

**Annual
Report
2024-25**



**East and North
Hertfordshire Teaching**
NHS Trust

Annual Report and Accounts 2024-25



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Performance Report

Introduction

Hello, my name is Anita Day, and I am proud to be the chair of East and North Hertfordshire Teaching NHS Trust.

Welcome to the Trust's annual report and accounts for 2024-25.

Firstly, I would like to thank all who work for the Trust, for all that you have done over the last year.

Working together for patients

As we move into what will be a challenging year for the NHS, working in partnership with others will be ever more important as we continue to strive for safe, effective and timely care for all of our communities.

Our achievement in attaining Teaching Trust status is a recognition of our investment in our people and future workforce, and we look forward to working even more closely with the University of Hertfordshire as they open their new medical school next year.

Our work as the lead on a local provider collaborative continues, strengthening links between our local trusts and looking at how to ensure our services are as seamless as possible for our patients, and future-proofing them to ensure sustainability.

And we continue to work closely as part of the Hertfordshire and West Essex Integrated Care Board and the East and North Hertfordshire Health and Care Partnership, to improve provision for our communities – particularly in areas such as frailty, hypertension, care closer to home, and paediatric audiology and community services.

Thank you for your continued support

Very generous donations and fundraising events mean the hospitals' charity has supported us to provide enhanced services and care to our patients, and to better support our staff.

The inaugural Hertfordshire Residential Development Awards took place in November, at a glittering event organised by our charity. The black-tie event was hosted by architect and television presenter, Damion Burrows, with special guests Saracens and England rugby players, Rosie Galligan and Marlie Packer. Raising over £50,000 for the charity, it's set to take place again later in 2025.

And the ever-popular annual Lister Abseil took place in March in glorious sunshine and raised £43k. 101 people took part including Steve Simper, a former NHS senior manager who is registered blind. Freeman, his trusted guide dog, waited at the bottom as Steve abseiled down the iconic 11-storey Lister tower block.

These are just two of the events that our fantastic charity team have organised over the last year – thank you for your continued support.



Just two of the many enhancements that your generous donations have enabled are:

- Therapy ponies visiting Lister Hospital every three weeks to bring joy and smiles to patients, visitors and staff. The therapy ponies boost wellbeing, lower stress and are a highlight in the day for anyone who sees them.
- A wound care simulator for dark skin to be used by the tissue viability team alongside their light skin model – ensuring we give the very best care to all members of our diverse community. The model will be used to teach pressure ulcer identification and wound care and show that patients with dark skin tone might present differently to those with light skin tone.



Thank you

I would also like to say a huge thank you to all of our volunteers who provide invaluable support in giving their time. Our volunteers carry out such a wide range of roles in the Trust it is impossible to list them all – from our award-winning Butterfly Service for those at the end of their life, to our newest volunteer Forget-Me-Not service which works with patients with dementia, and all the roles supporting our patients with wayfinding, eating support and in so many other ways.

Our Board

I'd like to thank our Board for their work in the last year – including those who have recently stood down, and to welcome new members.

A number of new non-executive directors joined the Trust, bringing a breadth of experience and expertise: Gillian Hooper, Janet Scotcher, Diana Skeete and Richard Oosterom. And Tichafara Phiri joined us as a NExT non-executive director.

More recently, Zoe Aslanpour officially joined the Board on 1 April as our non-executive director representing the University of Hertfordshire.

Welcome all. And thank you to Val Moore, Peter Carter, and Jonathan Silver for your service as non-executive directors.



Anita Day
Chair
29 June 2025

Performance Overview

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

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

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

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

Chief Executive's Statement

Firstly, I would like to thank everyone who works at the Trust for your continued hard work and commitment in the last year – including those from our partner and contracted organisations, and our students.

In April the Trust was moved from the NHS Oversight Framework segment 3 to segment 2. This is a great achievement by all involved and reflects the fantastic progress we have made in the last year on:

- The Trust's successful exit from the National Maternity Safety Support Programme
- Strong and improving performance in RTT 18-week targets – the best in the region and among the top quartile nationally
- A reduction in RTT 65-week waits
- Consistent delivery against the Cancer 62-day and Faster Diagnosis Standard targets
- Strong financial performance and leadership within the system.

Our Trust goals focus around 4 themes of quality, thriving people, seamless services and continuous improvement.

Quality

The Trust continues to put quality at the heart of its work.

In August the Trust was selected as one of the first trusts to implement Martha's Rule – a new patient safety initiative in hospitals. The Trust has a similar scheme in place since September 2023, Call 4 Concern, and Martha's Rule will build on this service allowing patients and families to contact the Critical Care Outreach Team if they have any concerns about patients deteriorating.

Our Lister Urgent Treatment Centre opened in January 2024 to adults, and in September it opened to children over 1 who need prompt urgent care but don't need to attend the emergency department.



Across the year we have met all our cancer access standards – meaning patients are accessing dedicated cancer care in a timely way.

We recognise the need for improvement in the Trust outpatient service, including process changes to the booking and phone systems as highlighted by patient feedback. An improvement programme is underway, which has already seen increased attendances per clinic, fewer patients not turning up, and a reduction in waiting lists. Further improvements are planned including streamlining the booking process for patients and staff.

People

The Trust is incredibly proud of the results of the 2024 NHS staff survey, which shows us to be the 4th most improved trust in England. There were improvements in all 9 of the NHS People Promises, 8 of them significant – and more people than ever said that they would recommend the trust as a place to work.

The Trust has continued to work on the development of line managers in the Trust (clinical and non-clinical) to equip them with the knowledge and skills to thrive and lead. So far 133 managers have enrolled on the training.



Our staff awards last year were our biggest since COVID, and generously funded by sponsors through the hospitals' charity. Over 400 staff attended and were rewarded in 13 categories including one nominated by the public.

Our Values into Practice awards also recognised 36 winners who have demonstrated their commitment to our values of include, respect and improve.

The Trust has also achieved recognition in external awards including the HSJ awards for chemotherapy at home, the healthcare security team of the year, for innovation by our people team, finance team of the year, recognition for our end-of-life care, and many other individual clinical recognitions.

We are pleased to support our staff who have links to the armed forces – either through previous service, reservists or forces families, and this has been recognised with us being re-awarded the Armed Forces Covenant Gold Award.

And finally, in March we had confirmation that our Trust would be recognised as a teaching trust – and would now be known as East and North Hertfordshire Teaching NHS Trust. This is testament to the quality and breadth of our teaching in many professions. Well done to all involved.



Seamless Services

We continue to work ever more closely with our NHS and wider partners in the local and regional areas.

At the end of March we launched the Herts and West Essex Vascular Network – the culmination of years in planning. This includes a hub and spoke model, creating a centre of excellence for vascular surgery around our brand new hybrid vascular theatre at Lister, and working with surgeons from both The Princess Alexandra Hospitals and West Hertfordshire Teaching Hospitals NHS Trusts.



March also saw us move to a system-wide supplier for pathology services – with the transfer of pathology services at the same three hospitals transferring to a new supplier Health Services Laboratories (HSL). This will see efficiencies and economies of scale for our communities.

Making progress on our elective care waiting lists remains a priority – and I was asked to lead the NHS England East of England learning improvement network on elective care.

In April 2025, the Trust was asked to be host provider in the east and north Hertfordshire area, so will play an even greater role in leading the provision of services in local area.

And finally, we continue to improve in our urgent and emergency care. March 2025 saw the best performance since June 2021, with 73.8% of people being treated, admitted or discharged within 4 hours. Our focus this year will be on improving this further to meet the needs of our emergency patients.

Continuous Improvement

Our ENH Production System (ENHPS) continues to roll out across the Trust, with 735 people having attended the Introduction to ENHPS course, and 2 rapid process improvement weeks (RPIWs) taking place and having demonstrable, sustainable impact. Two cohorts have completed the ENHPS for Leaders course which will enable this to roll out to further teams and have real benefit.

We have made great strides in digital improvements in the past year, including increasing the number of our services on the Patient Hub app and reducing the number of paper letters, moving to a digital pager system called Alertive, and launching our new OneEPR programme which aims to bring all systems in the Trust together reducing waste for both clinicians and patients, and reducing reliance on paper records.

Our progress on sustainability continues – with a recent grant of £2.1m to install more solar panels at Lister Hospital, reducing our carbon emissions and saving money.

Areas of further improvement this year will be on improving diagnostic performance, and reducing long waits in our emergency department.

And while we have seen great improvement in our staff survey results, we will continue to focus on making our Trust the best place to work – with engaged staff delivering safe, compassionate and timely care.



Adam Sewell-Jones
Chief Executive

29 June 2025

About the Trust

East and North Hertfordshire NHS Trust was created in April 2000, following the merger of two former NHS Trusts serving the east and north Hertfordshire areas. Today, the Trust provides a wide range of acute and tertiary care services from four hospitals, namely: the Lister in Stevenage; the New Queen Elizabeth Hospital II (QEII) in Welwyn Garden City; Hertford County in Hertford; and the Mount Vernon Cancer Centre in Northwood, within the London Borough of Hillingdon.

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

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



The area served by the Trust for acute hospital care covers a population of just over 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some three million people from across Hertfordshire, Bedfordshire, Luton, north-west London and parts of the Thames Valley. The Trust's main catchment is a mixture of urban and rural areas that are in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City.

From mid-2021 to mid-2023 the Trust saw a gradual two year upward trend in both Hospital Standard Mortality Rate and Summary Hospital Mortality Indicator mortality rates, followed by a strong downturn until mid-2024, since when both metrics have been on a stable level trend. While these trends have been mirrored nationally, the Trust has consistently remained well positioned, tracking below both national peer and our Model Hospital recommended peer group.

The birth rate is slightly lower than the England average, with the Trust's core catchment population forecast to rise by approximately 6% in the years to 2030; the most significant growth is expected in people aged 65 and over (25%) with this age group also more likely to have the greatest impact in terms of health needs. Black and minority ethnic groups (i.e. non-white British) make up approximately 10% of the population in east and north Hertfordshire. In addition, it is expected that just approximately 17,000 new houses are planned to be built in the Trust's core catchment area by 2030, in addition to plans to build a 72 bed care home in the Stevenage area.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 7,100 staff are employed by the Trust. The Trust's annual turnover is approximately £717 million.



Organisational Structure

The Trust has a divisional clinical operational structure. During 2024, services were reorganised to establish Care Groups within the four Divisions, each with clear triumvirate leadership.

- **Planned Care:** Surgery, Theatres Anaesthetics & Critical Care, Diagnostics & Ambulatory Care

- **Unplanned Care:** Urgent & Emergency Care, Acute Care, Chronic Conditions
- **Women and Children:** Women's Services, Children's Services
- **Cancer:** Lister Cancer Services, Mount Vernon Cancer Services

Supporting the clinical divisions are corporate teams including: finance and planning; digital; medical practice; education and research; nursing practice; risk management; estates and facilities; improvement and workforce and organisational development.

Hertfordshire and West Essex ICS

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

Through the work of the HCP, the Trust is involved in projects to ensure that services and care are co-ordinated and integrated for our local population, which includes the development of a community heart failure service to support people to be cared for safely within the community.

The Trust is also working with other hospitals within the ICS to deliver care for our patients, including collaboration to create a vascular hub on the Lister site.

Further information can be found on the ICS's website: <https://hertsandwestessexics.org.uk/>

Strategy overview and annual goal setting

The NHS and the Trust have been through a huge number of changes in recent years and against this backdrop, it felt right to redefine our vision to guide our work in the years ahead. This process was completed in 2023 and set out our new vision "to be trusted to provide consistently outstanding care and exemplary service" with our values defining how we achieve this: by including, respecting and improving.

Working alongside our improvement partner, the Virginia Mason Institute, we have applied their learning and successful deployment of strategic alignment to develop a process for agreeing and cascading our annual strategic goals, so they point the way for everyone in the organisation, at every level. Without this structure, departments and teams would function in silos, rather than a cooperative whole and teams would struggle to engage, because they would lack motivation or accountability to a clear and meaningful purpose.

The prioritisation of a few key goals is vital, as if everything is considered important in an organisation, nothing will get finished. It was therefore important to narrow the focus and engage teams in order that all our efforts are directed toward the highest priority goals. 'Catch ball' is an approach for involving the wider senior leadership team in this process, actively asking for feedback and input creating a two-way communication loop. To make the strategic plan as meaningful and purposeful as it can be, it is important staff have a voice rather than being given a mandate from above.

Once agreed the strategic goals are then cascaded down into the organisation, so that every department, team and individual can understand and contribute at their level. This approach is integrated into our annual Grow Together conversations, the ENHT appraisal process, so that the effort of all seven thousand staff is harnessed and pulling in the same direction. Teams are encouraged to publish their locally agreed objectives that align to the strategic

goals in their department and ward areas, and this is then one of the points of focus when senior leaders visit the genba (the place where the work is done).



Strategic goal cascade from vision to individual grow together conversations

This new approach to strategic goal setting, alignment and deployment promotes long-term impact in two ways. First, its repeatable and based on learning, evolving year after year. Second, it allows the opportunity to use elements of advanced daily management, tools and concepts from our new improvement method and management system, the ENH Production System, to weave strategic goals into the day-to-day work, conversations, and attention of teams.

Daily management involves a structured system that helps teams and departments ensure their day-to-day operations run smoothly and improve continuously, whilst also embedding accountability. This includes leader standard work with emphasis on leaders being present where the work is done (genba), focusing their time on teaching, guiding and coaching frontline staff to improve their daily work by reducing waste. Many of the concepts (e.g. production boards) involve visual management: highly visible cues that drive action so people can know at-a-glance the status of the team's daily work or can see when to take action (and what action to take) if abnormal conditions are observed. Whilst production boards focus on real-time issues, we will soon launch strategic alignment boards that will capture local activities aligned to the Trust's goals and vision. Coaching staff in these skills and tools is facilitated through a newly established ENHPS for Leaders training programme. During 2024/25 the first three cohorts were launched involving over sixty senior leaders, and in 2025/26 this number will increase to include an additional ninety leaders.



The importance and relevance of strategic alignment is reinforced through executive positive leader rounds involving senior leaders visiting the genba to role model and establish new standard work. This allows leaders to test the health of local processes, engage staff and create curiosity and encourage positive action. These visits are scheduled in advance to ensure local staff availability and are intentional; they use structured prompts to guide and coach teams to think about daily management, kaizen, and strategic alignment.

However, this is about more than goals, it's also about an organisational culture that consistently respects and values people. In this environment staff know their voices and actions fuel the organisation's success and that is the ambition we have set out to achieve. This type of organisational change does not happen overnight, it is a long-term philosophy that will shape our culture to one relentlessly focused on consistently delivering outstanding care and exemplary service.

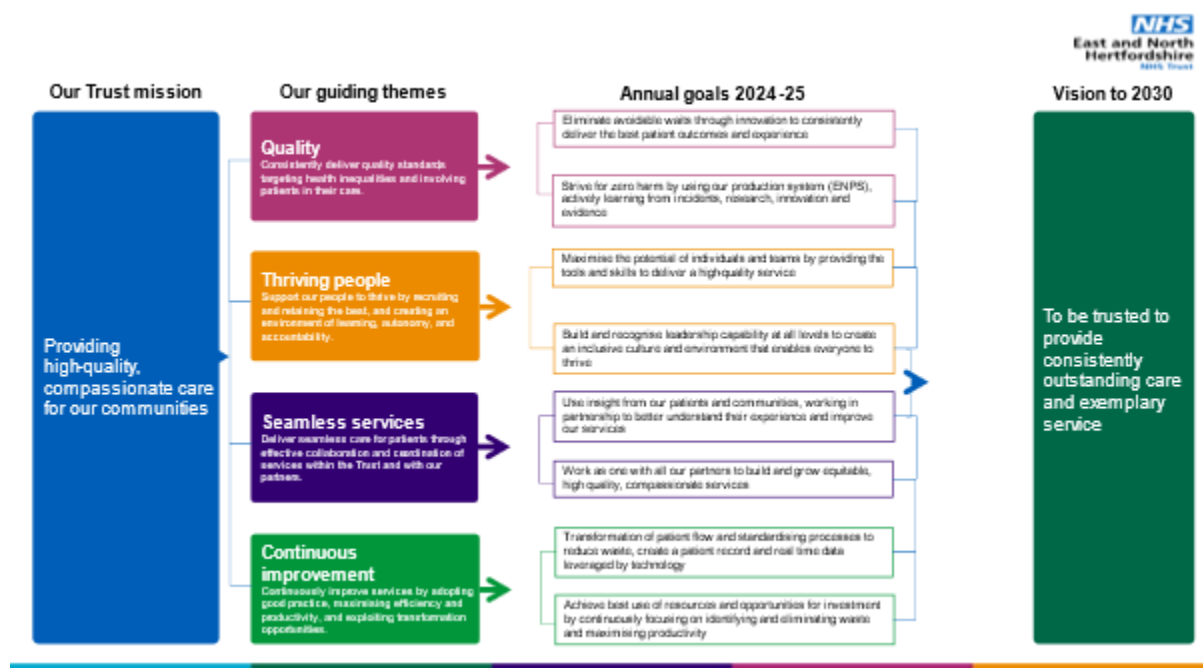
Our 2024/25 strategic objectives

Improvement work undertaken in support of achieving the strategic goals range from large scale transformational programmes that are cross functional and span multiple teams, to individual, small scale, incremental daily improvements. The following is therefore not an exhaustive list, but instead provides a range of examples of the types of activity that we completed during the year.

The strive for zero harm is a key principle of the ENH Production System and in response to a reported serious incident, members from our ophthalmology team, with support from the kaizen promotion office, undertook a rapid process improvement workshop in late 2024. The aim was to improve the patient injection pathway for age related macular degeneration. The week generated over 62 ideas and a series of Plan-Do-Study-Act (PDSAs) that were then tested on the genba. One PDSA led to a redesign of flow in the environment which evidenced a reduction in patient's physical steps in the process from 282 to 104. In addition, PDSAs tested during the week demonstrated a reduction in time for each appointment

attendance from 46 minutes to 24 minutes for patients requiring pressure checks, and from 34 minutes to 13 minutes for patients not requiring pressure checks. There were also savings in excess of £17k per annum identified from a reduction in medicines waste.

Next year will see a planned increase in the number of rapid process improvement workshops and other kaizen events held, which will support similar improvements across a variety of patient value streams representing each of our clinical divisions.



2024/ 2025 strategic goals

In response to the commitment to maximise the potential of our staff through the provision of the tools and skills to deliver high quality service, a senior leadership development programme has been rolled out involving divisional, care group and other senior teams. This initiative follows the redesign and launch of a new streamlined operating model within the clinical divisions. This formal programme incorporates a series of facilitated workshops that coach new leaders to embed a multi-disciplinary, boundaryless approach to leadership, as well as promoting cross-team working: a culture whereby people work with others to achieve their own objectives whilst also helping others to deliver theirs. These outcomes will be achieved through evidence-based leadership development and will utilise real life situations and shared experiences and connect peers to help learn and offer support to one another.

To build relationships with partners, working together to build and grow equitable, high quality compassionate services, we have established an Acute Provider Collaborative with Bedfordshire Hospitals, The Princess Alexandra Hospital, and West Herts Hospitals. This creates a formal model through which the trusts have committed to work together to improve patient care and outcomes and improve efficiency. The collaborative will initially focus on elective care, developing sustainable clinical services, with 'quick win' projects already identified and underway in interventional radiology, supporting the vascular hub services at Luton and Lister Hospitals, and in emergency ophthalmology.

To achieve the best use of our resources through eliminating waste our new kaizen promotion office has delivered training to over one hundred staff through our 'Introduction to ENHPS' course. The session helps attendees gain and apply an understanding of the foundational concepts of waste and value in healthcare. By learning the 5S tool, participants

learn a strategy for waste reduction through a simple process of 'sort, simplify, sweep, standardise, and self-discipline'(5S). Teams across the organisation are using 5S to improve efficiency and make best use of the resources they already have: the outpatients pharmacy team completed a 5S which enabled them to find things more quickly, speeding up the dispensing of medicines, increasing their effectiveness and improving patient experience. The team implemented a new process, reduced their packaging product lines by 44%, but still have what they need to hand, and no longer need costly additional storage or preparation space.

The examples previously described will multiply in the months and years ahead as we increase awareness, application and learning from the method through the various training and coaching offers provided. Ultimately each department and team no matter how big or small, will develop their own annual kaizen plans that will align their planned short and long-term improvements to the Trust's strategic goals.



Our 2025/26 Objectives

We have consciously moved away from targeted annual objectives which often made it difficult for teams to understand their role in delivery, and towards a reframing of multi-year, broader strategic goals. The intent is to provide clarity for divisions to understand and focus their resources and efforts to deliver the underlying transformational change required, which would never be realistically achieved within any given year.

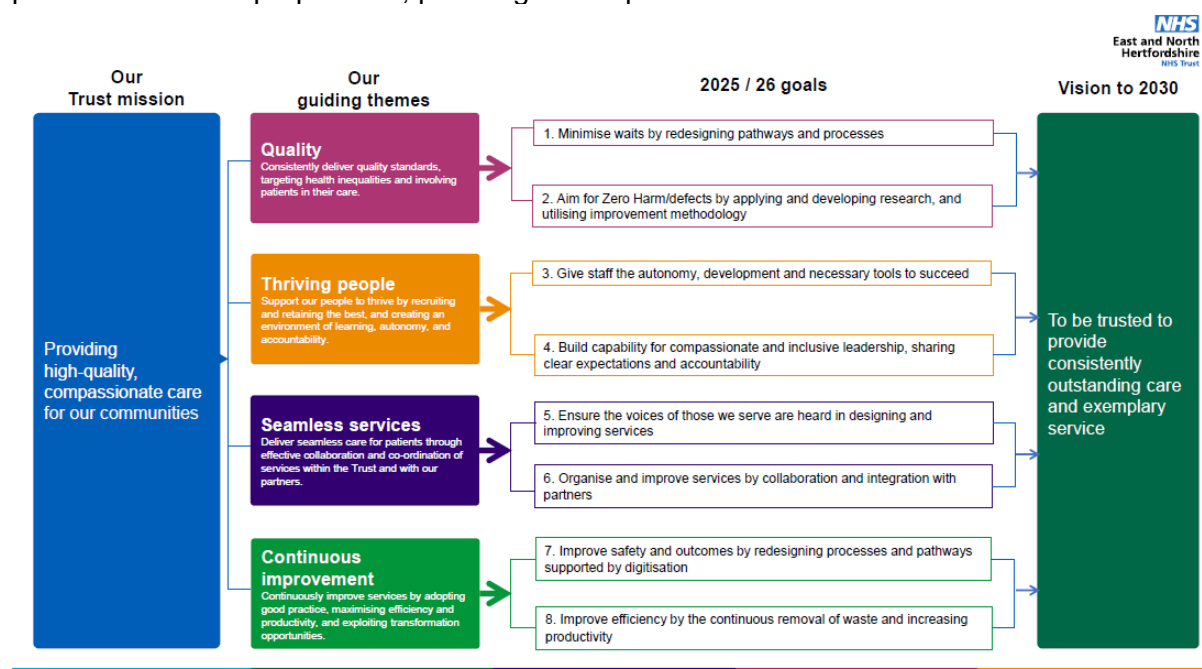
However, as part of the annual review process we also undertake an internal and external environmental scan, ensuring the direction of travel remains aligned with regional and national policy, as well as ensuring emergent risks, issues and opportunities are considered. This has not produced any significant changes, though the opportunity has allowed for a simplification of wording, making it even easier for teams to understand how they can play their part.

In the year ahead we will support improvement within the quality theme through innovation which will include the transformation of the outpatient pathway with a planned new electronic patient record. This will enable patients to access their records and manage appointments through a dedicated patient portal, enhancing patient choice and streamlining the booking process, while driving operational efficiencies within clinics.

Artificial intelligence powered solutions, integrated within the new electronic patient record will further transform operations by optimising waiting list management through predictive analytics and automating clinic scheduling and resource allocation for maximum efficiency and reduction in avoidable waits for patients.

To build leadership capability that creates an inclusive culture and environment, a new EDI steering group has been established which will oversee the delivery of a recently published EDI strategy. Initiatives under development include the adoption of a first 'do no harm' philosophy and policy across our employee relations framework. This work builds on the foundations of our embedded Healthy Teams interventions, a nationally recognised model. We will also continue to build on the excellent work of our various staff networks which have delivered a range of successes during the last eighteen months.

To use insights from our patients and communities, working in partnership to better understand their experience and improve our services the Trust is working as part of the ENH place to join up patient engagement, insight and resources across the area. This involves reviewing and restructuring our offer for Trust Members, working with the ICB as part of an engagement community of practice, and taking an active part in the ENH Community Assembly. In addition, as part of standard work, all future kaizen events and rapid process improvement workshops will include elements of patient engagement and co-production in their preparation, planning and implementation.



2025/ 2026 strategic goals

Finally, we will migrate to our new OneEPR digital system in late 2025, a programme which will deliver a single, unified electronic patient record which will help transform patient flows and standardise processes to reduce waste. It will improve patient care by providing real-time, accessible, and accurate health records. This digital transformation will empower healthcare teams with efficient workflows, seamless collaboration, and data-driven decision-making, ultimately improving patient outcomes and operational performance. The new electronic patient record will serve as a centralised digital record, creating a platform for artificial intelligence integration and emerging technologies that will enhance clinical decision-making and drive efficiency across the healthcare system.



Performance Appraisal

Across the course of 2024/25 the Trust has worked hard to achieve NHS performance priorities. This has reflected a continuing focus upon delivering high quality and responsive emergency care services recognising the importance of both reducing Emergency Department waiting times for both patients and ambulances. The Trust continues to make significant capacity investments to help deliver improvement.

In addition, the Trust has continued to expand capacity to deliver elective services to both reduce the total number of patients waiting for treatment and the length of time that they wait. As a result, the Trust has been able to deliver higher levels of day-case, inpatient elective and outpatient activity in 2024/25 than in 2023/24, which in turn were higher than in 2022/23. The drive to reduce waiting times further in line with national targets will continue in 2025/26.

The key performance headlines from the year are:

Financial performance:

- The Trust has performed well within a challenging financial performance and delivery environment throughout the 2024/25 financial year. Further increases in elective activity performance over 2023/24 and the delivery of a challenging £33.1m savings programme has allowed the Trust to deliver on its financial responsibilities whilst facing significant challenges and other material cost pressures over the course of the year.
- The adjusted financial performance for the Trust totalled a £1.5m surplus.

Operational performance:

- In 2024/25 197,008 patients attended one of our emergency departments, we cared for 48,069 inpatients and saw 703,137 patients in our outpatient settings.
- The focus in 2024/25 has continued to be on reducing waiting times and working to achieve elective and non-elective operational performance targets. This includes delivery against the elective recovery plan, including eradication of patient waits over 104 and 78 weeks from referral to treatment. During this year, the Trust met the delivery target for the vast majority of patients for no patients waiting more than 65 weeks from referral to treatment with the exception of community paediatrics, where the patient was available and fit for treatment. Specialities have continued to work towards a maximum wait of 52 weeks and for some they are heading towards maximum waits of 18 weeks. For community paediatrics the Trust is working with system and national leads to develop new community pathways with the aim of providing a more consistent and shortened pathway with particular reference to those with neurodiversity.
- The Trust has continued to work towards the four-hour urgent and emergency care (UEC) waiting time standard. Nationally the target was set at 78% for all patients; the Trust achieved 70% across the year as a whole and 74% during March 2025. The Trust's performance is in line with both regional and national average performance. Both Urgent Treatment Centres at the Lister and QEII site continue to deliver very well against the standard. There continues to be a focus on improving waiting times and patient experience for adults within the main emergency department at the Lister site to and this work will continue into the financial year 2025/26.
- Children's ED (Emergency Department) plans capital investment to improve access and care for children, young people and their parents / carers with the addition of a second triage room and a new entrance straight into Children's ED planned for 2025/2026.
- There has been an improvement in ambulance handover times with a material reduction in the proportion of ambulance handover delays over 60 minutes. Work to reduce this further will continue to achieve the 15-minute standard.
- The Clinical Decision Unit (CDU) is essential for alleviating overcrowding in the main waiting area, enhancing patient experience, and ensuring timely treatment. As a result, we are in the process of improving utilisation by reducing the maximum length of stay to 24 hours for bedded patients and 6 hours for chair patients, while aiming to increase occupancy to 95% for those who no longer need emergency care or admission.
- The Trust continues to perform well against the cancer targets and is in the top 10 trusts nationally for cancer waiting time performance. The Trust continues to work with commissioners and referring trusts to reduce the number of late referrals.
- Staff have worked to deliver significant improvements in access times for most diagnostic modalities. Pressure remains in MRI due to increasing demand in UEC, cancer and elective pathways. This is currently being worked through to ensure there is a sustainable delivery model to address current and future demand. Paediatric audiology also remains a concern as the service was temporarily halted while the estate, workforce and processes were reviewed. This has resulted in a backlog which is being reviewed with system colleagues.
- Stroke performance is monitored nationally through the Stroke Sentinel National Audit Programme (SSNAP) each calendar year. Through a series of service improvement

initiatives, the Trust successfully raised this rating to a B during 2023/4, which has been maintained for the past year. The service is expected to retain this B rating into 2025. However, due to significant changes in SSNAP's Key Performance Indicators (KPIs), no formal rating will be issued until later in 2025. Although improvements have been made, the service is still working on further improvements across all domains, in particular its 4-hour and thrombolysis performance.

Quality and safety performance:

- In terms of the Trust's mortality performance over the period, this remained favourable when benchmarked. The Trust continues to be well placed versus both national peer and our recommended Model Hospital peer group for both the key metrics of HSMR and SHMI:
 - Hospital Standardised Mortality Ratio (HSMR) – 83.5 for the 12 months to January 2025, which statistically is in the mid-range of trusts.
 - Summary Hospital-level Mortality Indicator (SHMI) – 0.9126 for the 12 months to October 2024, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stands at 21st out of all acute non-specialist trusts (119).
- During 2024/25, the Trust progressed with our first year of Patient Safety Incident Response Framework (PSIRF). PSIRF is the national approach devised by NHS England to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety nationally. This has included the delivery of our inaugural ENHT PSIRF Plan.
- In 2024/25, 904 formal complaints were received. A significant increase on the 763 received the previous reporting year 2023/24 a rise of 18%. There was also a significant increase in the number of PALS enquiries received, a total of 5864, a rise of over 1000 enquiries from 4657 the previous year 2023/24. Equating to a 26% rise.
- One MRSA case was reported in 2024/25, this is one less than 2023/24.

People performance:

- By the end of March 2025, the Trust has over 1,889 nursing and midwifery staff in post, supported by successful overseas and active domestic recruitment campaigns.
- The Trust also achieved a 1.08% reduction in agency spend as a percentage of the total staffing pay bill.
- Throughout 2024/25, the percentage of staff on annual leave, sick leave and parenting leave remained within set tolerance levels.

A significant element of our strategic risk management relates to driving performance improvement. Further information on this strategic risk management can be found in the Risk Profile section below and the risk section of the Annual Governance Statement.

Statement on adopting Going Concern basis

These accounts have been prepared on a going concern basis, in accordance with the financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual (FReM). Under this framework, the continued provision of the entity's services in the public sector is typically considered sufficient evidence of the going concern assumption.

In compliance with IAS 1 (Presentation of Financial Statements), management has assessed the Trust's ability to continue as a going concern. In making this assessment, management has considered the Trust's income and expenditure plan for the 2025/26 financial year, as well as its current cash position.

The Trust has developed a breakeven plan for 2025/26, which aligns with the breakeven plan for the Hertfordshire and West Essex Integrated Care System (ICS), of which the Trust is a part. The ICS plan is supported by the ICS Financial Recovery Board, which plays a key role in ensuring the successful delivery of both system-wide and individual organisational objectives.

The Trust's cash plan for 2025/26 does not rely on cash financing from the Department of Health and Social Care (DHSC), and it is projected to have a cash balance of £38.2 million as at 31 March 2026. Based on this, the Board has concluded that there is no material uncertainty regarding the Trust's ability to continue as a going concern during this period.

Given these factors and after making appropriate enquiries, the Directors have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future.

As required by the Department of Health and Social Care Group Accounting Manual 2024-25, the Directors have prepared the financial statements on a going concern basis. They believe that the services currently provided by the Trust will continue to be delivered in the foreseeable future in the public sector. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Performance Analysis

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

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

Key performance indicators

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

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

Delivery against our Trust objectives

Summary information about the delivery against the Trust's 2024/25 objectives can be found in the strategy and objectives sections earlier in the report.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. The CQC has not taken enforcement action against the Trust during 2024/25.

Following the Trust's CQC inspection in 2023, the Trust successfully submitted the action plan for CQC 'must' and 'should' actions as identified within the report. Evidence supporting 'CQC should' actions were submitted on Friday 30th August 2024.

The Trust has participated in other planned reviews by the CQC during 2024/25 relating to the following areas:

- JTAI on 22 October 2024. CQC inspectors conducted a joint targeted area inspections (JTAI) of arrangements and services for safeguarding children in local authority areas.

Other quality regulatory visits have included:

- Environment Agency Waste Management on 3rd March 2025. Inspectors conducted an informal visit to assess the Trust's waste management.

- SEND on 21st June 2024. The ICB visited to assess the Trust and local area arrangements for children and young people with special educational needs and/or disabilities (SEND).
- JAG Audit on 5th November 2024. Inspectors visited to assess the Endoscopy service for JAG accreditation.
- Cervical Screening Programme on 2nd July 2024. NHS England visited to assess the colposcopy service.

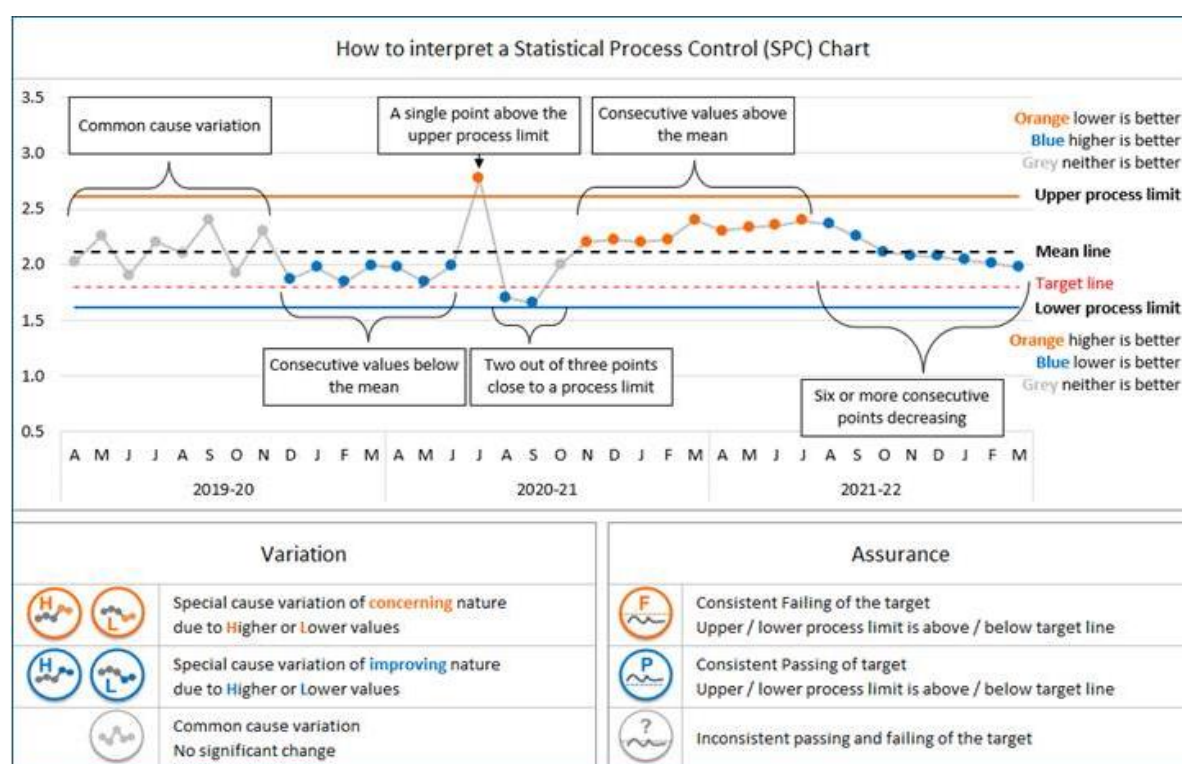
In 2024 the Trust added an extension to Urgent Treatment services, on the Lister site.

During 2024/25 the Trust has continued to review the quality governance framework. Actions to embed cultural change in good governance standards include new reporting frameworks to support the operational management structures. This is measured internal and external work plan of mock inspections and quality assurance reviews, and also well led governance of quality governance mock inspections.

In-depth performance review

This section of the annual report sets out in more detail the Trust's performance in 2024/25 in relation to key areas including clinical, operational, financial and workforce performance.

Below is the key to show what the lines in the graphs mean.

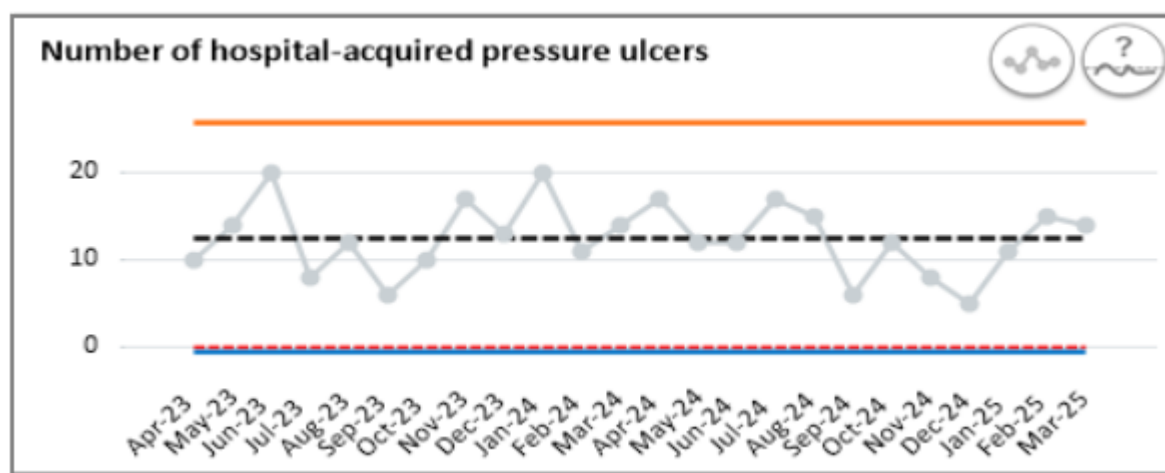


Quality and Safety

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

1. Reducing pressure ulcers (PU)

The Trust has reported 138 Hospital Acquired Pressure Ulcers (HAPU) for 2024-25 which is a 13.7% decrease from our previous year's data, after rollout of PSIRF from April 2024.



Every HAPU 2 and above is handled by the Ward Leadership/Manager to identify immediate local learning responses for all HAPU2, if further investigation required then PSIRF is followed. HAPU3, HAPU4 will be escalated to Division leads (DISH - UPC, DIRM - PC) for divisional input and learning responses or tools. Tissue Viability service will offer support where required for all. Some Local responses require an action plan which is done by the ward leadership / manager and shared with the department / ward.

