

Annual Report and Accounts 2025-26



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Performance Report

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.

Joint Chair and Chief Executive's Statement

This year has been one of significant progress, recognition and ambition for East and North Hertfordshire Teaching NHS Trust, shaped by the dedication of our people and our continued focus on delivering high-quality care for the communities we serve.

A defining milestone was reached on 1 April last year, when we formally became East and North Hertfordshire Teaching NHS Trust. Achieving teaching hospital status reflects the strength of our clinical services, our culture of learning, and our growing role in education, training and research. Through strengthened partnerships with our university partners, we continue to support and educate the next generation of NHS professionals.

Our achievements have also been recognised externally. Being named a finalist in the HSJ Trust of the Year awards reflects the collective progress made across quality, leadership and improvement. The Trust was ranked top of segment 2 in the NHS Oversight Framework (the new performance league table for NHS Trusts), which places us among the higher-performing NHS trusts nationally, and our cancer access targets were featured by the BBC as an example of best practice. In addition, Trust teams and individuals have received a wide range of regional and national awards, celebrating excellence in clinical care, innovation, education and compassionate leadership. Many of these successes are shared through our social media channels and news stories on our website at enherts.nhs.uk.

This has also been a strong year for our Trust Charity, which raised more than £1.5 million to support patients, staff and services across our hospital sites. These funds have helped to enhance patient environments, invest in equipment, and support initiatives that go beyond core NHS provision. This remarkable achievement would not have been possible without the generosity of our donors, fundraisers and supporters.

We would like to offer our heartfelt thanks to our volunteers, whose time, kindness and commitment enrich the experience of patients and visitors every day. Most importantly, we want to thank our staff. In what continues to be a challenging environment, colleagues across all roles have shown exceptional professionalism, resilience and compassion, consistently living our values and putting patients first.

As we look ahead, becoming a teaching hospital provides a strong foundation for the future. We remain committed to improving quality and safety through our East and North Hertfordshire Teaching NHS Trust Production System, supporting our workforce, reducing health inequalities and working collaboratively across our health and care system. Together, we will continue to build a Trust that delivers excellent care today while shaping a sustainable and innovative future for our communities.



Martin Armstrong
Chief Executive

26 June 2026



Anita Day
Chair

26 June 2026

About the Trust

East and North Hertfordshire Teaching 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.



East and North Hertfordshire Teaching NHS 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 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.

The birth rate is slightly lower than the England average, with the Trust's local population (East and North Hertfordshire) forecast to rise by approximately 2.3% in the years between 2025 and 2031; the most significant growth is expected in people aged 65 and over (12.7%) 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 there will be significant housing development ~16,000 new homes in North Hertfordshire by 2031, over 14,000 new homes in Welwyn and Hatfield and 7,600 new homes in Stevenage.

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 6,950 staff are employed by the Trust. The Trust's annual turnover is £762 million.



* An indicative visual of the Lister Hospital new front entrance due to open in the autumn of 2026.

Organisational Structure

The Trust has a divisional clinical operational structure. Services are grouped into 10 Care Groups within the four Divisions. Each Care Group and Division has 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.

Our Local System

East and North Hertfordshire Teaching NHS Trust is part of the Hertfordshire and West Essex Integrated Care System (ICS), which during 2025/26 began transitioning into a shadow merged Central East Integrated Care Board (ICB) from 1 October 2025. This new ICB, which brings together Hertfordshire, Bedfordshire, Luton and Milton Keynes (BLMK), and Cambridgeshire and Peterborough systems, was formally constituted from 1 April 2026.

Within this evolving system, the Trust has continued to collaborate closely with partners across health and care, including through its role in acting as the Host Provider and Senior Responsible Officer (SRO) for the East and North Hertfordshire Health and Care Partnership (HCP). Through the HCP, the Trust has supported the ongoing development of integrated

services for the local population, including services that enable more patients to be treated safely closer to home.

The Trust has also maintained strong collaboration with acute providers across the system to deliver high-quality and sustainable services, including the development of a vascular hub on the Lister site.

In exercising its functions during 2025/26, the Trust has had regard to the Hertfordshire and West Essex Integrated Care Board (ICB) Joint Forward Plan and has continued to work collaboratively with system partners in support of shared priorities where appropriate.

This is reflected through the Trust's contribution to a range of national and system-wide initiatives, including elective recovery, urgent and emergency care improvement, cancer services and transformation programmes delivered, where appropriate, in partnership with wider partners and the wider system.

The Trust continues to engage in the development and delivery of system-wide plans through its participation in partnership arrangements, including its role as Host Provider within the Health and Care Partnership, while maintaining focus on its statutory responsibilities and organisational priorities.



Strategy Overview and Objectives

Our strategic vision sets the long-term direction for the Trust: to be trusted to provide consistently outstanding care and exemplary service. This vision is supported by eight strategic goals focused across four themes incorporating quality of care, thriving people, seamless services and continuous improvement. Together, these goals are designed to

shape leadership behaviours, culture and system design, ensuring the organisation's vision is translated into meaningful day-to-day action across all services.

Each year, the organisation reviews these goals and considers insights and learning, as well as national NHS ambitions and policy changes. Once refreshed and approved at Board, strategic goals cascade through the organisation, translating into specific, measurable, achievable, relevant, time-bound, locally owned objectives that guide teams' priorities and improvement for the year ahead. Impact is measured through the Virginia Mason Institute (VMI) Health Check process, tracking maturity of the East and North Hertfordshire Production System (ENHPS) management system and improvement culture, alongside NHS Staff Survey results reflecting workforce experience, engagement and psychological safety.

The Strategic Delivery Plan 2026/27 – 2030/31 translates this ambition into a practical roadmap, outlining the priorities, transformation programmes and performance commitments that will guide progress during this timeframe, ensuring our strategy is delivered through coordinated action across services, partnerships and operational improvement.

