310**	**15,347**	**-**	**2,772**	**1,091**	**179,407**

13.3. (cont). Property, plant and equipment

There were no donated assets received in 2015-16, however in 2014-15 donated assets amounting to £219k were received from East and North Hertfordshire NHS Trust Charitable Fund

The land and building assets held by the Trust were revalued in year using the modern equivalent assets valuation methodology, in accordance with DH guidance and International Financial Reporting Standards. The revaluation was carried out by an independent qualified valuer. The effective date for the valuation was 1st April 2015.

Basis for Valuation

The Trust has revalued its land and building assets during 2015, as at a valuation date of 1st April 2015, in line with HM Treasury adopted standard approach to valuation based on modern equivalent assets. The Trust has recorded the new values in the annual accounts for the year ending 31st March 2016.

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

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

In certain circumstances the Existing Use Value has been derived from comparable recent market transactions on arm's length terms. This has been in respect of non specialist properties.

Existing Use Value is defined in UKPS 1.3 of the Red Book and in undertaking the valuations our surveyors have applied the conceptual framework of Market Value, which is detailed in PS3.2 together with the supplementary commentary which is included in items 2-5 of UKPS 1.3. Under UKPS1.3 the term "Existing Use Value" is defined as follows:

"The estimated amount for which a property should exchange on the date of valuation between a willing buyer and a willing seller in an arm's length transaction, after proper marketing wherein the parties had acted knowledgeably, prudently and without compulsion, assuming that the buyer is granted vacant possession of all parts of the property required by the business and disregarding potential alternative uses and any other characteristics of the property that would cause its Market Value to differ from that needed to replace the remaining service potential at least cost."

Definition of MEA

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

The economic lives of tangible fixed assets range from:	**Min life (years)**	**Max life (years)**
Buildings exc dwellings	19	90
Plant & 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 their review on a MEA basis.

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

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

14. Intangible non-current assets

14.1. Intangible non-current assets (Consolidated)

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	**£000's**	**£000's**	**£000's**	**£000's**	**£000's**
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**
Asset Financing: 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**

14.2. Intangible non-current assets prior year

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	-	1,983	1,172	-	7,672	10,827
Additions - purchased	-	605	50	-	0	655
Additions - internally generated	-	0	0	-	2,074	2,074
At 31 March 2015	-	2,588	1,222	-	9,746	13,556
Amortisation						
At 1 April 2014	-	951	624	-	4,544	6,119
Charged during the year	-	208	152	-	689	1,049
At 31 March 2015	-	1,159	776	-	5,233	7,168
Net book value at 31 March 2015	-	1,429	446	-	4,513	6,388
Net book value at 31 March 2015 comprises:						
Purchased	-	1,370	446	-	4,513	6,329
Donated	-	59	0	-	0	59
Total at 31 March 2015	-	1,429	446	-	4,513	6,388

Intangible non-current assets prior year (Restated)

2014-15	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Total
	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:						
At 1 April 2014	-	1,983	1,172	-	7,672	10,827
Additions - purchased	-	667	45	-	0	712
Additions - internally generated	-	0	0	-	2,043	2,043
At 31 March 2015	-	2,650	1,217	-	9,715	13,582
Amortisation						
At 1 April 2014	-	951	624	-	4,544	6,119
Charged during the year	-	205	151	-	658	1,014
At 31 March 2015	-	1,156	775	-	5,202	7,133
Net book value at 31 March 2015	-	1,494	442	-	4,513	6,449
Net book value at 31 March 2015 comprises:						
Purchased	-	1,370	442	-	4,513	6,325
Donated	-	124	0	-	0	124
Total at 31 March 2015	-	1,494	442	-	4,513	6,449

The accounts for 2014-15 had an immaterial mis-stated split of property, plant and equipment and intangible assets. A restated Statement of Financial Position has been produced to reflect the change, the value of which was £61k.

14.3. Intangible non-current assets

The Trust accounts for intangible fixed assets in accordance with IAS 38. All intangible fixed assets with a value of over £5,000 are amortised on a quarterly basis over its economic useful life. The Trust does not consider that its intangible fixed assets have an active market, and therefore use book value as a prudent indicator of fair value intangible assets.

The Trust does not hold intangible fixed assets with an indefinite useful life.