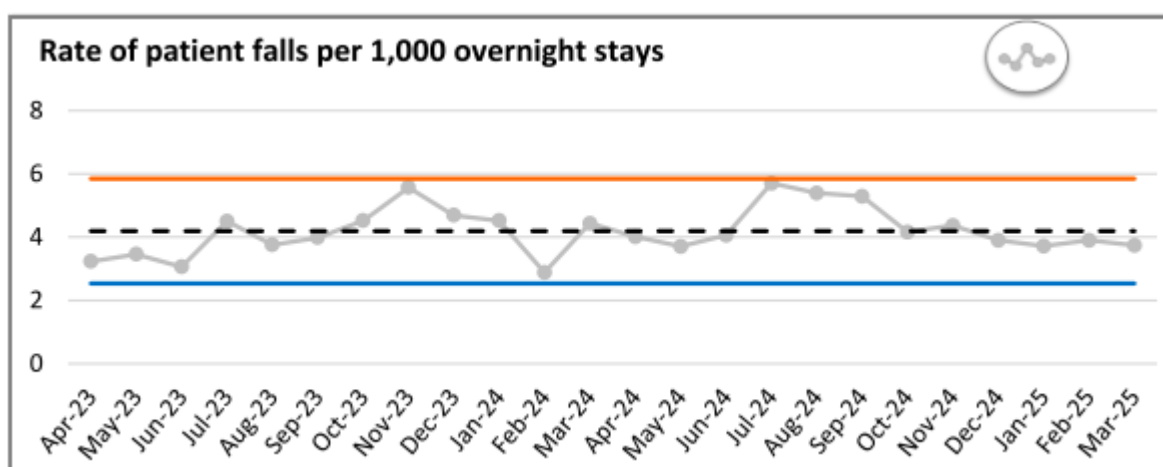
2024/25 Priorities update

1. From April 2024 PSIRF was rolled out to align the Trust with national standards. The ward leadership/manager lead in validation of PUs, however, there is still need for the Tissue Viability service to support with this until the process is embedded. Ward leadership lead in response to a HAPU through immediate actions to address patient harm.
2. The reduction of medical device related HAPU within Critical Care is ongoing and decline is noted yearly from 2022; 2023; 2024 as 37; 28; 25 new incidences reported.
3. Ward 10B continues to be supported with their HAPU Quality improvement project, which yielded good results at the end of 2024, by a 50% reduction in HAPU.
4. Reduction of Heel HAPU which are the leading cause of HAPU in the Trust. Improvement work started by Tissue Viability service supported by ENHPS.
5. The new ePR system will see the implementation of PURPOSE-T, risk assessment tool recommended by NWCSP which will align the Trust to the ICB and national standards.

The Tissue Viability service knows that there is a relatively good working understanding of PUs and completion of Risk Assessment. 3 priorities have been identified for improvement work over the coming year.

1. Evidence of successful mitigations/actions on risk assessment score. Provision of equipment, evidence of repositioning and accuracy of skin assessment. The 3 themes were identified the previous year for improvement works, this is ongoing.
2. Improvement in communication by appropriate documentation and handover in safety huddles at ward level, patient transfers and on discharge.
3. The new digital system will see the implementation of PURPOSE-T risk assessment tool as NWCSP recommendations. This will align our Trust with the ICS and national standards.

In 2024-25, the Trust's average falls rate per 1000 bed days is 4.5. We have seen an increase of 0.4 Falls per 1000 bed days compared with the previous year. The Trust's falls rate per 1000 bed days remains low compared to the national average of 6.6 (NHSE).



In 2024/25, we recorded 843 inpatient falls. While this is an 9.9% increase from previous year (695 falls). Inpatient falls with serious harm is lower this year (7) compared to the previous year (15).

While our Falls per 1000 Bed Days have increased slightly, falls with moderate to serious harm continues to go down. Our focus for improvement is compliance with our falls KPI's such as compliance with lying & standing blood pressure for inpatients over 65, vision assessment for inpatients over 65, timely completion of falls risk assessments, post fall documentation, and compliance with bay-watch. Our falls documentation will be adapted in the new EPR system that will be implemented this year. As the Trust implements the Patient Safety Incident Response Framework (PSIRF), we are adapting the way we respond to falls incidents and applying a range of system-based approaches to learning and improvement

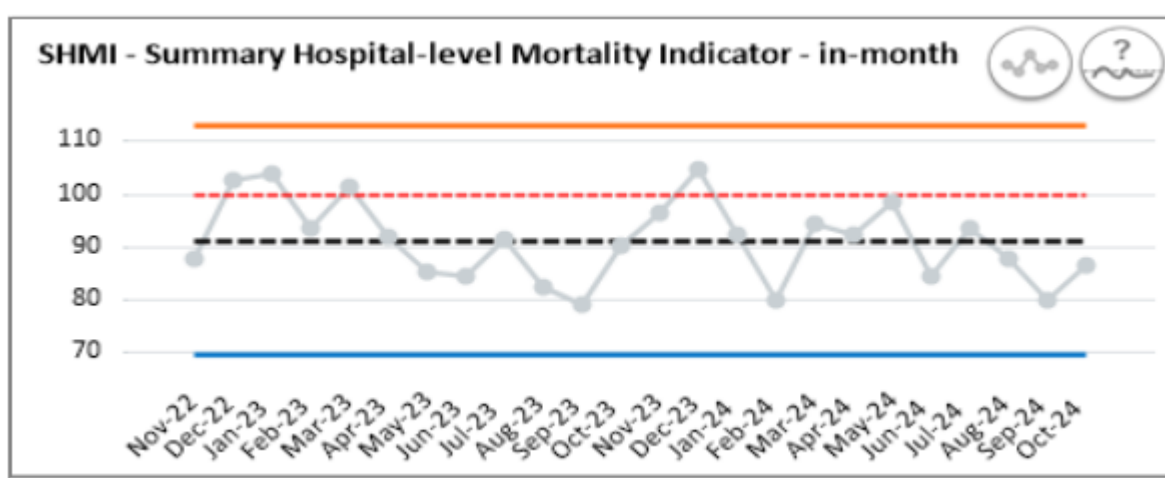
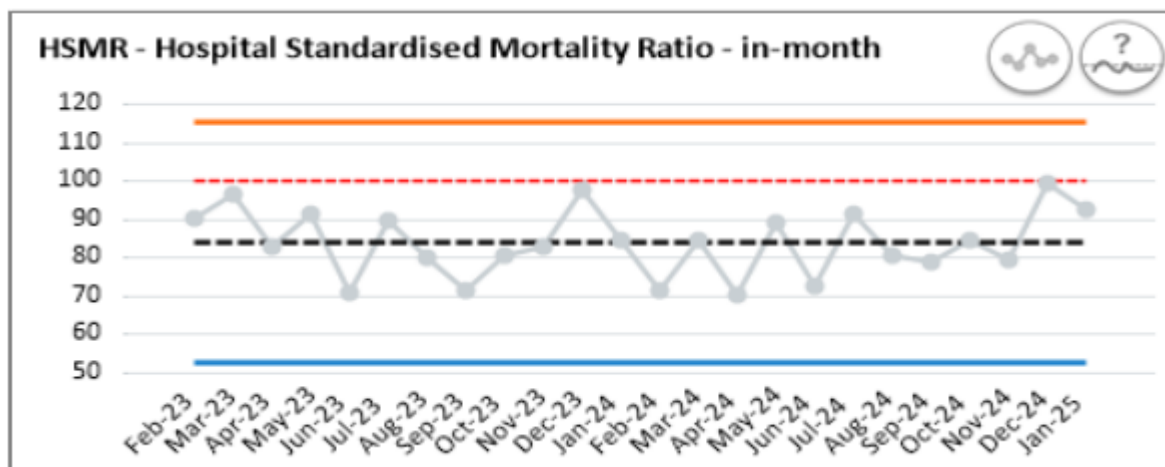
2. Mortality rates and learning from deaths

Mortality rates

While no longer our primary focus for assessing our mortality performance and the quality of care we provide, we continue to use key mortality metrics, as valuable indicators for further review and investigation. Along with other performance metrics such as length of stay and readmissions they help to evaluate the many factors that influence the quality of care we provide to those who die in our hospitals.

The Trust continues to be well placed versus both national peer and our recommended Model Hospital peer group for both the key metrics of HSMR and SHMI:

- Hospital Standardised Mortality Ratio (HSMR) – 83.5 for the 12 months to January 2025, which statistically is in the mid-range of trusts.
- Summary Hospital-level Mortality Indicator (SHMI) – 0.9126 for the 12 months to October 2024, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stands at 21st out of all acute non-specialist trusts (119).



Learning from deaths

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

It has been increasingly recognised that while monitoring mortality rates has a role to play in mortality governance, there is no direct correlation between these, and the quality of care provided by organisations.

In order to learn from deaths and improve the quality of our care, we recognise that it is vital that we have a robust process for reviewing the care received by our patients at the end of their life.

In July 2022 we adopted the *SJRPlus* format for mortality review, developed by the “Better Tomorrow” Future NHS collaborative, which has since transferred to Aqua (Advancing Quality Alliance). This brought our approach to mortality review in line with an increasing number of trusts across the country who use systems based on the original RCP structured judgement review programme established in 2016. The new approach is now well embedded, with individual outputs and thematic review outputs shared across the Trust, and where appropriate with the ICB and wider community. We continue to look for new ways of using our data to promote learning and drive quality improvement.

To support our work, development of our second Learning from Deaths Strategy is well underway. We are seeking to align this with emerging wider NHS and Trust strategic aims, to provide additional focus for our ongoing development and quality improvement work.

3. Patient safety Incident Investigations and Never Events

In November 2023 the Trust transitioned away from the Serious Incident framework and into the PSIRF (patient safety incident response framework). However, the Trust has 4 serious incidents that remain open, these relate to a cluster of incidents within our Paediatric Audiology service.

During 2024-25, the Trust embedded our adoption of the Patient Safety Incident Response Framework (PSIRF). The PSIRF embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systemic patient safety management. It focuses on proportionate responses being deployed to all patient safety incidents with the focus on learning and improving whilst also engaging and involving those affected.

The Trust's inaugural Patient Safety Incident Response Policy and Plan were approved by the Board on 5 July 2023 and the revised Policy and 2024/25 plan will be shared with the Trust Board in July 2025. These have been updated to reflect the learning from our inaugural PSIRF adoption year and following review of our safety profile and updated safety priorities moving forward. The Trust has 4 serious incidents that remain open, under the previous Serious incident Framework, these relate to a Paediatric Audiology cluster of incidents.

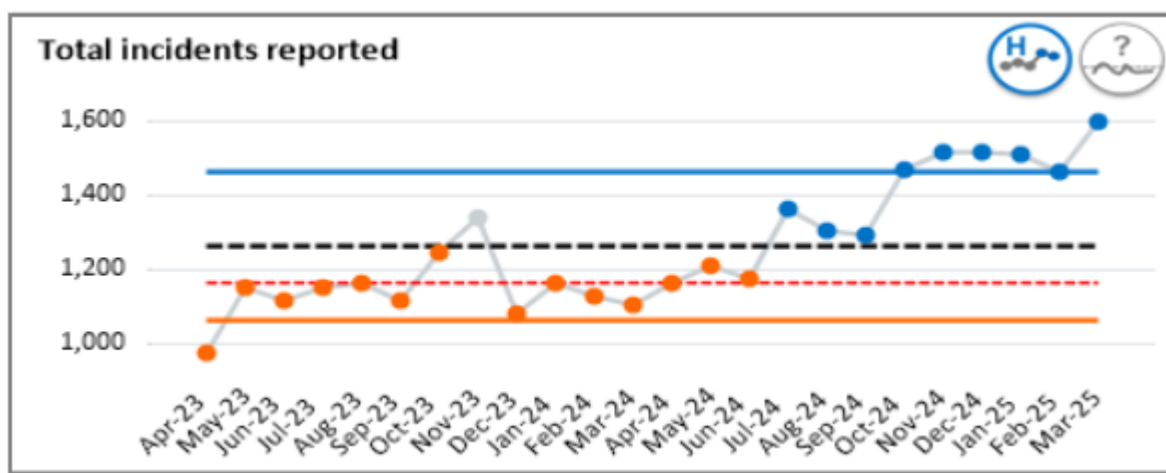
PSIRF plan priorities 2024/25

Patient incident type or issue	Planned response	Anticipated improvement route	Accountable team/officer
1. Improving the 'escalation' of deteriorating patients.	Learning response pathway – transforming into improvement	Create local safety actions and feed these into the safety improvement plan	Lead Nurse Critical Care Outreach & Associate Medical Director for Quality and Patient Safety
2. Reducing the frequency of drug administration errors	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts	Pharmacy Patient Safety Specialist
3. Ensuring the fundamentals of care for our vulnerable patients who lack capacity	Learning response pathway – transforming into improvement	Create local safety actions and feed these into the safety improvement plan	Director of Quality
4. Reducing safety risks for patients on waiting lists	Learning response pathway	Create local safety actions and feed these into the safety improvement plan	Deputy COO

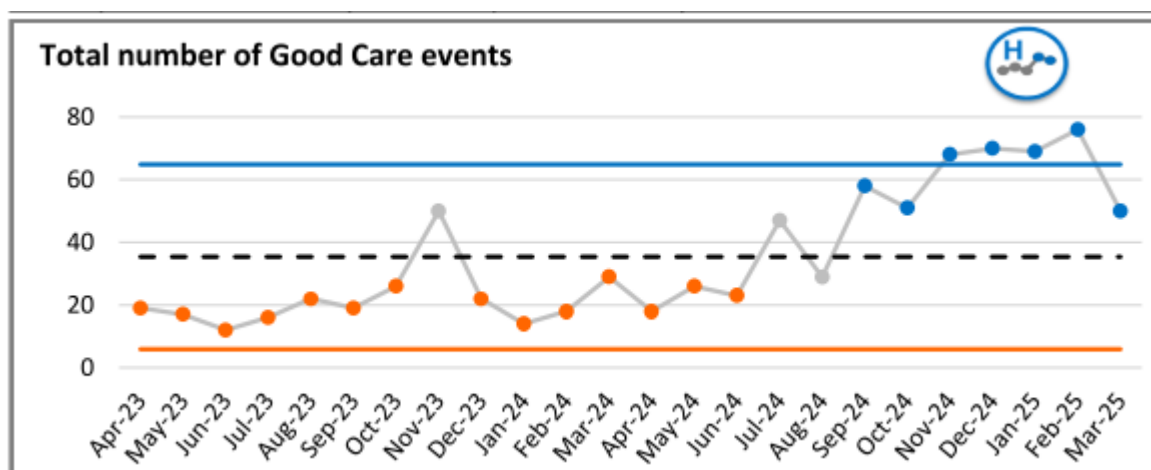
5. Reducing risks related to patient flow, including admission to discharge (ED pathways, in patient pathways and discharge processes)	Improvement response pathway (learning response pathway by exception)	Inform ongoing improvement efforts	Deputy COO
6. Reducing the risk to young people waiting access neurodiversity pathways.	Learning response - transforming into improvement	Create local safety actions and feed these into the system level safety improvement plan	Head of Nursing for Paediatric services and Head of Paediatric services

In November 2023 the Trust transitioned away from the SI framework and into the PSIRF. The PSIRF embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systemic patient safety management. It focuses on proportionate responses being deployed to all patient safety incidents with the focus on learning and improving whilst also engaging and involving those affected.

Since introducing PSIRF operational changes, the Trust has seen a sustained increase in the reporting of incidents, demonstrating more opportunity to learn and drive improvements. A total of 16,502 were reported in 2024/25 compared to 13,767 in 2023/24.

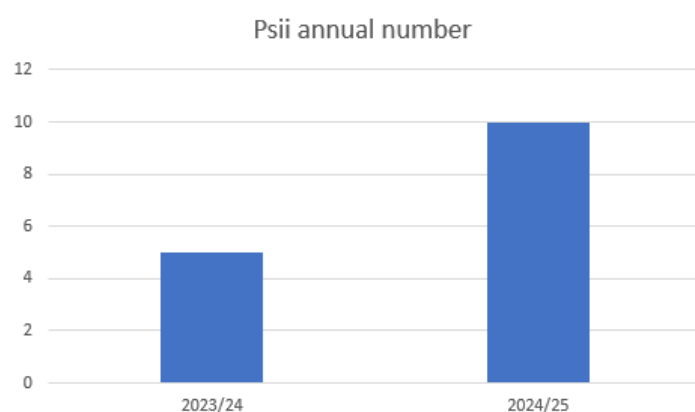


In February 2023 the Trust aligned our incident reporting system to the new Learning From Patient Safety Events system (LFPSE). This is the national NHS system for the recording and analysis of patient safety events that occur in healthcare. One of the biggest changes that brought to ENHT was that it allowed for reporting of 'good care' events which provides the opportunity to recognise excellence and positively learn from when things have gone well. As demonstrated below, we have seen a sustained improvement in the reporting of good care. A total of 582 good care events have been reported in 2024/25.



Under the PSIRF, a PSII is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning and is aligned to both a national and local criteria. The aim of a PSII is to provide an understanding of how an organisation's systems and processes contributed to a patient safety incident. They examine systems factors and use human factors methodology to identify areas for improvement and systems learning. There are specific national criteria that dictate when a PSII should be undertaken (for example if a Never Event occurs) and also ENHT have local safety priorities / criteria.

Since adopting the PSIRF in November 2023, the Trust has commissioned 17 Patient Safety Incident Investigations (PSIIs). Of those, 5 were reported in 2023/24 and 12 were reported in 2024/25.



During 2024/25 there were 4 incidents that occurred at the Trust which were considered by meet 'Never Event' criteria. This was two more than reported last year. Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or all appropriate safety recommendations are in place. It is of note that the Never Events were classified as minimum or no harm and occurred in different specialties of the hospital.

ENHT Never Events data	2023/24	2024/25
Wrong site surgery	2	1
Unintended retained object	0	1
Wrong prothesis	0	1
Nasogastric tube	0	1
Total	2	4

Three of the Never Events that occurred in 2024/25 were reviewed together in a larger thematic review of invasive procedures and the associated surgical safety checks. This is an iterative learning process which has included a number of specialties including theatres, ENT, Gynaecology and Plastic Surgery. The review is ongoing at the time of writing however learning and themes identified so far has included variation in surgical safety check processes across specialties, use of the whiteboard, communication and equipment storage. The never event relates to misplacement (i.e. Into the lungs) of a Nasogastric tube feeding - this involves inserting a thin, soft plastic tube through the nose and into the stomach to deliver liquid nutrition, medications, or fluids. It's a way to provide nutrition when someone cannot eat or drink normally due to swallowing difficulties, appetite loss, or other medical state

Adult and children's safeguarding services

Safeguarding is described as the act of 'protecting an individual's health, wellbeing, and human rights, while ensuring they can live without the threat of harm, abuse, or neglect.' This principle is a fundamental priority for all services provided by the Trust. The Trust is dedicated to ensuring that our statutory safeguarding obligations are consistently fulfilled in accordance with the Care Act (2014), the Children's Act (1989 and 2004), Working Together to Safeguard Children (2018), and the Mental Capacity Act (2005).

The members of the Trust safeguarding team, along with the chief nurse, who serves as the executive lead for safeguarding, remain active participants in the Hertfordshire-wide safeguarding partnerships for both adults and children. Additionally, we engage in the activities of the various subcommittees linked to these partnerships, thereby reinforcing our enduring commitment to a multi-agency approach to safeguarding through effective collaboration with our essential partner agencies.

The Trust's safeguarding committee, in conjunction with its clinical governance protocols, consistently integrates findings from various safeguarding reviews into practice. It ensures that safeguarding issues are effectively communicated from individual service levels up to the Trust Board. Additionally, the Safeguarding team participates in multiple quality improvement initiatives, providing guidance to teams on the implementation of specific strategies designed to minimise the risk of neglect or omissions at the point of care.

The Trusts safeguarding team consistently provides training and supervision to healthcare professionals employed in the Trust which is aimed at developing professional curiosity skills. This initiative enhances the ability of individual practitioners to identify and manage safeguarding issues effectively. Our safeguarding educational program, which is integrated within the organisation, adheres to the standards set forth for NHS trusts in the intercollegiate documents related to safeguarding both adults and children. In addition to the educational requirements specified in the intercollegiate documents, our safeguarding team offers supplementary training on various safeguarding topics to staff, which exceeds the mandated criteria. This training is conducted through the safeguarding champion forum established by our Trust.

During 2024/25 period, we retained the employment of a child sexual violence advisor and domestic abuse practitioners, establishing a Trust Domestic and Sexual Abuse Team (DSAT) with funding provided through a grant from the police and crime commissioner's office. So far in the current financial year, this service has assisted 500 victims of domestic abuse and sexual assault, with a significant rise in the identification of domestic abuse victims needing support, particularly within our maternity services. Owing to the success of this initiative, the crime commissioner's office has extended the service grant through to the end of the 2025/26 financial year. We have maintained our proactive efforts to monitor,

support, and assist patients with learning disabilities in attending their outpatient appointments through the implementation of a 'was not brought initiative.' As a result, we have noted an increase in attendance rates for outpatient appointments within this patient demographic. At the time of writing, all safeguarding policies within the Trust are in date and officially ratified, and are available on the Trust intranet for staff access.

There has been a notable rise in safeguarding referrals made by staff during the point of care for both adults and children, reaching historical high levels. This increase is likely attributed to the enhanced awareness and education provided to our staff. During 2024/25 more than 800 Deprivation of Liberty Safeguards (DoLs) applications were submitted to a supervisory authority concerning patients admitted to a clinical setting in the Trust. This represents a 7.5% increase compared to the prior year and marks the highest annual total for the Trust since the Mental Capacity Act was enacted in 2005.

Our safeguarding team is comprised of specialists in children's nursing, adult nursing, and midwifery. This team collaborates closely, with all members engaging in daily group supervision sessions facilitated by our safeguarding leads within a structured framework. This approach guarantees the consistent application of a 'think family' philosophy in our safeguarding practices and promotes the sharing of knowledge. Furthermore, the safeguarding team oversees our prevent responsibilities, executes the mental capacity strategy, and supervises the health liaisons team who provide support to service users with learning disabilities.

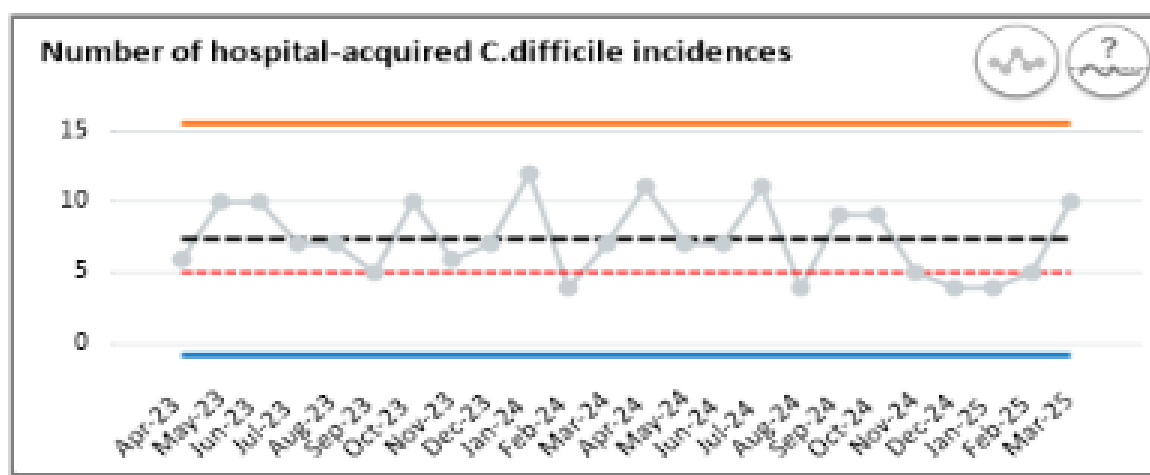
4. Infection prevention and control (IPC)

Non-COVID key infection control performance indicators for 2024/25

Month	C.difficile	MRSA BSI	MSSA	E.coli BSI	Pseudomonas aeruginosa BSI	Klebsiella spp BSI	Carbapenemase Producing Organisms (CPOs)
Apr 24	11	0	2	1	4	2	0
May	7	0	3	6	2	2	0
Jun	7	0	2	6	4	3	0
Jul	11	0	0	5	0	5	0
Aug	4	0	0	4	2	1	1
Sep	9	0	4	1	1	4	0
Oct	9	0	3	4	2	1	0
Nov	5	0	3	8	0	1	0
Dec	4	1	4	2	1	2	0
Jan 25	4	0	3	3	0	2	0
Feb	5	0	1	8	0	1	0
Mar	10	1	3	4	0	2	0
	Total	Total	Total	Total	Total	Total	Total
	86	2	28	52	16	26	1
	Threshold	Threshold	Threshold	Threshold	Threshold	Threshold	Threshold
	92	0	N/A	55	12	23	0

There was a 9% reduction in Escherichia coli (E coli) blood stream infections (BSI) compared to the previous year, and three cases below the annual threshold. Metcillin Sensitive Staphylococcus Aureus (MSSA) and gram negative BSI have marginally increased compared to the previous financial year. The Trust reported a total of two healthcare associated Metcillin Resistant Staphylococcus Aureus (MRSA) BSI, equal to 2023-2024. The first case was in December 2024, where a patient had a Panton-Valentine Leukocidin (PVL) strain of MRSA but their MRSA admission screen was missed. The post infection review (PIR), led by the ICD, revealed that the likely cause of the patient's sudden deterioration and death was due to rapid changes in respiratory symptoms due to influenza rather than as a result of the MRSA BSI. The patient had received appropriate treatment for their underlying medical conditions. The second case, in March 2025, was a patient who had suffered a stroke and had numerous underlying conditions, and was colonised with MRSA from a multi-site swab taken on admission. The patient had an indwelling device, a nasogastric tube for feeding, and a break in their skin integrity. The patient was given appropriate treatment, including decolonisation treatment, with support from the microbiology team. A PIR was held to ensure learning was identified and actions were carried out to prevent recurrence.

The IPC team continued to carry out internal PIRs for all reportable healthcare associated infection (HCAI) BSI, and timely feedback continued to be given to the ward and treating teams in order to support with prevention and control measures in all gram positive and negative BSI cases. The IPC team continued to work collaboratively with the vascular access lead (VAL) nurse, the tissue viability lead nurse, and urology clinical nurse specialists to deliver tailored training and education. Divisional leadership and communication to the wards were two of the main focuses of the preventative work. The aseptic non touch technique (ANTT) competency development and implementation work continued with a view to relaunching a Trust-wide standard process to support staff and services, with specialist pathways to take account of already established competencies. A peripheral intravenous cannulation (PIVC) competency has been rolled out by the VAL nurse, with a focus now on specialities such as the oncology and renal services.

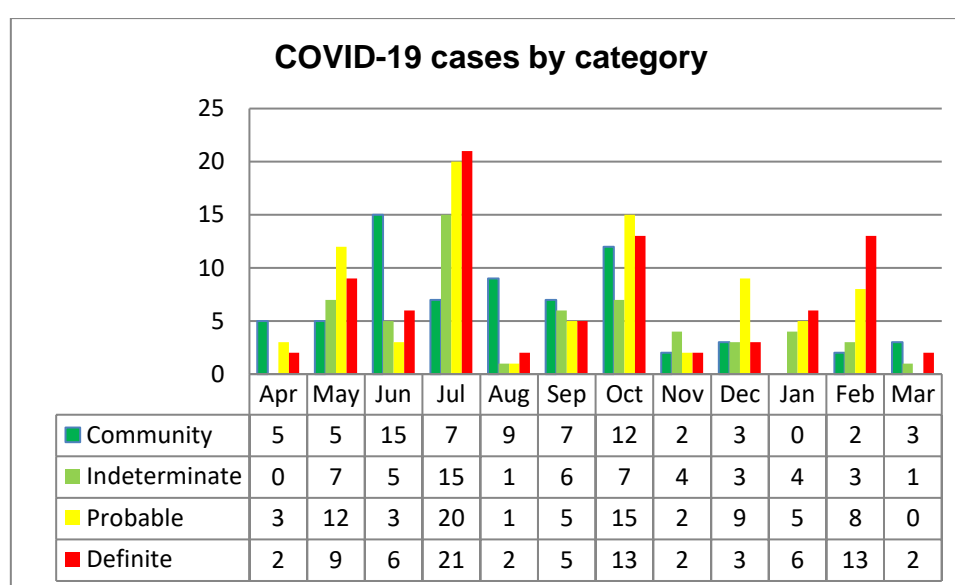


Trust-allocated cases of Clostridiodes difficile (C diff) infections are 84 against the threshold of 92 for the financial year 24/25.

The IPC team led the development of the Trust's C. diff action plan involving a multidisciplinary team, who were instrumental in influencing the outcomes. The plan has helped steer both individual team and collective actions in response to a variety of factors identified, in order to prevent the development of C diff infection or its spread. It involved

collaborative actions from the corporate, clinical, and operational teams, as well as colleagues from the Integrated Care Board (ICB). One example of an action in the C diff action plan was a weekly MDT meeting led by the Medical Director or Chief Nurse/ Director of Infection Prevention and Control (DIPC), which included the Infection Control Doctor and the Consultant Microbiologists, Lead Antimicrobial Pharmacist, the Deputy DIPC and IPC team, and the ward clinical teams. The weekly C diff MDT meeting commenced in May 2024 to support the prompt review of all C diff cases, with particular focus on preventing cases escalating from carriage to toxin producing infections. To date, 99% of the 84 hospital onset C diff cases reviewed were found to be clinically unavoidable. In the main, it was also found that patients received appropriate treatment, samples were sent in an appropriate timeframe, and patients were isolated promptly. A marked improvement in Trust practices from previous years. Ribotyping results to date have not indicated that any cross transmission events have taken place.

COVID key infection control performance indicators for 2024/25



There was a significant decrease in the total number of COVID-19 cases, for all four categories (see above chart), compared to 2023-2024, in line with national trends. There has been an increase in the healthcare associated COVID-19 cases this financial year (FY), particularly during the winter season, again, in line with national trends.

The IPCT reviewed all COVID-19 cases defined as probable and definite healthcare associated. PIRs were utilised to highlight findings and identify any lapses and/or learning. The MDT, which included nurses, doctors, Facilities colleagues, occupational health colleagues, and external stakeholders continued to be a part of IPC processes; ensuring that recommended actions were implemented. A proactive approach was taken in the timely recognition and management of patients with respiratory symptoms using lateral flow devices (LFD), along with Polymerase Chain Reaction (PCR) tests, to identify other causative organisms for respiratory infections. This multi-disciplinary approach enabled staff to provide appropriate care to our patients and, undoubtedly, prevented instances of cross transmission of infection to patients and staff.

Patient Experience

In 2024/25 22,999 patients responded to our friends and family test (FFT) survey, an improvement on the previous year of 22,369. The Trust's FFT responses for inpatient and

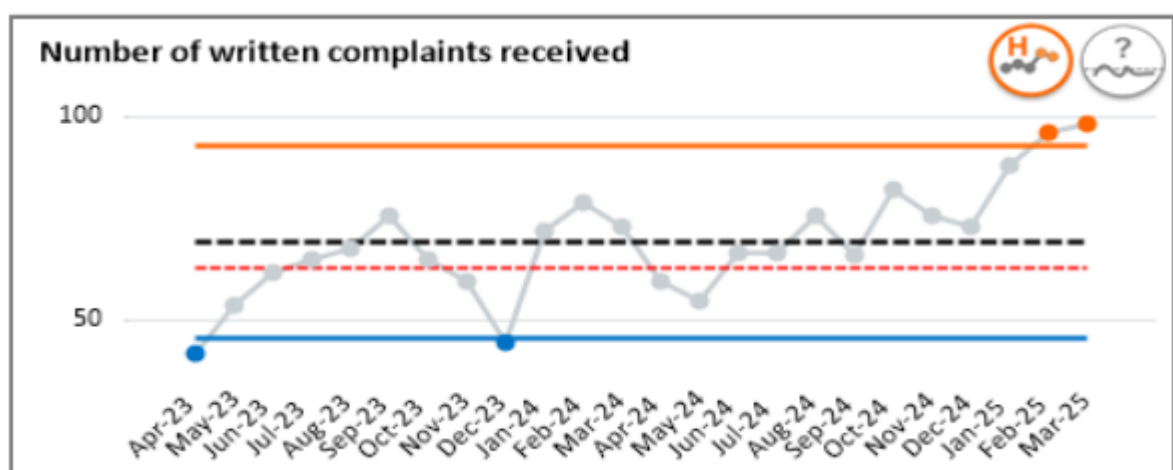
day cases are consistently higher than the national average for both the response rate and the proportion of patients who would recommend the Trust to their friends and family.

Throughout 2024/25 the Trust has re-established a consistent supportive network for our unpaid, paid and young carers. Providing growth on the current initiatives and expanding the provision with new and exciting ideas.

The Trust actively encourages feedback from patients and carers as this enables good practice to be shared and changes made to improve services. The Trust has a Patient and Carer Experience Programme Board (PACE programme) which includes patient and carer representatives. Sharing stories and experiences Trust wide to ensure consistent learning and improvement within each Division.

In 2024/25, 904 formal complaints were received. A significant increase on the 763 received the previous reporting year 2023/24 a rise of 18%.

There was also a significant increase in the number of PALS enquiries received, a total of 5864, a rise of over 1000 enquiries from 4657 the previous year 2023/24. Equating to a 26% rise.



Key themes from our Patient Advisory Liaison Service (PALS) are related to delays in appointments, poor communication and delayed/poor care/treatment.

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

- Carer Concessions Secured: Successfully implemented carer concessions across all four main sites, enhancing accessibility and support for carers.
- Enhanced Information & Support: Introduced an information pack for carers, also provided to patients with carers, ensuring they can easily access support through the Carer Experience Volunteer Team when needed.
- Expanded Volunteer Support: Increased the uptake of Carer Experience Volunteers and secured additional investment for Carer Companion visits, helping to ease worries and fears when a carer is admitted to the hospital.
- Dementia Grab packs provided to wards to make sure they have all the information they need, easily available to enable easy referral, to dementia service and to enable delivery of best practice, person centred dementia care.
- Coloured plates and adapted cutlery to enable people with dementia to maintain independence for longer with eating and drinking. These have been introduced initially to our elderly care and stroke wards with a plan for Trust wide roll out.

Operational Performance

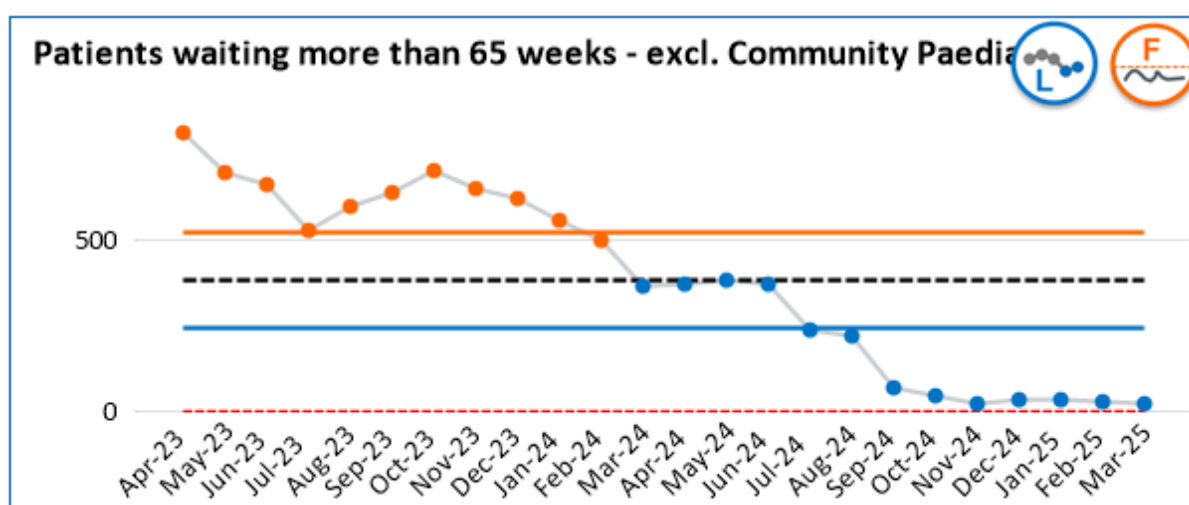
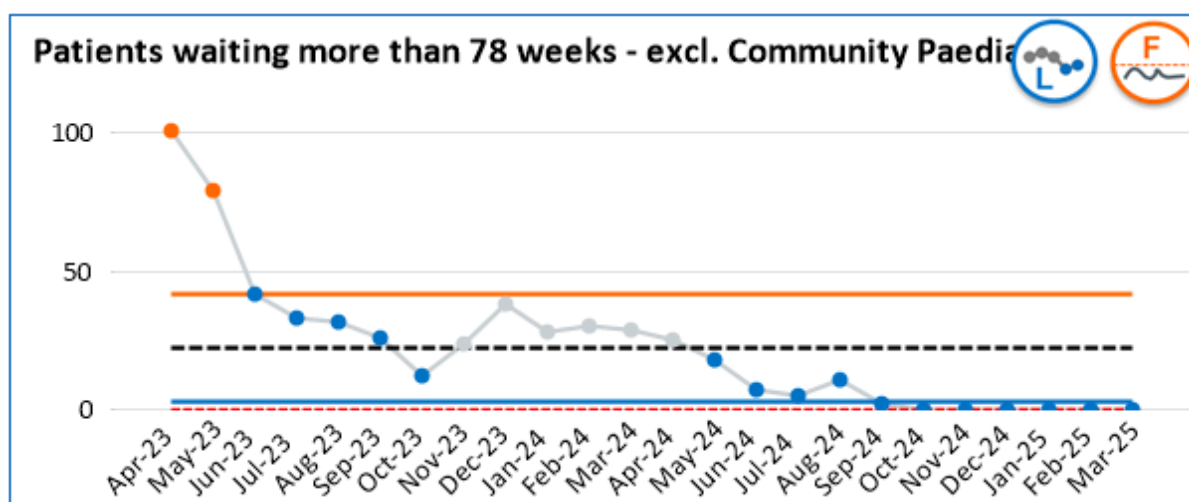
A summary of performance against the key metrics is provided below.

Referral To Treatment (RTT)

Nationally the drive was to eradicate any waits over 65 weeks, with a push to getting waiting times below 52 weeks and driving towards the 18-week target. The Trust through a variety of actions including recruitment turnaround, efficiency gains, additional clinical sessions, patient contact and validation of the waiting list, as well as some transformational work in outpatients and theatres has delivered a significant improvement in waiting times. The Trust participated in a national programme called 'Getting it right first time' (GIRFT) with the objective of sharing learning to reduce waiting times in a faster and more effective manner.

Community paediatric waiting times nationally have remained a concern with a clear gap between demand and capacity. The Trust has continued to work with system providers and commissioners to develop a standardised pathway with children and young people being able to access services in an equitable way.

Excluding Community Paediatrics, the Trust ended the year with 26 patients (0.05% of patients on a waiting list) waiting over 65 weeks due to patient choice, complexity or capacity.



At the end of the 2024/25 financial year, the majority of services were able to meet 52 weeks waiting times (1.66% of the total waiting list are waiting over 52 weeks) with the exception of Trauma & Orthopaedics, Pain Management, Oral Surgery and Urology.

Patients have continued to be contacted by text message if they have been waiting over 12 weeks, have not had an appointment in the last 12 weeks and don't have an appointment booked in the next four weeks, to ensure our waiting lists are made up of patients who are willing and able to attend. 114,892 text messages were sent asking if patients wanted to remain on the waiting list. The response rate was 85% with 7920 (6.89%) patients requesting discharge.

The Trust continues to promote the use of patient initiated follow up (PIFU) for those patients who do not require a follow up appointment but who may require direct access or information from clinical teams by contacting them directly. This will continue to be offered to appropriate patients in 2025/2026.