The RAG assessment presented below reflects the Board's overall judgement of organisational progress against each strategic theme during the reporting period. This involves triangulation of north star metrics that express system-level outcomes for strategic goals and long-term direction. These incorporate several NHS staff survey metrics that align closely to each area, and when consistently tracked over time help measure progress across the required cultural, behavioural and leadership changes necessary to deliver the vision.

Strategic Theme	Strategic Goal	Indicative RAG (Red, Amber, Green)
Quality	1.Minimise waits by redesigning pathways and processes.	
	2.Aim for Zero Harm/defects by applying and developing research and utilising improvement methodology.	
Thriving People	3.Give staff the autonomy, development and necessary tools to succeed.	
	4.Build capability for compassionate and inclusive leadership, sharing clear expectations and accountability.	
Seamless Services	5.Ensure the voices of those we serve are heard in designing and improving services.	
	6.Organise and improve services by collaboration and integration with partners.	
Continuous Improvement	7.Improve safety and outcomes by redesigning processes and pathways supported by digitisation.	
	8.Improve efficiency by the continuous removal of waste and increasing productivity.	

Performance Appraisal

Across the course of 2025/26 the Trust has continued to make good progress in delivering NHS performance priorities within a challenging and evolving operating environment. This has reflected a sustained focus on improving access, quality and patient experience, alongside continued investment in capacity and service transformation.

The Trust has maintained a strong focus on delivering high quality and responsive urgent and emergency care services, recognising the importance of reducing Emergency Department waiting times and ambulance handover delays. Through a combination of pathway improvements, enhanced clinical leadership and targeted capacity investment, the Trust has delivered improvements over the course of the year, with performance trajectories demonstrating positive momentum.

In elective care, the Trust has continued to deliver high levels of activity, enabling further progress in reducing both the overall waiting list and the number of patients waiting longer for treatment. This builds on sustained increases in day-case, inpatient and outpatient activity in recent years, with continued focus on productivity and pathway redesign supporting delivery. The Trust has also prioritised the reduction of long waits and the mitigation of clinical risk, in line with national expectations.

Performance delivery continues to be supported by a clear focus on workforce, productivity and system working. Key risks, including workforce supply, demand growth and patient flow, are actively managed through robust governance arrangements, strengthened operational grip and close collaboration with system partners. Over the year, the Trust has further developed its approach to service transformation, including the use of digital solutions and data to support sustainable improvement.

Looking ahead, the Trust is well positioned to build on this progress, with continued focus on urgent and emergency care improvement, elective recovery and outpatient transformation. This will be underpinned by a commitment to delivering high quality care, improving patient outcomes and experience, and ensuring the best possible use of resources.

The key performance headlines from the year are:

NHS Oversight Framework:

- The Trust was ranked in segment two in the NHS Oversight Framework (the new performance league table for NHS trusts) throughout 2025/26. The league table is separated into four segments, with segment one being the highest-rated and segment four being the worst-rated. Segment two places the Trust consistently in the higher-performing NHS trusts nationally.

Financial performance:

- The Trust has performed well in a challenging financial and operational environment throughout 2025/26. Maintaining elective activity performance during the year, alongside delivery of a demanding £35.8 million savings programme, enabled the Trust to meet its financial responsibilities despite significant challenges and a number of material cost pressures.
- Receipt of an additional £4.9 million of funding from NHS England enabled the Trust to report an adjusted financial surplus of £5.0 million. The £4.9m was a redistribution

of unused Deficit Funding Support to providers that achieved their 2025/26 financial targets and submitted compliant 2026/27 plans.

Operational performance:

- Cancer standards: The Trust met the national 62-day cancer standard (85%) across the year and continued to perform above the national average across all three cancer standards.
- Elective care (Referral to Treatment - RTT): RTT 18-week performance has improved and exceeded recovery expectations. The number of patients waiting over 52 weeks reduced, demonstrating progress against national elective recovery priorities.
- Urgent and Emergency Care: Performance improved to 74% from 70% the previous year but was below the March 2026 78% target.
- Diagnostics: The number and percentage of patients waiting over six weeks reduced in the second half of the year, representing improvement.
- Community Paediatric waiting times remained high, driven by a mixture of capacity and demand pressures within neurodiversity pathways.

Clinical (quality and safety) performance:

- Mortality: 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:
 - o Hospital Standardised Mortality Ratio (HSMR) – 84.17 for the 12 months to February 2026, which statistically is in the first quartile of Trusts.
 - o Summary Hospital-level Mortality Indicator (SHMI) – 0.9500 for the 12 months to December 2025, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stands at 40th out of all 118 acute non-specialist trusts.
- Infection prevention control (IPC): Of the seven infection types reported against in the main performance section below, four were within the threshold target or there is no national threshold. Three were over the threshold target: MRSA 4 cases against at target of zero; E. coli BSI with 51 cases against a threshold target of 46; and Carbapenemase-Producing Organisms (CPOs), 18 cases against at target of zero. The Trust was within target for C. difficile cases.
- There were zero Never Events during 2025-26.
- Complaints: In 2025/26, 1,115 formal complaints were received. A significant increase on the 904 received the previous reporting year 2024/25 a rise of 23%. In 2025/26 there was a decrease in the number of PALS enquiries received, a total of 5486 compared to 5778 in 2024/25.

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 delivered a £5.028m surplus 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 did not rely on cash financing from the Department of Health and Social Care (DHSC), and it finished with a cash balance of £41.069 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 2025-26, 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

Performance analysis purpose and structure

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 2025/26 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 2025/26.

Following the Trust's CQC hospital inspection in 2023, no further formal inspections by CQC have occurred in 2025/26.

Following successful application and imbedding of improvement actions with maternity services, NHSE formally removed the requirement intensive improvement programme support in 2025.

Other quality regulatory visits have included:

- o May 2025 - Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) to Radiology
- o June 2025 - NHSE QI Team visit to Respiratory

- o June 2025 - HTA Inspection to Mortuary
- o August 2025 - FDA inspection to MVCC
- o November 2025 - MHRA (Quality Control Laboratory GMP inspection) to Lister Pharmacy (identified a significant single deficiency within Lister Hospital Quality Control Laboratory, which has been resolved and closed as an issue by the MHRA)
- o November 2025 - Re- audit evidence review.