The economic lives of intangible fixed assets range from:	**Min life (years)**	**Max life (years)**
Software purchased	3	8
Licences and trademarks	2	8
Development Expenditure	5	8

15. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	6,309
Total charged to Annually Managed Expenditure	**6,309**
Financial Assets charged to SoCI	
Other- Change in Market valuation	2,372
Total charged to Annually Managed Expenditure	**2,372**
Total Impairments of Financial Assets charged to SoCI	**2,372**
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Other- Changes in market price	315
Total charged to Annually Managed Expenditure	**315**
Total Impairments charged to SoCI - DEL	**-**
Total Impairments charged to SoCI - AME	**8,996**
Overall Total Impairments	**8,996**

The impairments detailed above are in relation to the revaluation of the Trust's estate £6,624K and change in value of its investment in tPP £2,372k.

15. Analysis of impairments and reversals recognised in 2015-16

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	**£000s**
Impairments and reversals taken to SoCI	-	-	-	-	**-**
Loss or damage resulting from normal operations	-	-	-	-	**-**
Over-specification of assets	-	-	-	-	**-**
Abandonment of assets in the course of construction	-	-	-	-	**-**
Total charged to Departmental Expenditure Limit	**-**	**-**	**-**	**-**	**-**
	-	-	-	-	
Unforeseen obsolescence	-	-	-	-	**-**
Loss as a result of catastrophe	-	-	-	-	**-**
Other	-	-	-	-	**-**
Changes in market price	6,309	-	2,372	315	**8,996**
Total charged to Annually Managed Expenditure	**6,309**	**-**	**2,372**	**315**	**8,996**
Total Impairments of Property, Plant and Equipment changed to SoCI	**6,309**	**-**	**2,372**	**315**	**8,996**

16. Commitments

16.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	**50**	1,110
Total	**50**	1,110

17. Intra-Government and other balances

Not required under the FReM

18. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**1,616**	**2,464**	**-**	**164**	**-**	**-**	**4,244**	-
Additions	41,297	33,892	-	4	-	-	**75,193**	-
Inventories recognised as an expense in the period	(40,992)	(33,173)	-	(8)	-	-	**(74,173)**	-
Balance at 31 March 2016	**1,921**	**3,183**	**-**	**160**	**-**	**-**	**5,264**	**-**

Inventories- Consolidated

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**2,025**	**2,464**	**-**	**164**	**-**	**-**	**4,653**	-
Additions	41,630	33,892	-	4	-	-	**75,526**	-
Inventories recognised as an expense in the	(40,992)	(33,173)	-	(8)	-	-	**(74,173)**	-
Balance at 31 March 2016	**2,663**	**3,183**	**-**	**160**	**-**	**-**	**6,006**	**-**

Included under drugs is £742k (2014-15 409k) relating to ENH Pharma

19.1. Trade and other receivables

	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**16,174**	10,221	**-**	-
NHS receivables - capital	**-**	-	**-**	-
NHS prepayments and accrued income	**1,870**	7,988	**-**	-
Non-NHS receivables - revenue	**5,696**	7,619	**-**	-
Non-NHS prepayments and accrued income	**10,222**	8,998	**1,256**	-
PDC Dividend prepaid to DH	**630**	110	**-**	**-**
Provision for the impairment of receivables	**(1,002)**	(632)	**(368)**	(267)
VAT	**2,183**	1,781	**-**	-
Other receivables	**5,740**	4,640	**1,674**	1,619
Total	**41,513**	40,725	**2,562**	1,352
Total current and non current	**44,075**	42,077		

Trade and other receivables- Consolidated

	Current		Non-current	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000s	£000s	£000s	£000s
NHS receivables - revenue	**16,174**	10,221	**-**	-
NHS receivables - capital	**-**	-	**-**	-
NHS prepayments and accrued income	**1,870**	7,988	**-**	-
Non-NHS receivables - revenue	**5,696**	7,619	**-**	-
Non-NHS prepayments and accrued income	**10,222**	8,998	**1,256**	-
PDC Dividend prepaid to DH	**630**	110	**-**	**-**
Provision for the impairment of receivables	**(1,002)**	(632)	**(368)**	(267)
VAT	**2,183**	1,781	**-**	-
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Other receivables	**6,321**	5,562	**1,674**	1,619
Total	**42,094**	41,647	**2,562**	1,352
Total current and non current	**44,656**	42,999		

Included in other receivables is £1,239k relating to ENH Pharma (2014-15 1,218k). As a result of consolidating the Charity other receivables decreased by £658k