Urgent Care Pathways

The national four-hour standard recovery trajectory requires 78% of patients arriving at one of the emergency front doors to be admitted to hospital, transferred to a more appropriate care setting, or discharged home within four hours. This includes the Emergency Departments (ED) at the Lister site for adults and children, and the Urgent Treatment Centres (UTC) at Lister and the QEII hospital.

The Trust saw good consistent performance within the UTCs and Children's ED. The area of focus and ongoing work is adults attending the main emergency department.

The ambition of the programme continues to be to transform emergency care pathways to provide alternative(s) to the ED where appropriate, thereby reducing the volume of patients in ED and improving patient flow and experience.

Acute Medical Services (AMS) plans to reset its service model in April 2025 to enhance patient flow through the department from the ED. The goal is to reduce ED length of stay (LOS) and minimise admissions to inpatient wards from ED, while improving discharge rates and flow through the Short Stay Unit. As part of the Acute Reset, further efforts will be made to streamline GP arrivals to Acute Medicine for greater efficiency. Additionally, the Same Day Emergency Care (SDEC) service extended its opening hours until 10 pm, offering extra capacity and support with GP streaming.

The Surgical Assessment Unit (SAU) was formally re-established in January 2024 after being stood down during the COVID-19 pandemic. In December 2024, the Surgical Same Day Emergency Care (SSDEC) service was officially launched.

These integrated services provide dedicated assessment for emergency surgical patients, accommodating referrals directly from GPs or from the Emergency Department (ED) when further surgical evaluation is required.

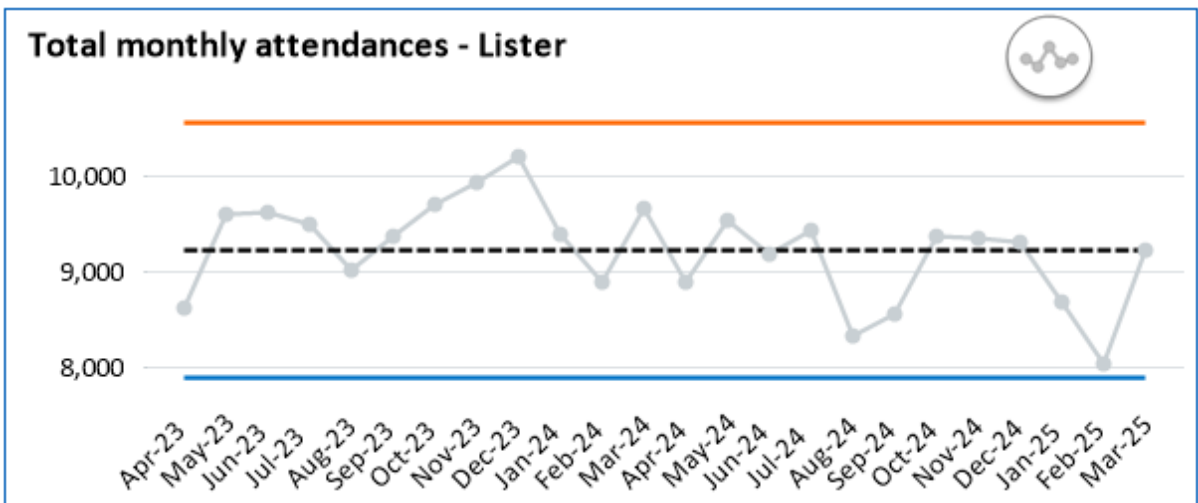
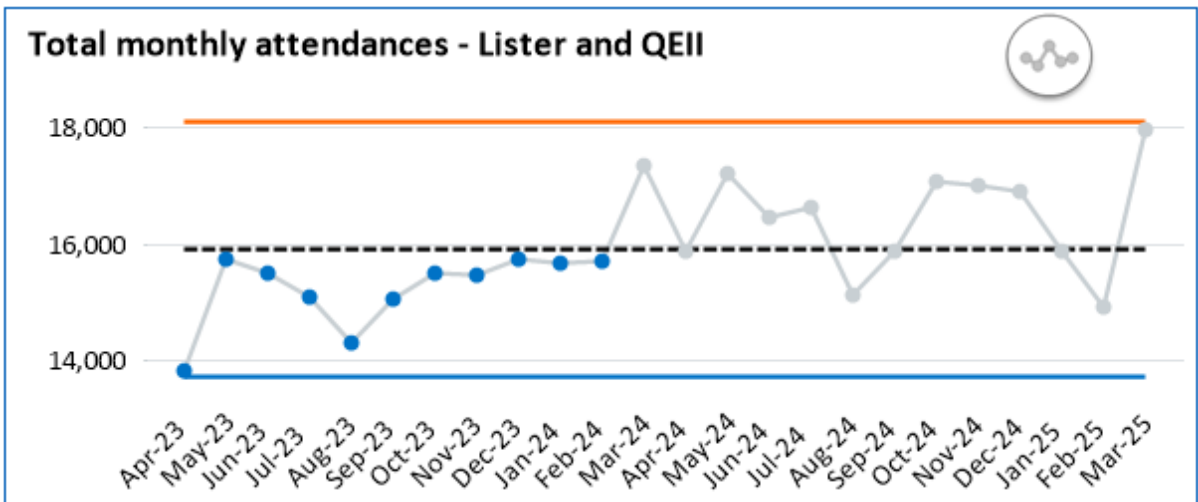
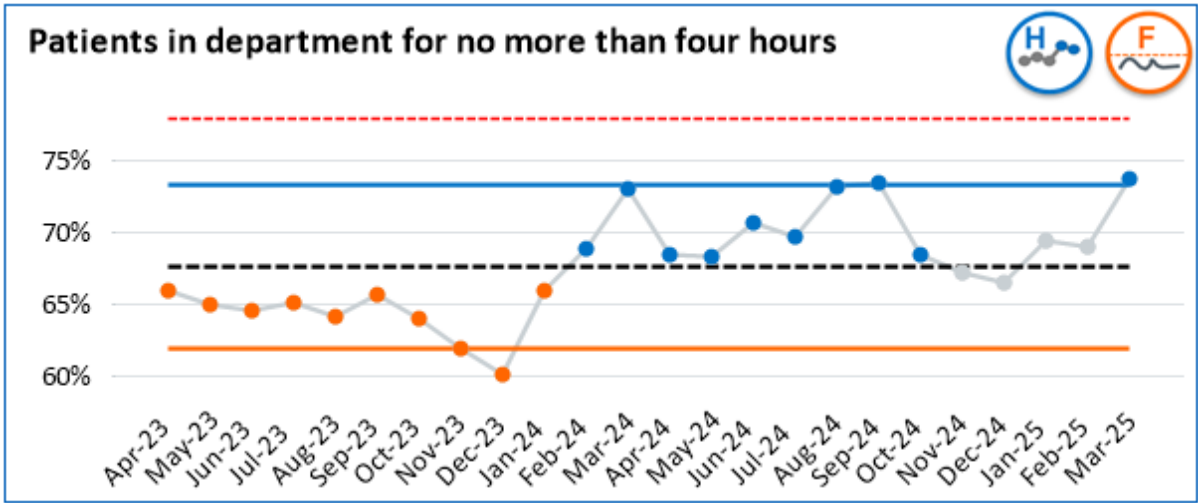
Effective from late April 2025, GP referrals will be directed straight to SSDEC, eliminating the need for patients to attend the ED following an extensive triage training programme.

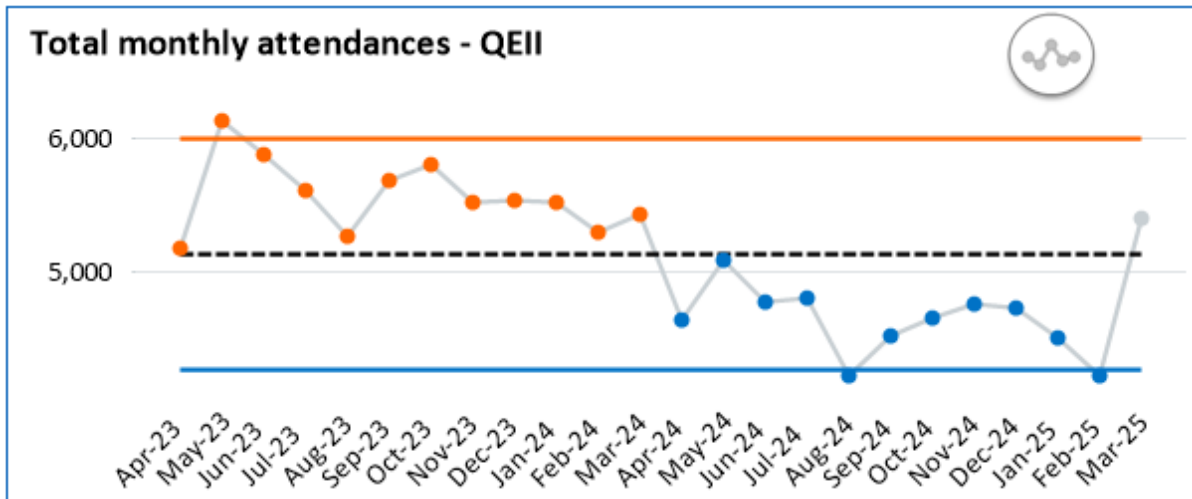
Together, SSDEC and SAU consistently assess more than 30 patients per day, alleviating pressure on urgent and emergency care services.

Children's ED has also been part of the ED improvement programme with the addition of a second triage room allowing for more effective streaming within the department. The development of the Children's Clinical Decision Unit (CCDU) and redesign of the medical

workforce roster to align with expected peak demand has shown an improvement in the paediatric ED four-hour performance during 2024/25.

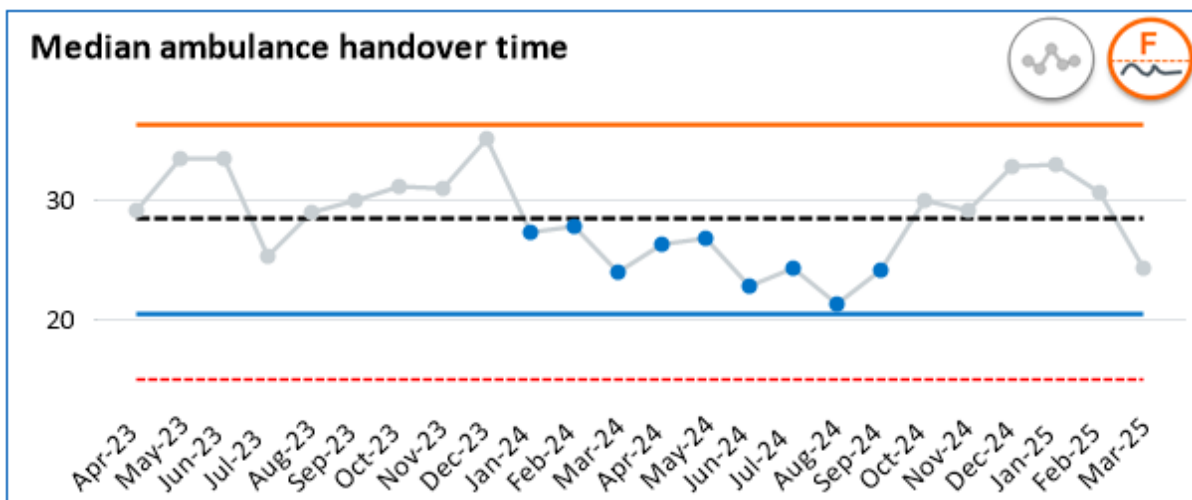
In March 2025, the Trust's four-hour performance improved to 74%.





Ambulance handover

The Trust with East of England Ambulance Service Trust (EEAST) and other partners including Hertfordshire Community Trust, primary care, and other acute providers, worked hard to significantly reduce handover time for those patients brought to the department by ambulance. The target is 65% handover within 15 minutes. During the first nine months of the year, our ambulance handover times consistently remained under 30 minutes. However, as winter approached, we experienced an increase in patient acuity, leading to longer handover times. Despite these challenges, we are now observing a positive trend, with handover times beginning to decrease as we implement targeted improvements.



Cancer performance

In the 2024/25 financial year, the Trust reported on the three priority standards. These standards are:

- the 28-day Faster Diagnosis standard,
- the 31-day General treatments standard,
- the 62-day General standard.

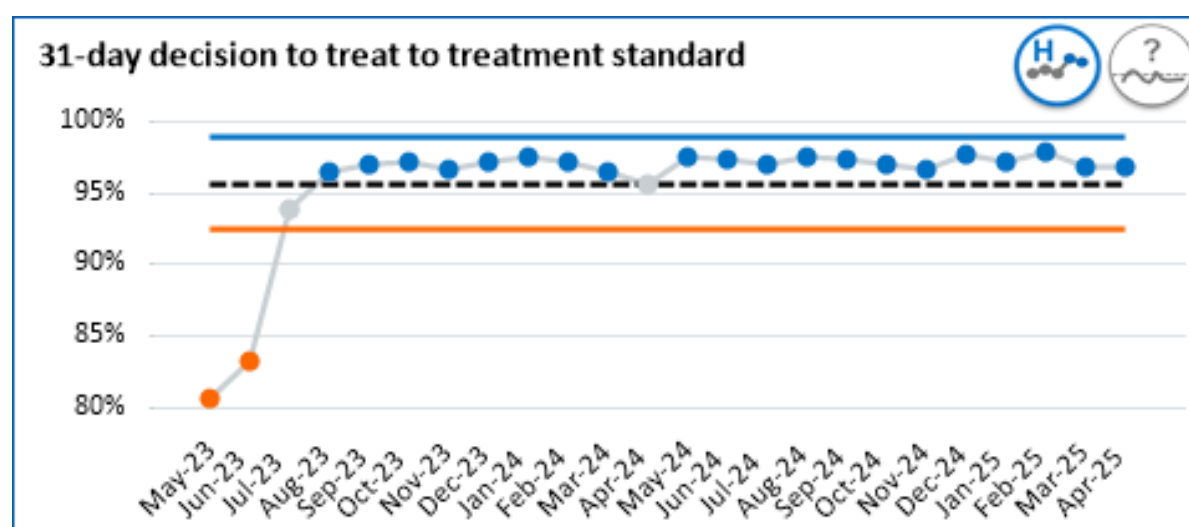
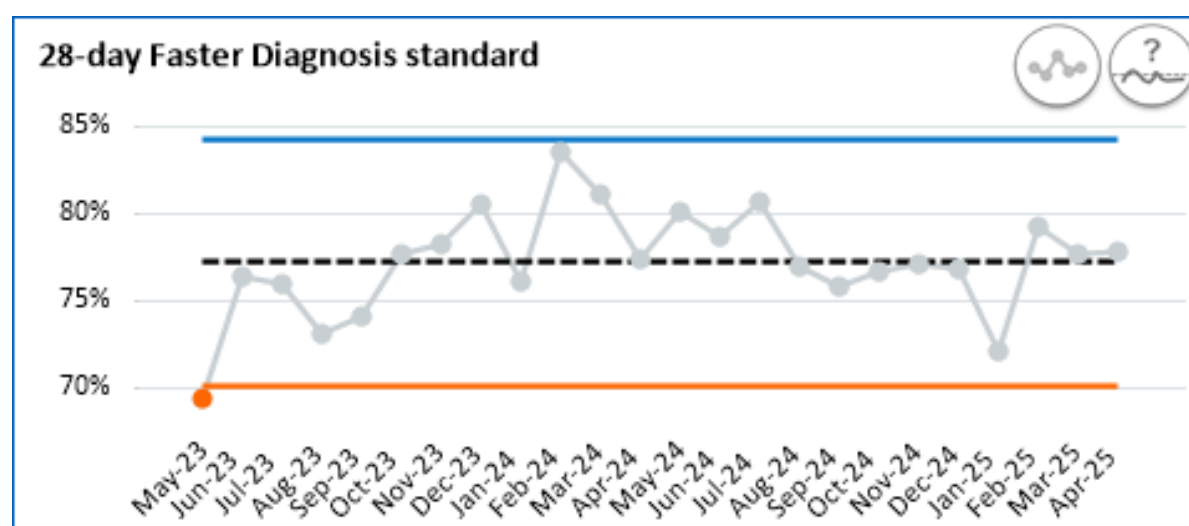
While cancer 62-day general standard performance was not sustained fully over the course of 2024/25, our performance remains one of the best regionally and within the 10 best trusts

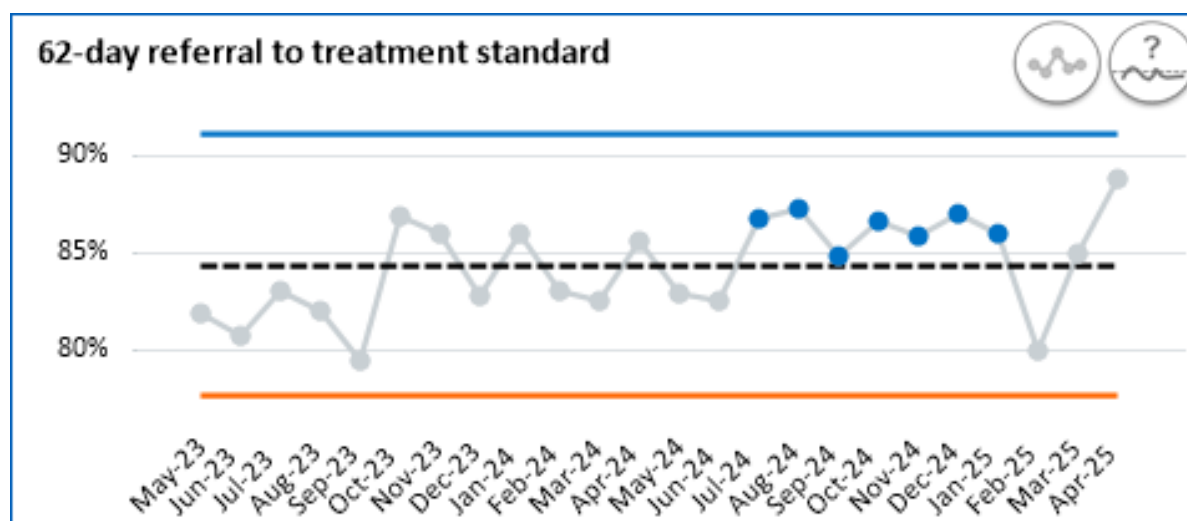
nationally. Factors for underperformance include high numbers of two week wait referrals putting substantial pressure on capacity in endoscopy, imaging and histopathology; patient choice delaying the diagnostic pathway, and complex investigation pathways. These all have remedial plans in place to reduce delays in 2025/26. A 'Two Week Wait' referral is a request from your General Practitioner (GP) to ask the hospital for an urgent appointment for you, because you have symptoms that indicate that you might have cancer.

31-day general treatment standard performance was consistently sustained for the year, despite a one-month dip in performance due to radiotherapy issues: increased downtime from aging linear accelerator (linac) machines, coupled with workforce shortages. The linac machines have now been replaced, and staffing is fully established.

The Trust's 28-day faster diagnosis performance was consistently sustained for the year, despite a one month dip in performance. The target for the new year has been reset to 80% by March 2026.

The Trust continues to use the NHS England pathway analyser tool for all tumour sites so we can clearly identify delays and make changes to improve the end-to-end pathway. The Trust's early adoption of the pathway analyser work has been recognised nationally and the cancer team has shared good practice with other trusts.

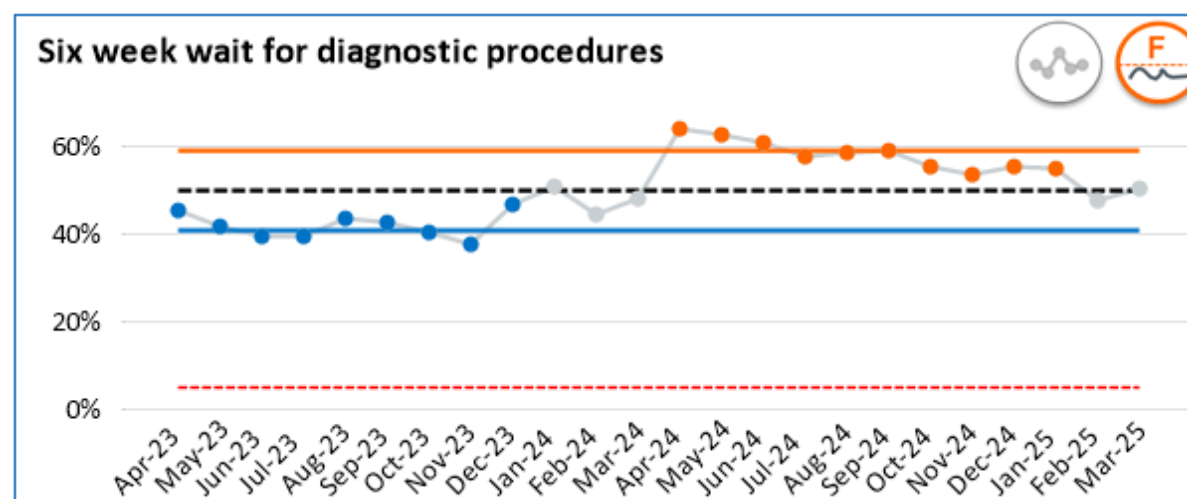




Diagnostics

Standard: less than 1% of patients should wait 6 weeks or more for a diagnostic test

The overall diagnostic performance for the Trust has improved materially this year despite increasing urgent and cancer referrals as a result of focussed capacity planning and work to improve productivity. The Trust has not achieved the overall diagnostic performance standard, although the number and percentage of patients waiting over 6 weeks and over 13 weeks continues to reduce. Since April 2024, there has been a reduction by 43% in the volume of patients waiting over 6 weeks; and by 64% for over 13 weeks.



Stroke performance

The Trust's stroke performance has maintained a B rating since July 2023. Sentinel Stroke National Audit Programme (SSNAP) has made changes in October 2024 and therefore the ratings will not be available until June 2025.

The number of confirmed stroke cases continue to increase over the average monthly baseline set by SSNAP of 63. Most recently in February 2025 we saw 91 confirmed strokes. There is also set to be new requirements in 2025-2026 to improve the number of

eligible patients sent for Thrombectomy at specialist centres as part of a national drive to improve stroke outcomes and survival rates in England compared with Europe. Further work is required to protect dedicated stroke beds during peak times and improve repatriation of out of area referrals.

The service has made progress across various domains, notably in Hyperacute Assessment (HASU) (which gained an A rating in 2024), including increasing the number of patients receiving CT scans within 20 minutes, supported by the new 'Straight to CT' pathway. Further advancements are expected with the introduction of CT Perfusion (CTP) in April 2025. However, delays continue to occur due to limited access to rapid MRI imaging. Additionally, the service has just finalised a year-long project with NHS England aimed at improving thrombolysis performance. The service has now met its Trust-specific target of a 14% thrombolysis rate, a figure set to be supported with the implementation of CTP, which will increase the number of patients eligible for life-saving treatment. The service also plans to fully integrate Stroke Video Triage in 2025 due to its demonstrated success in supporting a faster response to the stroke pre-alert pathway.

The assessment and intensity of therapy offered to patients by the multidisciplinary team (MDT) therapists (occupational therapy, physiotherapy, neuro-psychologists) improved in 2024. However, due to the new SSNAP targets, performance is expected to dip in 2025 due to the target increase in frequency and intensity of therapy per patient to 3 hours per day. Speech and language therapy services have faced significant staffing challenges in recent months, but a long-term pipeline for training and development is in place to ensure a robust, qualified team in the coming years. There is a new joint therapy-gym planned to support increased therapy demand which will be a huge benefit for patients within this service.

Despite these improvements, the service continues to face challenges in meeting performance targets within its specialist pathway domain. In particular, timely admission of patients to the Stroke Unit within four hours remains challenging. The Stroke team is committed to improving this. They plan to strengthen collaboration and build relationships with other departments to streamline pathways, to improve patient length of stay and onward care, establishing a clear and well-understood Stroke Service and HASU pathway. This will be supported by bolstering out-of-hours provision through the recruitment of new resident doctors and moving toward 7-day medical coverage, along with extended consultant cover over weekends.

Lastly, the Service continues to score an A rating on case ascertainment due to the effectiveness of the Stroke Data Team.

Patient Activity 2024/25:



Financial Performance

The Trust reported a surplus of £1.5 million against a planned £1m surplus position.

The Trust's financial performance during 2024/25 needs to be set within the context of the overall NHS funding framework. This year NHS providers have continued to receive fixed block allocations of core funding, with a move to variable funding for elective activity paid through the Elective Recovery Funding (ERF) mechanism. In the final quarter of the year the ERF value was capped at M8 performance on a system level.

The material reversal of non-recurrent items from 23/24 necessitated the Trust setting a significant cost improvement programme (CIP) for the financial year to address the underlying run rate deficit of £22.9m and deliver additional efficiency requirements in 24/25. The Trust CIP plan for 2023/24 totalled £33.6m (5%). During the course of the year the Trust delivered £33.7m.

The Trust has struggled to deliver on its ambitious targets to access ERF by delivering elective activity at a marginal rate, hampered by delayed recruitment, industrial action and winter and operational pressures. Underperformance against planned ERF delivery has been off set in year through non recurrent and technical items.

The early part of 2024/25 saw further impact and disruption in the form of continued and sustained industrial action across doctor staffing groups. The Trust remained agile to successfully minimise safety and financial impacts during these periods. The financial impact of which has seen the Trust receive additional funding via direct funding however the loss of ERF was a direct impact to the Trust's financial position.

In addition, the Trust has experienced a further range of additional unplanned cost pressures during the course of the year that have supplemented this challenging financial environment. In particular the Trust has remained agile and responded to a number of complications within the Trust Renal service which has driven higher than planned expenditure. Overall staffing costs have remained higher than planned throughout the year with particular focal points being medical staffing and CSW's. Medical staffing costs have increased significantly across the period, £13.2m (10%), reflecting the impact of increased costs to deliver elective activity as well as the planned increase to manage of urgent and emergency care pressures.

Further key features of financial performance during 2024/25 were:

- Income from patient care activities

Income from patient care activities increased from £609.6 million in 2023/24 to £656.8million in 2024/25 (£47.2million / a 7.7% increase). The overwhelming element of this increase represents the effect of additional allocations to support both the expected cost uplift impact on the Trust for 2024/25 and resources required to deliver key service priorities for the year. The elective recovery fund mechanism remained in place during 2024/25 to incentivise the expanded delivery of planned services. Elective performance allowed the Trust to secure additional funding through the ERF mechanism, however performance fell below its ambitious targets.

The Trust secured a total of £23m income earned through ERF in 2024/25, compared to £30.6m in 2023/24. Industrial action in the early part of the year did have a significant impact on the Trust's ability to deliver its planned activity levels.

- Other income receipts

A continuation of the improvement of other income receipts has been reported throughout 2024/25. Research and Development (R&D) income increased by £6.5m to £7.9m, and private patient income also increased significantly by £5.4m to £7m in 2024/25.

- Spend on Pay (including temporary staff)

Pay costs increased year on year by £31m from £398.2m to £429.2m. The majority of the increase was driven by national pay awards (£31.4m. Industrial action in the early part of the year has driven an additional £0.7m of pay costs to maintain a continuous and safe service.

Expenditure on temporary staff increased marginally year on year by £0.4m from £49m to £49.4m. Increases related to the Trust's need to expand elective recovery activity was partially offset by a reduction in the level of sickness absence across the Trust.

- Spend on Non-Pay

Expenditure on non-pay (excluding financing costs) increased year on year by £19.3m from £207.7m to £227m. This increase is driven by £3.6m of high-cost drugs usage/inflation, £1.1m utilities inflation, £3m general inflation and £1.9m against the EPR project. Further significant cost pressures in year included high expenditure on energy due to aging facilities and an increase in cost/volume of outsourced pathology tests. The increased activity in year to deliver elective targets led to a further £6.8m of non-pay expenditure.

- Capital investment / donated equipment.

The Trust expended £30.6 million on capital investments in 2024/25 including lease remeasurements. Significant investment was made in finalising a new vascular surgery theatre on the Lister site to enable an expansion of activity delivery and expansion of Renal capacity in response to significant risks in the service. In addition, the Trust continued with its requirement to the site with progressing its backlog maintenance programme as well as incurring expenditure in respect of both scheduled medical equipment replacement and also the enhancement of the Trust's digital infrastructure. The Trust was able to secure additional capital allocations of £7.6m within the year which enabled the Trust to deliver on the renal expansion and significantly improve its critical infrastructure.



- Cash

The Trust's cash balance has decreased by £16 million from £66.3m to £49.7m. The decrease in cash is primarily a consequence of the in-year capital purchase of property, plant and equipment.

- IFRS 16 impact

During the course of the year the Trust had right of use asset additions of £3.7m and remeasurement of existing assets of £1.7m. At 31 March 2025 the Trust's Right of Use (ROU) asset net book value was £95.9m reduced from £100.1m as at 31 March 2025.

People Performance

The Trust continues to deliver against key objectives set out within its People Strategy and the four pillars of: work, grow, thrive and care, all golden threads linking to the NHS People Promise and supporting delivery of ENHT mission and objectives.

Work Together

Recruitment

During 2024/25 the Trust made significant strides in recruitment efforts across all staff groups, culminating in an achieved vacancy rate of just under 8%, particularly notable successes were witnessed in Nursing and Midwifery qualified and medical staff groups, with reduced vacancy rates now at 9.6% and 3.8%.

At the end of March 2025, the Trust had over 1,893 Full Time Equivalent (FTE) nursing and midwifery staff in post, supported by active domestic recruitment initiatives and the Trust received recognition for its international recruitment efforts and commitment to providing high-quality pastoral care to internationally educated nurses and midwives, being awarded the NHS Pastoral Care Quality Award.

Furthermore, the Trust achieved numerous successes in recruiting 'hard to fill' medical roles throughout the year, resulting in the highest number of doctors in post since pre-2020, with 1,056 FTE doctors now in post.

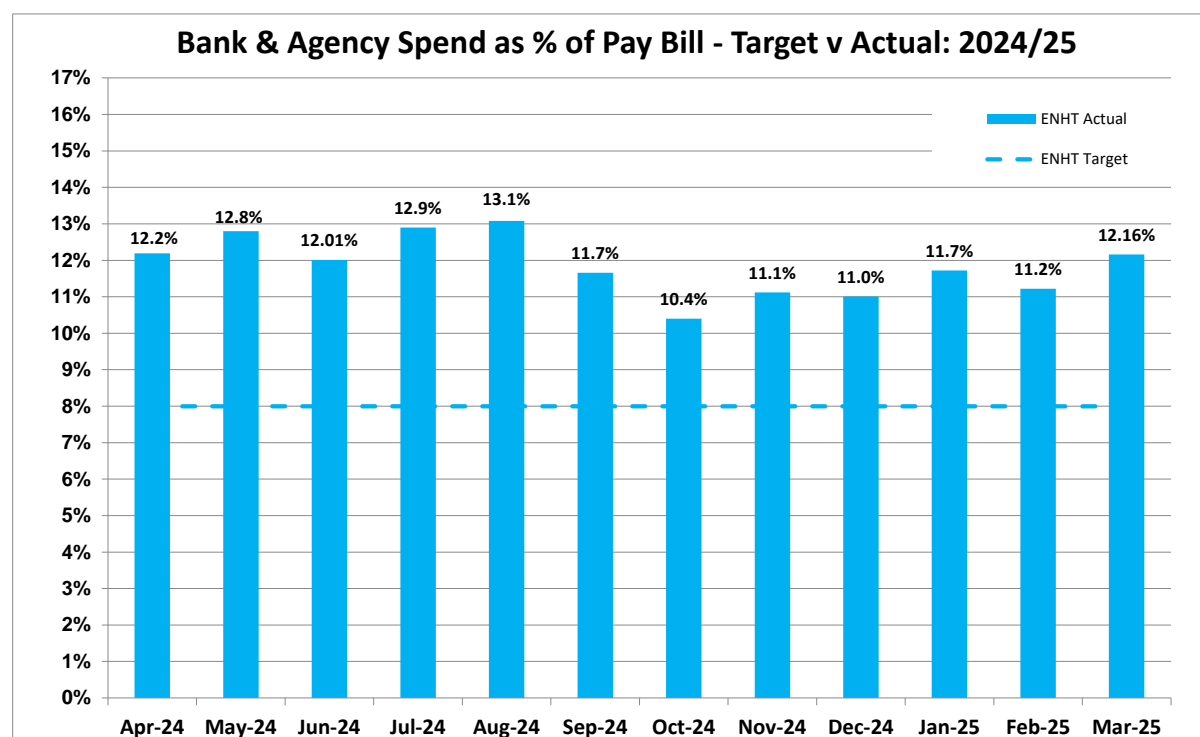
As a result of the Resourcing team becoming the East & North Hertfordshire flagship workstream for the East & North Hertfordshire Production System (ENHPS) work focusing on improving efficiencies and reducing waste through the Virginia Mason Institute methodology 2025/26 a 2-week improvement on time to hire to 13 weeks was achieved from the previous year.

Inclusive recruitment practices remain a key priority for the Trust, with implementation of the inclusion ambassador scheme ensuring equity and accessibility to roles. The initiative champions equality, diversity, and inclusion throughout the selection process, reinforcing the Trust's commitment to fostering a diverse and inclusive workforce.

Temporary Staffing

The Trust maintained strong performance in managing bank and agency staffing throughout 2024/25. The bank to agency ratio averaged 89% (bank), with agency placements at 11%, comfortably below the NHSE agency ceiling target. The Trust delivered a 2% reduction in

agency spend as a proportion of whole-time equivalent (WTE), which generated a £300,000 saving throughout the year.



Improvements and savings have been achieved throughout 2024/25 on Bank spends as a percentage of total WTE averaged 9.3% and agency spend averaged 2.6% of total WTE spend with over 100 reduced agency price cap breaches throughout 2024/25.

Notably, the Trust maintained its top-ranking position for agency spend across the ICB (Integrated Care Board) region for the third consecutive year.

The Trust continued to lead and work collaboratively with West Hertfordshire, Princess Alexandra, and Hertfordshire Community Trust with the ICB wide NHS Professionals managed service contract, resulting in generating a saving of £89,947 demonstrating the Trust's commitment to efficient staff utilisation and cost-effective solutions.

Electronic Rostering

91% of clinical staff (agenda for change) and 92% of medical staff are on rosters, providing a comprehensive overview across the organisation and facilitating better deployment and decision-making for managers.

Throughout 2024/25, the percentage of staff on annual leave, sick leave, and parenting leave remained within set tolerance levels, a positive indication of effective leave management and regularly reviewed roster controls.

62% of rosters were approved more than six weeks in advance of the start date, a 2% improvement from the previous year and ongoing work remains to continue improving the approval rate.

90% of the consultant workforce are on the roster system, with implementation activities ongoing to transition all remaining medical workforce onto electronic rostering by Q3 of

2025/26. These initiatives aim to enhance efficiency and effectiveness in staff deployment and roster management across the organisation.

Key priorities for 2025/26 include alignment of establishment and budgets within the roster system, provision of ongoing face-to-face training, and launching self-rostering on a unit-by-unit basis.

Medical Workforce

Resident Doctor Rotations

In August 2024, the compliance rate for issuing work schedules within the required 8-week timeframe was 54%. To improve this the medical workforce team implemented significant process change, leading to a compliance rate increasing to 95% in March 2025. Additionally, a new pay progression process aligned with changes to the Specialty Doctor and Specialist Doctor contracts has been successfully implemented.

Job Planning Summary 2024/25

The L2P job planning system has been fully embedded into business-as-usual processes, with administrative support for job planning provided by the medical workforce team. A standard operating procedure has been established for retrospective job plan payments to improve performance and reduce late claims. For 2025/26 ensuring all job plans are signed off prospectively, in accordance with the job planning policy is a key priority and focus.

The Trust is prioritising the implementation of team job planning, aligning demand and capacity to workforce needs. A job planning panel was reinstated to oversee non-compliant job plans, those exceeding 12 PAs, and recently signed-off job plans to ensure consistency. 90% of signed-off job plans are correctly aligned to payroll from monthly monitoring.

Local Negotiating Committee & Resident Doctor Forum

The Resident Doctor Forum (RDF) continues to serve as a crucial platform for engagement with our resident doctors. Over the past year, it has strengthened communication and addressing workforce concerns.

Medical Policies

- The Acting Down Policy and the Work Schedule & Exception Reporting Policy have undergone a full review and approval.
- The Job Planning Policy has been extended for six months to support the ongoing job planning project.
- The Annual Leave Policy is the next priority for review.

Revalidation & Appraisal

The Revalidation team has undergone leadership and process changes, successfully adapting a proactive approach to prioritise future appraisals over retrospective completions. Monthly Revalidation and Appraisal meetings have been established with the Responsible Officer and Lead Appraiser, maintaining a compliance rate of around 90%.

To support increasing medical staff numbers, the team successfully recruited and trained new appraisers. In 2025/26 the team will implement KPIs to consistently monitor performance, identify challenges, and demonstrate priorities and achievements to service users.

People Services

Since its launch in November 2022, our people team virtual assistant, 'Enquire,' had a significant increase in engagement and usage throughout the organisation, over 1,000 users

a month accessed the platform. Enquire performance has a remarkable 96% recognition rate, surpassing industry standards by 8%.

Enquire has attracted external interest with several NHS organisations purchasing the HR library to implement within their own organisations. This reflects the effectiveness and value of implementing digital solutions in enhancing HR processes and support across healthcare settings.

Enquire won the HPMA 2024 Capsticks award for Innovation highlighting its innovation and impact in the healthcare sector for people services, this recognition further validates the success and potential in revolutionising people digital systems.

Grow Together

Our Grow Together approach to create a golden thread throughout the organisation for every member of staff is showing positive improvements. Grow Together provides opportunity to discuss and create a great opportunity for line managers and their team to highlight role challenges, discuss flexibility and plan in appropriate support throughout the year providing a formal opportunity to show and record appreciation for the contribution at work and how their work aligns with the wider Trust goals. Compliance has continued to improve year-on-year since the introduction of the 'grow' model discussion, this incorporates health and wellbeing, development and career aspirations supported by a live objective tracker.

We measure success both through completion rates, which have delivered a significant 6% improvement from 2023 and 3.8% improvement in the number of staff receiving a GTR/appraisal in the last 12 months, our annual staff survey results demonstrate the positive impact too.

The approach has yielded over 5% improvement in '*people are feeling valued by their line managers and organisation*' since 2022. And by providing the opportunity to discuss career development/progression, the 2024 Staff Survey results showed a significant improvement and '*career progression/promotion in our Trust*' is now viewed as fair regardless of gender, religion, sexual orientation disability or age. However, more work is required around race in this regard.

Developmental aspirations data shared during Grow Together Review conversations will be utilised for development of targeted offers and sharing, where appropriate with divisional leads to create space when allocating 'stretch' and project assignment within teams for those ready and prepared for growth.

Talent Management & Leadership Development

Grow Together, our approach to ensuring continuous feedback is provided to colleagues, remains fully embedded within the Trust. The process culminates each year with ('Grow Together Review appraisal) undertaken for all staff within a defined April – August window. Built into this, is a system to support talent, career conversations and succession planning.

Active recruitment of Grow together Champions in each locality continued to support staff compliance with appraisal reviews. In the 2024 staff survey over 85% of staff indicated that they had undertaken an appraisal in the last year, with all indicators relating to appraisals showing an improvement.

Future leaders, development and step up programmes have continued to be supported throughout 2024/25 from work experience to specific apprenticeships and ICB wide programmes such as Emerging System Leaders programme (ESLP) and Accelerated Directors Development programmes.

Core Staff training and Development

We have one Learning Management System (LMS) known as ENH Academy, it continues to be the single point of access for all essential training and development including all statutory and mandatory training and role specific online training.