During 2025/26 the Trust has continued to review the quality governance framework. Measuring and monitoring 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 2025/26 in relation to key areas including clinical, operational and financial performance.

Clinical (quality and safety)

Mortality rates and learning from deaths

The Trust continues to perform well compared with both national peers and its recommended Model Hospital peer group for the key metrics of HSMR and SHMI.

- Hospital Standardised Mortality Ratio (HSMR) – 84.17 for the 12 months to February 2026, which statistically is in the first quartile of Trusts.
- Summary Hospital-level Mortality Indicator (SHMI) – 0.9500 for the 12 months to December 2025, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stands at 40th out of all 118 acute non-specialist trusts.

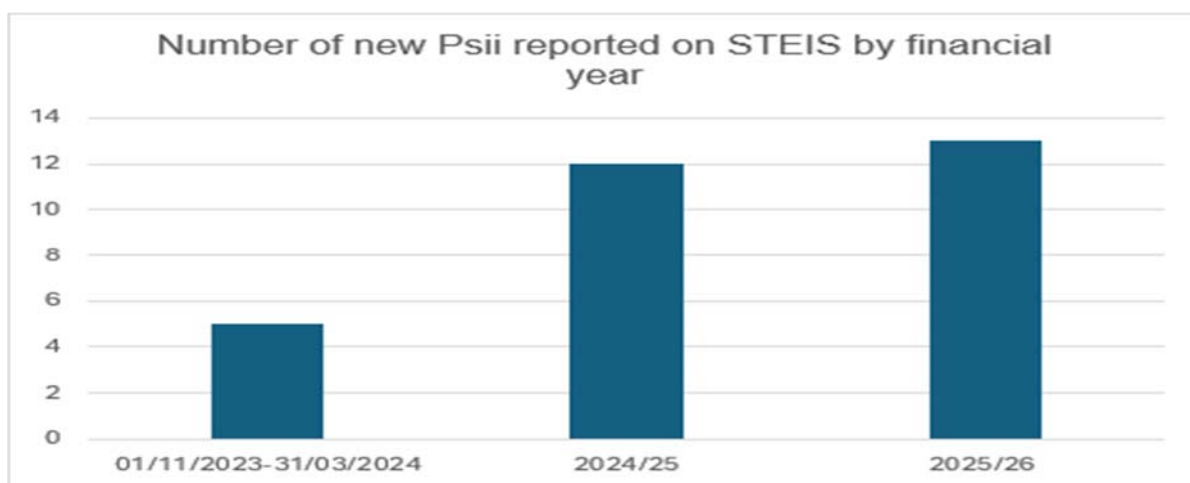
It has been increasingly recognised that while monitoring mortality rates has a role to play in mortality governance, there is no direct correlation between these, and the quality of care provided by organisations. However, together with other performance metrics such as length of stay and readmissions they continue to help us evaluate the many factors that influence the quality of care we provide to those who die in our hospitals. Of critical importance to our mortality performance monitoring is our structured judgment review process. This represents the cornerstone of our learning from deaths work, with individual outputs and thematic reviews shared across the Trust, and where appropriate with the ICB and wider community.

Patient Safety Incident Investigations (PSII) and Never Events

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. During 2025/26 there have not been any incidents reported which were considered to meet 'Never Event' criteria.

ENHT Never Events data	2023/24	2024/25	2025/26
Wrong site surgery	2	1	0
Unintended retained object	0	1	0
Wrong prosthesis	0	1	0
Nasogastric tube	0	1	0
Total	2	4	0

The Trust is in its third year of operating under the Patient Safety Incident Response Framework (PSIRF). PSIRF is the new 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.



A key theme identified from PSIs (Patient Safety Incident Investigations) in 2025/26 relates to delays in follow up for patients on waiting lists. A thematic review is underway examining incidents within Gastroenterology/Hepatology, Cardiology and Ophthalmology (medical retina pathway). This PSI was initiated following the identification of significant delays, missed appointments and confirmed patient harm. Emerging common themes include digital system errors, demand exceeding capacity, ineffective tracking and escalation processes, and workforce shortages.

Infection prevention and control (IPC)

Month	<i>C. difficile</i> 25-26	MRSA BSI 25-26	MSSA 25-26	<i>E.coli</i> BSI 25-26	<i>Pseudomonas aeruginosa</i> BSI 25-26	<i>Klebsiella spp</i> BSI 25-26	Carbapenemase Producing Organisms (CPOs) 25-26
Apr	9	1	3	3	0	3	1
May	2	0	0	3	1	1	0
Jun	6	0	1	4	0	2	0
Jul	7	0	4	3	4	5	4
Aug	7	0	2	9	2	4	2
Sep	5	0	2	5	0	0	2
Oct	8	1	2	4	1	0	2
Nov	2	0	1	9	0	3	4
Dec	4	0	5	6	0	0	1
Jan	7	2	4	2	0	2	0
Feb	5	0	3	3	1	1	3
Mar	6	0	2	5	0	1	1
Total	68	4	29	56	9	22	20
Threshold number 2025 - 2026	82	0	N/A	46	12	23	0

Key	
	No threshold set therefore is non-applicable
	On or below threshold trajectory
	Slightly above threshold trajectory by 1-5 cases
	Above threshold trajectory by 6 plus cases

- **C. difficile (C. diff):** 68 cases (below threshold of 82). Significant reduction in cases compared to last year, reflecting improvements in antimicrobial stewardship, compliance in the IPC risk assessments, and environmental decontamination processes.
- **MRSA blood stream infection (BSI):** 4 cases (threshold 0). All cases were fully investigated; themes centred on compliance with the IPC admission screening for MRSA and management of intravenous/indwelling devices.
- **MSSA:** 29 cases (no national threshold). Performance table: focus remains on invasive device care.
- **E. coli BSI:** 56 cases (threshold 46). Above threshold, urinary sources remain predominant and underlying comorbidities showed a significant risk factor.
- **Pseudomonas aeruginosa BSI:** 9 cases (threshold 12). Performance within limits. There have been zero cases in the past three months respectively. These demonstrate improved environmental risk factor and good aseptic non touch technique (ANTT) practices.
- **Klebsiella spp. BSI:** 22 cases (threshold 23). Performance within limits. These demonstrate an improvement in IPC practices related to indwelling and invasive devices.
- **Carbapenemase-Producing Organisms (CPOs):** 20 cases were identified. This increase reflects the recent focus on enhanced screening and greater system awareness; this also reflects higher local prevalence.