The great majority of trade is with Clinical Commissioning Groups (CCG's) . As CCG's 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 2016 £000s	31 March 2015 £000s
By up to three months	**4,328**	5,653
By three to six months	**1,961**	2,011
By more than six months	**2,791**	3,107
Total	**9,080**	10,771

19.3. Provision for impairment of receivables

	2015-16 £000s	2014-15 £000s
Balance at 1 April 2015	**(899)**	(841)
Amount written off during the year	**49**	163
(Increase)/decrease in receivables impaired	**(520)**	(221)
Balance at 31 March 2016	**(1,370)**	(899)

The provision for impairment of receivables is calculated based on the likelihood of recovery. As such all non-NHS debt has been analysed at invoice level and all overseas patient debt more than a year old not on a repayment plan has been provided for. Also within the figures quoted includes a provision relating to the NHS Injury cost recovery scheme to reflect the risk of write offs over a significant period, this has been increased from 16.5% to 21.99% as per Department of Health guidance of total receivables under this category this financial year.

20.1. Other Financial Assets - Non Current

	31 March 2016 £000s	31 March 2015 £000s
Opening balance 1 April	**2,293**	-
Additions	**2,584**	2,293
Impairment/reversals taken to SoCI	**(2,372)**	-
Total Other Financial Assets - Non Current	**2,505**	2,293

21. Cash and Cash Equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**600**	4,289
Net change in year	**15,263**	(3,689)
Closing balance	**15,863**	600
Made up of		
Cash with Government Banking Service	**15,813**	579
Commercial banks	**41**	12
Cash in hand	**9**	9
Liquid deposits with NLF	**0**	0
Current investments	**-**	0
Cash and cash equivalents as in statement of financial position	**15,863**	600
Bank overdraft - Government Banking Service	**-**	-
Bank overdraft - Commercial banks	**-**	-
Cash and cash equivalents as in statement of cash flows	**15,863**	600

Cash and Cash Equivalents - Consolidated

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	**1,583**	4,741
Net change in year	**15,933**	(3,158)
Closing balance	**17,516**	1,583
Made up of		
Cash with Government Banking Service	**15,813**	579
Commercial banks	**1,694**	530
Cash in hand	**9**	9
Liquid deposits with NLF	**0**	0
Current investments	**-**	465
Cash and cash equivalents as in statement of financial position	**17,516**	1,583
Bank overdraft - Government Banking Service	**-**	-
Bank overdraft - Commercial banks	**-**	-
Cash and cash equivalents as in statement of cash flows	**17,516**	1,583
Third Party Assets - Bank balance (not included above)	**0**	0
Third Party Assets - Monies on deposit	0	0

Included under commercial banks is £817k relating to the Charity (2014-15 £465k as a current investment) and £836k relating to ENH Pharma (2014-15 £518k).

22. Non-current assets held for sale

	Land	Total
	£000s	£000s
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**
Balance at 1 April 2014	-	**0**
Plus assets classified as held for sale in the year	11,913	**11,913**
Balance at 31 March 2015	**11,913**	**11,913**
Liabilities associated with assets held for sale at 31 March 2015	-	-

The asset held for sale valued at £11,913k at the beginning of 2014-15 was land at the former QE2 Hospital at Welwyn Garden City. Most of the land was sold during 2015-16 with the remaining land valued at £1,700k due to be sold during 2016-17.

23. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**8,905**	963	**-**	-
NHS payables - capital	**-**	-	**-**	-
NHS accruals and deferred income	**4,137**	8,047	**-**	-
Non-NHS payables - revenue	**16,383**	20,538	**-**	-
Non-NHS payables - capital	**825**	1,058	**-**	-
Non-NHS accruals and deferred income	**27,616**	22,517	**-**	-
Social security costs	**1,819**	1,876	**-**	**-**
Accrued Interest on DH Loans	**76**	-	**-**	**-**
Tax	**2,334**	2,360	**-**	**-**
Other	**3,278**	2,710	**-**	-
Total	**65,373**	60,069	**-**	-
Total payables (current and non-current)	**65,373**	**60,069**		

Trade and other payables- Consolidated

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
NHS payables - revenue	**8,905**	963	**-**	-
NHS payables - capital	**-**	-	**-**	-
NHS accruals and deferred income	**4,137**	8,047	**-**	-
Non-NHS payables - revenue	**16,383**	20,538	**-**	-
Non-NHS payables - capital	**825**	1,058	**-**	-
Non-NHS accruals and deferred income	**27,616**	22,517	**-**	-
Social security costs	**1,819**	1,876	**-**	**-**
Accrued Interest on DH Loans	**76**	-	**-**	**-**
Tax	**2,334**	2,360	**-**	**-**
Other	**5,110**	4,134	**-**	-
Total	**67,205**	61,493	**-**	-
Total payables (current and non-current)	**67,205**	**61,493**		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	**0**	0		
number of Cases Involved	**0**	0		
outstanding Pension Contributions at the year end	**2,862**	2,776		

Included under other is net £5k for the Charity (2014-15 net 63k) and net £1,827k relating to ENH Pharma (2014-15 £1,361k).