In Q1 2024 we launched our Trust wide Management Competence Framework, offering two pathways; a self-approach for the more experienced leaders and a Development programme for a cohort-based approach with mixed media learning. Since its launch three cohorts of 20 staff have participated in the specific modular approach with over 100 colleagues opting for the self-directed pathway the approach includes intermittent drop-in sessions facilitated by subject matter experts.

ENH Academy was upgraded with additional, relevant bite-size 'Skill Boosters' available for our time poor, learning on-the-move colleagues, the portfolio now includes performance management and Equality, Diversity and Inclusion topics to continue to support line manager grow their competencies, capability and confidence, supporting them to improve their managerial skillsets, crucial in team leadership and wider Trust objectives delivery.

This is aligned to our 2024/25 objective to 'build capacity for compassionate and inclusive leadership, sharing clear expectations and accountability' whilst creating an environment where our people can thrive. The results are that the 2024 Staff Survey results show our managers are compassionate and meet their teams to discuss effectiveness and deal with disagreements constructively, with clear feedback sharing. Our employees would recommend the Trust as a place to work and are happy with the standard of care that friends and relatives would receive in our care. We have improved cross-team collaboration to achieve objectives by 3% according to staff survey results and over 50% plan to stay and develop their career with our Trust.

Clinical and Medical Education

During 2024/25 the Trust has continued to focus on providing exceptional clinical Learning environments for our students and trainee with the aim to increase the numbers of registered staff within the organisation through training, in line with the NHS long term workforce plan. There are currently 118 students onsite across all programmes and 99 members of staff undertaking a preceptorship programme.

In 2024/25, the Trust was awarded the National Preceptorship for Nursing Quality Mark, evidencing excellence in supporting newly qualified nurses entering our workforce They are enrolled on the preceptorship programme designed to set them up for from the start of their career. The preceptorship team were shortlisted for a Nursing Times Workforce Award in the 'Preceptorship Programme of the Year' category.

There was a continued increase in our Clinical Support Workers (CSW) undertaking apprenticeships at the Trust (193 in total), a significant increase on our numbers in previous years. Approximately 50 staff per year progress on to Nurse Associate programmes and onwards to a Nursing apprenticeship degree course or top up programme.

For over 20 years the Trust has been a proud teaching hospital partner with the University of Cambridge and University College London (UCL), providing clinical placements and skills

training to undergraduate medical students across the Trust. In 2024/25, hosting over 100 UCL medical students and almost 200 Cambridge students in years 4, 5, and 6 of their studies.

Looking ahead, we are committed to expanding our academic excellence and research capabilities with the ambition to gain university hospital status. This reflects our dedication to developing both our current and future workforce, strengthening our reputation as a centre for clinical education, innovation, and professional development.

Future workforce

In 2024/25 the Trust had over 375 staff undertaking apprenticeships both in clinical and in non-clinical roles (level 2-7). This has increased our apprenticeship levy monthly utilisation to 70–75% and plans for 2025/26 are to align further with the NHS long term workforce Plan. This requires wider discussion in regard to the level of support for learners, especially within clinical teams. Other achievements throughout 2024/25 are:

- 42 registered degree nurse apprentices developed via apprenticeship pathway from healthcare support workers.
- 28 staff enrolled on the nursing associates two-year programme, and the staff will be counted in as qualified registrants on the same level as registered nurses (pay level band 4).
- 11 senior Care Support Workers enrolled and completing an 18-months programme, which results in progress from pay and work level band 2 to 3.
- 60 healthcare support workers participating in a 15-month recruitment pathway to the student nursing associate programme.
- 34 clinical support works graduated as degree Registered Nurses in 2024 and all successfully secured roles within the Trust.
- The Finance department have eight apprentices studying and developing their skills from roles at level 3 to level 7 in finance subjects.
- Pharmacy has 13 apprentices at level 2 and 3 with one level 6.
- There are seven senior leader apprentices in place across the Trust.



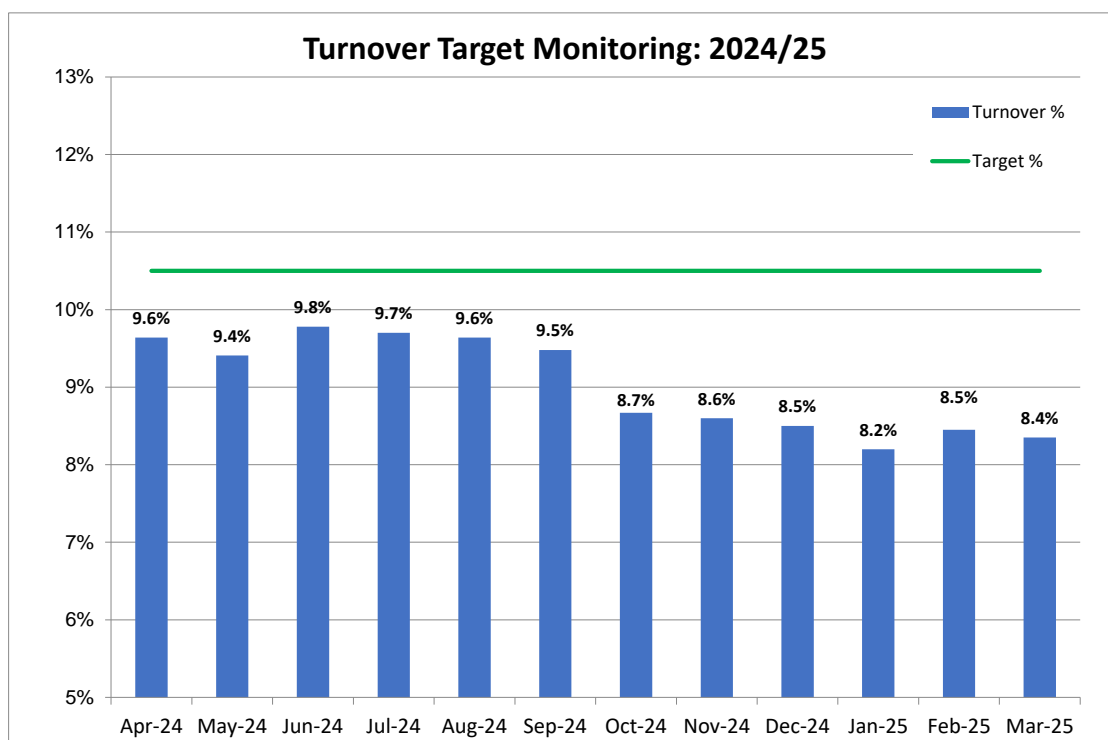
We continue to champion apprenticeships during our Learning at Work week with planned apprentice and provider engagement and are working to increase our schools widening participation work through attending career fairs as ambassadors to increase NHS career awareness for the schools in our communities and encourage our teams to host work experience placements from our local schools. An example of success is within our Estates and Facilities division when they attended their first school widening participation raising awareness of the range of diverse roles and careers available in our Trust.



Thrive Together

Retention

The Trust's overall turnover rate has remained below target for the last 12 months, with significant reductions in the number of staff who have resigned. This demonstrates stability within the workforce following a turbulent post-COVID period.



Staff survey

The 2024 staff survey results published in March 2025 demonstrate an increased response rate from our workforce of 50%, meaning the results are reliable and valid and the highest ever for the Trust. The Trust showed statistical improvement in each of the seven NHS People Promise domains and two themes. With two of the people promise themes being significantly above sector average. Overall, we had 19 questions (18%) improve significantly, one that decreased significantly and 88 questions (81%) of the survey that either showed small improvement or stayed the same. Due to these results according to work carried out by the health service journal we had overall the fourth most improved staff survey results in the country.

We continue to celebrate where we improve and our localised focus in 2025/26 will support the following key areas:

Morale – the focus relates to engaging teams to see understand any barriers that exist in accessing equipment and resources and working with stakeholders in digital and capital projects, to ensure key changes to the site's digital and estates-based infrastructure of the Trust is communicated to our teams and staff.

A voice that counts – we will focus on sharing examples from when staff raise unsafe clinical practice and share stories of when staff speaking up has led to improvements in patient care with collaboration from our Freedom to Speak Up Guardian and staff networks. Work is required to address and eliminate race discrimination towards staff from service users, patients, and staff-on-staff. We will improve data sharing where staff make complaints by publishing our case work data to demonstrate statistics on outcomes of investigations and through embedding our EDI strategy and showcasing work that a steering group has been involved in at directorate and team levels and we will prioritise investment to launch active bystander training across the Trust to highlight the importance of breakaway training for staff.

Reward and recognition we continue to promote our annual Time to Shine Staff Awards and celebrating staff through our monthly ViP Awards. A review of our staff benefits intranet page to enable staff easier access to promote and increase scheme awareness for example securing a partnership with Tickets For Good where staff can access free or discounted tickets for live entertainment events.

We are always learning – the focus here is to highlight issues in accessing clinical supervision in teams and divisions to work with key stakeholders on local action plans to enable change in this.

Inclusion and engagement

We continue to deliver our plans arising from mandated equality reports (WRES/WDES, Gender Pay and EDS2022) and link these to the NHS people promises and have published our up-to-date public sector duty equality data on our internet homepages.

In 2024/25 we have enabled Executives to sponsor a staff network, providing strategic guidance and championing network objectives at senior meetings, this will continue into 2025/26.

Model Employer monthly data shows an overall 100% compliance on a 78% target for 2024. In 2025/26 this will be examined further to understand the nuances across professional groups to plan to address identified variances.

In 2024/25 we strengthened our Inclusion Ambassadors programme in recruitment and introduced sharing interview questions and model answers with the interview panel at least 24 hrs before the interview, as well as sharing example questions to candidates to support preparation. For 2025/26 we will revitalise our Recruitment and Selection training by embedding Unconscious Bias training mandated for all appointing managers, providing consistent and a standardised ability of appointing managers.



Flexible Working

Across the Trust the 2024 staff survey shows access to discussions around flexible working and opportunities for flexible working have improved from 6.17 in 2023 to 6.35 in 2024, we are significantly above the acute based sector average of 6.24.

To ensure this upward trend within the Trust is maintained we will highlight the ESR flexible working request process and discuss and implement a range of team-based rostering and/or support for hotdesking in areas where scores are lower and use feedback and best practice from areas that have seen increases in scores to support these areas learn and improve in performance around flexible working.

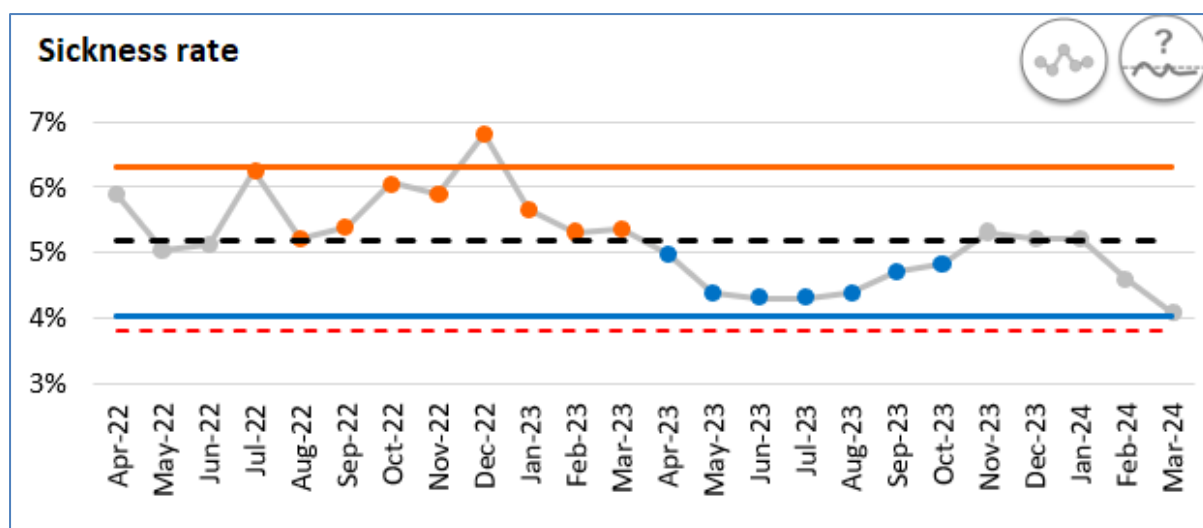
Care Together

A monthly VIP award for 'staff recognition' launched in 2024/25 using Trust values to recognise individuals or teams, and the annual staff award event continues to receive charity support with suppliers sponsoring the event to maximise value for money.

Health at Work

The Health at Work Service coordinated a comprehensive range of services to proactively prevent health and wellbeing problems, promote physical and psychological safety, provide accessible, early support and treatment when health problems occur throughout 2024/25.

Health at Work have provided advice to promote health and reduce sickness absence, referrals for physiotherapy and priority access to mental health support. Immunisations have been provided to protect colleagues and those they care for from infection.



Wellbeing is promoted by the network of wellbeing champions, mental health first aiders, wellbeing events, webinars and on the intranet. Team and individual reflection sessions have provided regular opportunities for colleagues to explore the emotional aspects of their role, and the menopause network has been a popular new peer support group.

Digital Performance 2024/25

Key Achievements in 2024/25

The Digital team delivered a wide-ranging portfolio of projects in 2024/25 to improve clinical systems, enhance infrastructure, and strengthen digital resilience across the Trust.

Programme Delivery

A total of 27 major projects and 30 system enhancements were successfully completed, alongside 30 full application upgrades, with 17 more in progress. These upgrades significantly improved user experience and prepared core systems for the wider Electronic Patient Record (EPR) implementation.

Key clinical systems such as Auditbase (audiology Electronic Patient record), OpenEye (Ophthalmology Electronic patient record), K2 Maternity EPR were delivered this year. Our bleep systems have now been replaced with a new Smartphone app called Alertive which allows clinicians to securely message each other and receive full patient details on the alerts. On the corporate side, robotic process automation (RPA) was introduced in People Services to drive operational efficiency.

Digital Infrastructure & Cyber Resilience

The Trust invested in critical infrastructure improvements, including:

- Refurbishment of Multidisciplinary Team (MDT) rooms to support collaboration
- Support for multiple office relocations and building refurbishments
- Ongoing delivery of cybersecurity and digital resilience programmes
- Team Integration & Workforce Development: Previously siloed teams, including Radiology IT, MVCC IT, and Pathology IT, were successfully integrated into the central digital team. Staff have received targeted training to improve digital capability and service delivery across the organisation.

Outpatients Transformation

As part of a wider Outpatients Improvement Programme:

- A Call Answering Service was launched to improve patient access

- The Patient Hub enabled digital communication via the NHS App and SMS, with over 75,000 notifications sent
- Clinic digitisation progressed, with 37% of clinics and 39% of sessions now active on the system
- A New Electronic document management system is being configured due to go live in October 2025 will digitise the existing patient files to make them more accessible on the and in outpatient clinics.

OneEPR: Transforming Patient Care Through a New Electronic Patient Record

In April 2024, the Trust launched its ambitious OneEPR programme — a two-year project to implement a single, modern Electronic Patient Record (EPR) system across all Trust sites. The programme is being delivered in partnership with Dedalus, Europe's largest EPR provider.

The Trust has entered a 10-year agreement to implement ORBIS U, which will replace the Trust's two existing EPR systems and digitise many remaining paper-based processes. This will improve clinical efficiency, support integrated care, and enhance patient safety.

The programme is clinically led, with clinicians from across the Trust actively collaborating in design workshops alongside Dedalus experts and the Trust's Digital team. Together, they are co-designing the new system to ensure it fits the needs of frontline teams.

The first phase of OneEPR is planned to go live in early 2026, marking a major milestone in the Trust's digital transformation journey.

These developments form a strong foundation for the Trust's digital future and support safer, more efficient, and patient-centred care.

East and North Hertfordshire Hospitals Charity

Our hospitals' charity had a fantastic year raising funds to support patients, families and staff across all our sites. Kind donations, legacies and fundraising by the local community has funded projects that include an app to help prepare children for their hospital visit; special chairs for patients having chemotherapy and music and dance sessions for patients who are living with dementia. It also funded new equipment, refurbishments and staff reward and recognition schemes.



The charity's Lister Abseil, Rainbow Run, Fire Walks and Moor Park events proved ever popular and had over 1,900 participants who helped raise over £150k.

The charity also held its inaugural Hertfordshire Residential Development Awards hosted by architect and television presenter, Damion Burrows, with special guests Saracens and England rugby players, Rosie Galligan and Marlie Packer.

The charity would like to thank its supporters, volunteers and NHS colleagues for their continued support in helping us to go above and beyond for our patients, their families and our staff.

Research and Development

Introduction: Patients are central to our research efforts. We begin by thanking everyone who participated in or supported research at the Trust. Without research, we cannot develop new treatments or improve healthcare practices.

The Trust is proud to be part of the [National Institute for Health and care Research](#) which exists to enable and deliver world-leading health and social care research that improves people's health and wellbeing, and promotes economic growth.

Benefits of Research: Being research-active has two main benefits. Firstly, patients who participate in research receive direct benefits from new treatments. Secondly, all patients, whether they participate in research or not, benefit indirectly from the Trust being research-active, leading to better overall care and outcomes. Research evidence supports this: [Research active hospitals have lower mortality rates](#) and [patients' perception and experience of care is higher in research active organisations](#). [Staff have increased job satisfaction and NHS employers can improve recruitment and retention](#) when staff are enabled to be involved in research.

Patient and Public Involvement in research: From our ongoing research participant survey in 2024/5, we received 132 responses. Patients frequently mentioned the excellent care they received from doctors, nurses, and the research team. They appreciated the prompt responses to their questions and the constant updates on their treatment progress. Clear and informative communication was highly valued, as was personalised and compassionate care. Patients expressed satisfaction with the outcomes of their treatments and appreciated the efficiency of the treatment process.

Patients also provided feedback on areas for improvement. They expressed a desire for more information about their treatment, including side effects, recovery times, and results of blood tests. Suggestions included better follow-up communication, handling of side effects and discomfort, and ensuring privacy and comfort during treatment.

The Trust's Patient and Public Involvement in Research Panel meets on a regular basis to help us better understand how we can design our local research to meet the needs of our patients. Example projects include research on swallowing difficulties, tinnitus therapy, AI for menopause management and social isolation in dialysis.

As a Trust we also place information on our [website](#) to support public and patient engagement events, to signpost how people can find out how research affects patient care and to provide examples of how research can enhance patient outcome and experience. In addition we signpost people to the [#BePartofResearch](#) website – this is a free service which makes it easy to find and take part in vital health and care research across the UK.

Strategic Approach: At the start of 2024/5, we published our [four-year research strategy](#), developed in conjunction with patients, the public, and our wider healthcare partners. Our goal is *to be recognised and valued as an organisation where people can take part in and benefit from research*. The research strategy supports the organisation's mission *to provide consistently outstanding care and exemplary service*.

We set six objectives for the four-year research strategy:

1. Align research with local needs by listening to and acting on the voice of our people.
2. Make research inclusive for all people and put in place actions to make research more accessible.
3. Foster local and national collaborations to increase research opportunities for local participation.
4. Include the opportunity for people to take part in research as an essential design consideration for all our services.
5. Ensure all colleagues recognise research as an essential and rewarding part of effective patient care.
6. Implement national approaches to make best use of data, digital systems, and AI to support research in a way that is trusted.

In the first year of the new strategy, we focused on building on current research strengths, developing plans to address known areas for improvement, implementing government initiatives, and developing a plan for financial growth to expand our research offerings to patients.

We provided leadership and support across our local system, the East of England, and nationally. Examples include leading the [East and North Hertfordshire Health Care Partnership](#) Research and Innovation Group, seconding research staff to the [Hertfordshire and West Essex Integrated Care system](#) and working with the National Institute for Health and care Research [East of England Regional Research Delivery Network](#).

3) Research Activity: Over the last 10 years, more than 27,368 people from across the Trust volunteered to take part in at least one of 544 different research studies across all 24 national specialties, addressing local health needs. In 2024/25 (based on data available 1st April 2025) , the Trust recruited a total of 2,206 research participants across 96 projects covering 15 different clinical specialties.

In 2024, the Trust had 348 [research publications](#) authored by Trust staff, including 35 jointly published with the [University of Hertfordshire](#). The publications encompass a diverse array of research fields and are disseminated in several high-impact journals.

We are particularly proud that we have made a new oesophageal cancer screening trial available to our patients and 2,071 have volunteered to take part. This research study seeks to determine whether we can use a quick 'pill-on-a-thread' test to screen people with chronic heartburn for early signs of oesophageal cancer. We made it easier for patients to take part in convenient places by the use of a mobile screening van like this one.



4) Future Plans: Our focus in 2025/6 is to deliver the second year of our research strategy. We plan to make progress against each of our objectives and success indicators, ensuring research is aligned with local needs, inclusive, and supported by partnerships, data, and digital tools.

Social matters

Stakeholder engagement

Since the general election the Trust has hosted a number of visits from our new local MPs, including briefing meetings and visits to clinical areas.

In March the Trust welcomed Baroness Merron, Under-Secretary of State for Patient Safety, Women's Health and Mental Health. The Baroness visited the Hertfordshire Endometriosis Centre based at Lister Hospital, where she spoke to staff and patients about their work and treatment. The Baroness also visited theatres to see the surgical robot used to treat endometriosis.

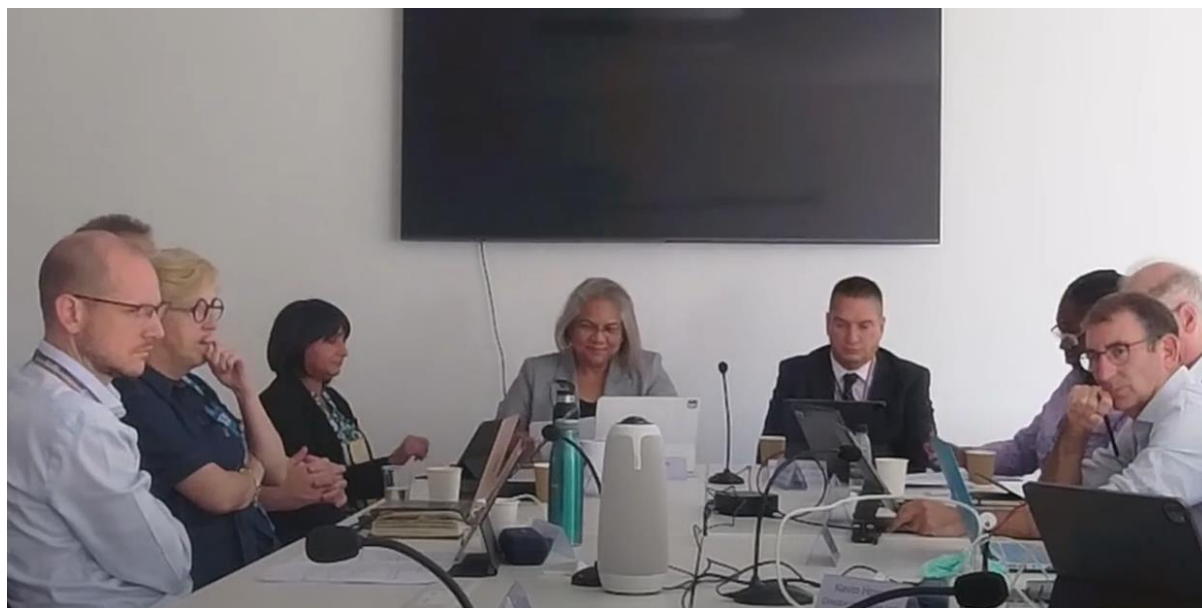
The Trust continues to attend meetings of the Hertfordshire Health Overview and Scrutiny Committee, and provide briefings on topics of interest or concern. In addition, the Trust has attended Bedfordshire Health Overview and Scrutiny Committee to discuss the closure of the Bedford renal unit in 2024.

Patient groups continue to drive improvement across the Trust, in particular in renal services via the Lister Area Kidney Patients Association (LAKPA), and with the Lister Maternity Voices Partnership. The Trust Board's Chair, Anita Day, attended the LAKPA Annual General Meeting to talk about future plans for the renal service.

The Chief Nurse and Chief Executive meet quarterly with representatives from Healthwatch Hertfordshire, and a quarterly meeting is held to discuss partnership opportunities and priorities with the University of Hertfordshire.

Representatives from both Healthwatch Hertfordshire and the University of Hertfordshire have recently joined the Board.

Since July 2024 Trust Board meetings have been livestreamed, with over 1,500 views of the five meetings.



Public membership

A quarterly newsletter is shared with the Trust's 477 members, including information about services, improvements and opportunities to get involved. Our members have been involved in taking part in surveys, assessments of the physical environment of the Trust, in our patient and carer experience group and in our annual general meeting.

Annual general Meeting (AGM) 2024

The Trust held its AGM in September 2024 as a virtual event, with the offer of spaces to attend in person. [The 2024 AGM can be viewed here on YouTube.](#)

390 people watched the 2024 AGM – either via the livestream or the recording of the meeting.

Work with GPs

The Trust continues to deliver a successful GP query helpline, providing a link between primary care and our clinicians – answering an average of 115 queries per month.

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

Monthly online patient case forums allow GPs to discuss particular anonymised cases with specialty consultants.

Risk Profile

As of 31 March 2025, the Trust had 12 principal risks defined on the Board Assurance Framework (BAF) (set out below) each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified. The BAF sets out the principal risks identified by the Board to delivering the Trust's strategy. The BAF underwent a review in April 2024

with two new risks added (the future of cancer services and investment) plus three risks descriptions being amended.

Risk no	Strategic Risk	Oversight and Assurance Committee
Strategic priority 1: Consistently deliver quality standards, targeting health inequalities and involving patients in their care		
1	Investment (capital, system allocation and no growth)	Finance, Performance & Planning
2	Health inequalities	Quality & Safety
3	System and internal financial constraints	Finance, Performance & Planning
Strategic priority 2: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability		
4	Workforce shortages and skills mix to meet quality standards	People & Culture
5	Culture, leadership and engagement	People & Culture
6	Autonomy and accountability	People & Culture
Strategic priority 3: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners		
7	System inertia	Finance, Performance & Planning
8	Improving performance and flow	Finance, Performance & Planning
9	The future of cancer services	Quality & Safety
Strategic priority 4: Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities		
10	Digital transformation	Finance, Performance & Planning
11	VMI – getting out what the Trust needs <i>[VMI is a process improvement methodology]</i>	People & Culture
12	Clinical engagement and change	Quality & Safety

The future of cancer services BAF 9 risk was added to the BAF given the ongoing national delay on an agreement on the future of services delivered at Mount Vernon Cancer Centre and where they transfer to. The Mount Vernon site is an old premise which poses challenges for quality of care such as it does not have an accident and emergency service on site and the premises is expensive and problematic to repair and maintain. The Investment (capital, system allocation and no growth) BAF 1 risk was added to reflect the size of the challenge of maintaining the Trust's estate and equipment where capital funding struggles to keep up with need, requiring difficult prioritisation decisions.

At 31 March 2025 no BAF risks remained rated a '20'. The highest risk score was '16'. This is the second year in a row where there is not a 20 rated risk on the BAF at the end of the financial year. This compared to one risk in 2022-23 (Risk 3: Financial Constraints), one risk rated '20' in 2021/22 (Risk 1: Operational Performance) and two risks rated '20' at the end of 2020/21 (Risk 4: Capital and Risk 10: Estates and Facilities).

Two risk scores increased at year-end in light of the NHS Business Plan. In 2024/25, Risk 3 (Financial constraints) reduced from '20' to '12' but increased to '16' at year-end. Risk 1 (Capital investment) also increased to '16' at year-end. No other BAF scores increased during the year through mitigation action. Seven of the 12 BAF risks were red-rated (scoring 15 and above) at the end of the financial year. Two of these are the two new risks identified at the start of the year (Risk 1: Investment, and Risk 9: The future of cancer services). A further two of the seven red-rated risks are system-related risks (Risk 8: Improving performance and flow and Risk 9: The future of cancer services), which are highly reliant on external stakeholders.

The Board and the lead committees for BAF risks receive reports bi-monthly on progress with the BAF to assure that the mitigations are operating (where this is within the Trust's ability to do so) and that those mitigations are effective or further actions are identified.

Further details on the BAF and risk management can be found in the Annual Governance Statement.

Statements Relating To Social Matters

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

Respect for human rights and anti-fraud, bribery, and corruption matters

We are committed to taking all necessary steps to counter fraud, bribery, and corruption within the NHS, through continuing to develop an open and honest culture. A clear Anti-Fraud and Bribery policy is in place at the Trust, which was reviewed and approved by the Trust's Audit Committee in October 2023. The policy is due for review before October 2026. The policy reflects current guidance and reference to the NHS Counter Fraud Authority Strategy released in June 2023.

At the time of writing, the Trust is anticipating reporting an overall outcome of green for the 2024/25 Counter Fraud Functional Standard Return, which is a self-assessment against the NHS Counter Fraud Authority (NHSCFA) Requirements of the Government Functional Standard GovS 013: Counter fraud; however, this rating may be subject to change upon submission.

RSM are contracted as the Trust's counter fraud provider and are responsible for taking forward all anti-fraud work locally and in accordance with the national Counter Fraud

Functional Standard. They report directly to the Chief Finance Officer, as the Trust's Accountable Officer for fraud.

Equality of service delivery

The work on tackling health inequalities (unfair and avoidable differences in health across the population) is summarised below and remains ongoing.

Smoke Free Site

Smoking remains the leading preventable cause of death and disability in the UK and is the largest cause of health inequalities. More than half of people who smoke will die early with the reduction in life expectancy exclusively associated with smoking.

On 1 April 2025, we became a smoke-free Trust, meaning smoking on our four hospitals sites is no longer permitted. This brings us in line with 82% of other hospitals in UK.

As a Trust we offer systematic smoking cessation interventions for our service users including availability of cytisine (a medication that reduces nicotine craving and enables smoking cessation that can be maintained) as well as targeted support in the form of advice in smoking cessation clinics.

Blood Borne Virus Testing in Emergency Department

We have committed to being in the third wave of Trusts looking to roll out Blood Borne Virus testing in service users who attend the Emergency Department with acute illnesses and ailments.

The blood borne viruses testing aims to identify three infections: HIV, Hepatitis C and Hepatitis B infections. We will be able to identify service users with infections with these viruses that they were unaware about and were asymptomatic. We anticipate rolling this testing programme in the first quarter of the new financial year.

Significant inequalities exist in identifying and treating those living with HIV, HCV and HBV and addressing these inequalities is paramount. Tackling these challenges requires reaching those who do not test in traditional settings such as sexual health clinics. On the other hand, vulnerable people disproportionately attend ED and opt out testing provides an important opportunity to test and diagnose asymptomatic infections.

Developing pathways of care for patients with sickle cell disease

Sickle cell disease can affect anyone, but in the UK it's more common in people with African and Caribbean backgrounds. Long-term, sickle cell disease can damage organs within the body, including the heart, lungs and kidneys and lead to problems with bones and extremities. Sickle cell disease is estimated to affect 1 in every 2000 live births in England. As such it is one of the most common genetic conditions affecting people in England.

In our catchment population, 0.4% of people are living with sickle cell disease which is higher than the UK prevalence of 0.2%.

We have enhanced our pathways of care for patients presenting with a sickle cell crisis with severe pain so that service users have access to high quality pain relief (patient controlled analgesia: PCA) and support from dedicated Nurse Specialist in Haematology who also supports Nursing Staff on the Ward to deliver high quality timely care. We have adapted the training programme for staff to better understand the condition, know what to expect when service users present with a crisis and deliver appropriate care. Training Nurses to be familiar with opioid based analgesia and PCA set up and use has improved care experience and quality for our service users living with the condition.

Transform Advanced Kidney Care (Transform AKC)

The Trust's Kidney Care service is one of the five pilot sites in the country selected to improve equitable access to the highest quality AKC service for all patients through sustainable and systemic changes in practice. We will be focussing on service users under our catchment (1.4 million across 3 counties) who are from BAME background to enable timely and resilient access to multi-professional care that enables activation on the transplant waiting list as well as encouraging family and friends of service users to consider live donation.

The project is scheduled to run for three years and hard end points like time to activation on the transplant list, live donation rates, engagement with health living support (optimal blood pressure control, optimal diabetic control) will be studied and reported through the UK Kidney Association.

Combined mental and physical health support for service users with T1DE (type 1 Diabetes with Disordered eating)

We are at the early stages of designing a joint mental and physical health care pathway for service users with Type 1 diabetes who have disordered eating. The prevalence is difficult to quantify but is thought to be 1% in pre-adolescence to as high as 27-39% in late adolescence and early adulthood. Service users often do not access specialist services and even when they do, variable availability of inter-related paediatric, young adult and mental health professionals' results in fragmentation of care and episodes of physical health crisis requiring in-patient care and in-patient stays that are often prolonged and support being episodic. The aim will be to create a working group composed of professionals in mental health, paediatrics, adult diabetic services, nutritionists working in partnership with stakeholders in Primary Care, Council (Schools) to formulate care pathways for adolescent and early adult service users with T1 Diabetes that can provide support and safety as well as identifying risk profiles for T1DE.

Addressing Health Inequalities: Work Programme

The highlighted areas of work when implemented will address some of the care access inequity that is reported and understood in Hertfordshire. This is by no means an exhaustive list. The programme that the ICB is developing aligned with Core20Plus5 priorities informs scope and scale for us as an Acute Trust. It is well understood that stakeholders within the ICB will be required to work together for achieving the broader ICB objectives when finalised. However, as an Acute Trust, there are areas where work has begun and in progress:

1. waiting list surveillance,
2. the role of Acute Trust in health surveillance for service users with learning disabilities and mental illnesses,
3. chronic illness management support (diabetes, kidney disease),
4. musculoskeletal health inequalities and deprivation--- exploring a service delivery in the community for better access and roles of First Contact Practitioners),
5. Staff training and education in understanding inequities in care and measures to improve access and support for self-management (patient activation).

Sustainability statement

Task Force on Climate Financial Disclosure (TCFD)

Due to the patient focussed objectives of the Trust, the Trust does not fully comply with the Task Force on Climate Financial Disclosure. However, good progress is being made as evidenced below:

- All climate related risk continues to be identified and added to the Trust's risk register.
- Risks are reviewed on a monthly basis via the Trust Risk Management Group Meeting and reported up to the Trust's Quality & Safety Committee.
- Both climate-related risks and strategy are reported and monitored on a bi-annual basis at the Trust Sustainability Board and reported up to the Trust Finance, Planning and Performance Committee (FPPC).
- The Trust is currently refreshing its Green Plan, which is due to be submitted to the NHS England by 31 July 2025. The refresh will incorporate updated strategic direction and key actions, along with revised metrics and local targets to achieve the net-zero targets 2040 (direct) and 2045 (indirect).

Sustainability: 3 years on

In January 2022, the Trust formally adopted its Green Plan (2021-24), a live strategy outlining our aims, objectives, and delivery plans for sustainable development.

The Green Plan sets out the Trust's carbon emission targets and resource use reduction targets in line with the Greener NHS' Net Zero NHS' national ambitions and the UK Climate Act (2008). Three years on the Trust continues to work towards the NHS Long Term plan of achieving Net Zero by 2040, through embedding sustainability at the heart of decision making across the Trust.

Following government guidance released in February 2025, the Trust is to work about refreshing the Green Plan for the next 3-year cycle. All plans are to be refreshed in line with statutory guidance with below actions to be achieved by 31 July 2025.

- Refreshed green plans to be approved by Trust Board
- Plan to be published on the Trust website
- Plan to be shared with NHS England

What we have achieved over 2024/25

Estates & Facilities

- £250,000 was awarded to the Trust from the National Energy Efficiency Fund (NEEF) to install additional LED lighting in the Lister hospital as well as further upgrades to its Building Management System (BMS) along with installing heat meters across its central heating and hot water system, to increase visibility of the distribution of heat across the Lister site.
- £2,100,000 was awarded to the Trust from NEEF for solar panel installation on the Emergency Department building, New Ward Block and Strathmore Wing as well the largest array being installed across the main Lister Hospital car park.
- Renewal of the Combined Heat and Power (CHP) is underway to ensure an increased level of reliability and enhanced energy efficiency, while enabling the rollout of the Trust's Heat Decarbonisation Plan.
- The Heat Decarbonisation Plan (HDP) has been completed, in partnership with Veolia Energy and critiqued by Carbon Architecture. The HDP sets out a roadmap for the Lister to transition from existing CHP to low carbon technologies. The Trust will be applying for funding via the Public Sector Decarbonisation Scheme (PSDS) in October. If successful, the Trust will start the decarbonisation transition journey.
- Ongoing partnership working with the Digital Team on a range of energy saving projects including peripheral digital equipment shut down overnight and recycling and repurposing of digital equipment.

- Catering are progressing obtaining SOIL association accreditation - target date June 2025.
- The catering department converted from plastic utensils to recycled wooden cutlery in the restaurant.

Green Ambassadors Network (GA)

- GA Network established (30 members).
- Net Zero Board lead appointed.
- Established Sustainability Board with a Chair and Deputy Chair.
- The Trust Green Plan features on the Trust Corporate Induction Programme.
- Ongoing communications-led promotion of green initiatives (national and local).

Sustainable care models

- Re-usable PPE pilot at MVCC – reusable alternatives generate 80-90% less waste than single-use face masks, have 3 to 11 times lower climate change impacts. A pilot project was successful in proving it was possible to re-use PPE, with the roll-out to progress in 2025, with support from the ICS Procurement Team.
- Green Scholar: the project examined ways to reduce the carbon footprint of the head and neck cancer radiotherapy pathway by targeting carbon hotspots including surgery, medications and travel to radiotherapy. The finding recommendations will roll-out in 2025.
- Anaesthetic Gas (N2O) waste reduction: the Lister Hospital site switched from a pipe supply to a cylinder supply to prevent leakage.

Researchers at the East and North Hertfordshire NHS Trust have published five significant studies in 2024, highlighting the intersection of healthcare and climate change. These studies underscore the environmental impact of medical practices, particularly in asthma care.

- One study, led by Khezrian et al., examined the [greenhouse gas \(GHG\) emissions associated with severe asthma exacerbations along the care pathway](#).
- Another study by Tran et al., published in Thorax, explored the [carbon footprint disparities in inhaler device use across Nordic countries and the UK](#).
- Vartiainen and colleagues conducted a study, also published in Thorax, which revealed that [thoughtful prescription of inhaled medication could reduce inhaler-related GHG emissions by 85%](#).
- Wilkinson et al. contributed to the body of research with their study on the [SABINA healthCARE-Based enviroNmental cost of treatment \(CARBON\) study](#).
- Lastly, another study by Vartiainen et al., published in BMJ Open Respir Res, examined the potential to [reduce inhaler-related GHG emissions through better prescribing practices](#).

Travel and logistics

- Nine new electric vehicle charging points have gone-live, locations include Maternity, the Estates Office and the Treatment Centre. An expression of interest was submitted for additional EV charges.
- EV charging workplace scheme (NHS Fleet) has been established for all staff.
- Five electric vehicles (non-patient transport fleet) are now fully embedded.
- Stream (track and trace logistics software) has been installed for fleet vehicles – transport mapping is in progress, with the aim to reduce emissions related to better transport route planning.

Greenspace and biodiversity

- Nature Recovery Ranger Project – funding has been awarded from the National Lottery to fund 2-year 0.8WTE post to be based at Mount Vernon Hospital. The project goes live in April 2025.
- Smoke Free Hospital Site - the Trust has officially become a smoke free site. The removal of the smoking shelter enables an accessible space to be completely landscaped and transformed into a green space for our Staff, Patients and Visitors with works to commence May 2025.

Carbon emissions and reporting

The Trust is responsible for mandatory collection of data, monitoring and reporting against targets across the programme at national, regional and system level to the NHS Greener NHS, via the following frameworks:

- NHS Estates Net Zero Carbon Delivery Plan.
- Net Zero travel and transport strategy.
- Greener NHS Data Collection.