Overall, during 2025/26, the Trust maintained strong IPC performance across most monitored healthcare associated infections (HCAIs). More than half of the organisms monitored and reported through UK Health Security Agency (UKHSA) Health Care Associated Infections (HCAIs) Data Capture System (DCS) remained below threshold, with significant improvements seen in C. difficile infection (CDI) case numbers. The areas of challenge for the organisation were in Carbapenemase Producing Organisms (particularly Enterobacterales), all of which are being addressed through targeted clinical interventions.

A thematic review of healthcare-associated infection cases identified recurring factors increasing patient risk. While most antimicrobial prescribing complied with Trust guidance, episodes of prolonged or complex antibiotic use were noted, alongside incomplete infection prevention and control (IPC) risk assessments on admission and inconsistent documentation of invasive devices, contributing to HCAI acquisition. Gaps in wound care planning, and delays in infection sampling and screening, also led to avoidable delays in diagnosis and management in some cases. High levels of patient acuity, clinical complexity and multiple comorbidities further increased infection risk, highlighting the need for strengthened documentation, sustained clinical vigilance and continued focus on antimicrobial stewardship.

For more in-depth information about quality and safety, the Trust's 2025-26 Quality Account, which can be found on the Trust's website.

Patient Experience

In 2025/26 there were 26,047 Friends and Family Test (FFT) surveys completed by patients, which is slightly less than the previous year of 26,436.

The Trust's FFT responses for A&E, inpatient and outpatient surveys are consistently higher than the national average for the positive responses.

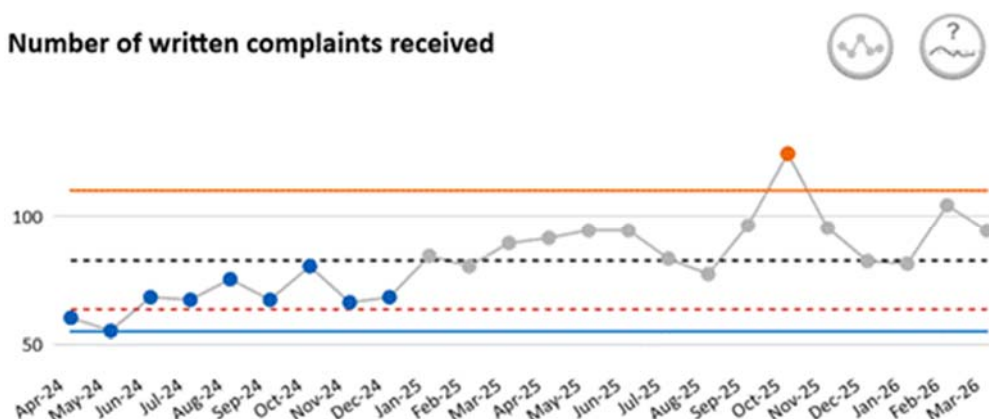
The Trust actively encourages feedback from patients and carers as this enables good practice to be shared and changes made to improve services. The Trust has a Patient and Carer Experience Group (PACE programme) which includes patient and carer

representatives. Sharing patient stories and experiences Trust-wide ensures consistent learning and improvement within each Division.

In 2025/26 1,115 formal complaints were received. A significant increase in complaints on the 904 complaints received the previous reporting year 2024/25, a rise of 23%. Themes and learning from complaints are discussed within divisional governance meetings and reported via the Patient and Carer Experience (PACE) meeting.

There has been a decrease in PALS enquiries received this year, a total of 5486 compared to the 5778 in 2024/2025. This has been due to the amount of appointment concerns being redirected back to the correct services to answer.

Number of written complaints received



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

Initiatives to improve patient and carer experience during the year in light of feedback included:

- Patient surveys that have been reviewed to ensure they are in line with the CQC including an adapted survey for special needs schools to support patients to give feedback on their experience.
- Introduction of dementia grab packs across wards, providing accessible information and promoting completion of the new person-centred care poster to strengthen personalised care planning.
- Dementia-friendly environmental improvements on Ashwell ward, including colour-coded bays and enhanced orientation signage to improve safety and independence.
- Trust-wide launch of a finger food menu, promoting dignity, autonomy and improved nutrition for patients who struggle with cutlery use or prefer smaller meal choices.
- Introduction of the Carer Responsibility Index (CRI), an age-adjusted tool that identifies and prioritises carers based on responsibility levels.
- Carer surveys became mandatory for inpatient areas. This financial year marks the first full year with the carer experience survey live across inpatient areas.

The increased volume of complaints being received impacts the speed at which the complaints team can process, along with managing existing complaints, and also divisions to respond. Therefore, adjustments have been made in the complaints team and divisional leads to try and assist with speed of responses.