24. Other liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
PFI/LIFT deferred credit	**-**	-	**-**	-
Lease incentives	**-**	-	**-**	-
Other	**203**	203	**5,015**	5,218
Total	**203**	203	**5,015**	5,218
Total other liabilities (current and non-current)	**5,218**	**5,421**		

The "Other" liabilities relates to the inclusion of the Lister Hospital multi storey car park in the assets of the Trust.
The car park has been funded through a private/public partnership arrangement. The liabilites relating to the car park asset will be amortised over a 30 year period at the end of which ownership will transfer to the Trust.
The liability relating to the car park is split between other liabilities and other financial liabilities (Note 26).

25. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Loans from Department of Health	**8,493**	8,488	**79,356**	53,580
PFI liabilities:				
Main liability	**289**	307	**7,115**	7,404
LIFT liabilities:				
Total	**8,782**	**8,795**	**86,471**	**60,984**
Total borrowings (current and non-current)	**95,253**	**69,779**		

Borrowings / Loans - repayment of principal falling due in:

		31 March 2016	
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	8,493	289	**8,782**
1 - 2 Years	2,588	356	**2,944**
2 - 5 Years	36,133	767	**36,900**
Over 5 Years	40,635	5,992	**46,627**
TOTAL	**87,849**	**7,404**	**95,253**

26. Other financial liabilities

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Financial liabilities carried at fair value through profit and loss	**150**	145	**2595**	2745
Total	**150**	145	**2,595**	2,745
Total other financial liabilities (current and non-current)	**2,745**	2,890		

27. Deferred income- Restated

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**6,842**	5,353	**-**	-
Deferred revenue addition	**-**	1,489	**-**	-
Transfer of deferred revenue	**(1,462)**	-	**-**	-
Current deferred Income at 31 March 2016	**5,380**	6,842	**-**	-
Total deferred income (current and non-current)	**5,380**	6,842		

Other liabilities disclosed on the face of the Statement of Financial Position were inadvertently included as deferred income in 2014-15. The note for 2015-16 has been restated accordingly.

Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	**31 March 2016 £000s**	31 March 2015 £000s
Opening balance at 1 April 2015	**6,842**	5,353	**5,218**	5,420
Deferred revenue addition	**-**	1,489	**-**	-
Transfer of deferred revenue	**-**	-	**-**	(202)
Current deferred Income at 31 March 2016	**6,842**	6,842	**5,218**	5,218
Total deferred income (current and non-current)	**12,060**	12,060		

28. Finance lease obligations as lessee

The Trust has no finance lease obligations as lessee

29. Finance lease receivables as lessor

The Trust has no finance lease obligations as lessor

30. Provisions

		Comprising:		
	Total	**Early Departure Costs**	**Legal Claims**	**Other**
	£000s	**£000s**	**£000s**	**£000s**
Balance at 1 April 2015	**1,115**	937	65	113
Arising during the year	**36**	9	27	-
Utilised during the year	**(106)**	(106)	-	-
Reversed unused	**-**	-	-	-
Unwinding of discount	**13**	13	-	-
Change in discount rate	**-**	-	-	-
Transfers to NHS Foundation Trusts on being authorised as FT	**-**	-	-	-
Transfers (to)/from other public sector bodies under absorption accounting	**-**	-	-	-
Balance at 31 March 2016	**1,058**	**853**	**92**	**113**
Expected Timing of Cash Flows:				
No Later than One Year	**288**	83	92	113
Later than One Year and not later than Five Years	**331**	331	-	-
Later than Five Years	**439**	439	-	-

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016	215,985
As at 31 March 2015	100,885