External sustainability reporting requirements

Other than the Green Plan guidance, the following documents set out sustainability reporting requirements for NHS bodies:

- The NHS standard contract for NHS providers.
- The Group Accounting Manual for DHSC bodies.
- The Foundation Trust Annual Reporting Manual for foundation trusts.

“There are currently no requirements for NHS Trusts or Integrated Care Boards (ICBs) to develop and publish their own carbon footprints. The time and resources spent on foot-printing needs to be proportionate and should not distract from acting. Organisations that have the capacity and skills may choose to focus on foot-printing their organisation, while other organisations may need to focus resources on taking action to reduce emissions”.

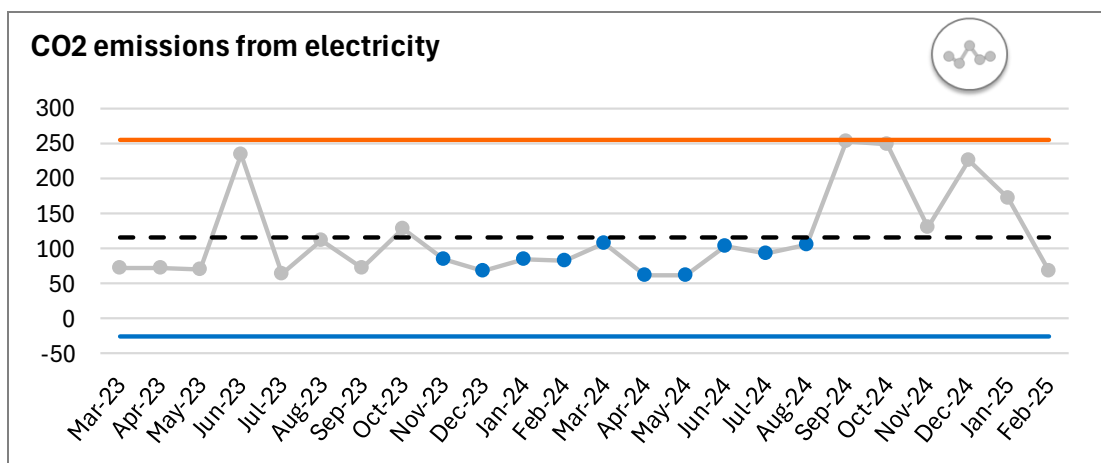
“All Trusts should be annually reporting on progress towards delivering against their Green Plans, as set out in the Green Plan guidance. From 2023/24 NHS England will report annual emissions estimates for the whole NHS via the NHSE annual report and accounts”.

(National Greener NHS Team (NHS England) February 2024.)

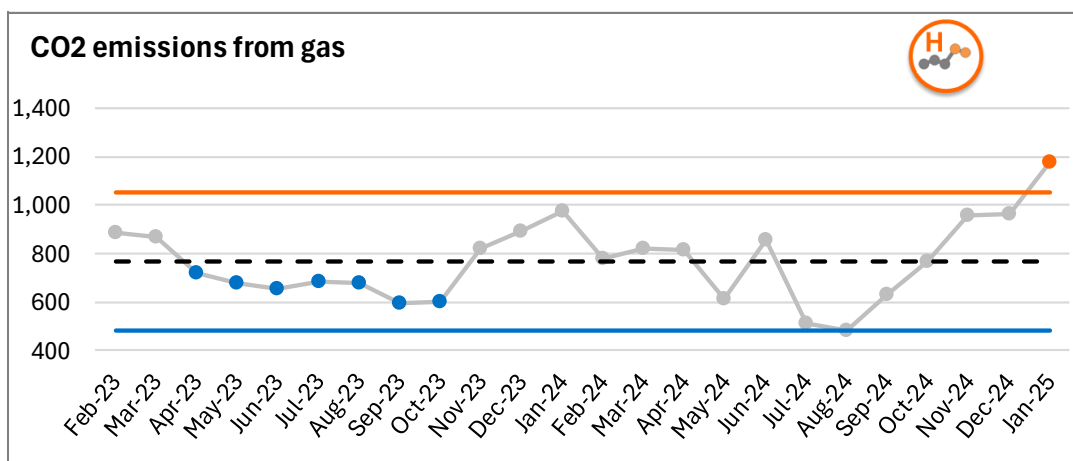
The essential focus for Trusts is to achieve key actions outlined in the ‘Should do’ and ‘Could do’ checklist, which underpins the Green Plan guidance to achieving Net Zero. Our Trust has progressed extremely well against this checklist as highlighted above against the respective workstreams.

Carbon footprint – internal monitoring

The Trust has developed a methodology for data collection that can be used to calculate its annual carbon footprint, based on monitoring emissions from electrical and gas only. These data flows are continually analysed to identify trends and provide the Trust with the ability to create bespoke action plans to mitigate against potential inconsistencies.



CO2 emissions from electricity (graph 1). Peak in emissions during June, and then August-December due to Energy Centre down-time, resulting in increased reliance from the main-grid.



CO2 emissions from gas (graph 2.) Shows seasonal variation, higher usage over winter months.

Developing such a dashboard will enable the Trust to better align with its Green Plan and its aim of becoming Net Zero by 2040. Being able to analyse trends within these data flows can be invaluable in implementing targeted carbon efficiency projects.

As the Trust continues to invest capital and secure further external government funding in energy efficiency projects, the Trust is expecting to be able to track accurately the reduction in carbon emissions. This will allow the Trust to measure whether it is projected to achieve its annual carbon emissions reduction targets.

Waste reporting

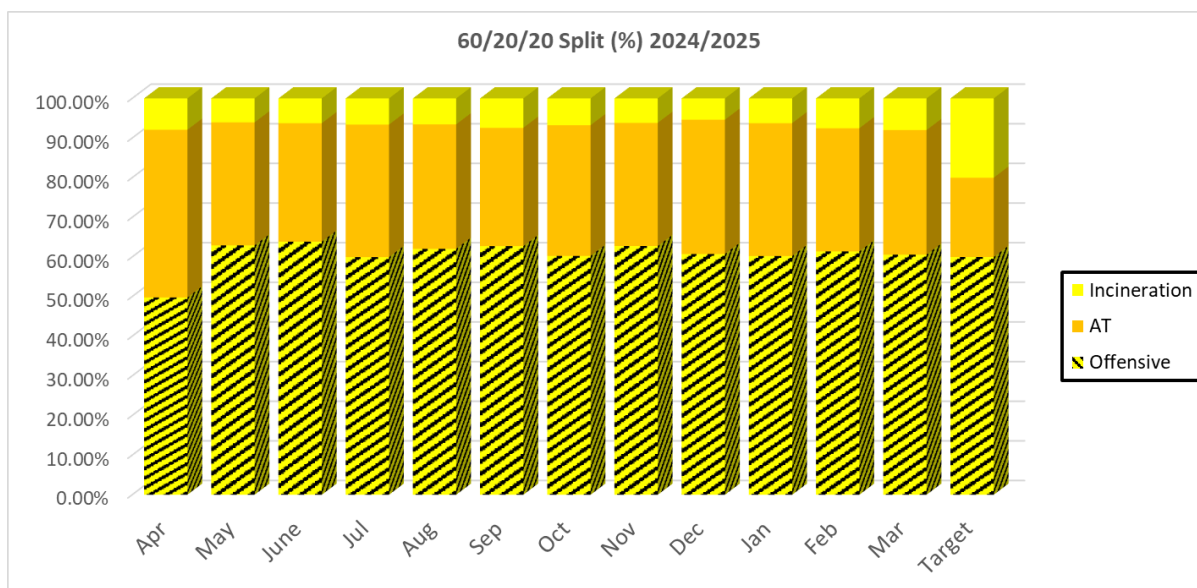
2024/2025 has seen continuation and maintenance of delivery of NHSE targets. Service improvement, efficiency, cost-effectiveness, safety and sustainability have been the key drivers for this year's activities.

National targets	Trust achievement
<i>To achieve 0% waste to landfill across all waste streams by end 2023.</i>	This target was achieved ahead of schedule - 1 st June 2023 and continues to be maintained. This includes both clinical and non-clinical waste.
<i>To achieve the clinical waste segregation targets set in the NHS England Clinical Waste strategy by 2026 (20% incineration waste; 20% AT*/Infectious waste; 60% offensive waste)</i>	This target was achieved in May 2024, ahead of the 2026 deadline and has continued to be maintained. See below for further details.
<i>To ensure full compliance with Healthcare Technical Memorandum 07-01 – Safe and Sustainable Management of Healthcare Waste.</i>	Sharpsmart trend audits have continued with good engagement from colleagues in wards and departments. The Environment Agency conducted a hazardous waste audit in March 2025, whilst the full report has not been received, the initial feedback was positive. Recommendations included increasing staff training and education. In addition, replication of good practice seen in some departments should be extended to all areas.
<i>To minimise, reduce and avoid waste where possible, encouraging the organisation to move away from waste disposal to resource management.</i>	Storage areas have been identified to ensure that usable office furniture can be stored pending reissue to other departments. This will save both the cost of disposal of good quality items and the cost of buying new goods. The refurbishment of broken IT equipment also contribute to this aim. Usable pharmaceutical products are also returned to main pharmacy where safe to do so.

Clinical Waste Segregation

The reintroduction of the Offensive waste* stream into all clinical areas has continued, resulting in the achievement of this target in May 2024. In the 2023/2024 ERIC return, ENHT reported some progress toward but did not achieve the target in year. It is expected that at year end this target will have been achieved.

	Target	2023/2024	2024/2025
High temperature incineration (HTI)	20%	11.6%	6.6%
Alternative treatment (AT)	20%	60.2%	32.8%
Offensive	60%	28.2%	60.6%
TOTAL %	100%	100%	100%

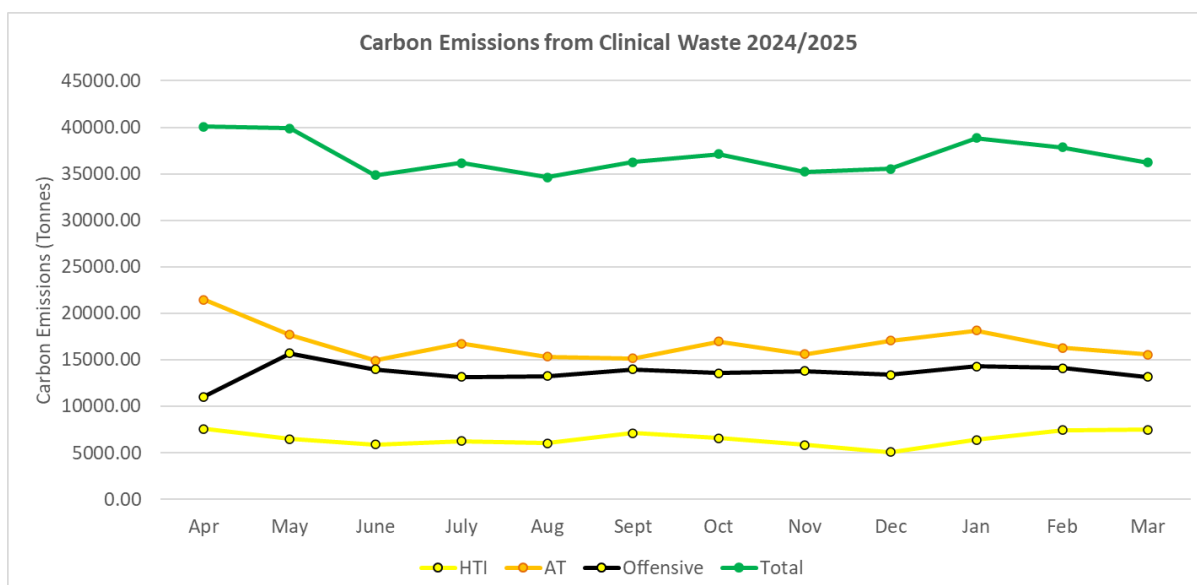


Safe and effective waste segregation and disposal is essential to ensure compliance with legislation. It also ensures the most cost effective and carbon efficient means of treatment and disposal. How clinical waste is segregated depends upon its use prior to needing disposal. This will define the treatment it will require to destroy it.

Carbon Emissions Reduction from Clinical Waste Disposal

Moving to reusable sharps containers has also changed the way in which the contents are treated. This has diverted waste from high temperature incineration to alternative treatment, contributing further to the reduction in carbon emissions.

2024/2025 carbon emissions from clinical waste continue to reduce as we maintain the clinical waste segregation improvements. Year to date shows an overall reduction of 9.6% in carbon emissions from the treatment of clinical waste.



** The offensive waste stream is used for the disposal of "unpleasant" non-infectious healthcare waste. Its reintroduction recognises that most of the waste derived from the*

treatment of patients is non-infectious and as such does not require any treatment prior to its use as Refuse Derived Fuel.

AT Waste – is derived from items used to treat infectious patients. It is treated in a rotoclave to disinfect it and is then shredded. The resulting floc is then used as Refuse Derived Fuel. Waste for incineration is highly infectious and/or hazardous waste where destruction by high temperature incineration is the safest option. This method of destruction results in the highest carbon emissions.

Accountability Report

The accountability report consists of three sections:

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

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

Adam Sewell-Jones, Chief Executive
29 June 2025

Corporate Governance Report

This part of the annual report consists of:

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

Directors' Report

The Trust Board

The Trust Board plays a key role in setting the values, aims and strategic direction for our Trust. They also review our performance against our objectives as well as national targets in areas including quality and safety, operational performance and financial sustainability. It is their responsibility to make sure we have the financial and human resources we need to provide our services. Led by an independent chair and composed of a mixture of both executive and independent non-executive members, the Board has a collective responsibility for the performance of the organisation.

The purpose of NHS Boards is to govern effectively, and in so doing build patient, public and stakeholder confidence that their health and healthcare is in safe hands. The Board does this by:

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

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

The Board met in formal public session on seven occasions during 2024/25. Members of the public were able to attend the Board in person. The Board met on a further six occasions for Board Development sessions.

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

As of 31 March 2025, the Board consists of a non-executive chair, five non-executive directors and five executive directors – the Chief Executive, Medical Director, Chief Nurse, Director of Finance and Chief Operating Officer. In addition, two associate non-executive directors, a NExT non-executive director and five further executive directors – the Chief People Officer, Chief Information Officer, Director of Improvement, Director of Estates & Facilities – participate in Board meetings, but do not have voting rights. In addition, whilst the Trust was awaiting Teaching Hospital status, an observer representative from the University

of Hertfordshire attended the Board. A representative from Healthwatch is invited to the Public Board. The executive and non-executive members function as a team, working closely together, although with different responsibilities.

During 2024/25, three non-executives retired, Jonathan Silver, Val Moore and Peter Carter. Gill Hooper, Diana Skeete and Janet Scotcher replaced the retiring non-executives. In addition, Richard Oosterom joined as an additional associate non-executive and Tichafara Phiri joined as a NExT non-executive.

The Chair continues to review the skills, experience and capacity required from the non-executive directors for the challenges ahead which resulted in an additional associate non-executive director post and NExT non-executive role being created.

During 2024/25 no executive directors left the Trust. However, Thomas Pounds, Chief People Officer's final day at the Trust was the last day of the financial year, 31 March 2025.

The Chair and non-executive directors are appointed by NHS England, on behalf of the Secretary of State for Health and Social Care (associate and NExT non-executive directors can be appointed following local recruitment policies). The normal term of office served by the chair and non-executive directors since April 2023 is three years, renewable for a further three-year period with a maximum term of six years in line with NHS Trusts Code of Governance.

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 Senior Independent Director. Each Board member is required to meet the Fit and Proper Persons test. This is undertaken on appointment and reviewed annually and includes a self-declaration process. Board performance is evaluated further through focussed discussions at Board development days, meetings, observation, annual evaluation of the Board committees and an ongoing in-year review of the board assurance framework and delivery of the Trust's strategic objectives.

The role of the NHS Trust Chair

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

- Providing leadership to the Board, ensuring its effectiveness in all aspects of its role, and taking responsibility for setting its agenda.
- Helping to shape and set the culture of the Board, which should serve as an example for the rest of the organisation to follow.
- Fostering effective relations with stakeholders, both internal and external to the Trust.
- Arranging the regular evaluation of the performance of the Board, its committees and individual directors, including the Chief Executive.
- Facilitating the effective contribution of non-executive directors and ensuring constructive relations between executive and non-executive directors.

The role of Non-Executive Directors

Non-executive directors work alongside other non-executives and executive directors as an equal member of the Board. They share responsibility with the other directors for the decisions made by the Board. Non-executive directors use their skills and personal experience, including as members of their communities, to:

- Contribute to the formulation plans and strategy – bringing independence, external perspectives, skills, and challenge to strategy development.
- Ensure accountability – holding the executive to account for the delivery of strategy; providing purposeful, constructive scrutiny and challenge; chairing or participating as a member of key committees that support accountability; being accountable individually and collectively for the effectiveness of the Board.
- Shape culture and capability – actively supporting and promoting a healthy culture for the organisation; providing visible leadership in developing a healthy culture so that staff recognise non-executive directors as a safe point of access to the Board for raising concerns; championing an open, honest and transparent culture within the organisation.
- Review process, structures and intelligence – satisfying themselves of the integrity of reporting mechanisms, and financial and quality intelligence including getting out and about, observing and talking to patients and staff; providing analysis and constructive challenge to information on organisational and operational performance.
- Support engagement – ensuring that the Board acts in the best interests of patients, the public and other stakeholders; being available to staff if there are unresolved concerns; showing commitment to working with key partners.

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

The non-executive directors have a range of individual roles and responsibilities that are agreed with the Trust Chair often in response to national guidance and recommendations. These lead roles were reviewed and updated by the Chair during the year.

The Trust Board 2024/25

This section of the annual report provides details of Board members as well as of other non-voting directors, including the Board committee membership during 2024/25.

Key to principal committee membership:

ARC – Audit and Risk Committee

RC – Remuneration Committee

FPPC – Finance, Performance and Planning Committee

QSC – Quality and Safety Committee

P&C – People and Culture Committee

CTC – Charity Trustee Committee

Notes regarding committee attendance:

1. Any Board member is welcome to attend any Board committee, whether a designated member or not; and many do so on a regular basis. The exceptions for this are the Chair does not attend ARC and only non-executive directors and invited executives attend RC.

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

The Board carried out a review of the effectiveness of the Board and its committees for 2024-25 between November to March 2025 and the results were presented at each relevant committee as well as at a Board Seminar on 9 April 2025. Further information can be found in the Annual Governance Statement. The new Chair reviewed the balance and appropriateness of the Board membership and concluded that additional capacity was needed on the Board. Therefore, an additional associate non-executive director role joined the Board in September 2024 and a NExT non-executive director in March 2025.

Board members

Anita Day, Trust Chair

Anita is a chartered accountant with a background in biomedical science, and was previously an international management consultant who specialised in culture transformation and organisational optimisation. Her UK board experience encompasses stints as both director and chair in the private, public and third sectors.

Her NHS career includes time as a non-executive director at Nottingham University Hospitals NHS Trust and Worcestershire Acute Hospitals NHS Trust, and as Chair of Worcestershire Acute Hospitals NHS Trust.

In addition to her role as Chair of ENHT, she is a non-executive member of the Lincolnshire Integrated Care Board, where her particular areas of focus are workforce strategy, health inequalities and digital transformation.

She has also recently been appointed Cohort Director for NHSE's Aspiring Chair Programme, which aims to support 40 top talent non-executives to become the NHS chairs of the future.

Karen McConnell, Non-Executive Director and Vice Chair

Karen, who lives in St Ippolyts (near Hitchin), studied Bacteriology at Newcastle University before joining the Northern Regional Health Authority as a finance trainee in 1983. In 1985 she joined the Audit Commission where she completed her accountancy training. Karen held a variety of senior positions at the Audit Commission, including her role as a district auditor and regional director, before leading the Audit Practice and its 900 staff through the transition of outsourcing the Commission's work to the private sector during 2011 and 2012.

Karen was appointed as the Comptroller and Auditor General (C&AG) for Jersey in January 2013 and completed her seven year term in December 2019. In her role as C&AG she provided the States of Jersey with independent assurance that the public finances of Jersey were being regulated, controlled and accounted for in accordance with the law. Karen is the Chair of ENH Pharma Ltd and acts as an adviser to Public Sector Audit Appointments Limited.

Val Moore, Non-Executive Director (until 31 August 2024)

Val Moore, who lives in Cambridge, worked in several roles for the National Institute for Health and Care Excellence (NICE) between 2006 and 2015 – most recently as its implementation programme director. Originally trained as a science and physical education teacher, Val moved into the NHS in 1990 working in health promotion prior to taking up roles including as executive director in the former Cambridgeshire Health Authority and then regional director for the Health Development Agency (1999 to 2006). Val is the Citizen Lead for Cambridgeshire and Peterborough Adopting Innovation Hub and was a Trustee of Living Sport until July 2023.

Jonathan Silver, Non-Executive Director (until 31 July 2024)

Jonathan, who lives in Aldenham, studied operational research and accountancy at Strathclyde University, graduating in 1978. On qualifying as a chartered accountant with Grant Thornton in 1981, he moved to Fisons plc. After five years, Jonathan joined Laird plc – which was a global technology company providing systems, components and solutions that protect electronics from electromagnetic interference and heat, and that enable connectivity in wireless applications and antennae systems. Following 29 years with Laird, the last 21 of which had been as its chief financial officer and main board director, Jonathan retired in 2015.

He is a Non-Executive Director and Audit Committee Chairman of Henderson High Income PLC, a Non-Executive Director and Audit Committee Chairman of Baillie Gifford China Growth Trust PLC and a Non-Executive Director and Audit Committee Chairman and Senior Independent Director of Spirent Communications PLC.

Peter Carter OBE, Non-Executive Director (until 20 September 2024)

Peter Carter was Chief Executive of the Royal College of Nursing (RCN) from 2007 to 2015. Prior to that he was Chief Executive of the CNWL NHS Trust for 12 years. Peter is a fellow of the RCN, an Honorary fellow of the Royal College of GPs, an Ad Eundem of the Royal College of Surgeons of Ireland. In 2011 he was awarded the inaugural Presidents medal of the Royal College of Psychiatrists.

During his time at the RCN, the College achieved recognition in the Sunday Times top 100 companies to work for and achieved the gold award for Investors in people. He was a member of the 'Crown Commission' that led to the implementation of Non-Medical prescribing. He is a published author and has appeared in TV documentaries and has been interviewed many times on TV and radio. He has twice been the subject of the BBC TV programme Hardtalk.

David Buckle, Non-Executive Director and Senior Independent Director

A GP in Woodley, Berkshire for over 30 years, David also has had a long career in clinical leadership and, subsequently, medical management. In 2018 he became Medical Director for a large PCT responsible for primary care commissioning. In 2015, he was appointed as the medical director for the Herts Valleys Clinical Commissioning Group before retiring in early 2018. David was a non-executive director for the Berkshire Healthcare NHS Foundation Trust where he chaired the Quality committee and then a Non-executive for Salisbury Hospital Foundation Trust.

David has been a member of the Society for the Assistance of Medical Families for over three decades, becoming a director of this charity in 2017 before being voted its President in May 2018. He is also a trustee and Vice-Chair for the Stroke Association, the country's largest stroke charity. David had Crohn's disease at the age of 13 and is now a trustee for the Charity Crohn's and Colitis uk. David was delighted to Chair our Hospital charity until early 2025.

Nina Janda, Associate Non-Executive Director (non-voting Board member)

Nina joined the Trust Board in September 2023. Nina lives in St Albans and has spent much of her career establishing teams and organisations that have focused on using data analytics to transform patient care and operational processes across a number of health systems including the NHS, Europe, Australia and the USA. This has included developing and driving an international division at Dr Foster Intelligence and founding a unique global program that compared and improved health outcomes across 10 countries. In 2018, Nina became the CEO of Global Health Data @Work, a non-profit organisation, funded by global hospitals with the purpose of working collaboratively to transform their health systems.

Diana Skeete, Non-Executive Director

Diana is a results-oriented consultant specialising in delivering transformational people management change programmes across the private, public and non-profit sectors. With over 30 years of experience, she has supported a range of organisations, from start-up to maturity to achieve their organisational goals.

Diana is passionate about equipping individuals and organisations with the tools to build competitive advantage in the people management, workforce development, equity, health and wellbeing sectors. Diana is currently conducting research into inclusive approaches to managing the menopause in the workplace.

Diana is a graduate of the London School of Economics, Honorary Fellow for the Women's Health Programme, The George Institute for Global Health, UK; a Salzburg Global Fellow (Women As They Age Programme) and is a Fellow of the Chartered Institute of Personnel and Development. She is also a former Reader for the Queen's Anniversary Prize for Further and Higher Education (specialising in reviewing equality, diversity and inclusion initiatives) and a former trustee of the non-profit, Action for Race Equality (ARE), formerly the Black Training & Enterprise Group (BTEG).

Janet Scotcher, Non-Executive Director

Janet was Chief People Officer at Cambridge University Press & Assessment with responsibilities spanning organisational change, HR services and partnering, learning and development, internal communications, and employee engagement.

Janet was previously Director of HR and Organisational Development at the Wellcome Sanger Institute, Director of HR at Hinchingsbrooke Health Care NHS Trust and General Manager for Children's Services at Cambridgeshire and Peterborough NHS Trust.

Throughout her career, Janet has focused on improving outcomes for children and young people. She has an eclectic background in both HR and general management, with experience of taking organisations through cultural transformation.

With a degree in tropical disease and accreditation as an Agile practitioner, Janet is a graduate from Lord Ashcroft International Business School and Glasgow University.

Richard Oosterom, Associate Non-Executive Director (non-voting Board member)

Richard is an experienced senior executive who worked most of his career in the IT and technology sector throughout Europe and in the US and Asia.

During his commercial career of more than 30 years, he has built a track record in business turnaround, growth acceleration and major transformation, including mergers and acquisitions and right-shoring.

Richard currently provides consulting and interim management services for large organisations in transformation and is an active mentor for start-ups, especially in Healthcare and Healthtech.

He served 7 years as a non-executive for the Worcester Acute Hospitals NHS Trust and is the chairman of the South Midlands Pathology Network.

Gill Hooper, Non-Executive Director

Gill is a registered nurse and has held board roles since 1994. She was chief nurse for Northern Devon Healthcare NHS Trust and West Hertfordshire NHS Trust where she also held the roles of director of operations and deputy chief executive.

She has experience in acute commissioning and held roles in national organisations – including the Modernisation Agency, Monitor and Health Education England.

Since 2014 Gill has been the Managing Director of Healthhelp Ltd, working with trust boards and all members of the senior team to strengthen leadership. She was a clinical leadership associate at KPMG until 2024.

Gill has been an independent clinical chair, leading acute and community trust CQC inspections, and also a national professional advisor for well-led reviews at CQC where she influenced the regulatory approach to well-led inspections.

In 2020 Gill was appointed to an Honorary Readership in the School of Health Sciences at the University of East Anglia and in 2024 published a book 'Overcoming Selective Blindness' offering tools and techniques for improving services and strengthening governance processes from the bedside to the boardroom.

Tichafara Phiri, NExT Non-Executive Director

Tichafara is a strategic healthcare innovator with a background in delivering digital solutions that improve patient access, health equity, and system efficiency. He has led and advised on initiatives at the intersection of technology and healthcare, focusing on strengthening service delivery for underserved populations and diaspora communities.

With experience spanning public health advocacy, healthtech entrepreneurship, and cross-border care infrastructure, Tichafara brings a systems-thinking approach to board-level governance. He has collaborated with both NHS-aligned and international organisations to design patient-centric models that integrate financial inclusion, preventative care, and digital transformation.

As a NExT Non-Executive Director, Tichafara is committed to amplifying community voice, championing inclusive innovation, and supporting the Trust's strategic goals in reducing health inequalities and enhancing access through technology-enabled care.

Adam Sewell-Jones, Chief Executive

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

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

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

Martin Armstrong, Chief Finance Officer and Deputy Chief Executive

Martin started his NHS career as a national financial management trainee in 1994 at the South Tees Community and Mental Health NHS Trust. Since that time, he has worked in several financial management roles in the North-east, London and the South-east – including at the Princess Alexandra Hospital as its deputy director of finance from 2003 to 2007, followed by becoming its director of performance from 2007 to 2009. Martin's most recent role before joining the Trust in October 2016 was director of finance, information and performance at the North Middlesex University Hospital Trust. Martin was appointed Deputy Chief Executive in April 2020.

Justin Daniels, Medical Director

Justin is a Consultant Paediatrician who works clinically at ENHT in children's ED and in the paediatric department. He has previously subspecialised in caring for children with HIV. He worked at North Middlesex University Hospital (NMUH) as a consultant for 17 years, leading on child protection and then becoming the clinical and subsequently divisional director. He became the associate medical director at NMUH in 2020. During his time at North Middlesex he completed the Nye Bevan course run by NHS leadership. He was seconded in 2022 to Barking, Havering and Redbridge University Hospitals NHS Trust as deputy Chief Medical Officer.

He has previously served on NICE's technology appraisal committee looking at the clinical and cost effectiveness of new treatments within the NHS. He has also been a non-executive on a CCG board and a trustee for a national charity (The Lullaby Trust). He is currently a governor at the University of Hertfordshire. He is also an honorary senior lecturer at University College London.

Theresa Murphy, Chief Nurse

Theresa has over 30 years' experience in complex health and care settings.

Theresa began her career as a senior nurse in critical care, transplantation and acute medicine and has been the chief nursing officer in a range of organisations including Portsmouth University Hospital Trust, North Middlesex University Hospital, The Hillingdon Hospital Foundation Trust and The London Clinic. After becoming a registered general nurse in 1987, Theresa trained in neuroscience, transplant nursing and critical care.

Theresa holds an LLB and was a London scholar for Florence Nightingale Foundation; she is currently studying for a Professional Doctorate of Nursing and has previously attended Oxford University for global executive studies. Theresa is a clinical trustee for Dementia UK.

Theresa is passionate about patient focused care and advancing clinical practice.

Lucy Davies, Chief Operating Officer

Lucy joined the NHS as a graduate management trainee and progressed through roles in operations, performance and transformation. Lucy has significant experience in developing teams and leading change at team, division, trust and system level.

Lucy joined the Trust in 2022 from Royal National Orthopaedic Hospital NHS Trust, where she led cultural change and operational improvement as Chief Operating Officer and Director of Strategy & Improvement. Lucy also led an innovative programme of mutual aid for North Central London Integrated Care System as part of its elective recovery programme.

In 2025 Lucy was elected to co-chair the NHS Providers national Chief Operating Officer Network. Lucy is mum to two young men and lives in north London.

Thomas Pounds, Chief People Officer (non-voting Board member) (until 31 March 2025)

Thomas worked previously in the Trust as the Deputy Director of Workforce and Organisational Development. Thomas began his career in the NHS in 2003, working for NHS Professionals. He joined the East and North Hertfordshire NHS Trust team in 2015 as Head of Temporary Staffing and Medical Resourcing. He then progressed to Deputy Director of Workforce and Organisational Development, leading key strategic work including the Integrated Care System bank network agreement which helped to save the NHS millions in agency costs. Thomas was appointed as the Chief People Officer in April 2021 and is the executive lead for East and North Hertfordshire Hospitals' Charity.

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

Thomas left the Trust on 31 March 2025 and joined the Royal Free Hospital Board.

Mark Stanton, Chief Information Officer (non-voting Board member)

Mark is an experienced executive CIO with a strong track record in delivering large-scale digital transformation across healthcare and other industries. Since April 2019, he has served as Chief Information Officer and Executive Director at the Trust, where he leads the Trust's digital strategy, oversees digital services and Outpatients back office, and plays a key role in regional initiatives like the Eastern Imaging Network as the Senior responsible Officer (SRO) of ImageEast and SRO for the Cancer Network Digital programme.

Before joining the Trust, Mark was CIO at Dudley Group NHS Foundation Trust, where he launched a clinically-led EPR programme and successfully commercialised IT operations. His private sector experience includes Senior IT leadership roles at InHealth, BUPA, and General Motors, where he led data centre migrations, global IT service delivery, and enterprise transformation.

Mark began his career managing large-scale IT operations and data centres, evolving into consultancy and strategic CIO-level roles over the past decade.

Kevin O'Hart, Chief Kaizen Officer (non-voting Board member)

Kevin moved from an early career in finance and capital markets and qualified as a registered nurse in 2000. He has since worked clinically in a number of NHS trusts including University College Hospitals London and East Suffolk and North Essex NHS Foundation Trust.

Kevin initially joined East and North Hertfordshire NHS Trust as programme management office director in April 2017, before moving into a new position as Director of Improvement in November 2019. More recently to reflect the development of our new single improvement method called the East and North Herts Production System, Kevin was appointed as Chief Kaizen Officer in January 2024.

With an extensive and varied clinical background, Kevin has held a number of senior corporate roles in nursing, quality, governance and risk with more recent experience focusing on project management and transformation, at both sub-board and executive level. Kevin joined the Trust Board in July 2022.

Kevin Howell, Director of Estates and Facilities (non-voting Board member)

Kevin joined the Trust in January 2020. With nearly 40 years' experience in the NHS, Kevin has held several senior and executive Estates and facilities roles in the London area – including the PRU Hospital, Barnet and Chase Farm, Watford, North Middlesex and St

Georges. He has led on the development of two new hospitals and a new midwifery led unit in north London. Kevin joined the Trust Board in July 2022.

Kevin leads on the development and implementation of the Estates and Facilities Strategy. The role encompasses hard Facilities Management services (engineering and building), soft Facilities Management services (cleaning and catering), security and electro biomedical engineering (medical devices).

Kevin's passion is ensuring the safety of patients, visitors and staff whilst under our care, ensuring a sustainable future for the Trust.

Name	Title	Appointment Date	Term(s) of Office	Term of Office ends
Anita Day	Trust Chair	1 February 2024	Three Years	31 January 2027
Karen McConnell	Non-Executive Director (Vice-Chair)	7 January 2019	Four Years + Four Years	6 January 2027
Val Moore	Non-Executive Director	1 September 2016	Four Years + Four Years	31 August 2024
Jonathan Silver	Non-Executive Director Designate*	16 October 2017	N/A	N/A
	Non-Executive Director	1 February 2018	Two Years + Four Years + 6 months extension	31 July 2024
Peter Carter	Non-Executive Director	3 September 2018	Four Years + Four Years	20 September 2026 (retired early)
David Buckle	Non-Executive Director Associate*	17 September 2018	N/A	N/A
	Non-Executive Director	8 September 2022	Four years	7 September 2026
Nina Janda	Non-Executive Director Associate*	1 September 2023	Two years	31 August 2025
Diana Skeete	Non-Executive Director	1 September 2024	Three years	31 August 2027
Janet Scotcher	Non-Executive Director	1 September 2024	Three years	31 August 2027
Richard Oosterom	Non-Executive Director Associate*	1 September 2024	Three years	31 August 2027
Gill Hooper	Non-Executive Director	3 December 2024	Three years	2 December 2027
Tichafara Phiri	NExT Non-Executive Director*	12 March 2025	1 year	11 March 2025
Adam Sewell-Jones	Chief Executive	1 January 2022	N/A	N/A
Martin Armstrong	Finance Director & Deputy Chief	31 October 2016	N/A	N/A

	Executive			
Justin Daniels	Medical Director	17 April 2023	N/A	N/A
Theresa Murphy	Chief Nurse	2 September 2022	N/A	N/A
Lucy Davies	Chief Operating Officer	19 April 2022	N/A	N/A
Tom Pounds	Chief People Officer*	1 April 2021	N/A	31 March 2025
Mark Stanton	Chief Information Officer*	9 February 2021	N/A	N/A
Kevin O'Hart	Chief Kaizen Officer*	1 July 2022	N/A	N/A
Kevin Howell	Director of Estates & Facilities*	1 July 2022	N/A	N/A

**Attends and participates in Trust Board meetings, but without voting rights*

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

Declarations of Interests of the Board of Directors

The Board of Directors undertake a review of their conflicts of interest on at least an annual basis, as well as ensuring any interests that arise in year are declared as and when appropriate. Every member of the Board reviewed and updated their declarations during 2024/25.

At each meeting of the Board and at the sub committees of the Board a standing item also requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda items, including any changes to a previously declared interest that is relevant to an agenda item.

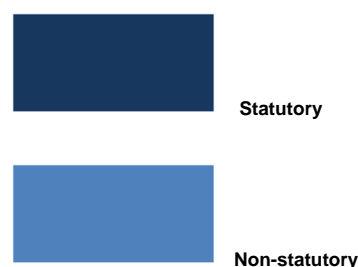
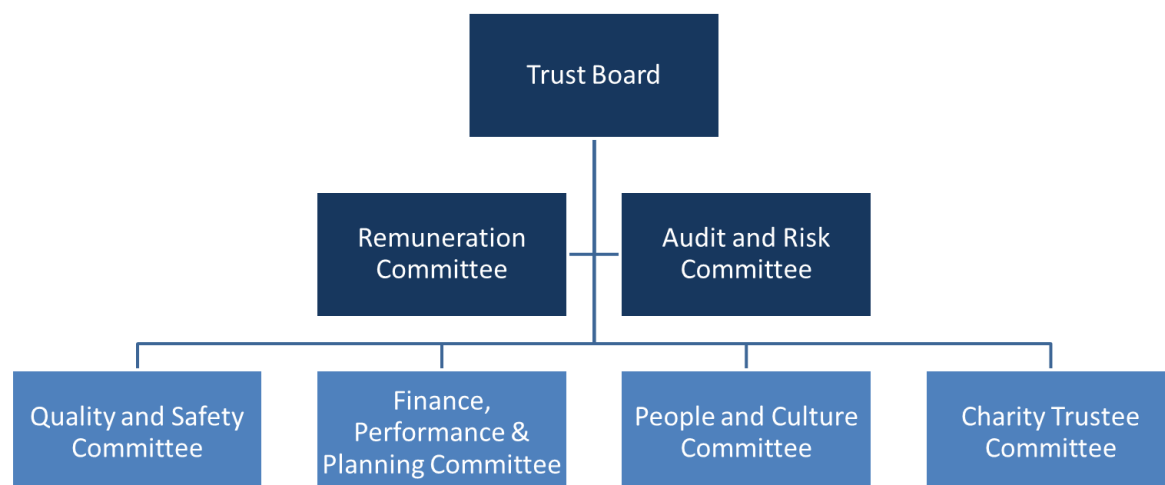
The Register of Interests is published on the Trust's website (here: <https://www.enherts-tr.nhs.uk/about/board/introduction/>).

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

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

Governance structure

The Trust Board has a number of formal Board assurance committees (see the diagram below for the committee structure on 31 March 2025) that are supported by a system of line accountability through executive directors, often supported by further operational assurance groups. Each Board assurance committee provides a summary report to the next Trust Board meeting. An internal review of each committee is undertaken annually to ensure that it continues to meet its terms of reference and operate effectively.