Operational Performance

Category	Metric Name	Date Range	Target	Performance	Met / Not Met/ Exceeded	Notes
Cancer Care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Apr-25 to Feb-26	80%	77.8%	Not met	Mar-26 will be finalised on 7th May 2026 National trajectory of 80% by March 2026
Cancer Care	Percentage of patients treated for cancer within 62 days of referral	Apr-25 to Feb-26	85%	85.1%	Met	Mar-26 will be finalised on 7th May 2026 National target of 70%; Trust trajectory of 85%
Elective Treatment	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	As at Mar-26	64.2%	69.1%	Exceeded	Trajectory of 64.2% (5% improvement from 2024-25)
Elective Treatment	Percentage of patients waiting over 52 weeks for elective treatment	As at Mar-26	0.7%	0.6%	Exceeded	National target of 1% or less; Trust trajectory of 0.7% or less
Elective Treatment	Percentage of patients waiting over 52 weeks for community services	As at Mar-26	n/a	75.6%	N/A	
Urgent and Emergency Care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	2025-26	78%	74.0%	Not met	National trajectory of 78% by March 2026
Diagnostics Waiting Times	Percentage of patients waiting more than six weeks for a diagnostic test	As at Mar-26	n/a	49.0%	N/A	No national target/trajectory in 2025-26
Patient Safety	Number of MRSA cases	2025-26	0	4		Actual cases only
Patient Safety	Proportion of C. difficile infections versus threshold	2025-26	< 100%	82.9%		Actual cases (68) divided by annual threshold (82)
Patient Safety	Proportion of E. coli bacteraemia versus threshold	2025-26	< 100%	121.7%		Actual cases (56) divided by annual threshold (46)
Effectiveness and Experience of Care	Summary Hospital-level Mortality Indicator (SHMI)	Dec -24 to Nov -25	< 1	0.9444		Latest publication Trust banding is "2 - as expected"

The Trust has continued to deliver strong Cancer performance with achievement of the 62-day standard of 85%. Work continues to take place to improve access to diagnostic imaging, in particular MRI, to support improved diagnosis within 28 days. The Trust ranks well nationally against all 3 cancer standards.

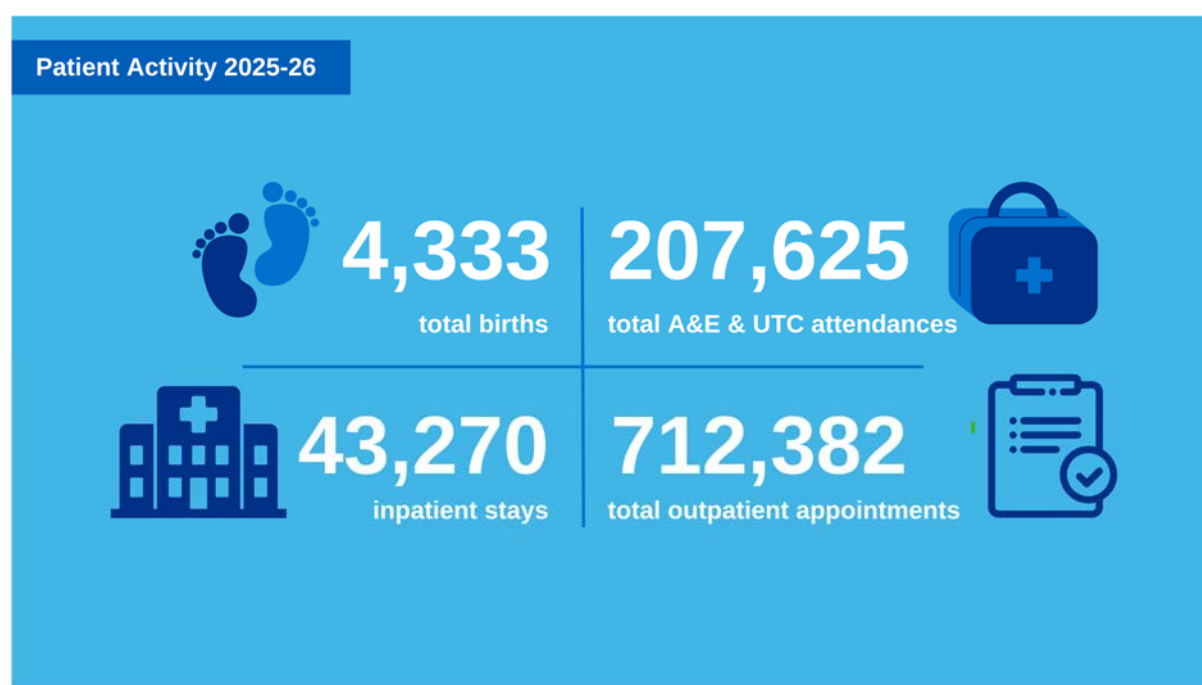
The Trust has improved access for patients cared for on elective pathways with achievement of referral to treatment (RTT) targets) for percentage waiting within 18 weeks and reduction in percentage waiting over 52 weeks in 2025/26.

Community Paediatric services remain a focus for the Trust with internal pathway improvements now starting to deliver additional capacity and positive impact on access times. Work continues with partners in Hertfordshire to further enhance neurodiversity waits for our children and young people through standardising pathways and moving to more multidisciplinary models of care.

Performance in Urgent and Emergency Care (UEC) has improved year-on-year, with 74% of patients seen within four hours in 2025/26, up from 70% in 2024/25. The Trust continues to focus on improvements in Urgent and Emergency Care (UEC) pathway for both Adults and Children.

Diagnostic waiting times have seen a reduction in the number of patients waiting over six weeks for diagnostic services in the last six months of 2025/26. Significant investment during 2025/26 in both environment and workforce will support the continuous improvement of our Paediatric and Adult Audiology services in 2026/27. Improving access to MRI is the focus of further transformation work in 2026/27.

Patient Activity 2025/26



Financial Performance

The Trust's adjusted financial position at the end of the financial year was a surplus of £5 million against a planned breakeven position. This is the measure used by NHS England to rate the Trust's financial performance. The reported position after making several technical adjustments was a deficit of £23.4million.

The Trust's financial plan was set to achieve a breakeven position before technical accounting adjustments, including capital donations, depreciation on donated assets and asset revaluations. Despite a challenging operational and financial environment across the NHS, and a significant cost improvement programme (CIP) requirement of £35.8m, the Trust delivered the above-reported surplus of £5 million.