Early Departure costs relating to other staff: This provision is for the constructive obligation with the NHS Pensions Agency relating to staff that have retired early. The obligation is assessed using information provided by the Pensions Agency on pension enhancement and an assessment of expected lives using Government Actuary Department tables. The Trust is invoiced quarterly to reflect payments made on behalf of the trust by the Pension agency, this cost is charged to the provision.
Other provisions relate to Carbon Tax (£75,000) and the Lease Car scheme (£38,000).
Discount rate applied above for unwinding discount was 1.37%

31. Contingencies

	31 March 2016	31 March 2015
	£000s	£000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(62)**	-
Employment Tribunal and other employee related litigation	**-**	-
Redundancy	**-**	-
Other	**-**	(34)
Net value of contingent liabilities	**(62)**	(34)
Contingent assets		
Contingent assets	**-**	-
Net value of contingent assets	**-**	-

The net contingent liability relates to Litigation Authority Third Parties Scheme. The value is calculated by NHS Litigation Authority on a claim by claim basis and communicated to the Trust via an annual report.

32. PFI and LIFT - additional information

The Trust has one PFI scheme which relates to Hertford County Hospital. The hospital largely provides outpatient and therapy services to the local community. The facility became operational on 1st November 2004 with a contract period of 28.5 years. The contract is due to end on 31st March 2033.

The contract is paid in the form of an annual unitary charge that covers repayment of capital, cost of financing and service costs. The future commitment of the elements of the charge at 31st March 2016 are as follows:

	£000s
Capital	7,404
Lifecycle replacement cost	4,042
Interest	5,834
Contingent rental	9,002
Service	2,163

The Lessor is obligated to maintain Hertford County Hospital for the period of the contract. Lifecycle capital replacement costs are incurred by the Lessor as part of required routine maintenance; these costs are part of the annual unitary charge which is charged in monthly instalments. This element is subsequently capitalised as a capital enhancement of the asset in the year the costs are incurred.

The contingent rental costs relate to the effect of inflation on the finance charge over the period of the contract. The cost is charged annually to the Statement of Comprehensive Net Income under finance costs.

The Trust is financially committed to the PFI scheme for the term of the contract stated above.

The terms of the contract are such that the asset becomes a Trust property at the end of the PFI contract period. The fair value of the asset will be reviewed annually to ensure carrying values are appropriately recorded.

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2015-16 £000s	2014-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	**-**	-
Service element of on SOFP PFI charged to operating expenses in year	**100**	98
Total	**100**	98

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

No Later than One Year	**103**	100
Later than One Year, No Later than Five Years	**437**	427
Later than Five Years	**1,623**	1,736
Total	**2,163**	2,263

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2015-16 £000s	2014-15 £000s
No Later than One Year	**835**	876
Later than One Year, No Later than Five Years	**3,080**	3,236
Later than Five Years	**9,322**	10,002
Subtotal	**13,237**	14,114
Less: Interest Element	**(5,833)**	(6,403)
Total	**7,404**	7,711

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	**2015-16 £000s**	2014-15 £000s
No Later than One Year	**289**	307
Later than One Year, No Later than Five Years	**1,123**	1,191
Later than Five Years	**5,992**	6,213
Total	**7,404**	7,711

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**

Number of off SOFP PFI Contracts

Total Number of off PFI contracts	**0**
Number of off PFI contracts which individually have a total commitments value in excess of £500m	**0**

33. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	**2015-16 Income £000s**	**Expenditure £000s**	2014-15 Income £000s	Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges	-	90	-	87
Interest Expense	-	569	-	848
Impairment charge - AME	-	-	-	-
Impairment charge - DEL	-	-	-	-
Other Expenditure	-	442	-	98
Revenue Receivable from subleasing	-	-	-	-
Impact on PDC dividend payable	-	-	-	-
Total IFRS Expenditure (IFRIC12)	**-**	**1,101**	**-**	**1,033**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)	-	1,383	-	1,370
Net IFRS change (IFRIC12)	**-**	**(282)**	**-**	**(337)**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		**52**		64

	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	**90**	-
Interest Expense	**569**	-
Impairment charge - AME	**0**	-
Impairment charge - DEL	**0**	-
Other Expenditure		
Service Charge	**100**	1,383
Contingent Rent	**290**	-
Lifecycle	**52**	-
Impact on PDC Dividend Payable	**0**	-
Total Revenue Cost under IFRIC12 vs ESA10	**1,101**	**1,383**
Revenue Receivable from subleasing	**0**	**0**
Net Revenue Cost/(income) under IDRIC12 vs ESA10	**1,101**	**1,383**