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

Attendance of Directors at Board Meetings 2024-25

Trust Board member	1 May 24	10 July 24	11 Sept 24	6 Nov 24	15 Jan 25	12 Mar 25	24 Mar 25*	Total attendance
Anita Day, Chair of the Trust Board	Apologies	✓	✓	✓	✓	✓	✓	6 of 7
Karen McConnell, Vice-Chair of the Trust Board	✓	✓	Apologies	Apologies	✓	✓	✓	5 of 7
Val Moore, Non-Executive Director	✓	✓						2 of 2

Peter Carter, Non-Executive Director	✓	✓	✓					3 of 3
Jonathan Silver, Non-Executive Director	Apologies							0 of 1
David Buckle, Non-Executive Director	✓	✓	✓	✓	✓	✓	Apologies	6 of 7
Nina Janda, Associate Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	6 of 7
Diana Skeete, Non-Executive Director			✓	✓	✓	✓	✓	5 of 5
Janet Scotcher, Non-Executive Director			✓	✓	✓	✓	Apologies	4 of 5
Richard Oosterom, Associate Non-Executive Director			Apologies	✓	✓	✓	✓	4 of 5
Gillian Hooper, Non-Executive Director					✓	✓	Apologies	2 of 3
Adam Sewell-Jones, Chief Executive	✓	✓	✓	✓	✓	✓	Apologies	6 of 7
Martin Armstrong, Deputy Chief Executive & Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	7 of 7
Justin Daniels, Medical Director	✓	✓	✓	✓	✓	✓	✓	7 of 7
Lucy Davies, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	7 of 7
Thomas Pounds, Chief People Officer	✓	✓	✓	✓	✓	✓	✓	7 of 7
Mark Stanton, Chief Information Officer	✓	✓	✓	✓	✓	✓	✓	7 of 7
Theresa Murphy, Chief Nurse	✓	✓	✓	✓	✓	✓	✓	7 of 7
Kevin Howell, Director of Estates and Facilities	✓	✓	✓	✓	✓	✓	Apologies	6 of 7
Kevin O'Hart, Chief Kaizen Officer	✓	✓	✓	✓	✓	✓	✓	7 of 7
Eilidh Murray, Director of Communications and Engagement		✓	✓	✓	✓	✓	Apologies	5 of 6
Tichafara Phiri, NExT Director						✓	✓	2 of 2
	Not a Board member							

*Extraordinary board meeting – 24 Mar 25

Attendance of Members at Remuneration Committee Meetings 2024/25

The *Remuneration Committee* approves the remuneration and terms of service for Very Senior Managers and monitors the level and structure of remuneration for senior management below Executive Directors. All Non-Executive Directors are members of the Remuneration Committee.

Remuneration Committee member	3 April 24	29 May 24	11 Sept 24*	6 Nov 24	4 Feb 25	14 Mar 25	Total attendance
Jonathan Silver, Chair and Non-Executive Director	✓	✓					2 out of 2
Anita Day, Chair of the Trust Board (Committee Chair from 11 September 2024)	✓	✓	✓	✓	✓	✓	6 out of 6
Karen McConnell, Vice-Chair of the Trust Board	✓	✓	Apologies	Apologies	✓	✓	4 out of 6
Val Moore, Non-Executive Director	✓	✓					2 out of 2
Peter Carter, Non-Executive Director	Apologies	Apologies					0 out of 2
David Buckle, Non-Executive Director	✓	✓	✓	✓	✓	✓	6 out of 6
Nina Janda, Associate Non-Executive Director	✓	✓					2 out of 2
Janet Scotcher, Non-Executive Director			✓	✓	✓	✓	4 out of 4
Adam Sewell-Jones, Chief Executive	✓	✓	✓	✓	✓	✓	6 out of 6
Thomas Pounds, Chief People Officer	Apologies	✓	✓	✓	✓	✓	5 out of 6

*The membership of the committee was reduced from 11 September 2025 to free up non-executive director capacity for other activities.

Attendance of Members at Audit and Risk Committee Meetings 2024/25

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

Audit & Risk Committee member	9 Apr 24	18 June 24	9 July 24	20 Nov 24	19 Dec 24	14 Jan 25	Total attendance
Jonathan Silver, Chair and Non-Executive Director	✓	✓	✓				3 of 3

Karen McConnell, Non-Executive Director (Committee Chair from 20 November 2024)	✓	✓	✓	✓	✓	✓	6 of 6
David Buckle, Non-Executive Director				✓	✓		2 of 2
Richard Oosterom, Associate Non-Executive Director				Apologies	Apologies	Apologies	0 of 3
Nina Janda, Non-Executive Director				Apologies	✓	✓	2 of 3
Gillian Hooper, Non-Executive Director					✓	✓	2 of 2

The following non-statutory committees have also been established by the Board:

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

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

The *People and Culture Committee* meets bi-monthly and has a membership of three non-executive directors. The Committee provides assurance to the Board that appropriate arrangements are in place to deliver the Trust's People Strategy and enhance equality, diversity and inclusion for the Trust's staff.

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.

Information governance

Please see the Information Governance section of the Annual Governance Statement below.

Disclosures set out in the NHS Trust Code of Governance

The Trust has applied the principles of the NHS Trust Code of Governance on a comply or explain basis. The NHS Trust Code of Governance came into force from 1 April 2023. However, prior to this the Trust already aimed to comply with the relevant principles of the NHS Foundation Trust Code of Governance and the UK Corporate Governance Code. The new NHS Trust Code is modelled on the 2018 version of the UK Corporate Governance Code. NHS England recognises that departure from the specific provisions of the Code may be justified in particular circumstances, and reasons for any non-compliance with the Code should be explained. This "comply or explain" approach has been in successful operation for

many years in the private sector and within the NHS foundation trust sector. There are no provisions within the NHS Trust Code of Governance that the Trust did not comply with during 2024/25 apart from those set out below. The NHS Trust Code of Governance also sets out a number of disclosure requirements and these are provided below.

Code of Governance compliance statement

The Trust has applied the principles of the NHS Trust Code of Governance on a comply or explain basis. The Board considers that it complies with the main and supporting principles of the Code of Governance.

In relation to the more detailed provisions of the Code of Governance, the Trust is compliant with the provisions, with the following exceptions:

A2.2: The Trust's strategy requires a "formally agreed statement" with reference to the ICP's strategy and the Trust's role within system.

The Trust's current strategy was developed and approved prior to the ICB strategy being produced. The Trust has committed to do this in our next strategy refresh.

A2.5: Ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Metrics should disaggregate by ethnicity and deprivation where relevant.

For the first element, significant work has gone into developing effective metrics and the Trust is compliant. Integrated Performance reports go to every Board meeting. For the second element, we have made progress on disaggregating performance data by both ethnicity and socioeconomic status, although with regard to the ethnicity data, like many organisations, we are not yet content with the quality of our baseline data.

C5.2: Directors involved in recruitment are required to do equality, diversity and inclusion training, including unconscious bias training.

All directors (executive and non-executive) have undertaken equality, diversity and inclusion training. Executive directors have undertaken cultural competence training which covered unconscious bias. In addition, all executives and some non-executive directors have undertaken reciprocal mentoring training which covered unconscious bias. Not all non-executives, due to the part-time nature of their roles and outside commitments, were able to take part in the multiple day reciprocal mentoring sessions. When the opportunity arises, unconscious bias training will be delivered to the remaining non-executive directors.

Table of supporting explanation for required disclosures

Reference	Summary of requirement	Disclosure
A2.1	Describe the Trust's contribution to the objectives of ICP and ICB and place-based partnerships	See sections: Hertfordshire and West Essex ICS Strategy overview and objectives
A2.1	Annual Report (AR) describes how sustainability has been addressed	See Sustainability statement section

A2.3	AR explains the Board's activities in promoting the wellbeing of the workforce	See People performance section and Developing Workforce Safeguards section in the Annual Governance Statement.
A2.8	AR explains how the interests of stakeholders are considered in discussions/decision-making.	An "Impact section" was added to Board and Committee coversheet template in 2022.
A2.8	AR sets out how the organisation's governance processes oversees collaboration with other organisations	See sections: Hertfordshire and West Essex ICS Strategy overview and objectives The Trust is working with the ICB and partners on developing the governance for HCPs.
B2.6 and 2.7	AR identifies NEDs who are 'independent'	See the Board members section for the length of time on the Board for each NED. It is recognised that two Non-Executive directors have served over six years on the Board, but none have served over nine years. The two non-executives who have exceeded six years had already started their second terms before the new Code came into force. The Board considers all of the current Non-Executive Directors (NEDs), including the Chair, to be independent, including those who have served over six years. All appointments to the Board are the result of open competition. To maximise independence, all new appointments and re-appointments since 1 April 2023 have and will continue to be for three year terms and not extending beyond six years in total, without exceptional reason in line with the new Code of Governance and with NHS England agreement. Independence is kept under review and is based on whether each Director is independent in character, judgment and behaviour. The Chair holds meetings with the Non-executive Directors without the Executive Directors being present.
C4.2	Along with the description of each Director's skills, expertise and experience, the AR should include a statement about its balance, appropriateness for requirements of Trust	This is covered in "The Trust Board 2024/25" section of the report above and within the Annual Governance Statement.
C4.7	AR well-led external review requirement to declare any connection with the Trust or individual directors	There has been no well-led review in 2024/25. The last well-led review concluded in 2022/23. Both the current Chair and the Chief Executive are members of faculty of the Good Governance Institute which carried out the most recent well-led review. Neither were involved in the procurement decision-making. The current Chair was not in post at the time of the well-led review.

C4.13	AR report on Remuneration Committee to cover: Approach to succession-planning Policy on diversity and inclusion Ethnicity of Board and senior mgrs Gender balance of snr mgt and direct reports	These are all covered in annual cycle for the Remuneration Committee, apart from the equality policy which goes to People and Culture Committee.
D2.4	AR explains how the Audit Committee/Audit Panel: has assessed the independence and effectiveness of the external audit process and significant issues relating to financial statements	The audit committee typically assesses the independence and effectiveness of the external audit process through various means, such as reviewing the auditor's qualifications, performance, and objectivity, as well as evaluating the adequacy of audit procedures and the auditor's communication with management. Significant issues relating to financial statements are addressed through thorough examination and discussion, ensuring transparency and compliance with regulatory standards.
D2.6	Directors assert the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.	The Annual Report is emailed to Board members prior to approval and this duty is highlighted to Board members.
D2.8	The Board "should monitor the Trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report."	Internal audit reviews risk management annually – see the annual governance statement section. The Trust's Risk Strategy was reviewed and approved by the Board in May 2023. An annual review of risk takes place at Board Seminar and this happened in April 2023, 2024 and 2025.

External auditor

In compliance with the requirements of the NHS Shared Business Services Framework, the Trust opted to reappoint BDO LLP as the Trust's external auditors from 2022/23 on the expiry of the initial contract (and subsequent extensions) at the end of March 2020. Since the start of the previous contract, BDO LLP has acted as external auditor for the Trust each year since 2015/16. BDO were re-appointed in 2024, with a new partner.

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

Internal auditor

The Trust's internal auditor (a function that is currently outsourced) is responsible for undertaking internal audit functions on behalf of the Trust. The head of internal audit reports to each meeting of the Trust's Audit Committee on the audit activity undertaken. The system of internal control is designed to manage risk to a reasonable level, rather than to eliminate

all risk of failure to achieve policies, aims and objectives; therefore, it can only provide reasonable and not absolute assurance of effectiveness.

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

RSM were appointed as the Trust's new internal auditors for the financial year 2024/25.

Statement of the Chief Executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS England, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

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

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

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

Signed: Adam Sewell-Jones, Chief Executive

Date: 28 June 2025

East and North Hertfordshire NHS Trust Annual Governance Statement 2024/25

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East and North Hertfordshire NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East and North Hertfordshire NHS Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors set the policy framework and strategy and provides leadership for the management of risk across the organisation. In 2024/25 the Chief Nurse was the Executive Lead for risk management with the Head of Corporate Governance leading on the Board Assurance Framework (BAF). The executive team lead on the areas of risk within their portfolios and are nominated as the lead for specific strategic risks on our Board Assurance Framework.

The Board Assurance Framework (BAF) identifies the principal risks to the achievement of the Trust's strategic objectives, together with the key controls and assurances and any gaps in those controls and assurances. Through this framework the Board gains assurance from the appropriate Executive Director that risks are being appropriately managed throughout the organisation. This is reviewed bi-monthly by the Executive Director Lead for each risk and jointly through the Board Committees. The BAF is considered by the Audit and Risk Committee, relevant Board Committee and at every other public meeting of the Board. This is supported by the Directors detailed reports to the Board and its committees, which include workforce, finance, operational performance and quality and safety.

The Board reviewed and updated the Risk Management Strategy in 2023, including amending the risk appetite. We have made progress in implementing our Risk Management Strategy, Board Assurance Framework and Accountability Framework structure to ensure these provide clear and comprehensive risk management and fully support the corporate governance systems. During 2024/25 the Board and Audit and Risk Committee have regularly reviewed progress of risk management.

The operational responsibility for risk management is managed by the relevant clinical division or corporate directorate. The Risk Management Group, chaired by the Deputy Chief Executive oversees corporate risk and reports to the Trust Management Group. A process of

review, challenge and escalation of divisional and corporate directorate risks, as contained in the risk register, is conducted through the Risk Management Group. This provides check and challenge on the accuracy of risk scoring and enables easier identification and escalation of the biggest corporate risks.

Areas of high risk are escalated to the Audit and Risk Committee, Quality and Safety Committee (QSC), Finance, Performance and Planning Committee (FPPC), People and Culture Committee (P&C) and the Trust Board. The Board Committees have continued to strengthen their scrutiny of the risks through the use of spotlight reviews into specific areas. In addition, during 2024, the Board introduced a process of spotlighting two BAF risks at each Board meeting.

The Board receives support and training on risk management with dedicated BAF sessions at Board Seminar in April 2024 and April 2025 and a BAF training session in December 2022 and on risk strategy and appetite in October 2022. It is planned for risk appetite to be reviewed in April 2026. The Compliance and Risk Team provide support and training to staff and leadership teams on risk management and the risk register. The Health, Safety and Security Team provide mandatory training on health, safety and security and fire to all staff across the organisation.

During 2024/25 the Board had six development sessions to consider key areas of strategic significance, including our strategic priorities, governance and risk, financial strategy and business planning, estates strategy, future developments in healthcare, people strategy, digital strategy and the role of AI, commercial strategy, Board effective working and ICB collaboration. The expectation is that these sessions provide strategic focus to the organisation, enabling it to proactively respond to and support the achievement of strategic priorities for the local health economy in ways which are clinically and economically effective for the Trust.

The Trust Chair and Chief Executive continue to monitor the size and the balance of skills and experience of the Board to ensure it is appropriate for the requirements of the business and the future direction of the Trust. There was only one executive director change during 2024-25 with the Chief People Officer leaving the Trust at the end of March 2025. Three non-executive directors retired during 2024-25. In addition to recruiting to fill these two posts, two Associate non-executive directors were recruited to help achieve the new Chair's ambition to increase non-executive director capacity and the ability for non-executive directors to visit and observe more Trust services in their assurance role. In addition, a NExT Director started in March 2025.

We recognise the importance of investing in our staff and supporting their well-being to ensure high-quality care and better outcomes for our patients. We continue to develop our continuous Improvement models with the support from our quality improvement and transformation teams, providing simple, easy to understand models for staff at every level of the organisation to adopt and use. All of which seek to develop our people capability and drive ownership and continuous improvement through services. The Quality Improvement Team has continued to support the quality improvement priorities.

We seek to learn from good practice in a number of ways including from internal and external reviews, clinical audit programme, incidents, feedback from complaints and patient and carer experiences, and feedback from staff. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff through governance half days, monthly patient safety newsletters, Trust daily bulletins, staff forums and the organisational development programme. The Trust oversight of risk management is achieved through an annual risk review at a Board development day, an executive monthly Risk Management Group, Division and Corporate publication of new and emerging risks and planned

mitigations. Local services share oversight of risks through risk clinics, quality newsletters, posters, virtual staff meetings, messages of the week and safety huddles. In addition, to support identifying learning from serious incidents as soon as possible, bi-weekly serious incident review panels and divisional risk clinics are held to support the management and scrutiny of organisational risk.

The risk and control framework

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

Our risk management strategy aims to provide the framework and outline the processes needed to support the Trust in delivering its strategic and other objectives by identifying and managing risks. Our aim is to ensure that the effective management of risk is an integral part of everyday management by having comprehensive risk management systems in place with clear responsibility and accountability arrangements throughout the Trust.

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

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

We do this by:

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

The Risk Register is populated with risks arising from sources throughout the organisation, specifically:

- Business and Service Delivery Plans – i.e., principal risks to the Trust achieving key performance standards or safe service delivery.
- Incident Forms (electronic) – if it is apparent from an adverse event form, or subsequent investigation into the adverse event, that there is a significant risk then it will be transferred to the risk register.
- Health & Safety Risk Assessments – Health and Safety risk assessments are a legal obligation for the Trust, and managers are responsible for ensuring these

assessments are undertaken. Any risk identified from these assessments will be included on the Risk Register.

- Local Risk Assessments – where local assessments have identified risks.
- External Assessment / Audit – significant risks identified by any internal / external audit e.g., Care Quality Commission, NHS Resolution, Health & Safety Executive notices, will be placed on the Risk Register.
- External Guidance / Alerts – NICE, Quality Strategies, etc. that are not yet implemented.
- Results of Feedback – Learning from our patients and the public, whether through analysis or learning resulting from complaints, claims, surveys, observation of practices etc.

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

We have in place established risk assessment tools for all identified risks. These enable staff to quantify risks in their respective areas and decide what action, if any, needs to be taken with a view to reducing or eliminating those risks. A common risk score matrix is used by the Trust with risks logged onto 'local' and 'corporate' risk registers.

The Internal Auditor annual review of risk management and the Board Assurance Framework concluded a 'reasonable assurance' rating in both 2023/24 and 2024/25.

Consistent improvements have been made to corporate risk management during the year. The Risk Management Group (RMG) is now well established and the group are having a positive impact on how risks are managed at a local level, with reductions seen in the overall total number of risks on the risk register, together with more appropriate and consistent risk scoring and effective controls and assurances in place to mitigate risk. The Corporate Risk Register (CRR) has been successfully aligned with the Board Assurance Framework through strengthened processes for risk escalation and de-escalation. This serves as an effective tool for managing high-priority risks and tracking mitigation actions.

The Trust continues to strengthen the management of risks (clinical and non-clinical) with oversight and management responsibilities held by the established Risk Management Group (RMG) achieving a positive impact on local risk management practices.

Led by the Compliance and Risk team, targeted risk clinics and training continued through 2024/25 and will remain a priority focus for 2025/26. The Compliance and Risk team together with the RMG continue to facilitate a cultural change to using risk registers proactively to support change and improvement.

Board Assurance and Reporting

Our Trust Board has four established committees to discharge its responsibilities on Board assurance. These are the Audit and Risk Committee, Quality and Safety Committee, the Finance Performance and Planning Committee and People and Culture Committee. These are constituted as key assurance mechanisms and an annual review of each of the committees is undertaken to ensure they continue to meet their terms of reference and the requirements of the Code of Governance and the Provider Licence. They are each chaired by a Non-Executive Director. In addition, the Board has the Charity Trustee Committee to provide assurance and support for its responsibility as a Corporate Trustee. Directors' attendance at the Board and its Committees is recorded and monitored. Attendance at the

Board and statutory committees are reported in Corporate Governance section of the Annual Report.

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

The Finance, Performance and Planning Committee (FPPC) supports the governance structures and provides assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee plays a key role in ensuring the sustainability of the Trust.

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

The People and Culture Committee (P&C) provides assurance to the Board that appropriate arrangements are in place to deliver the Trust's People Strategy and Equality, Diversity and Inclusion Strategy to improve equality and inclusion for the Trust's people.

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

The Accountability Framework is embedded into practice supported by an integrated performance report and enhanced business intelligence. Performance Review Meetings support the Accountability framework. The Integrated Performance Report includes the key performance measures for the Trust. The relevant sections of the report are reviewed at every QSC, FPPC, P&C and Trust Board meeting. This provides the lead director an opportunity to highlight any risk issues relating to the metrics. In addition, the Committees receive detailed reports and deep dives/spotlight reviews into specific issues, and local and national data to support its scrutiny under strategy, culture and accountability. The framework and decision making is supported by business intelligence.

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

Review of Board and Committee effectiveness

The Board carried out a review of the effectiveness of the Board and its committees for 2024/25 between December 2024 to March 2025 and the results were presented at each relevant committee as well as at a Board Seminar on 9 April 2025. Significant improvements identified included changes to the Board and Committee coversheets to include a proposed management assurance rating to relevant assurance items, moving some P&C meetings to in-person, changes to the committee report template and support for the creation of a dedicated Digital Committee (which will need Board approval during 2025-26) to help ensure delivery of key digital programmes.

Principal Strategic Risks

The BAF underwent an annual review to agree the top strategic risks in April 2024 with two completely new risks added to the BAF (investment and the future of cancer services). Two separate workforce BAF risks were combined into a single risk.

The Trust at the end of 2024/25 had 12 principal risks defined on the Board Assurance Framework each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified. In addition, the risks on the corporate risk register (the top operational, non-strategic risks) are mapped onto the BAF. During 2024/25 the Audit and Risk Committee undertook a deep dive review of the BAF and improvements identified from this included introducing assurance scores, named leads and timescales for actions on each BAF.

At 31 March 2025 no BAF risks remained rated a '20'. The highest risk score was '16'. This is the second year in a row where there is not a 20 rated risk on the BAF at the end of the financial year. This compared to one risk in 2022-23 (Risk 3: Financial Constraints), one risk rated '20' in 2021/22 (Risk 1: Operational Performance) and two risks rated '20' at the end of 2020/21 (Risk 4: Capital and Risk 10: Estates and Facilities).

Two risk scores increased at year-end in light of the NHS Business Plan. In 2024/25, Risk 3 (Financial constraints) reduced from '20' to '12' but increased to '16' at year-end. Risk 1 (Capital investment) also increased to '16' at year-end. No other BAF scores increased during the year. Seven of the 12 BAF risks were red-rated (scoring 15 and above) at the end of the financial year. Two of these are the two new risks identified at the start of the year (Risk 1: Investment, and Risk 9: The future of cancer services). A further two of the seven red-rated risks are system-related risks (Risk 8: Improving performance and flow and Risk 9: The future of cancer services), which are highly reliant on external stakeholders.

The Board and the lead committees for BAF risks receive reports bi-monthly on progress with the BAF to assure that the mitigations are operating (where this is within the Trust's ability to do so) and that those mitigations are effective or further actions are identified.

Principal risks to compliance with the NHS Provider Licence section 4 (governance)

No principal risks have been identified to compliance with NHS provider licence condition 4. This condition covers the effectiveness of governance structures, the responsibilities of directors and committees, the reporting lines and accountabilities between the Board, its committees and the executive team.

Developing Workforce Safeguards

Ensuring effective workforce planning, deployment of staff and safe staffing levels remains a priority. The Trust has built up workforce plans from specialty level which focus on the long-term sustainability of the services. This work has informed the over-arching Trust workforce plan which sets out the target for substantive and temporary workforce over the next five years. The plan is now being adapted to meet the priorities of the NHS workforce plan of train, retain, reform. This includes the continued development of internal development pathways such as nurse associate roles as well as an expansion of apprenticeship opportunities.

We are also developing new roles and new ways of working; an example being the introduction of anaesthetic associates while continuously developing how we work across the system to improve our patient pathways. We have focused heavily on retention of our workforce and have exceeded our target.

Key improvements have included developing management capability, providing a high quality and long-term induction programme and focusing on the learning and development needs of our workforce. The plan is reviewed by the People and Culture Committee and Finance, Performance and Planning Committee (FPPC). Nursing establishment reviews take place annually to ensure service needs are met with oversight and approval at the Quality and Safety Committee (QSC) and at Board.

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

- Regular performance management meetings between members of the executive team and each division.
- Exception reporting via the Trust's Trust Management Group, which meets bi-weekly.
- Monthly meetings via the Trust Board's People and Culture Committee and FPPC, as well as through the committee's monthly report to the Trust Board.

CQC registration requirements

The Trust is fully compliant with the registration requirements of the Care Quality Commission. The Trust's current registration status is 'requires improvement' following inspections in the summer of 2023.

Conflicts of Interest

The Trust introduced an online Declaration of Interests system in April 2022 for the first time that makes both declaring interests easier and monitoring compliance more effective. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance. In addition, the website provides a separate Board register of interests. The online system helps significantly in tracking compliance and progress, with 90% of staff expected to make an annual declaration having done so by March 2025.

NHS 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 accurately updated in accordance with the timescales detailed in the Regulations.

The Trust auto enrols all staff every three years into the pension scheme where they have opted out. Letters are sent out to affected staff that informs staff they will be auto enrolled or they can opt out again. All deductions around pensions follow NHS guidance for that particular pension scheme. For example, under agenda for change with the percentage for differing pay bands.

Equality, diversity and human rights legislation compliance

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

Since 1 April 2015, all NHS organisations were required to demonstrate how they are

addressing race equality issues in a range of staffing areas through the nine-point Workforce Race Equality Standard metric. This standard has been embedded within current practice. The Trust Board approved an Equality, Diversity and Inclusion Strategy in March 2024.

Climate and a Green Plan

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Board annually reviews progress against the Green Plan.

Quality governance

The Trust's quality and safety governance structure and arrangements enable the Trust to maintain and continually improve quality from 'ward to board'. Governance structure now contain a rolling programme of well-led quality governance deep dives, through self-assessment and providing evidence within each division provides annual assurance across performance of well led quality governance domains. There are clearly defined corporate and local indicators for quality and safety that are now displayed with the Trust Quality Management system 'ENHance'. This structure delivers the well-led CQC framework and provides clear assurance from wards upwards, and from the Board to the clinical areas.

Quality governance has a number of elements. These include the QSC which reports to the Board. The QSC is responsible for ensuring that effective arrangements are in place for the oversight and monitoring of all aspects of clinical quality and safety, including identifying potential risks to the quality of clinical care. The Board relies on the committee to provide advice on clinical quality, patient safety and risk, and for assurance on areas of clinical governance and audit. It focuses on promoting a culture of openness and organisational learning. On behalf of the Board, the QSC reviews compliance and receives assurance in meeting regulatory standards set by the CQC. Performance is also monitored via FPPC and Performance Review Meetings.

The Chief Nurse and Medical Director are the nominated Trust Executives for the Quality Report. The Board has agreed that the Quality Report will be considered and recommended by the QSC. QSC was also responsible for deliberating on priorities for inclusion in the Quality Report which are set out in this Annual Report.

The nature of a complex health setting means even the best control and assurance systems do not identify all issues. The Trust continues to work hard on addressing minimising surprise issues and tackling any non-compliance with governance standards.

The CQC rated the Trust as Requires Improvement, with CQC's report published in November 2023. Improvement forums were in place to achieve the delivery of identified 'must do' and 'should do' regulatory requirements by August 2024.

There were four never events during 2024/25 and the learning responses to these are undertaken through using an evidence based SEIPS framework (Systems Engineering Initiative for Patient Safety). The Trust has transitioned from investigating incidents under the Serious Incident (SI) Framework to the Patient Safety Incident Response Framework (PSIRF), and the Trust's inaugural Patient Safety Incident Response Policy and Plan were approved by the Board on 5 July 2023. A revised PSIRF Policy and 2024/25 PSIRF plan will be shared with the Trust Board in July 2025. These have been updated to reflect the learning from our inaugural PSIRF adoption year and following review of our safety profile and updated safety priorities moving forward.

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

The Trust reported a surplus of £1.5million against a planned £1m surplus position. This performance saw the Trust continue to meet the duty to break even.

The NHS financial framework for 2024/25 continued to build on the arrangements put in place to promote the recovery of core services and productivity following the COVID pandemic. Following a sector wide exercise in 2022/23 a 'baseline reset' adjustment was implemented to correct material issues with contract values and allocations as well as absorb reduced COVID funding into core allocations.

Funding received by the Trust was allocated under a combination of fixed block arrangements (non-elective) and variable activity payments (elective) to incentivise reduction in patient waits and progress meeting in operational key performance indicators. Variable funding for elective activity above target flowed into the system and Trust via the Elective Recovery funding (ERF) mechanism.

Early 2024/25 saw continued service and financial disruption resulting from sustained industrial action across doctor staffing groups. The Trust worked hard to minimise the safety and financial effects of this disruption. The financial impact of the action, which resulted in both additional staffing costs and lost income due to the delivery of lower than planned elective activity, was partially mitigated by the receipt of both additional funding to cover the direct costs.

Progress against the delivery of the financial plan was monitored by the Finance, Performance and Planning Committee (FPPC) and reported to Board. The Trust continued to build upon the themes from the prior year to focus on mitigating and improving areas of adverse performance.

Operating within a financially challenged system, the Trust worked with Hertfordshire and West Essex ICS to engage and deliver in a number of ICS wide workstreams designed to deliver efficiencies and recovery the system wide financial position. Ultimately the Trust was able to deliver a financial outturn position that supported the achievement of an overall balanced position for the system as a whole.

As a part of ICS wide workstreams from 2023/24 the Trust continued to uphold a number of controls throughout 2024/25 within the Deficit Control Regime, including the required double lock expenditure approval process as required by the NHS England Outturn Variance protocol.

The Trust utilised its revised Cost Improvement Programme (CIP) delivery protocol to identify and deliver against its challenging £33.8m efficiency target for 2024/25. The Trust was able to further build upon its excellent performance at elective activity restoration and ability to secure additional funding through the Elective Recovery Fun (ERF) during 2023/24 to help deliver on the efficiency ask, along with other recurrent and non-recurrent cost reduction schemes.

The Trust appointed a new internal audit provider during 2024/25 to ensure that the Trust has robust processes and controls in place. For 2024/25 The Trust's annual Internal Audit programme in relation to finance focussed on an independent review of our key financial controls, Payroll processes, Cost Improvement Plan (CIP) governance and delivery and Financial Sustainability plans. The independent review provided reasonable assurance for financial controls and payroll and partial assurance for CIP and sustainability.

NHS Improvement undertook a Use of Resources assessment in August 2019 and rated the Trust as 'requires improvement.' This has not been reviewed in this reporting year. The Trust continued to utilise the embedded Executive Programme Board structure intended to co-ordinate the delivery of key transformation activities which will contribute to the achievement of improved value for money arrangements. Furthermore, the Trust has invested and focussed upon improving the quality of business intelligence reporting available across the Trust as a means of improving the quality of business and financial decision making. During 2024/25 the Trust built upon improved governance arrangements and processes in the creation, approval and documentation of business cases. This combined with a focus on strategic critical infrastructure planning has seen a significant improvement in the Trust's assurance over management of resources within the capital programme.

The Trust recognises that the ongoing achievement of its targeted cost improvement plans represent a key element in the delivery of ongoing financial balance. To this end the Trust acknowledges the need to build savings and efficiency plans that have strong recurring foundations and are not overly reliant upon one off benefits. The Trust has responded to this requirement with a growing emphasis and focus upon making sustained productivity improvements. This has been underpinned to the development of regular productivity reports to the FPPC, enhanced productivity opportunity analytics and the agreement of productivity improvement schemes supported by its Project Management Office (PMO). The Trust recognises the significant financial challenge going into 2025/26, in response the Trust has rescoped The outputs of these activities have then been used to design and underpin the 2025/26 financial and savings plan.

The Trust's external auditor, BDO, has identified a significant weaknesses in the Trust's arrangements for ensuring the economical, efficient, and effective use of resources, specifically in relation to its financial sustainability.

The Trust has taken decisive steps to meet its Cost Improvement Programme (CIP) target for 2025/26. Key actions include an internal audit review of CIP governance for 2024/25, the implementation of a strengthened governance and delivery framework, and learning from past delivery challenges. Investments have been made in a dedicated PMO team and a senior delivery director to enhance oversight. The Trust has also introduced robust reporting tools (e.g. Power BI) and established monthly board-level assurance meetings to ensure strategic leadership and effective programme delivery.

Information governance

The Trust achieved a status of 'Standards Met' for the 2023/2024 DSPT Audit, and the independent assessment executed by our auditor gave the Trust a rating of 'Substantial' in all 10 standards and a confidence rating of 'High'. This was in the context last year's DSP Toolkit internal audit provided an 'unsatisfactory' finding and the Trust had not achieved a status of 'Standards Met' since the 2020-2021 DSPT Audit.

For the 2024/25 DSPT Audit, the outcome will not be known in time for this Annual Governance Statement. The Trust was required to complete a baseline submission by 31 December 2024. The submission date was missed. To rectify this, a contractor was brought in to assist to free up capacity to focus on the DSPT Audit.

Four data breaches met the threshold for reporting to the Information Commissioner (ICO) in this financial year (compared to five in 2023/24). For three of these breaches the ICO advised it was satisfied that appropriate measures were taken in that instance. The fourth is outstanding at the time of writing.

There are no cyber security governance matters to highlight and learning has been extracted from cyber-attacks against other NHS trusts. Equally, given the growing levels and sophistication of cyber-attacks, cyber security is a top risk on the Corporate Risk Register with a score of 20.

Data quality and governance

Data quality assurance at the Trust is supported by the Data Quality Strategy and Data Quality Policy. These two documents set out the ten key principles to support the production and assurance of high-quality data and its management across the organisation.

To ensure good quality data, the Trust upholds the five data quality principles: Accuracy, Completeness, Reliability, Relevance and Timeliness.

The strategy is built around the aspiration of 'get it right first time' when recording data (good quality data is everyone's responsibility) and defines responsibilities for specific roles across the organisation for its delivery. The strategy is implemented through the Data Quality Steering Group and supported by a rolling monthly audit and governance programme. The Audit Committee receives a bi-monthly update on all the key workstreams to help provide assurance to the Board, continue to improve data quality, to progress and improve patient experience, service delivery and patient flow.

Key workstreams include supporting the Trust's Demand and Capacity programme, future development of the Data Quality key performance indicators dashboard, routine monitoring of the Ethnicity Capture and Monitoring dashboard and supporting the specialty operational teams.

The quality and accuracy of elective waiting time data

The Trust assures the quality and accuracy of elective waiting time data using waiting lists, also known as Patient Tracking Lists (PTLs) available on Qlikview, the Trust's business intelligence system. The Trust has a team of Referral To Treatment (RTT) validators who have specific service and pathway expertise to ensure the waiting list is compliant with national rules. They review and correct the pathways where appropriate for patients waiting to start first definitive treatment on the RTT waiting list. In addition, there is a Validation Dashboard on Qlikview which provides daily oversight of the validation status of the RTT PTL. It identifies any potential Data Quality (DQ) issues and also when the patient pathway was last validated. These data quality cohorts are mirrored in the nationally available LUNA system that measures PTL data quality across all the trusts in the country.

Emergency Planning

The Trust has a rating of "Substantially Compliant" against the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance rating in 2024/2025.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been

advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

For the 12 months ended 31 March 2025, the Head of Internal Audit opinion for East and North Hertfordshire NHS Trust is as follows: The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work identified further enhancements to the framework of risk management, governance and internal control to ensure it remains adequate and effective.

Internal audit carried out eight reviews during 2024/25. Positively, audits central to determining confidence in the system of internal controls achieved reasonable assurance ratings for core financial controls and risk management.

Four audit reviews produced a reasonable assurance rating; four produced a partial assurance rating and none produced a limited assurance rating.

The partial assurance ratings related to CIP governance and delivery; Consultant job planning; Financial sustainability; and Establishment management and controls.

Significant changes that took place during the year that impact on governance were the appointment of a new internal auditor, RSM, and the introduction of the new PSIRF methodology.

The most significant governance development areas that have been identified relate to DPST, estates critical engineering functions, establishment growth controls and CIPs project management. DPST is a focus because of the history of lower scores or not meeting the submission deadline and therefore the Audit Committee concluded that enhanced monitoring of DPST progress in-between committee meetings was warranted. The renal PSII presented at January 2025 Public Board relating to water contamination highlighted critical engineering functions. The Audit Committee has asked for a separate compliance report on critical engineering functions and fire safety in addition to the report that already goes to QSC and water and electrics compliance has been added to the 2025-26 internal audit plan in light of the control issues identified in the renal PSII. The health and safety and estates duties being assured to QSC were reviewed and the first revised report was presented to April 2025's QSC, with enhanced consideration of fire risk. With regards to establishment controls to manage workforce growth, a Trust-wide recruitment freeze was enacted from the start of April 2025 for non-clinical managerial and administrative posts. A range of activities have been progressed to tackle accountability for CIPs delivery, including the Chief Executive taking over chairing the meeting responsible for CIPs delivery.

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 Board provides oversight of risks relating to the Trust's Strategy and supporting enabling strategies.
- The Audit and Risk Committee provides an independent and objective review of the Trust's system of internal control, integrated governance and risk management.
- The Board Assurance Framework provides evidence of the process of the effectiveness of controls that manages the principal risks to the organisation. Risks noted on the Board

Assurance Framework are reviewed by the Finance, Performance and Planning Committee, People and Culture Committee and Quality and Safety Committee as appropriate to their areas of focus and overall responsibility is retained by the Board.

- Internal auditors review the board assurance framework and the effectiveness of the system of internal control as part of the internal audit work to assist in the review of effectiveness. The internal auditors gave the BAF and risk management a reasonable assurance rating for 2024/25.
- The Board, Audit and Risk Committee, Quality and Safety Committee, the Risk Management Group and the Trust Management Group advise me on the implications of the results of my review of the effectiveness of the system of internal control.
- All the relevant committees within the corporate governance structure have a timetable of meetings and a reporting structure to enable issues to be escalated.
- The Quality and Safety Committee provides assurance on the progress of all areas of quality, safety and compliance and associated risks within its terms of reference.
- The Finance, Performance and Planning Committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the Quality and Safety Committee for further scrutiny, while providing proactive risk management within the areas of activity covered by its own remit.
- The People and culture Committee provides oversight of the related plans and risks relating to the workforce.
- Clinical Audit – the annual clinical audit programme is reviewed and approved through the Clinical Effectiveness Group and progress is monitored through the Divisions and Quality and Safety Committee. The Audit and Risk Committee receives the annual self-assessment against the assurance framework.
- Internal Audit, through its annual audit plan, provides assurance and comment on matters related to internal control. New internal auditors, RSM, were appointed in 2024.
- The annual review of the Trust's Standing Orders, Scheme of Reservation and Delegation and the Standing Financial Instructions was carried out in January 2025 by the Audit and Risk Committee.
- The Senior Information Risk Owner, who is supported by the Data Protection Officer and an Information Governance Steering Group, provide information governance assurance via the Data Security and Protection toolkit submission and IGSoC.
- The Board endeavours to ensure that all senior staff, clinical and other, through various meetings and review processes, including attending the Board Committees as required are held to account in all areas for delivery against finance, performance, people, quality, governance and risk issues. The Accountability Framework Structure and Integrated Performance Report support this.
- We commission and support external reviews and expertise to review and strengthen our governance. Examples include a well-led review that reported to Board in March 2023 and for risk management. This has provided assurance and additional recommendations, which have been progressed.
- We provide programme and enhanced governance support to areas under pressure or where additional support is required.
- We have Authorised Engineers who provide an independent review of our compliance and effective management of safety against a number of statutory requirements including water, electrical, fire, decontamination, ventilation and medical gases.
- Executive Directors, Senior Managers of the Trust and identified risk leads are proactively engaged in maintaining and reviewing the effectiveness of the system of internal control. This is supported by positive engagement with CQC and recent Internal Audit reports.

BDO has identified three significant control deficiencies in relation to IT General Controls. These are:

- 1) Inappropriate privileged access on Oracle, ESR and JAC.

- 2) Lack of evidence for Lorenzo to identify privileged users, generic accounts and those with access to make changes on the application.
- 3) The qualified NHS Shared Business Services (SBS) SOC1 report.

With regards to privileged users, the Trust has implemented a clear segregation of user roles. While the number may appear higher than expected, it has been reviewed and reduced to the minimum necessary to maintain operational effectiveness and security.

The Trust acknowledges the auditors' concerns regarding the identification of privileged users, generic accounts, and users with change-making access in Lorenzo. While we maintain that controls are in place to manage user access effectively, we recognise that documentation and evidence could be further strengthened. To address this, we are enhancing our monitoring processes and improving the maintenance of user access records to ensure clearer audit trails and more robust oversight.