The technical adjustments that get to the adjusted financial position are shown in the table below:

Financial Performance against plan	Plan	Actual	Variance
	£'000	£'000	£'000
Total Surplus	120	-23,316	-23,435
Less:			
Impairment movements		28,859	28,859
Capital donations (I&E impact)	-120	39	158
Technical accounting adjustments		-554	-554
Adjusted Financial Performance Surplus	0	5,028	5,028
The Adjusted Financial Performance Surplus is a measure of the financial performance before a number of technical adjustments as shown in the table above. This is the main financial measure against which the Trust's financial performance is viewed by our regulator. Excluding these adjustments, the Trust reported a deficit of £23million			

National priorities for the NHS during 2025/26 continued to focus on recovery of core services, improving productivity beyond pre-pandemic levels and strengthening financial discipline and system balance. Systems were required to operate within fixed resource limits, deliver substantial efficiency and productivity improvements (including c.4% productivity growth and at least a 1% cost base reduction), and achieve financial balance at system level. While greater flexibility was afforded to Integrated Care Systems (ICSs) through reduced ringfencing, this was accompanied by strengthened expectations that organisations live within their means and prioritise delivery of key operational standards.

Within this framework, the Trust operated under a block contract arrangement with its main commissioner, Hertfordshire and West Essex Integrated Care Board (ICB), providing a high degree of income certainty, subject to the delivery of agreed operational and performance standards.

The reversal of non-recurrent benefits realised in 2024/25 required the Trust to establish a substantial CIP programme of £35.8m to address its underlying run-rate deficit and deliver the in-year financial plan. While the programme was delivered in full, £18.5m of the savings achieved were non-recurrent in nature. Although progress was made in reducing management and administrative costs, delivery of recurrent efficiencies remained challenging. As a result, the Trust entered 2026/27 with an increased CIP requirement, driven in part by the £18.5m underlying gap created by the reliance on non-recurrent savings

schemes. Further information can be found in the Annual Governance Statement on the action that has been taken to tackle this CIP non-recurrent challenge.

During the year, the Trust continued to experience disruption arising from sustained industrial action across medical staffing groups. The Trust responded effectively to maintain patient safety and service continuity. The financial impact was mitigated through national reimbursement arrangements and the protection of block contract income.

The Trust also faced a range of additional cost pressures, particularly in relation to workforce. Pay expenditure remained above plan, driven by medical and nursing staffing requirements and the continued use of premium staffing to manage sickness absence and service pressures.

Despite a highly challenging financial and operational environment, the Trust achieved its financial plan and delivered a reported surplus, predominantly consisting of additional funding received from NHSE at year end of £4.9m. The overall position reflects strong financial control and delivery against a demanding CIP. However, the reliance on non-recurrent measures highlights the ongoing challenge of achieving sustainable recurrent efficiencies, which will remain a key focus for 2026/27.

Further key features of financial performance during 2025/26 were:

	Plan	Actual	Variance
	£'000	£'000	£'000
Income from patient care activities	679,500	699,386	19,886
Other operating income	51,608	62,643	11,035
Total Operating Income	731,109	762,029	30,920
Employee expenses	-470,191	-474,475	-4,284
Other Operating expenses	-222,643	-244,611	-21,968
Depreciation & impairments	-30,744	-59,447	-28,703
Total Operating Expenditure	-723,578	-778,533	-54,955
PDC dividend expense	-5,844	-4,908	936
Finance income	1,829	1,859	30
Finance expense	-3,396	-3,133	263
Other gains/(losses) including disposal of assets	0	-630	-630
Net Deficit	120	-23,316	-23,437
Adjustments (remove impairments, capital donations and PFI adjustments)	-120	28,344	28,465
Adjusted Financial Performance Surplus	0	5,028	5,028

Income from patient care activities

The national payment system for 2025/26 comprised a combination of activity-based funding for elective services, aligned to Elective Recovery Fund (ERF) requirements, and blended payment mechanisms for non-elective care. Within this framework, the Trust agreed a block contract with the ICB covering most clinical services. Full receipt of contract income was

contingent upon delivery against key performance requirements, including reductions in patient waiting times and progress against national operational standards, particularly Referral to Treatment (RTT) targets.

Income from patient care activities increased from £656.8 million in 2024/25 to £699.4 million in 2025/26, representing an increase of £42.6 million (6.5%). This increase primarily reflects additional funding allocations to support inflationary cost pressures and delivery of national service priorities.

Other income receipts

The Trust struggled in year to grow its other income streams beyond inflationary uplifts. Research and Development income remained static with 2024/25 at £7.9 million, while private patient income decreased by £0.6m following a sharp increase in 2024/25.

Spend on Pay (including temporary staff)

Total pay costs increased by £21.3 million, from £453.2 million in 2024/25 to £475.5 million in 2025/26 (excluding pension cost contributions). The increase was primarily driven by national pay awards of £25.4 million, offset by reduced staffing costs delivered through the Trust CIP programme.

Expenditure on temporary staffing decreased by £7.5 million, from £49.4 million to £41.9 million.

Spend on Non-Pay

Non-pay expenditure (excluding financing costs) increased by £17.7 million, from £226.8 million to £244.5 million. Key drivers included inflationary pressures on high-cost drugs (£5.1 million) and consumable cost inflation (£12.7 million).

Additional pressures arose from increased higher volumes and costs of outsourced pathology services.

Capital investment / donated equipment.

The Trust invested £35.6 million in capital during 2025/26, including lease remeasurements. This comprised a core capital allocation of £21.9 million and £13.7 million of additional external funding secured during the year.

Capital Funding Source	£m
Provider CDEL- System funded	13.9
IFRS 16 CDEL (excl. dilapidations release)	6.8
Dilapidations release	1.2
NHSE additional CDEL	13
Grants/Donations/Other	0.7
Total	34.4



* An indicative visual of the hallway in the Lister Hospital new front entrance due to open in the autumn of 2026.