34. Financial Instruments

34.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Trust Development Agency. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, it has low exposure to credit risk. The maximum exposures as at 31 March 2016 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 has funded its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

34.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	-	-	-	**-**
Receivables - NHS	-	18,162	-	**18,162**
Receivables - non-NHS	-	7,044	-	**7,044**
Cash at bank and in hand	-	15,868	-	**15,868**
Other financial assets	-	-	-	**-**
Total at 31 March 2016	**-**	**41,074**	**-**	**41,074**
Embedded derivatives	-	-	-	-
Receivables - NHS	-	17,662	-	17,662
Receivables - non-NHS	-	8,791	-	8,791
Cash at bank and in hand	-	600	-	600
Other financial assets	-	-	-	-
Total at 31 March 2015	-	27,053	-	27,053

34.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	-	-	**-**
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**
Embedded derivatives	-	-	-
NHS payables	-	5,756	5,756
Non-NHS payables	-	39,305	39,305
Other borrowings	-	62,068	62,068
PFI & finance lease obligations	-	7,711	7,711
Other financial liabilities	-	8,311	8,311
Total at 31 March 2015	-	123,151	123,151

35. Events after the end of the reporting period

There are no non-adjusting events after that the reporting period that require disclosure

36. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the East and North Hertfordshire NHS Trust.

The Department of Health is regarded as a related party. During the year the East and North Hertfordshire NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

The most significant related parties in any one category are listed below:

	Income £000s	Expenditure £000s	Debtors £000s	Creditors £000s
East and North Hertfordshire CCG	211,729	2,921	3,381	3,311
NHS England	89,965	17	3,743	13
Health Education England	12,071	38	459	34
The Hillingdon Hospital NHS Foundation Trust	232	9,187	202	2,575
HMRC	-	13,689	-	4,153
NHS Pension Scheme	-	19,819	-	2,861
NHS Litigation Authority	-	11,632	-	-
Bedfordshire CCG	21,114	-	183	-
Herts Valley CCG	14,238	-	143	651
NHS Professionals	-	34,875	-	-

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 2016 £679k was owed to the Trust by the Charity. There were also transactions between the Trust and its subsidiary company, ENH Pharma Limited, which were carried out on a strict commercial footing.

Transactions with ENH Pharma Limited (Subsidiary company)	£ 2015-16	£ 2014-15
Sales to parent company	903,690	470,100
Purchases from subsidiary company	8,197,241	1,729,602
Amounts due from subsidiary company	1,026,910	113,938
Amounts owed to subsidiary company	0	283,371

37. Losses and special payments

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	6,416	38
Total losses and special payments	55,708	179

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	217,435	162
Special payments	11,027	36
Total losses and special payments	228,462	198

38. 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.

38.1. 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
Turnover	270,257	286,332	309,074	331,312	340,309	346,402	350,543	365,313	376,050	**384,712**
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)**
Adjustment for:										
Adjustments for impairments	-	-	-	21,758	1,906	88	12,658	781	19,297	**8,996**
Adjustments for impact of policy change re donated/government grants assets	-	-	-	-	-	287	290	(414)	(254)	**472**
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*	-	-	-	(38)	(37)	-	-	-	-	**-**
Absorption accounting adjustment				-	-	-	-	(22,411)	-	**-**
Other agreed adjustments	22,379	-	-	-	-	-	**-**	-	-	**-**
Break-even in-year position	**20,852**	**2,003**	**2,070**	**2,500**	**3,328**	**3,568**	**532**	**109**	**(3,613)**	**(16,226)**
Break-even cumulative position	**(2,248)**	**(245)**	**1,825**	**4,325**	**7,653**	**11,221**	**11,753**	**11,862**	**8,249**	**(7,977)**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, the 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 %
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**
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**

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

38.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual average relevant net assets based on the accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

38.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	**10,740**	16,585
Cash flow financing	**10,245**	16,556
Finance leases taken out in the year	**-**	-
Other capital receipts	**-**	-
External financing requirement	**10,245**	16,556
Under/(over) spend against EFL	**495**	29

38.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	**9,746**	28,648
Less: book value of assets disposed of	**(9,309)**	-
Less: capital grants	**-**	-
Less: donations towards the acquisition of non-current assets	**-**	(549)
Charge against the capital resource limit	**437**	28,099
Capital resource limit	**692**	28,100
(Over)/underspend against the capital resource limit	**255**	1