The Trust acknowledges the recommendation to engage with SBS to better understand the nature of the deficiencies identified during their third-party evaluation. We agree that it is important to gain clarity on these issues and will proactively liaise with SBS to assess any potential impact on our operations. Appropriate actions will be considered based on the findings to mitigate any risks.

Conclusion

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

Signed:

Adam Sewell-Jones, Chief Executive

Date: 29 June 2025

Modern Slavery Act Statement

The Modern Slavery Act 2015 requires certain commercial organisations with an annual turnover of £36 million or more to prepare and publish an annual slavery and human trafficking statement. This statement should detail the steps the organisation has taken to ensure that slavery and human trafficking are not occurring in its operations or supply chains.

NHS trusts are typically public sector bodies and are not required to comply with the reporting requirements of the Modern Slavery Act because they do not meet the criteria of being a commercial organisation. NHS trusts do not typically have the £36 million turnover from non-governmental sources (e.g., private patients), which is required to trigger the obligations under the Act.

While NHS trusts may be exempt from the reporting requirements, they are still committed to tackling modern slavery. This includes having policies and practices in place to identify and respond to potential cases of modern slavery within the healthcare environment.

If suspected victims of modern slavery are identified within NHS trust settings, safeguarding teams and duty social workers manage referrals through established adult victim referral pathways, such as the HMSP adult victim referral pathway. This ensures that victims are not discharged until a proper management plan is agreed upon and actioned.

NHS trusts may not be legally required to report annually on slavery, but we play a vital role in identifying and supporting victims of modern slavery. We have systems in place to safeguard individuals who may be at risk and to raise awareness among staff about recognizing and reporting suspected cases.

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 2024/25)
- Remuneration tables
- Pension entitlement table
- Pension benefits table

Remuneration policy

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

The Remuneration and Appointments Committee is a committee of the Trust Board, consisting of the Chair and all the non-executive directors. It is chaired by Ms Anita Day (who is also the chair of the Trust Board). The Committee is supported by the Chief Executive, Chief People Officer and the Trust Secretary. The Remuneration and Appointments Committee aims to meet four times a year but will schedule additional meetings if needed. It met five times in total during 2024/25. Details of directors' remuneration are given later in this section of the report.

Every year, the Board's Remuneration and Appointments Committee considers the performance and contribution of each director against their portfolio and to the organisation. This is carried out in parallel with due consideration of remuneration for individual posts within regional and national markets. To support this work, the Remuneration and Appointments Committee considers the latest benchmarking data produced by NHS England regarding foundation and non-foundation Trust executive salaries.

Executive Director pay is based on the following agreed principles;

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

The Committee also pays due consideration to what is happening in the financial environment and with its other employees when determining executive director's remuneration. Remuneration for executive directors does not include any performance-

related bonuses and none of them receive personal pension contributions other than their entitlement under the NHS pension scheme.

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

The remuneration and terms of office of non-executive directors are those set out by NHS England. In September 2019 NHS England published a structure to align remuneration for chairs and non-executive directors of NHS Trusts and NHS foundation trusts. These recommendations have been implemented by the Trust. For non-executive directors, a single uniform annual rate of £13,000 will apply. Trusts also have local discretion to award limited supplementary payments depending on the organisations' size in recognition of designated extra responsibilities. Further information about such payments is provided in the document below. For chairs, it is intended that ranges will apply according to respective trust designations (i.e. groups 1 to 5) based on organisations' size (annual turnover) and complexity. Variation between lower quartile and upper quartile values should be a function of both the relative complexity of the role and the skills and experience of the chair. The ranges are consistent with the structure associated with very senior manager (VSM) remuneration. Pay awards agreed nationally for other staff groups working at the Trust and the wider NHS, including staff on Agenda for Change contracts, medical and dental staff and very senior managers are determined by the Senior Salaries Review Body, which looks at senior salaries and pay conditions across the public sector.

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

Staff sharing scenarios

The Trust contributes to a third of the cost several staff members as part running of the Integrated Care Partnership (ICP). This include a contribution to an executive director salary for Ruth Forbes who is the Development Director for the ICP.

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Remuneration tables

Name and title	2024/25							2023/24						
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Compensation for loss of office	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	Compensation for loss of office	TOTAL
	(bands of £5,000)	Rounded to nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £5,000)	Rounded to nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000	£000
	Executive directors													
Adam Sewell-Jones	215-220	2	0	0	7-5-10	0	225-230	205-210	1	0	0	252.5-255	0	460-465
Chief Executive														
Martin Armstrong	170-175	0	0	0	20-22.5	0	190-195	165-170	0	0	0	0	0	165-170
Director of Finance														
Theresa Murphy	145-150	1	0	0	15-17.5	0	165-170	140-145	0	0	0	40-42.5	0	180-185
Director of Nursing														
Michael Chilvers (to 16.04.23)	0	0	0	0	0	0	0	10-15	0	0	0	0	0	10-15
Medical Director														
Justin Daniels (from 17.04.23) *	225-230	1	0	0	145-147.5	0	370-375	190-195	1	0	0	110-112.5	0	300-305
Medical Director														
Lucy Davies	150-155	1	0	0	17.5-20	0	170-175	145-150	0	0	0	0	0	145-150
Chief Operating Officer														
Thomas Pounds (to 31.03.25)	140-145	0	0	0	22.5-25	0	165-170	130-135	4	0	0	0	0	130-135
Chief People Officer														
Mark Stanton	140-145	3	0	0	37.5-40	0	180-185	135-140	0	0	0	32.5-35	0	165-170

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Chief Information Officer														
Kevin O’ Hart	130-135	0	0	0	20-22.5	0	150-155	125-130	0	0	0	5-7.5	0	135-140
Director of Improvement														
Kevin Howell	145-150	0	0	0	0	0	145-150	160-165	0	0	0	0	0	160-165
Director of Estates & Facilities														

Name and title	2024/25						2023/24					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ellen Schroder (to 01.11.23)	0	0	0	0	0	0	30-35	0	0	0	0	30-35
Chair												
Anita Day (from 02.01.24)	50-55	6	0	0	0	55-60	10-15	3	0	0	0	10-15
Chair												
Val Moore (to 31.08.24)	5-10	2	0	0	0	5-10	10-15	5	0	0	0	10-15
Jonathan Silver (to 31.07.24)	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15
Peter Carter (to 20.09.24)	5-10	0	0	0	0	5-10	10-15	0	0	0	0	10-15
Nina Janda (from 01.09.23)	10-15	0	0	0	0	10-15	5-10	1	0	0	0	5-10
David Buckle	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15

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Karen McConnell	10-15	0	0	0	0	10-15	20-25	0	0	0	0	20-25
Janet Scotcher (from 01.09.24)	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Gillian Hooper (from 03.12.24)	0-5	0	0	0	0	0-5	0	0	0	0	0	0
Diana Skeete (from 01.09.24)	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Richard Oosterom (from 01.09.24) **	0	0	0	0	0	0	0	0	0	0	0	0
Tichafara Phiri (from 11.03.25) ***	0	0	0	0	0	0	0	0	0	0	0	0

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

- The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. The Trust's contribution to directors' pensions was 14.3% of salary for 2024/25 (this was topped up to 23.7% by NHSE) (20.6% in 2023/24). In summary, the figures calculated in the *All pension related benefits* column take in to account several factors, the principal one being the total maximum income that the person would receive covering the following 20-year period if they retired at the end of the financial year in question.
- Benefits-in-kind relate to taxable benefit available to NHS staff for the reimbursement of regular car user allowance, lease cars and removal expenses for new starters. During 2010/11 the Trust introduced a HM Treasury-approved salary sacrifice scheme for vehicles. Available to all staff, the scheme has been utilised by some of the executive directors, which has the effect of reducing the salary paid during 2023/24 and 2024/25.
- Salary sacrifice amounts have not been included in the current or prior year figures.
- * The amount of remuneration for Justin Daniels that relates to his non-managerial role is £68,471.04 (£157,276.63 relates to his managerial role).
- ** Richard Oosterom is paid via invoice and has received £6,500 during the year to cover the period 01/09/24 – 28/02/25.
- *** Tichafara Phiri joined on 11.03.25 and was not paid in the 2024-25 financial year.

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

Pension benefits

Name and title*	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash equivalent transfer value at 1 April 2024	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2025	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	£000	£000	£000	£000
Adam Sewell-Jones*	0-2.5	0	60-65	160-165	1,308	12	1,432	0
Chief Executive								
Martin Armstrong	0-2.5	0	55-60	145-150	1,152	0	1,274	0
Director of Finance								
Theresa Murphy	0-2.5	0	60-65	165-170	1,421	28	1,563	0
Director of Nursing								
Michael Chilvers* (to 16.04.23)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medical Director								
Justin Daniels (from 17.04.23)	7.5-10	10-12.5	75-80	205-210	1,526	158	1,812	0
Medical Director								
Lucy Davies	0-2.5	0	65-70	170-175	1,386	27	1,525	0
Chief Operating Officer								
Thomas Pounds	0-2.5	0	35-40	90-95	633	17	709	0
Chief People Officer								
Mark Stanton*	2.5-5	0	25-30	0	374	33	448	0
Chief Information Officer								
Kevin O'Hart*	0-2.5	0	35-40	95-100	802	23	894	0
Director of Improvement								
Kevin Howell	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Director of Estates & Facilities								

- Michael Chilvers left the pension scheme with effect from 1st April 2019.
- Adam Sewell-Jones opted back into the pension scheme April 2023.
- Kevin Howell opted out of the pension scheme prior to joining the Trust Board on 1st July 2022.
- There is no mandatory lump sum available for Mark Stanton.

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. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 2024 CETV figures.

Real increase in CETV reflects the increase in CETV funded effectively by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

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

On 1 April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between 1 April 2015 and 31 March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on 31 March 2022, with active members becoming members of the 2015 Scheme on 1 April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on 1 October 2023. This is called 'rollback'.

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

Compensation on early retirement or for loss of office

There were no such payments in 2024/25. This information is subject to audit by the Trust's auditors, BDO LLP.

Payments to past directors

There were no such payments in 2024/25. This information is subject to audit by the Trust's auditors, BDO LLP.

Pay multiples (fair pay disclosure) for 2024/25

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 2024/25 was £222,500 (2023/24 – £197,500). This was 5.5 times (2023/24 – 5.1 times) the median remuneration of the workforce, which was £40,795 (2023/24 – £39,016).

Regarding the ratio of highest paid director to median remuneration of the workforce, as the median pay has increased as well as the mid-point band of the highest paid director, this has resulted in a slightly higher ratio.

Salary sacrifice amounts have been included in the current and prior year calculations.

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

Further fair pay disclosures required for 2024/25

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

The banded remuneration of the highest paid director / member in East and North Hertfordshire NHS Trust in the financial year 2024/25 was £220k - £225k (2023/24, £195k-£200k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table along with the percentage change in remuneration of highest paid director.

	24/25 Increase / (decrease)	23/24 Increase / (decrease)
<u>Percentage change in salary in respect of highest paid director</u>		
Change in salary and allowances from the previous year in		
respect of the highest paid director:	12.66%	-4.82%
Change in performance pay and bonuses from the previous		
year in respect of the highest paid director:	N/A	N/A
Average change in salary and allowance from the previous		
year in respect of all employees (excluding highest paid director):	5.42%	10.54%
Average change in performance pay and bonuses from the previous		
year in respect of all employees (excluding highest paid director):	N/A	N/A

2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	29,114.00	40,795.19	53,751.20
Salary component of total remuneration (£)	29,114.00	40,520.95	53,278.06
Pay ratio information	7.64	5.45	4.14
2023-24	25th percentile	Median	75th percentile
Total remuneration (£)	28,456.86	39,016.46	51,688.00
Salary component of total remuneration (£)	28,415.74	38,836.27	51,306.01
Pay ratio information	6.94	5.06	3.82

Year	25th percentile total remuneration ratio	25th percentile salary ratio	Median total remuneration ratio	Median salary ratio	75th percentile total remuneration ratio	75th percentile salary ratio
24/25	7.64	7.64	5.45	5.49	4.14	4.18
23/24	6.94	6.95	5.06	5.09	3.82	3.85

In 2024/25, 36 employees (2023/24, 60 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £2,000 to £401,300 per annum (for 2023/24, – the reported range was £10,000 to £336,232).

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

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

Staff report

This section covers:

- Staff numbers and costs
- Staff composition
- Sickness absence data
- Staff turnover percentage
- Staff engagement
- Staff policies regarding equality and diversity
- Trade Union Facility Reporting Time
- Other employee matters
- Expenditure on consultancy
- Off-payroll engagements
- Exit packages

Staff numbers and costs

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

Average number of employees	2024/25			2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	433	538	971	1,039
Administration and estates	1,629	78	1,707	1,784
Healthcare assistants and other support staff	936	70	1,006	1,112
Nursing, midwifery and health visiting staff	1,827	32	1,859	2,090
Scientific, therapeutic and technical staff	0	5	5	0
Nursing, midwifery and health visiting learners	541	22	562	543
Healthcare science staff	159	8	167	175
Total average numbers	5,523	752	6,275	6,743
Of which:				
Number of employees (WTE) engaged on capital projects	14	2	16	6

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

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

Staff costs	2024/25			2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	312,838	-	312,838	287,464
Social security costs	35,318	-	35,318	32,660
Apprenticeship levy	1,585	-	1,585	1,485
Employer's contributions to NHS pensions	60,559	-	60,559	46,809
Pension cost - other	65	-	65	93
Termination costs	-	-	-	-
Temporary staffing costs	-	48,770	48,770	49,046
Total gross staff costs	410,365	48,770	459,135	417,556
Recoveries in respect of seconded staff	(4,856)		(4,856)	(4,524)
Total staff costs	405,509	48,770	454,279	413,032
External financing				
Costs capitalised as part of assets	1,041	-	1,041	328

Staff composition

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

Gender	Headcount March 2025	FTE March 2025
Female	5221	4560.98
Male	1738	1651.97
Total	6959	6212.95

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

Gender	Headcount 31 March 2025
Female	8
Male	10

Sickness absence data

Sickness absence rates have been between 4.16% and 5.93% during 2024/25 with the highest rates around wintertime, peaking at 5.93% in December 2024.

The absence rate for the 12-month period ending March 2025 was 4.49%, a reduction on the previous year from 4.6%.

Trust sickness absence by month:

Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
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4.16 %	4.32 %	4.18 %	4.70 %	4.21 %	4.54 %	4.54 %	5.03 %	5.93 %	5.27 %	4.87 %	4.29 %
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The three highest levels of absence are attributable to Anxiety/Stress/Depression followed by Cold/Cough/Flu then “Other MSK problems”. We will continue to promote a range of support for staff to remain well in work and encourage proper rest periods, taking of annual leave and continue to locally triangulate absence data with staff survey results, patient complaints and staff complaints to identify areas that may require higher levels of development and support to create healthy workplaces in those team areas.

Staff turnover percentage

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

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

Staff Engagement

The table below shows the Trust’s staff engagement score since 2017, as recorded in the NHS staff survey. The engagement score for 2024 shows an increase in staff responding, and an increase in the overall staff engagement score.

	2017	2018	2019	2020	2021	2022	2023	2024
Score	6.7	6.8	6.9	6.9	6.8	6.7	6.8	6.9
Number of responses	1608	2373	2600	2641	2640	2955	2994	3338

Staff policies regarding equality and diversity

Trust staff and candidates for roles with disabilities continue to be supported in recruitment through the Trust’s compliance with the two-tick accreditation and throughout their employment with the newly developed reasonable adjustment passport.

The Inclusion Ambassador schemes continue to support interview panels ensure and enable equity during the interview stage. A review of the role to identify level of success and any gaps and the experience of ambassadors will happen in 2025/26 as part continuous improvement work in resourcing and recruitment.

A policy to protect staff against sexual violence and aggression at work was reviewed during 2024/25 and communications relating to the confidential email to disclose incidents are shared with staff. The People team are working closely with the hospital domestic and sexual abuse specialist to ensure specialist support is available to the individual’s involved and specialist advice is provided to any subsequent investigative process.

The impact of all other policies is reviewed at the EDI Steering group to consider where remedial action is needed.

Trade Union Facility Reporting Time

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

Table 1 - Relevant Union officials

What was the total number of our employees who were relevant union officials during the period April 2024 to March 2025.

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
13	6212.95*

*March 2025

Table 2 – Percentage of time spent on facility time

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

Percentage of time	Number of employees
0%	
1 – 50%	11
51 - 99%	
100%	2

Table 3 Percentage of pay bill spend on facility time

Provide the total cost of facility time	£120,082.56
Provide the total pay bill	£429,608,485
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.028%

*estimate

Table 4 Paid trade union activities

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

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

Expenditure on consultancy

In 2024/25 £616,540.57 was spent on consultancy costs.

Off-payroll engagements

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

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

For all off-payroll engagements as of 31 March 2025, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2025	4
Of which the number have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	2
For four or more years at the time of reporting	1

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

For all off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	0
Of which...	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	10
No. of engagements reassessed for compliance or assurance purposes during the year	8
Of which: no. of engagements that saw a change to IR35 status following review	0

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

For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "Board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	0

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	2	2
£10,000 - £25,000	-	2	2
£25,001 - 50,000	-	-	-
£50,001 - £100,000	1	-	1
£100,001 - £150,000	2	-	2
£150,001 - £200,000	-	1	1
>£200,000	-	-	-
Total number of exit packages by type	3	5	8
Total cost (£)	£364,748	206,147	£570,895

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

There were no other departures where special payments have been made in 2024/25.

Reporting of compensation schemes - exit packages 2023/24

	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
Exit package cost band	Number	£000	Number	£000	Number	£000
<£10,000	-	-	12	£33	12	£33

£10,001 to £25,000	1	£13	4	£57	5	£70
£25,001 to 50,000	-	-	-	-	-	-
£50,001 to £100,000	3	£231	-	-	3	£231
£100,001 to £150,000	-	-	-	-	-	-
Total number of exit packages by type / total resource cost (£)	4	£244	16	£90	20	£334

Exit packages: other (non-compulsory) departure payments	2024/25		2023/24	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	21	16	90
Exit payments following Employment Tribunals or court orders	3	185	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	5	206	16	90
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

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 number in Note 6.1 which will be the number of individuals.

Non-contractual payments requiring HMT approval includes any non-contractual severance payment made following judicial mediation.

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

Parliamentary accountability and audit report

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

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

Fees and charges

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

Remote contingent liabilities

There were no remote contingent liabilities during 2024/25.

Losses and special payments

The Trust is required to declare if it has had any loss, made any special payments, or made a gift more than £300,000. The Trust has included information on losses and special payments in note 30 of the financial statements.

During 2024/25 the Trust has no individual case of Losses and Special Payments in year that exceeded £300,000.

Gifts

There were no gifts during 2024/25.

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policy laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

By order of the Board.

Date: 29 June 2025

Adam Sewell-Jones, Chief Executive

Date: 29 June 2025

Martin Armstrong, Finance Director

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF EAST AND NORTH HERTFORDSHIRE NHS TRUST

Opinion on the financial statements

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Group and of the Trust as at 31 March 2025 and of the Group's and of the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with applicable law and International Financial Reporting Standards as adapted and interpreted by the Government Financial Reporting Manual 2024-25 and further interpreted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements of East and North Hertfordshire NHS Trust ("the Trust") and its subsidiary ("the group") for the year ended 31 March 2025, which comprise the Statements of Comprehensive Income, the Statements of Financial Position, the Statements of Cash Flows, the Consolidated Statement of Changes in Equity, the Statement of Changes in Equity, and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards as adapted and interpreted by the Government Financial Reporting Manual 2024-25 and further interpreted by the Department of Health and Social Care Group Accounting Manual 2024-25.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice prepared by the Comptroller and Auditor General and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We are independent of the Trust and the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Group or the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the group and the Trust is in accordance with the expectation set out in the Department of Health and Social Care Group Accounting Manual 2024-25 that entities prepare their accounts on a going concern basis where it is anticipated that they will continue to provide their services into the future. In reaching our conclusions relating to going concern, we had regard to the guidance provided in Practice Note 10 Audit of financial statements

and regularity of public sector bodies in the United Kingdom (Revised 2024) issued by the Public Audit Forum on the application of ISA (UK) 570 Going Concern to public sector entities.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report and Accounts, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2024-25, and
- the other information published together with the audited financial statements is consistent with the financial statements.

Matters on which we are required to report by exception

Use of resources

We are required to report to you if, in our opinion, we have not been to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2024, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2025:

Significant weakness in arrangements	Recommendation
<p>The Trust set itself a target of making £35 million of cost savings in 2025/26. By May 2025 the Trust had not identified detailed plans for how it will make £12 million (34%) of these savings.</p> <p>This matter is evidence of a significant weakness in the Trust's arrangements for financial sustainability, in that the Trust did not have adequate arrangements in place to bridge its funding gaps and identify achievable savings.</p>	<p>We recommended that the Trust ensure its efficiency programmes and cost-saving measures are robust, effective to mitigate these risks and identified early enough for implementation.</p>

Other matters on which we report by exception

We are required report to you if:

- the Annual Governance Statement is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters except on 27 June 2025 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014. This was in relation to the Trust breaching its breakeven duty for the year ended 31 March 2025.

Responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of directors' responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of their intention to dissolve the Trust without transfer of its services or functions to another entity.

As explained in the Statement of the Chief Executive's responsibilities as the accountable officer of the trust, the Chief Executive as the accountable officer of the Trust, is responsible for ensuring that value for money is achieved from the resources available to the Trust.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

Non-compliance with laws and regulations

Based on:

- Our understanding of the Trust and the industry in which it operates;
- Discussion with management, and those charged with governance; and
- Obtaining and understanding of the Trust's policies and procedures regarding compliance with laws and regulations

we considered the significant laws and regulations to be the applicable accounting framework, the National Health Service Act 2006, the NHS provider licence, the Health and Social Care Act 2012, the Health and Care Act 2022, and VAT and PAYE legislation.

The Trust is also subject to laws and regulations where the consequence of non-compliance could have a material effect on the amount or disclosures in the financial statements, for example through the imposition of fines or litigations. We identified such laws and regulations to be the Data Protection Act 2018, and money laundering, corruption and bribery legislation.

Our procedures in respect of the above included:

- Review of minutes of meetings of those charged with governance for any instances of non-compliance with laws and regulations;
- Review of correspondence with regulatory and tax authorities for any instances of non-compliance with laws and regulations;
- Review of financial statement disclosures and agreeing to supporting documentation;
- Involvement of tax specialists in the audit; and
- Review of legal expenditure accounts to understand the nature of expenditure incurred.

Fraud

We assessed the susceptibility of the financial statements to material misstatement, including fraud. Our risk assessment procedures included:

- Enquiry with management, the Trust's head of internal audit, the Trust's local counter fraud specialist and those charged with governance regarding any known or suspected instances of fraud;
- Obtaining an understanding of the Trust's policies and procedures relating to:
 - Detecting and responding to the risks of fraud; and
 - Internal controls established to mitigate risks related to fraud.
- Review of minutes of meeting of those charged with governance for any known or suspected instances of fraud;
- Discussion amongst the engagement team as to how and where fraud might occur in the financial statements;
- Involving forensic specialists in our fraud engagement team meeting; and
- Performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud.

Based on our risk assessment, we considered the areas most susceptible to fraud to be income recognition, expenditure recognition, and the posting of journals.

Our procedures in respect of the above included:

- Testing a sample of journal entries throughout the year, which met defined risk criteria, by agreeing to supporting documentation;
- Review of the Trust's counter-fraud reporting and assessing the impact of reported fraud investigations ;
- Assessing significant estimates made by management for accrued receivables and accrued liabilities for bias,
- Testing pre- and post-year end transactions for receivables and liabilities and substantively testing a sample of accrued receivables and liabilities.
- Understanding, assessing and challenging management's estimation process for accrued receivables and accrued liabilities,
- Considering the outcome of prior year estimates for accrued receivables, and

- Obtaining evidence from management to support the validity and accuracy of estimated accruals, considering alternative and contradictory evidence and, where available, comparing estimated accruals to evidence received after the balance sheet date.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members who were all deemed to have appropriate competence and capabilities and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

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

A further description of our responsibilities is available on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

We are required under section 21 of the Local Audit and Accountability Act 2014 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General, having regard to the Auditor Guidance Notes prepared and published by the National Audit Office on behalf of the Comptroller and Auditor General.

Certificate - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for East and North Hertfordshire NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice ("the Code") until we have received confirmation from the National Audit Office that the Department of Health and Social Care group audit has been certified by the Comptroller & Auditor General and therefore no further work is required to be undertaken in order to discharge the auditor's duties in relation to consolidation returns under the Code. We are satisfied that this work does not have a material effect on the financial statements.

Use of our report

This report is made solely to the Directors of East and North Hertfordshire NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014. 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 Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Ciaran McLaughlin
Key Audit Partner

For and on behalf of BDO LLP, local auditor
Ipswich, UK

29 June 2025

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 year ended 31 March 2025

Statements of Comprehensive Income

Group and Trust			
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	656,767	609,608
Other operating income	4	60,513	48,976
Operating expenses	6,8	<u>(719,276)</u>	<u>(653,125)</u>
Operating (deficit) / surplus from continuing operations		<u>(1,996)</u>	<u>5,459</u>
Finance income	9	2,602	3,365
Finance expenses	10	(3,394)	(4,335)
PDC dividends payable		<u>(5,981)</u>	<u>(5,273)</u>
Net finance costs		<u>(6,773)</u>	<u>(6,243)</u>
Other (losses) / gains	11	(85)	-
Corporation tax expense		<u>(289)</u>	<u>(292)</u>
Deficit for the year		<u><u>(9,143)</u></u>	<u><u>(1,076)</u></u>
Will not be reclassified to income and expenditure:			
Impairments	7	(655)	(6,877)
Revaluations	16	1,544	1,104
Other reserve movements		<u>(17)</u>	<u>6</u>
Total comprehensive expense for the year		<u><u>(8,271)</u></u>	<u><u>(6,843)</u></u>

Statements of Financial Position

	Note	Group		Trust	
		31 March	31 March	31 March	31 March
		2025	2024	2025	2024
		£000	£000	£000	£000
Non-current assets					
Intangible assets	12,13	22,215	24,882	22,215	24,882
Property, plant and equipment	14,15	251,966	253,762	251,923	253,699
Right of use assets	17	95,866	100,166	95,866	100,166
Other investments / financial assets	18	-	-	1,000	1,000
Receivables	20	2,394	2,421	2,394	2,421
Total non-current assets		372,441	381,231	373,398	382,168
Current assets					
Inventories	19	9,833	8,757	8,515	7,474
Receivables	20	38,929	40,595	38,061	39,847
Cash and cash equivalents	21	49,720	66,324	47,674	64,354
Total current assets		98,482	115,676	94,250	111,675
Current liabilities					
Trade and other payables	22	(85,908)	(96,310)	(86,152)	(96,453)
Borrowings	24	(10,902)	(10,826)	(10,902)	(10,826)
Other financial liabilities		(412)	(209)	(412)	(209)
Provisions	25	(5,179)	(9,149)	(5,179)	(9,149)
Other liabilities	23	(4,328)	(7,488)	(4,328)	(7,488)
Total current liabilities		(106,729)	(123,982)	(106,973)	(124,125)
Total assets less current liabilities		364,194	372,925	360,675	369,718
Non-current liabilities					
Trade and other payables	22	-	(3,394)	-	(3,394)
Borrowings	24	(127,706)	(134,519)	(127,706)	(134,519)
Other financial liabilities		(4,124)	(1,141)	(4,124)	(1,141)
Provisions	25	(6,413)	(7,249)	(6,413)	(7,249)
Total non-current liabilities		(138,243)	(146,303)	(138,243)	(146,303)
Total assets employed		225,951	226,622	222,432	223,416
Financed by					
Public dividend capital		390,166	382,566	390,166	382,566
Revaluation reserve		52,280	51,391	52,280	51,391
Income and expenditure reserve		(216,495)	(207,335)	(220,014)	(210,541)
Total taxpayers' equity		225,951	226,622	222,432	223,416

The notes on pages 133 to 188 form part of these accounts.

Name	Adam Sewell-Jones
Position	Chief Executive
Date	28 June 2025

Statements of Cash Flows

	Note	Group		Trust	
		2024/25 £000	2023/24 £000	2024/25 £000	2023/24 £000
Cash flows from operating activities					
Operating (deficit) / surplus		(1,996)	5,459	(2,885)	4,812
Non-cash income and expense:					
Depreciation and amortisation	6.1	28,846	29,538	28,827	29,515
Net impairments	7	10,411	2,950	10,411	2,950
Income recognised in respect of capital donations	4	(96)	(200)	(96)	(200)
Decrease / (increase) in receivables and other assets		432	(11,059)	552	(10,973)
(Increase) in inventories		(1,076)	(622)	(1,041)	(615)
(Decrease) / Increase in payables and other liabilities		(10,535)	5,611	(10,145)	6,026
(Decrease) in provisions		(4,852)	(1,008)	(4,852)	(1,008)
Tax (paid) / received		(287)	(259)	-	-
Net cash flows from operating activities		20,847	30,410	20,771	30,507
Cash flows from investing activities					
Interest received		2,602	3,365	2,602	3,365
Purchase of intangible assets		(676)	(712)	(676)	(712)
Purchase of PPE		(26,414)	(32,096)	(26,414)	(32,096)
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(107)	-	(107)	-
Receipt of cash lease incentives (lessee)		-	250	-	250
Receipt of cash donations to purchase assets		96	200	96	200
Net cash flows used in investing activities		(24,499)	(28,993)	(24,499)	(28,993)
Cash flows from financing activities					
Public dividend capital received		7,600	8,863	7,600	8,863
Movement on loans from DHSC		(2,588)	(2,588)	(2,588)	(2,588)
Capital element of lease liability repayments		(9,118)	(8,768)	(9,118)	(8,768)
Capital element of PFI		(734)	(703)	(734)	(703)
Interest on loans		(954)	(1,057)	(954)	(1,057)
Other interest		(19)	(28)	(19)	(28)
Interest paid on lease liability repayments		(1,196)	(1,154)	(1,196)	(1,154)
Interest paid on PFI		(770)	(789)	(770)	(789)
PDC dividend paid		(5,153)	(4,894)	(5,153)	(4,894)
Cash flows from used in financing activities		(20)	(4)	(20)	(4)
Net cash flows used in financing activities		(12,952)	(11,122)	(12,952)	(11,122)
Decrease in cash and cash equivalents		(16,604)	(9,705)	(16,680)	(9,608)
Cash and cash equivalents at 1 April - brought forward		66,324	76,029	64,354	73,962
Cash and cash equivalents at 31 March	21	49,720	66,324	47,674	64,354

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	382,566	51,391	(207,335)	226,622
(Deficit) for the year	-	-	(9,143)	(9,143)
Impairments	-	(655)	-	(655)
Revaluations	-	1,544	-	1,544
Public dividend capital received	7,600	-	-	7,600
Other reserve movements	-	-	(17)	(17)
Taxpayers' and others' equity at 31 March 2025	390,166	52,280	(216,495)	225,951

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	373,703	57,656	(202,802)	228,557
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(3,955)	(3,955)
(Deficit) for the year	-	-	(1,076)	(1,076)
Impairments	-	(6,877)	-	(6,877)
Revaluations	-	1,104	-	1,104
Transfer to retained earnings on disposal of assets	-	(492)	492	-
Public dividend capital received	8,863	-	-	8,863
Other reserve movements	-	-	6	6
Taxpayers' and others' equity at 31 March 2024	382,566	51,391	(207,335)	226,622

Statement of Changes in Equity for the year ended 31 March 2025

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	382,566	51,391	(210,541)	223,416
(Deficit) for the year	-	-	(9,456)	(9,456)
Impairments	-	(655)	-	(655)
Revaluations	-	1,544	-	1,544
Public dividend capital received	7,600	-	-	7,600
Other reserve movements	-	-	(17)	(17)
Taxpayers' and others' equity at 31 March 2025	390,166	52,280	(220,014)	222,432

Statement of Changes in Equity for the year ended 31 March 2024

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2023 - brought forward	373,703	57,656	(205,650)	225,709
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023	-	-	(3,955)	(3,955)
(Deficit) for the year	-	-	(1,434)	(1,434)
Impairments		(6,877)	-	(6,877)
Revaluations	-	1,104	-	1,104
Transfer to retained earnings on disposal of assets	-	(492)	492	-
Public dividend capital received	8,863	-	-	8,863
Other reserve movements	-	-	6	6
Taxpayers' and others' equity at 31 March 2024	382,566	51,391	(210,541)	223,416

Adjusted Financial Performance

	2024/25	2023/24
Adjusted financial performance (control total basis):		
Deficit for the year	(9,143)	(1,076)
Add back all I&E impairments / (reversals)	10,411	2,950
Remove I&E impact of capital grants and donations	390	486
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	846	2,085
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(1,053)	-
Add back I&E impact of IFRIC 12 schemes on an IAS 17 basis	-	(1,271)
Remove net impact of DHSC centrally procured inventories	28	28
Adjusted financial performance surplus	1,479	3,202

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

Note 1.3 Consolidation

Subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

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

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

The Trust has judged that the financial performance and position of its Charity is not material to the results of the Trust and, as a result, the decision has been made not to consolidate for 2024/25.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

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

Revenue from NHS contracts

Income generated from contracts with the National Health Service (NHS) constitutes the primary revenue stream for the Trust. These contracts, established with commissioners for healthcare services, are funded within a set budget at the Integrated Care System (ICS) level. The bulk of the Trust's NHS revenue is derived from contracts with NHS commissioners under the NHS Payment Scheme (NHSPS), which superseded the National Tariff Payment System on April 1, 2023.

Under the NHSPS, Aligned Payment and Incentive (API) contracts serve as the primary payment mechanism for contractual values exceeding £0.5 million. API contracts in the fiscal year 2024/25 incorporate both fixed and variable components. The variable portion encompasses income generated from various healthcare activities, such as elective procedures, outpatient services, diagnostic imaging, and chemotherapy, among others, as outlined in the NHSPS. This income is calculated based on actual activity at NHSPS prices. Conversely, the fixed component encompasses income for services not contingent upon activity levels. High-cost drugs and devices, excluded from national price calculations, are reimbursed separately by NHS England.

Monthly fixed payments for the fiscal year 2024/25 were determined based on projected elective activity targets, subject to adjustments throughout the year, particularly in response to the Elective Recovery Fund (ERF). Deviations from projected performance levels prompt corresponding adjustments to the variable portion of payments within API contracts.

For integrated care boards with anticipated low-volume activity (annual value below £0.5 million), providers receive an annual fixed payment outlined in NHSPS documentation, classified as 'other clinical income'. Additionally, Elective Recovery Funding supports integrated care boards in commissioning elective services within their systems, indirectly impacting the Trust's revenue through system performance metrics.

In summary, revenue from NHS contracts forms the backbone of the Trust's income, with various mechanisms in place to adjust payments based on actual performance and system-wide initiatives.

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Education and training

Health Education England provide funding to maintain education and training capacity and retain students on education and training programmes. Income is recognised in line with the requirements of IFRS 15. Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.¹

Non-patient care services to other bodies

The Trust provides non-patient related services to other NHS bodies for which income is recognised in line with IFRS15. Revenue is recognised when performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.7 Expenditure on other goods and services

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

¹ Health Education England became part of NHS England at the start of 23/24.

Note 1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

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

Measurement

Valuation

The Trust's land and buildings are valued annually at the reporting date by an independent, qualified valuer in accordance with Department of Health and Social Care (DHSC) guidance and the NHS Group Accounting Manual.

Specialised assets are valued using the Modern Equivalent Asset (MEA) methodology. The valuation basis for specialised properties is the Current Value in Existing Use, primarily derived using the Depreciated Replacement Cost (DRC) approach. The DRC method estimates the current cost to replace an asset with its modern equivalent, less deductions for physical deterioration and obsolescence, consistent with the Royal Institution of Chartered Surveyors (RICS) Valuation – Global Standards.

Non-specialised properties are valued using the investment method, with valuations reflecting market conditions and assumptions consistent with the RICS Red Book and related guidance.

Land is valued based on the construction of a modern equivalent asset on an alternative site, adjusted for the expected footprint and site requirements, in line with MEA principles.

Revaluation gains and losses are accounted for in accordance with the Trust's accounting policies: net increases in valuation are credited to the revaluation reserve, while impairments are recognised in the statement of comprehensive income.

All property, plant and equipment assets are initially measured at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are subsequently measured at valuation. Assets held for their service potential and in use (operational assets delivering frontline or back-office services) are measured at current value in existing use. Assets held for their service potential but classified as surplus, with no plans for reuse, are measured at fair value where no sale restrictions exist at the reporting date, provided they do not meet the definitions of investment properties or assets held for sale.

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

Land and non-specialised buildings: market value for existing use

Specialised buildings: depreciated replacement cost on a modern equivalent asset basis

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. The MEA basis assumes replacement with a modern asset of equivalent capacity that meets the location requirements of the services provided. Where applicable, assets held at depreciated replacement cost have been valued on an alternative site basis, provided this meets the location requirements.

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

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

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

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

Impairments

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

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

De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated and grant funded assets

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

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

This includes assets donated to the trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's *FReM*, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

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

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

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

Note 1.9 Intangible assets

Recognition

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

Software

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

The Trust holds material intangible assets for its Electronic Patient Record (EPR) system Lorenzo. Two assets with a combined NBV of £11.7m and remaining amortisation period of 8 years are held in the Trusts books.

Measurement

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Development expenditure	5	10
Software licences	5	15

Note 1.10 Inventories

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

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. The Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.11 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.

Recognition of Cash Transfers

The Trust recognises cash and cash equivalents when it obtains control of the funds, typically when the amounts are credited to its bank accounts. For payments made via BACS or other electronic transfer systems, the reduction in cash is recognised when the funds have been cleared and are no longer under the control of the Trust.

Similarly, liabilities are derecognised only when settlement occurs. For transfers initiated before the reporting date but not settled until after the reporting date, the cash balance remains unchanged, and a corresponding liability continues to be recognised until settlement.

This policy ensures that cash and liabilities are not misstated due to timing differences between the initiation and settlement of transactions.

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

Note 1.12 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Recognition of Transfers (e.g., BACS and Other Electronic Payments)

For transfers such as BACS payments, financial assets and liabilities are recognised when the Trust becomes party to the underlying financial arrangement and control of the asset has transferred or the obligation to settle arises.

Outgoing payments (e.g. supplier settlements) made via BACS are recognised as a reduction in cash and a liability only when the funds have been cleared from the Trust's bank account, i.e., on settlement date, not the initiation date. Until settlement occurs, the liability remains recognised and cash is not reduced.

Incoming receipts via BACS are recognised as a financial asset when the Trust obtains control of the funds, typically when the payment is cleared into the Trust's bank account.

This approach ensures that assets and liabilities are not misstated due to timing differences between the initiation and settlement of payment instructions.

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

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

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

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

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

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

Derecognition

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

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

Note 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 26 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.15 Public dividend capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.16 Value added tax

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

Note 1.17 Corporation tax

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

Note 1.18 Third party assets

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

Note 1.19 Losses and special payments

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

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

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. The expected impact of applying the standard in future periods has not yet been assessed

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury. The impact of applying these changes in future periods has not yet been assessed.

Note 1.22 Sources of estimation uncertainty

On an ongoing basis, the Trust evaluates its estimates using historical experience, consultation with experts and other methods considered reasonable in the circumstances. As estimates carry with them an inherent level of uncertainty, we perform sensitivity analysis where this is practicable and where, in management's opinion, it provides useful and meaningful information. This sensitivity analysis is performed to understand a range of outcomes that could be considered reasonably possible based on experience and the facts and circumstances associated with individual areas of the financial statements that are subject to estimates. Actual results may differ significantly from the estimates, the effect of which is recognised in the period in which the facts that give rise to the revision become known. The following paragraphs describe the estimates and judgements relating to PPE, where the Trust believes to have the most significant impact on the annual results as reported in accordance with IFRS.