Significant investments were made across key strategic priorities, including:

- Urgent and Emergency Care (£2.6 million): delivery of a new ambulance handover facility to improve patient flow and reduce delays.
- Audiology refurbishment (£1.8 million): enhancement of clinical environments to improve patient experience and operational efficiency.
- Cardiac catheter laboratory replacement: strengthening diagnostic and interventional capacity.
- Brachytherapy services: investment supporting high-quality cancer care provision.
- Strathmore Unit infrastructure works: addressing critical estate risks to ensure safety and sustainability.
- Digital infrastructure: continued investment supporting transformation and improved care delivery.
- Clinical equipment upgrades: replacement and modernisation of essential medical equipment.
- Backlog maintenance: targeted reduction of high-risk estate backlog.

The Trust has exercised its functions in accordance with system capital resource plans, working within the capital allocations and prioritisation processes agreed across the Integrated Care System.

Capital investment decisions during 2025/26 have been aligned to system priorities, including urgent and emergency care capacity, diagnostic capability, cancer services and digital infrastructure, ensuring consistency with the ICB's capital strategy and long-term estate plans.

The Trust continues to work with system partners to ensure that future capital investment supports both organisational and wider system objectives.

Cash

The Trust's cash balance decreased by £6.6 million during the year, from £47.7 million at 31 March 2025 to £41.069 million at 31 March 2026.

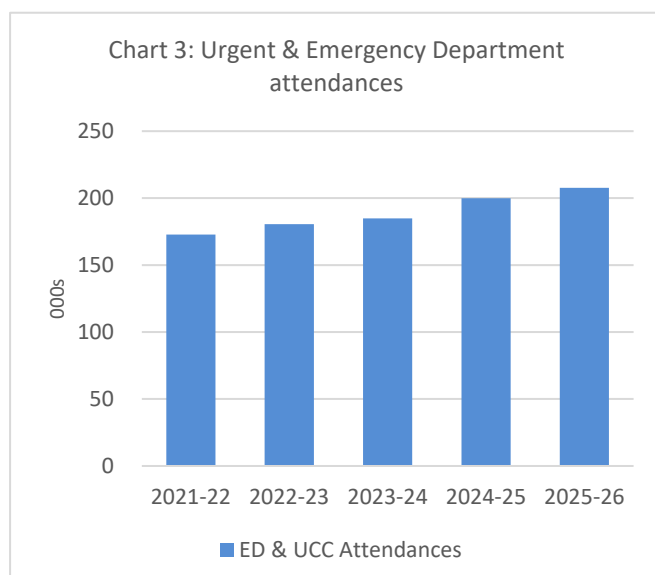
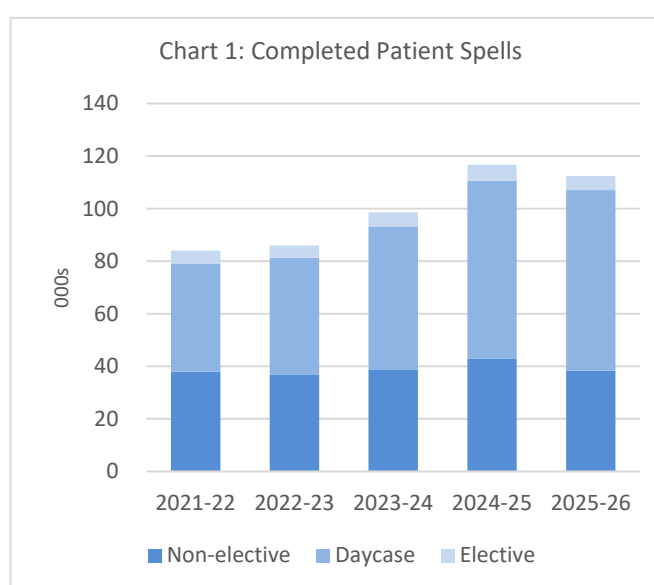
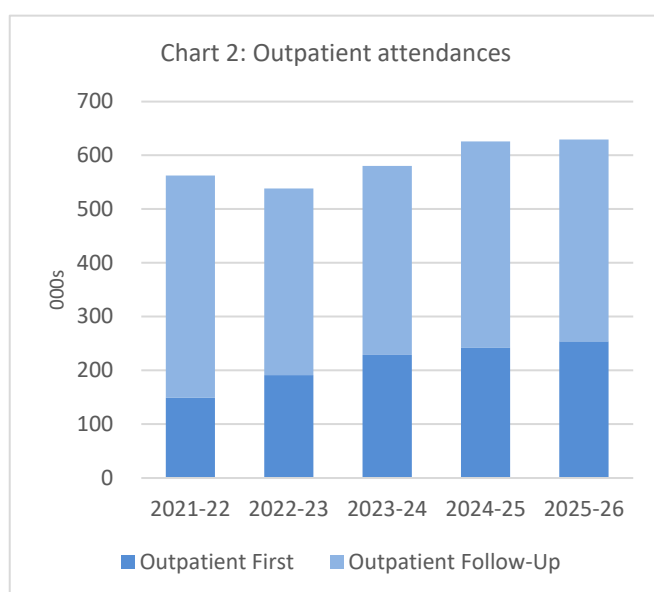
The reduction in cash primarily reflects in-year capital expenditure on property, plant and equipment, as the Trust continued to invest in its estate, infrastructure and clinical equipment to support service delivery and operational resilience.