- Valuation of Tangible Assets - Note 15 and 16

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

- Land – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
- Non specialised buildings (Right of Use Assets) - investment method

The current valuation exercise was carried out in March 2025. The values in the valuer report have been used to inform the measurement of property assets at valuation in these financial statements.

Significant uncertainty in valuation relates principally to land and our specialised buildings. The valuer, in arriving at the value of specialised buildings, estimates the build costs based on current market indices. The build cost inflation estimated by the valuer for March 2025 was 2.31%. A 5% change in estimated build costs will result in a 4.78% change in the carrying value of buildings. Land valuation inflation was estimated at 10% by the valuer for March 2025 and this has been driven by pressures on land values outside of London. A 5% change in the market rate will result in a 5% change in the carrying value of land.

Note 1.23 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Note 2 Operating Segments

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature) (Group)	2024/25	2023/24
	£000	£000
Income from commissioners under API contracts - variable element*	179,703	166,630
Income from commissioners under API contracts - fixed element*	344,643	320,237
High cost drugs income from commissioners	64,773	61,192
Other NHS clinical income	33,457	40,233
Private patient income	6,967	5,422
National pay award central funding***	1,507	320
Additional pension contribution central funding**	24,062	14,364
Other clinical income	1,655	1,210
Total income from activities	656,767	609,608

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source) (Group)

	2024/25	2023/24
Income from patient care activities received from:	£000	£000
NHS England	104,141	156,166
Integrated care boards	543,962	446,810
Non-NHS: private patients	6,967	5,422
Non-NHS: overseas patients (chargeable to patient)	433	361
Injury cost recovery scheme	1,013	605
Non NHS: other	251	244
Total income from activities	656,767	609,608

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

	2024/25	2023/24
	£000	£000
Income recognised this year	433	361
Cash payments received in-year	248	236
Amounts added to provision for impairment of receivables	450	660
Amounts written off in-year	381	1,033

Note 4 Other operating income (Group)

	2024/25	2023/24
	£000	£000
Other operating income from contracts with customers:		
Research and development	7,923	6,452
Education and training	22,155	19,993
Non-patient care services to other bodies	26,761	18,731
Other	3,132	3,034
Other non-contract operating income:		
Education and training - notional income from apprenticeship fund	176	176
Receipt of capital grants and donations and peppercorn leases	96	200
Charitable and other contributions to expenditure - consumables (inventory) donated for COVID response (comparative only)	-	216
Revenue from operating leases	270	174
Total other operating income	60,513	48,976

Other contract income includes:

Car parking income of £1,471k (2023/24 £1,133k)

Catering (non-patient) of £1,295k (2023/24 £1,420k)

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

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	5,488	5,213

Note 5.2 Transaction price allocated to remaining performance obligations (Group)

	31 March	31 March
	2025	2024
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	4,328	7,488
Total revenue allocated to remaining performance obligations	4,328	7,488

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

Note 6.1 Operating expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,856	7,959
Purchase of healthcare from non-NHS and non-DHSC bodies	10,881	9,633
Staff and executive directors costs **	452,853	410,819
Remuneration of non-executive directors	146	138
Supplies and services - clinical (excluding drugs costs)	49,023	41,886
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	28	244
Supplies and services - general	16,386	15,581
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	78,768	73,587
Inventories written down	222	258
Consultancy costs	617	585
Establishment	5,607	5,669
Premises	29,111	24,287
Transport (including patient travel)	1,259	1,588
Depreciation on property, plant and equipment	25,503	26,254
Amortisation on intangible assets	3,343	3,284
Net impairments	10,411	2,950
Movement in credit loss allowance: contract receivables	467	89
Change in provisions discount rate(s)	2	(27)
Fees payable to the external auditor		
audit services- statutory audit *	268	250
Internal audit costs	203	190
Clinical negligence	20,193	19,622
Legal fees	596	334
Insurance	118	298
Research and development	385	2,001
Education and training	1,895	1,778
Expenditure on short term leases	429	264
Redundancy	-	654
Charges to operating expenditure for PFI schemes	(699)	151
Car parking & security	798	614
Hospitality	34	6
Losses, ex gratia & special payments	19	20
Other services, eg external payroll	1,534	1,401
Other	20	758
Total	719,276	653,125

* The audit fee is stated on a gross basis for the Trust and net for the subsidiary. The total amount NET of VAT is £223.5k

** Employer pension contributions paid by NHSE on the Trusts behalf (£24.062m).

Note 6.2 Auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2023/24: £1 million).

Note 7 Impairment of assets (Group)

	2024/25	2023/24
	£000	£000
Net impairments charged to operating surplus resulting from:		
Changes in market price	10,411	2,950
Total net impairments charged to operating surplus	10,411	2,950
Impairments charged to the revaluation reserve	655	6,877
Total net impairments	11,066	9,827

Impairments relating to Changes in Market Price and those Charged to the Revaluation Reserve relate to the Trust's Property, Plant and Equipment. This reflects the movements in value of properties based on their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis.

Note 8 Employee benefits (Group)

	2024/25	2023/24
	Total	Total
	£000	£000
Salaries and wages	312,188	287,464
Social security costs	35,318	32,660
Apprenticeship levy	1,585	1,485
Employer's contributions to NHS pensions	60,559	46,809
Pension cost - other	65	93
Temporary staff (including agency)	49,420	49,046
Total gross staff costs	459,135	417,557
Recoveries in respect of seconded staff	(4,856)	(4,525)
Total staff costs	454,279	413,032
Of which		
Costs capitalised as part of assets	1,041	328
Total employee benefits excl. capitalised costs	453,238	412,704

Please note, the £453,238k is made up of Staff and executive director costs £452,853k and Research and development staff costs £385k.

Note 8.1 Retirements due to ill-health (Group)

During 2024/25 there were 2 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £43k (£60k in 2023/24).

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

Note 9 Finance income (Group)

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,602	3,365
Total finance income	2,602	3,365

Note 10.1 Finance expenditure (Group)

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	954	1,057
Interest on lease obligations	1,196	1,154
Interest on late payment of commercial debt	19	28
Finance costs on PFI service concession arrangements:		
Main finance costs	770	789
Remeasurement of the liability resulting from change in index or rate	451	1,296
Total interest expense	3,390	4,324
Unwinding of discount on provisions	4	11
Total finance costs	3,394	4,335

* From 1 April 2023, IFRS 16 liability measurement principles are applied to PFI service concession liabilities. Increases to imputed lease payments arising from inflationary uplifts are now included in the liability, and contingent rent no longer arises. More information is provided in Note 28.

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	19	28

Note 11 Other (losses) / gains (Group)

	2024/25	2023/24
	£000	£000
Loss on disposal of ROU assets	(85)	-
Total loss on disposal of assets	(85)	-

Note 12.1 Intangible assets - 2024/25

Group	Software licences £000	Development expenditure * £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024	41,106	4,788	-	45,894
Additions	394	282	-	676
Disposals/derecognition	(632)	(276)	-	(908)
Valuation / gross cost at 31 March 2025	40,868	4,794	-	45,662
Amortisation at 1 April 2024	17,031	3,981	-	21,012
Provided during the year	3,177	166	-	3,343
Disposals/derecognition	(632)	(276)	-	(908)
Amortisation at 31 March 2025	19,576	3,871	-	23,447
Net book value at 31 March 2025	21,292	923	-	22,215
Net book value at 1 April 2024	24,075	807	-	24,882

Note 12.2 Intangible assets - 2023/24

Group	Software licences £000	Development expenditure * £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023	39,634	4,788	760	45,182
Additions	712	-	-	712
Reclassifications	760	-	(760)	-
Valuation / gross cost at 31 March 2024	41,106	4,788	-	45,894
Amortisation at 1 April 2023	13,910	3,818	-	17,728
Provided during the year	3,121	163	-	3,284
Amortisation at 31 March 2024	17,031	3,981	-	21,012
Net book value at 31 March 2024	24,075	807	-	24,882
Net book value at 1 April 2023	25,724	970	760	27,454

*Development expenditure is software that has been developed internally by the Trust.

Note 13.1 Intangible assets - 2024/25

Trust	Software licences £000	Development expenditure * £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024	41,002	4,788	-	45,790
Additions	394	282	-	676
Disposals/derecognition	(632)	(276)	-	(908)
Valuation / gross cost at 31 March 2025	40,764	4,794	-	45,558
Amortisation at 1 April 2024	16,927	3,981	-	20,908
Provided during the year	3,177	166	-	3,343
Disposals/derecognition	(632)	(276)	-	(908)
Amortisation at 31 March 2025	19,472	3,871	-	23,343
Net book value at 31 March 2025	21,292	923	-	22,215
Net book value at 1 April 2024	24,075	807	-	24,882

Note 13.2 Intangible assets - 2023/24

Trust	Software licences £000	Development expenditure * £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2023	39,530	4,788	760	45,078
Additions	712	-	-	712
Reclassifications	760	-	(760)	-
Valuation / gross cost at 31 March 2024	41,002	4,788	-	45,790
				-
Amortisation at 1 April 2023	13,811	3,818	-	17,629
Provided during the year	3,116	163	-	3,279
Amortisation at 31 March 2024	16,927	3,981	-	20,908
Net book value at 31 March 2024	24,075	807	-	24,882
Net book value at 1 April 2023	25,719	970	760	27,449

*Development expenditure is software that has been developed internally by the Trust.

Note 14.1 Property, plant and equipment - 2024/25

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024	21,780	170,138	13,828	73,814	18,948	2,680	301,188
Additions	-	11,600	4,325	4,969	2,695	21	23,610
Impairments	-	(3,783)	-	-	-	-	(3,783)
Reversals of impairments	2,245	883	-	-	-	-	3,128
Revaluations	-	(15,921)	-	-	-	-	(15,921)
Reclassifications	-	12,439	(15,509)	2,891	179	-	-
Disposals/derecognition	-	(2)	-	(171)	(5,035)	(1,369)	(6,577)
Valuation/gross cost at 31 March 2025	24,025	175,354	2,644	81,503	16,787	1,332	301,645
Accumulated depreciation at 1 April 2024	-	2,982	-	29,251	12,822	2,371	47,426
Provided during the year	-	7,909	-	5,954	1,916	104	15,883
Impairments	-	12,674	-	-	-	-	12,674
Reversals of impairments	-	(2,263)	-	-	-	-	(2,263)
Revaluations	-	(17,465)	-	-	-	-	(17,465)
Reclassifications	-	(67)	5	62	-	-	-
Disposals/derecognition	-	(2)	-	(171)	(5,035)	(1,369)	(6,577)
Accumulated depreciation at 31 March 2025	-	3,768	5	35,096	9,703	1,106	49,678
Net book value at 31 March 2025	24,025	171,586	2,639	46,407	7,084	226	251,967
Net book value at 1 April 2024	21,780	167,156	13,828	44,563	6,126	309	253,762

Note 14.2 Property, plant and equipment - 2023/24

Group	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2023	26,071	169,914	6,108	72,970	16,921	2,646	294,630
Additions	-	6,760	12,355	15,666	2,027	34	36,842
Impairments	(4,291)	(3,831)	-	-	-	-	(8,122)
Reversals of impairments	-	1,245	-	-	-	-	1,245
Revaluations	-	(8,604)	-	-	-	-	(8,604)
Reclassifications	-	4,654	(4,635)	(19)	-	-	-
Disposals / derecognition	-	-	-	(14,803)	-	-	(14,803)
Valuation/gross cost at 31 March 2024	21,780	170,138	13,828	73,814	18,948	2,680	301,188
Accumulated depreciation at 1 April 2023	-	2,308	-	39,329	11,387	2,260	55,284
Provided during the year	-	7,682	-	4,725	1,435	111	13,953
Impairments	-	4,023	-	-	-	-	4,023
Reversals of impairments	-	(1,323)	-	-	-	-	(1,323)
Revaluations	-	(9,708)	-	-	-	-	(9,708)
Disposals / derecognition	-	-	-	(14,803)	-	-	(14,803)
Accumulated depreciation at 31 March 2024	-	2,982	-	29,251	12,822	2,371	47,426
Net book value at 31 March 2024	21,780	167,156	13,828	44,563	6,126	309	253,762
Net book value at 1 April 2023	26,071	167,606	6,108	33,641	5,534	386	239,346

Note 14.3 Property, plant and equipment financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	24,025	161,348	2,639	44,034	7,084	189	239,319
On-SoFP PFI contracts	-	8,422	-	-	-	-	8,422
Owned - donated/granted	-	1,815	-	2,373	-	37	4,225
NBV total at 31 March 2025	24,025	171,585	2,639	46,407	7,084	226	251,966

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Note 14.4 Property, plant and equipment financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,780	156,688	13,775	41,757	6,126	256	240,382
On-SoFP PFI contracts	-	8,570	-	-	-	-	8,570
Owned - donated/granted	-	1,898	53	2,806	-	53	4,810
NBV total at 31 March 2024	21,780	167,156	13,828	44,563	6,126	309	253,762

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Included within Buildings are a number of assets that have not been revalued relating to tenant improvement works that are not part of the Trust's freehold (£7,528k).

¹ All PPE buildings are owned.

Note 15.1 Property, plant and equipment - 2024/25

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2024	21,780	170,138	13,828	73,814	18,878	2,501	300,939
Additions	-	11,600	4,325	4,969	2,695	21	23,610
Impairments	-	(3,783)	-	-	-	-	(3,783)
Reversals of impairments	2,245	883	-	-	-	-	3,128
Revaluations	-	(15,921)	-	-	-	-	(15,921)
Reclassifications	-	12,439	(15,509)	2,891	179	-	-
Disposals/derecognition	-	(2)	-	(171)	(5,035)	(1,369)	(6,577)
Valuation/gross cost at 31 March 2025	24,025	175,354	2,644	81,503	16,717	1,153	301,396
Accumulated depreciation at 1 April 2024	-	2,982	-	29,251	12,755	2,252	47,240
Provided during the year	-	7,909	-	5,954	1,916	85	15,864
Impairments	-	12,674	-	-	-	-	12,674
Reversals of impairments	-	(2,263)	-	-	-	-	(2,263)
Revaluations	-	(17,465)	-	-	-	-	(17,465)
Reclassifications	-	(67)	5	62	-	-	-
Disposals/derecognition	-	(2)	-	(171)	(5,035)	(1,369)	(6,577)
Accumulated depreciation at 31 March 2025	-	3,768	5	35,096	9,636	968	49,473
Net book value at 31 March 2025	24,025	171,586	2,639	46,407	7,081	185	251,923
Net book value at 1 April 2024	21,780	167,156	13,828	44,563	6,123	249	253,699

Note 15.2 Property, plant and equipment - 2023/24

Trust	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2023	26,071	169,914	6,108	72,970	16,851	2,467	294,381
Additions	-	6,760	12,355	15,666	2,027	34	36,842
Impairments	(4,291)	(3,831)	-	-	-	-	(8,122)
Reversals of impairments	-	1,245	-	-	-	-	1,245
Revaluations	-	(8,604)	-	-	-	-	(8,604)
Reclassifications	-	4,654	(4,635)	(19)	-	-	-
Disposals / derecognition	-	-	-	(14,803)	-	-	(14,803)
Valuation/gross cost at 31 March 2024	21,780	170,138	13,828	73,814	18,878	2,501	300,939
Accumulated depreciation at 1 April 2023	-	2,308	-	39,329	11,320	2,142	55,099
Provided during the year	-	7,682	-	4,725	1,435	110	13,952
Impairments	-	4,023	-	-	-	-	4,023
Reversals of impairments	-	(1,323)	-	-	-	-	(1,323)
Revaluations	-	(9,708)	-	-	-	-	(9,708)
Disposals / derecognition	-	-	-	(14,803)	-	-	(14,803)
Accumulated depreciation at 31 March 2024	-	2,982	-	29,251	12,755	2,252	47,240
Net book value at 31 March 2024	21,780	167,156	13,828	44,563	6,123	249	253,699
Net book value at 1 April 2023	26,071	167,606	6,108	33,641	5,531	325	239,282

Note 15.3 Property, plant and equipment financing - 31 March 2025

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	24,025	161,349	2,639	44,034	7,081	148	239,276
On-SoFP PFI contracts	-	8,422	-	-	-	-	8,422
Owned - donated / granted	-	1,815	-	2,373	-	37	4,225
Total net book value at 31 March 2025	24,025	171,586	2,639	46,407	7,081	185	251,923

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Note 15.4 Property, plant and equipment financing - 31 March 2024

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	21,780	156,688	13,775	41,757	6,123	196	240,319
On-SoFP PFI contracts	-	8,570	-	-	-	-	8,570
Owned - donated / granted	-	1,898	53	2,806	-	53	4,810
Total net book value at 31 March 2024	21,780	167,156	13,828	44,563	6,123	249	253,699

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¹ All PPE buildings are owned.

Note 16 Revaluations of property, plant and equipment

The Trust's land and buildings valuations at 31 March 2025 were performed by Avison Young (previously Bilfinger GVA), an independent valuation firm, in Birmingham.

The valuer applied the RICS Appraisal and Valuation Manual, consistent with DHSC and HM Treasury requirements. Definitions and valuation concepts were applied in line with the RICS Valuation – Global Standards 2022 and UK VPGA 6 of the Red Book, including detailed interpretations of Existing Use Value and Market Value.

The MEA concept assumes replacement by a modern structure with equivalent productive capacity, using modern materials and techniques. For example, Lister Hospital's modern equivalent asset was modelled as a five-storey building occupying 64% of its current land, while Hertford County Hospital's was modelled as a three-storey building occupying 84% of its current land.

During the year, the Trust recognised a net increase in the valuation of property, plant and equipment amounting to £889k (comprising gross impairments of £655k and revaluations of £1,544k). An impairment charge of £10,411k was recognised in the statement of comprehensive income. This primarily relates to impairment on the newly opened Vascular Hub and other backlog maintenance incurred during 2024/25.

Note 17 Leases - East And North Hertfordshire NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.

In addition to the freehold owned by the Trust, it also leases a number of other buildings in the South East of England to carry out its obligations as a healthcare provider. These are leased from other NHS Providers as well as other bodies external to government.

In addition, the Trust leases a large proportion of its medical equipment from Lifecycle, who act as a contract manager for the Trust.

Note 17.1 Right of use assets - 2024/25

Group and Trust	Property	Plant &	Of which:	
	(Buildings)	machinery	Total	leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	107,431	8,923	116,354	81,316
Additions	1,588	1,964	3,552	1,365
Additions - up front lease payments (before or on commencement)	-	107	107	-
Remeasurements of the lease liability	1,124	580	1,704	233
Movements in provisions for restoration / removal costs	42	-	42	36
Disposals / derecognition	(1,973)	(1,653)	(3,626)	(1,365)
Valuation/gross cost at 31 March 2025	108,212	9,921	118,133	81,585
Accumulated depreciation at 1 April 2024	12,343	3,845	16,188	8,965
Provided during the year	7,482	2,138	9,620	5,788
Disposals / derecognition	(1,973)	(1,568)	(3,541)	(1,365)
Accumulated depreciation at 31 March 2025	17,852	4,415	22,267	13,388
Net book value at 31 March 2025	90,360	5,506	95,866	68,197
Net book value at 1 April 2024	95,088	5,078	100,166	72,351
Net book value of right of use assets leased from other NHS providers				8,140
Net book value of right of use assets leased from other DHSC group bodies				60,057

Note 17.2 Right of use assets - 2023/24

Group and Trust	Property	Plant &	Of which:	
	(Buildings)	machinery	Total	leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023	107,970	8,200	116,170	82,898
Additions	(203)	850	647	-
Remeasurements of the lease liability	1,435	22	1,457	254
Movements in provisions for restoration / removal costs	2,237	-	2,237	2,172
Disposals / derecognition	(4,008)	(149)	(4,157)	(4,008)
Valuation/gross cost at 31 March 2024	107,431	8,923	116,354	81,316
Accumulated depreciation at 1 April 2023	5,891	1,903	7,794	4,481
Provided during the year	10,210	2,091	12,301	8,492
Impairments	250	-	250	-
Disposals / derecognition	(4,008)	(149)	(4,157)	(4,008)
Accumulated depreciation at 31 March 2024	12,343	3,845	16,188	8,965
Net book value at 31 March 2024	95,088	5,078	100,166	72,351
Net book value at 1 April 2023	102,079	6,297	108,376	78,417
Net book value of right of use assets leased from other NHS providers				8,325
Net book value of right of use assets leased from other DHSC group bodies				64,026

Note 17.3 Revaluations of right of use assets

The Trust's Right of Use assets were reviewed at 31 March 2025 by an independent, qualified valuer Avison Young (previously known as Bilfinger GVA), 3 Brindley Place, Birmingham, B1 2JB in accordance with DHSC guidance and the NHS Group Accounting Manual.

As noted in the Trust's accounting policies, ROU assets are subsequently measured using the revaluation model. In some cases, management consider that cost is an appropriate proxy for valuation and where this is the case no formal valuation is undertaken. This is typically the case where:

- a market rent is being paid, or
- the term is short enough that material increases in value are unlikely to arise, or
- there are regular rent reviews to market rent and the property is not overrented.

Each ROU asset is assessed individually to determine whether a formal valuation is necessary. Following the review, all ROU assets are being valued using the cost model. The carrying value of all Right of Use assets classified as Buildings at 31 March 2025 is £90.271m.

Note 17.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 24.1.

	Group	
	2024/25	2023/24
	£000	£000
Carrying value at 1 April	102,484	108,898
Lease additions	3,552	897
Lease liability remeasurements	1,704	1,457
Interest charge arising in year	1,196	1,154
Lease payments (cash outflows)	(10,314)	(9,922)
Carrying value at 31 March	98,622	102,484

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 17.5 Maturity analysis of future lease payments at 31 March 2025

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2025	31 March 2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year	8,622	4838
- later than one year and not later than five years	24,934	18,434
- later than five years	79,343	53,009
Total gross future lease payments	112,899	76,281
Finance charges allocated to future periods	(14,277)	(6,385)
Net lease liabilities at 31 March 2025	98,622	69,896
Of which:		
Leased from other NHS providers		8,812
Leased from other DHSC group bodies		61,084

Note 17.6 Maturity analysis of future lease payments at 31 March 2024

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2024	31 March 2024
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year	8,591	4,834
- later than one year and not later than five years	26,422	18,422
- later than five years	81,754	57,489
Total gross future lease payments	116,767	80,745
Finance charges allocated to future periods	(14,283)	(7,063)
Net finance lease liabilities at 31 March 2024	102,484	73,682
Of which:		
Leased from other NHS providers		8,873
Leased from other DHSC group bodies		64,809

Note 18 Other investments

The Trust's principal subsidiary undertakings as included in its consolidated accounts are below.

The Trust holds a £1,000k investment in ENH Pharma Ltd. The subsidiary's accounts are prepared as at 31 March 2025 and for the year then ended.

ENH Pharma Ltd is 100% owned and was incorporated on 28 July 2014 in the United Kingdom. Its principal activity is outpatient pharmacy. As at 31 March 2025, the subsidiary's total profit for the year was £849k (2023/24: £854k), with gross assets of £6,451k (2023/24: £5,954k) and net assets of £4,531k (2023/24: £4,205k).

The risk of the MVCC out-patient pharmacy moving to another provider in the short term has reduced over the last couple of years. If it does happen, ENH Pharma operations may be reduced but ENH Pharma would continue to operate profitably and be an ongoing entity. There is also the possibility of ENH Pharma continuing to support the out-patient pharmacy at MVCC if another provider takes over the hospital.

The Trust therefore do not feel it to be an impairment risk.

Note 19 Inventories

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Drugs	3,979	3,986	2,661	2,703
Consumables	5,643	4,659	5,643	4,659
Energy	211	112	211	112
Total inventories	9,833	8,757	8,515	7,474

Inventories recognised in expenses for the year were £78,768k (2023/24: £73,587k). Write-down of inventories recognised as expenses for the year were £222k (2023/24: £258k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £216k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

Note 20.1 Receivables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Contract receivables	27,763	28,196	27,699	28,135
Allowance for impaired contract receivables / assets	(1,426)	(1,116)	(1,426)	(1,116)
Prepayments (non-PFI)	6,352	7,090	6,352	7,090
VAT receivable	3,201	3,246	2,397	2,559
Clinician Pension	21	8	21	8
Other receivables	3,018	3,171	3,018	3,171
Total current receivables	38,929	40,595	38,061	39,847
Non-current				
Contract receivables	1,418	1,418	1,418	1,418
Allowance for impaired contract receivables / assets	(353)	(353)	(353)	(353)
Prepayments (non-PFI)	799	849	799	849
Clinician Pension	530	507	530	507
Total non-current receivables	2,394	2,421	2,394	2,421
Of which receivable from NHS and DHSC group bodies:				
Current	21,112	22,309	21,112	22,309
Non-current	530	507	530	507

Note 20.2 Allowances for credit losses - 2024/25**Group and Trust****Contract
receivables and
contract assets
£000**

Allowances as at 1 April 2024	1,469
New allowances arising	467
Utilisation of allowances (write offs)	(157)
Allowances as at 31 March 2025	1,779

Note 20.3 Allowances for credit losses - 2023/24**Group and Trust****Contract
receivables and
contract assets
£000**

Allowances as at 1 April 2023	1,892
New allowances arising	89
Utilisation of allowances (write offs)	(512)
Allowances as at 31 March 2024	1,469

Note 21 Cash and cash equivalents movements

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

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	66,324	76,028	64,354	73,962
Net change in year	(16,604)	(9,704)	(16,680)	(9,608)
At 31 March	49,720	66,324	47,674	64,354
Broken down into:				
Cash at commercial banks and in hand	2,070	1,976	24	6
Cash with the Government Banking Service	47,650	64,348	47,650	64,348
Total cash and cash equivalents as in SoCF	49,720	66,324	47,674	64,354

Note 21.1 Third party assets held by the trust

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

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Monies on deposit	7	11
Total third party assets	7	11

Note 22.1 Trade and other payables

	Group		Trust	
	31 March 2025 £000	31 March 2024 £000	31 March 2025 £000	31 March 2024 £000
Current				
Trade payables	23,632	27,764	23,916	27,953
Capital payables	2,300	5,104	2,300	5,104
Accruals	42,060	45,649	42,060	45,649
Annual leave accrual	2,477	3,830	2,477	3,830
Social security costs	4,403	4,243	4,388	4,228
Other taxes payable	4,964	4,856	4,949	4,835
PDC dividend payable	880	52	880	52
Pension contributions payable	5,192	4,618	5,182	4,608
Other payables	-	194	-	194
Total current trade and other payables	85,908	96,310	86,152	96,453
Non-current				
Other payables	-	3,394	-	3,394
Total non-current trade and other payables	-	3,394	-	3,394
Of which payables from NHS and DHSC group bodies:				
Current	11,773	14,119	11,773	14,119

Note 23 Other liabilities

	Group and Trust	
	31 March	31 March
	2025	2024
	£000	£000
Current		
Deferred income: contract liabilities	4,328	7,488
Total other current liabilities	4,328	7,488

Note 24.1 Borrowings

	Group and Trust	
	31 March	31 March
	2025	2024
	£000	£000
Current		
Loans from DHSC	2,626	2,630
Lease liabilities	7,480	7,493
Obligations under PFI	796	703
Total current borrowings	10,902	10,826
Non-current		
Loans from DHSC	27,685	30,273
Lease liabilities	91,142	94,991
Obligations under PFI	8,879	9,255
Total non-current borrowings	127,706	134,519

Note 24.2 Reconciliation of liabilities arising from financing activities (Group and Trust)

Group - 2024/25	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	32,903	102,484	9,958	145,345
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,588)	(9,118)	(734)	(12,440)
Financing cash flows - payments of interest	(954)	(1,196)	(770)	(2,920)
Non-cash movements:				
Additions	-	3,552	-	3,552
Lease liability remeasurements	-	1,704	-	1,704
Remeasurement of PFI / other service concession liability resulting from change in index or rate	-	-	451	451
Application of effective interest rate	950	1,196	770	2,916
Carrying value at 31 March 2025	30,311	98,622	9,675	138,608

Group - 2023/24	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2023	35,499	108,898	5,412	149,809
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,588)	(8,768)	(703)	(12,059)
Financing cash flows - payments of interest	(1,057)	(1,154)	(789)	(3,000)
Non-cash movements:				
Application of IFRS 16 measurement principles to PFI liability on 1 April 2023			3,955	3,955
Additions	-	897	-	897
Lease liability remeasurements	-	1,457	-	1,457
Remeasurement of PFI / other service concession liability resulting from change in index or rate			1,296	1,296
Application of effective interest rate	1,049	1,154	789	2,992
Other changes	-	-	(2)	(2)
Carrying value at 31 March 2024	32,903	102,484	9,958	145,345

Note 25.1 Provisions for liabilities and charges analysis (Group and Trust)

	Pensions: early departure costs £000	Legal claims £000	Re- structuring £000	Equal Pay (including Agenda for Change) £000	Lease dilapidations - amounts previously charged to revenue £000	Lease dilapidations - cost capitalised under IFRS16 £000	Redundancy £000	Other £000	Total £000
At 1 April 2024	733	69	465	1,699	9,326	3,134	457	515	16,398
Change in the discount rate	2	-	-	-	-	-	-	(5)	(3)
Arising during the year	135	112	66	-	-	94	-	33	440
Utilised during the year	(109)	(106)	(465)	(1,341)	(1,551)	(268)	(375)	(19)	(4,234)
Reversed unused	(25)	-	-	-	(881)	(52)	(82)	-	(1,040)
Unwinding of discount	4	-	-	-	-	-	-	27	31
At 31 March 2025	740	75	66	358	6,894	2,908	-	551	11,592
Expected timing of cash flows:									
- not later than one year;	98	75	66	358	2,161	2,400	-	21	5,179
- later than one year and not later than five years;	447	-	-	-	-	-	-	73	520
- later than five years.	195	-	-	-	4,733	508	-	457	5,893
Total	740	75	66	358	6,894	2,908	-	551	11,592

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

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

Redundancy provision relates to costs that are likely to be paid.

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

Equal Pay provision relates to the NHS Band 2 to Band 3 equal pay issue relating to a widespread concern that many healthcare workers, especially healthcare assistants (HCAs) and support workers, were performing duties at Band 3 level while still being paid at Band 2 rates — which raised equal pay and job grading concerns under both Agenda for Change and the Equality Act 2010. Whilst the majority of the back pay was settled in 24/25, there was a proportion not that has been settled in 25/26.

Other provision relates to clinician pension costs.

The discount rate applied to provisions above is 2.40%.

Note 26 Clinical negligence liabilities

At 31 March 2025, £346,416k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire NHS Trust (31 March 2024: £259,670k).

Note 27 On-SoFP PFI service concession arrangements

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

The Trust pays a monthly contractual unitary payment, which covers the cost of facilities management services, financing and lifecycle replacement of assets components. Further information on the nature and value of these payments is included below.

Note 27.1 On-SoFP PFI service concession arrangement obligations

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

	Group and Trust	
	31 March 2025	31 March 2024
	£000	£000
Gross PFI service concession liabilities	13,233	14,612
Of which liabilities are due		
- not later than one year	1,509	1,053
- later than one year and not later than five years	6,226	5,643
- later than five years	5,498	7,916
Finance charges allocated to future periods	(3,558)	(4,654)
Net PFI service concession arrangement obligation	9,675	9,958
- not later than one year	796	703
- later than one year and not later than five years	4,062	2,629
- later than five years	4,817	6,626

Note 27.2 Total on-SoFP PFI service concession arrangement commitments

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

	Group	
	31 March 2025	31 March 2024
	£000	£000
Total future payments committed in respect of the PFI service concession arrangements	18,869	20,756
Of which payments are due:		
- not later than one year	2,123	2,053
- later than one year and not later than five years	9,036	8,738
- later than five years	7,710	9,965

Note 27.3 Analysis of amounts payable to service concession operator

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

	Group	
	2024/25	2023/24
	£000	£000
Unitary payment payable to service concession operator	1,192	1,964
Consisting of:		
- Interest charge	770	789
- Repayment of balance sheet obligation	734	703
- Service element and other charges to operating expenditure *	(699)	151
- Capital lifecycle maintenance	387	321
Total amount paid to service concession operator	1,192	1,964

* Throughout 2024-25 the Trust has been making deductions against poor service performance and this has resulted in a credit balance.

Note 28 Financial instruments

Note 28.1 Financial risk management

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

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

Currency risk

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

Interest rate risk

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

The Trust may also borrow from government for revenue financing subject to approval by NHSE. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2025 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 commissioners of healthcare (ICBs and NHS England), which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained through its ICS allocation. The Trust is not, therefore, exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets (Group)

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2025	
Trade and other receivables excluding non financial assets	30,420
Cash and cash equivalents	49,720
Total at 31 March 2025	80,140

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2024	
Trade and other receivables excluding non financial assets	31,316
Cash and cash equivalents	66,324
Total at 31 March 2024	97,640

Note 28.3 Carrying values of financial assets (Trust)

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2025	
Trade and other receivables excluding non financial assets	30,356
Cash and cash equivalents	47,674
Total at 31 March 2025	78,030

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2024	
Trade and other receivables excluding non financial assets	31,255
Cash and cash equivalents	64,355
Total at 31 March 2024	95,610

All financial assets are held at amortised cost

Note 28.4 Carrying values of financial liabilities (Group)

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2025	
Loans from the Department of Health and Social Care	30,311
Obligations under leases	98,622
Obligations under PFI service concessions	9,675
Trade and other payables excluding non financial liabilities	69,253
Other financial liabilities	4,536
Total at 31 March 2025	212,397
	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2024	
Loans from the Department of Health and Social Care	32,903
Obligations under leases	102,484
Obligations under PFI service concessions	9,958
Trade and other payables excluding non financial liabilities	78,517
Other financial liabilities	4,938
Total at 31 March 2024	228,800

Note 28.5 Carrying values of financial liabilities (Trust)

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2025	
Loans from the Department of Health and Social Care	30,311
Obligations under leases	98,622
Obligations under PFI service concessions	9,675
Trade and other payables excluding non financial liabilities	69,539
Other financial liabilities	4,536
Total at 31 March 2025	212,683
	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2024	
Loans from the Department of Health and Social Care	32,903
Obligations under leases	102,484
Obligations under PFI service concessions	9,958
Trade and other payables excluding non financial liabilities	78,706
Other financial liabilities	4,938
Total at 31 March 2024	228,989

All financial liabilities are held at amortised cost.

Note 28.6 Fair values of financial assets and liabilities

The book value of financial assets and liabilities (other than lease/PFI liabilities) is considered a reasonable approximation of fair value.

Note 28.7 Maturity of financial liabilities

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

	Group		Trust	
	31 March 2025	31 March 2024	31 March 2025	31 March 2024
	£000	£000	£000	£000
In one year or less	83,263	95,972	83,509	96,115
In more than one year but not more than five years	45,467	47,087	45,467	47,087
In more than five years	106,837	112,926	106,837	112,926
Total	235,567	255,985	235,813	256,128

Note 29 Losses and special payments

	2024/25		2023/24	
Group and Trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Bad debts and claims abandoned	101	420	199	1,084
Stores losses and damage to property	54	240	59	272
Total losses	155	660	258	1,356
Special payments				
Compensation under court order or legally binding arbitration award	3	124	-	-
Ex-gratia payments	34	119	28	137
Total special payments	37	243	28	137
Total losses and special payments	192	903	286	1,493

Special severance payments include any non-contractual payments made following judicial mediation, and noncontractual payments in lieu of notice.

Cases over £300,000

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

Note 30 Related parties

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

The Department of Health and Social Care is the Trust's parent department and there has been a number of material transactions with other public sector bodies, the most significant of which were with NHS England, Health Education England¹, the Hillingdon Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust, HMRC, the NHS Pension Scheme, NHS Resolution, Hertfordshire & West Essex ICB, Bedfordshire, Luton and Milton Keynes ICB, NHS Hertfordshire and West Essex ICB, North West London ICB, Cambridgeshire and Peterborough ICB and NHS Professionals.

In addition to the above bodies, there were a number of transactions between the Trust and its charity, the East and North Hertfordshire NHS Trust Charitable Fund. In 2024-25 the Trust received £1,028k (2023-24 £1,011) from the charity. The majority of these receipts were for the re-imbursement of running costs and donations made for the benefit of patients and staff. There was £58k (2023-24 £81k) receivable balance from the charity at the end of the financial year.

¹ Health Education England became part of NHS England at the start of 23/24.

Note 31 Events after the reporting date

From the 1 April 2025 onwards, The Trust will be renamed as East and North Hertfordshire Teaching NHS Trust

Note 32 Better Payment Practice code

	2024/25	2024/25	2023/24	2023/24
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	69,881	275,739	71,552	250,440
Total non-NHS trade invoices paid within target	66,171	243,546	66,514	224,398
Percentage of non-NHS trade invoices paid within target	94.7%	88.3%	93.0%	89.6%
NHS Payables				
Total NHS trade invoices paid in the year	2,618	43,036	2,518	32,651
Total NHS trade invoices paid within target	1,738	29,607	1,843	25,429
Percentage of NHS trade invoices paid within target	66.4%	68.8%	73.2%	77.9%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

The Trust adopts the NHS Standard Terms and Conditions when entering into contractual arrangements, which requires invoices to be paid within 30 days of receipt. For the purpose of this disclosure, it has been assumed that all invoices which were paid within the 30 day target were due to be paid within that period.

Obligations for Late Payment Interest for failure to pay within the due terms are included within Note 11.1.

Note 33 Capital Resource Limit

	2024/25	2023/24
	£000	£000
Gross capital expenditure	29,649	39,658
Less: Disposals	(85)	-
Less: Donated, granted and peppercorn leased capital additions	(96)	(200)
Charge against Capital Resource Limit	29,468	39,458
Capital Resource Limit	29,468	39,458
Under spend against CRL	-	-

Note 34 Breakeven duty financial performance

	2024/25
	£000
Adjusted financial performance surplus (control total basis)	1,479
IFRIC 12 breakeven adjustment	207
Breakeven duty financial performance surplus	1,686

Note 35 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		2,500	3,328	3,568	532	109	(3,613)	(16,226)	(29,533)
Breakeven duty cumulative position	1,825	4,325	7,653	11,221	11,753	11,862	8,249	(7,977)	(37,510)
Operating income		331,312	340,309	346,402	350,543	365,313	376,050	384,712	411,870
Cumulative breakeven position as a percentage of operating income		1.3%	2.2%	3.2%	3.4%	3.2%	2.2%	(2.1%)	(9.1%)
		2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
		£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		(24,424)	(13,543)	1,452	2,528	361	(6,136)	3,302	1,686
Breakeven duty cumulative position		(61,934)	(75,477)	(74,025)	(71,497)	(71,136)	(77,271)	(73,969)	(72,284)
Operating income		420,968	444,903	498,597	540,900	578,461	610,600	658,584	717,280
Cumulative breakeven position as a percentage of operating income		(14.7%)	(17.0%)	(14.8%)	(13.2%)	(12.3%)	(12.7%)	(11.2%)	(10.1%)

* The Trust's adjusted financial performance for 2024-25 was £1,479k. There are technical adjustments relating to PFI remeasurement accounting that has improved the breakeven duty by £207k.

The Trust first reported cumulative deficit in 2015-16 of £7,977k (-2.1% of operating income). The Trust is in the tenth year of consecutive break-even duty breach achieving a cumulative deficit of £72,283 (-10.1% of operating income) above the -0.5% permitted. The Trust recorded a surplus of £1,686k in 2024-25.