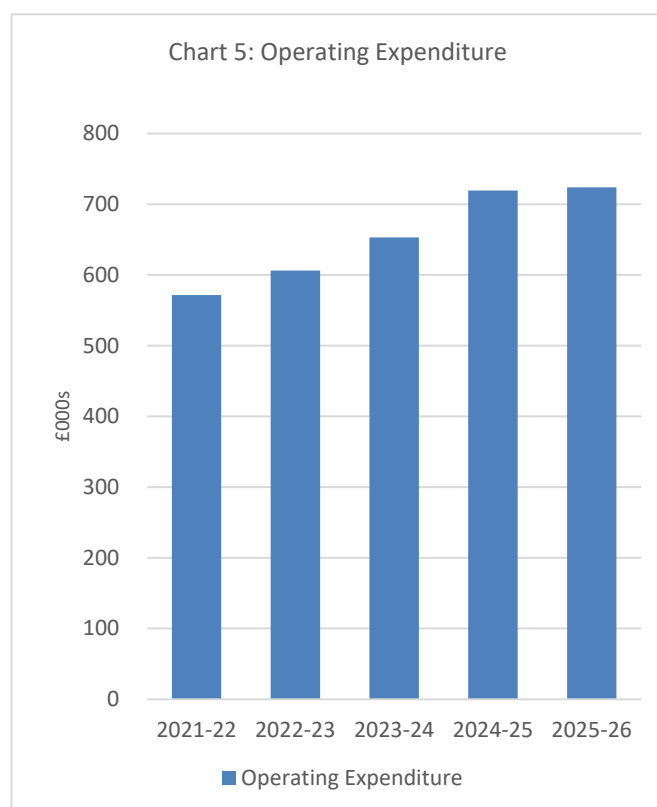
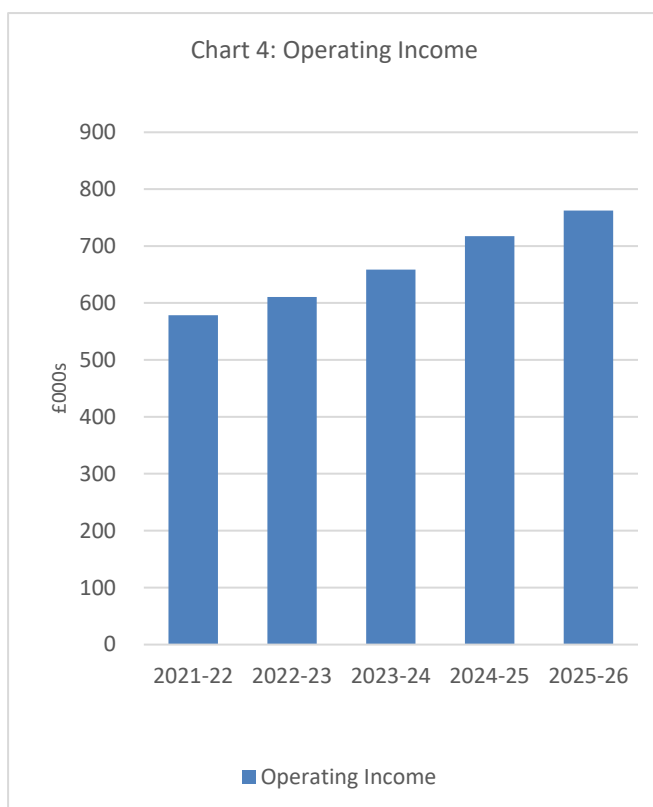
IFRS 16 impact

Under IFRS 16, the Trust recognises right-of-use (ROU) assets and associated lease liabilities on its balance sheet. During the year, the Trust recorded additions to right-of-use assets of £2.2 million, together with remeasurements of existing lease assets of £4.5 million.

As at 31 March 2026, the net book value of right-of-use assets was £93.3 million, compared to £95.9 million at 31 March 2025. The reduction reflects disposals and depreciation of lease assets over the year, partially offset by new additions and remeasurements.

Trends in activity, income and expenditure





During 2025/26, the Trust saw 629,228 outpatients, 5,343 inpatients, 68,670 day-case patients and 207,670 accident and emergency & UTC attendances. We also provided over 280,000 contacts across emergency care, diagnostics and renal bringing our total patient contacts to 1.19 million.

Future financial plans and expected future performance

Looking ahead, the Trust expects the financial environment in 2026/27 and beyond to remain highly challenging. The organisation is planning for continued system financial balance requirements and limited growth in core funding allocations, alongside ongoing inflationary pressures, particularly in workforce and non-pay expenditure.

The Trust has identified a significant cost improvement programme requirement for 2026/27, driven in part by the non-recurrent nature of a proportion of 2025/26 savings. A key priority will be the delivery of sustainable recurrent efficiencies through service transformation, productivity improvement and reduction in temporary staffing usage.

Based on current planning assumptions, the Trust expects to operate within a tightly constrained financial envelope, with performance dependent on delivery of operational standards, elective recovery activity and system support arrangements. Continued focus on financial discipline, alongside transformation programmes aligned to the Strategic Delivery Plan, will be critical to ensuring long-term financial sustainability.

East and North Hertfordshire Hospitals Charity

Our hospitals' charity continued its great work raising funds for projects to support patients, families and staff above the remit of the NHS.

Their popular community events programme, which included the Lister Abseil, Rainbow Run and the newly rebranded Moor Park 10 & more events helped to raise nearly £150k, while

the second year of its Hertfordshire Residential Development Awards event raised £89k. England Rugby star, Rosie Galligan, again, attended the awards show as a special guest. She also kindly paid a visit to the children's ward at Christmas, to hand out presents and pose for photographs with children and staff members.

Some of the projects that the charity has funded this year include: providing new equipment for patients who have had a stroke, to help in their rehabilitation; a much-needed makeover to the waiting area, quiet room and staff room on the Urology ward and the funding of a new clinical nurse specialist role dedicated to supporting children and young people with learning disabilities or autism. These young patients can find the hospital environment additionally challenging, so the new nurse is now on hand to support them and has already made an incredible difference for these young patients and their families and received overwhelmingly positive feedback.

The charity would like to thank everyone who has helped them fund all their projects and to the staff and volunteers who help them make the experience for patients, the very best it can be.



Research and Development

Introduction: 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: The Trust remains committed to ensuring that patients and the public are meaningfully involved in the design and delivery of research. Feedback from research participants during 2025/26 indicates high levels of satisfaction, with participants reporting that they felt respected, valued and well supported, and that many would consider taking part in research again. Opportunities for improvement identified through feedback include clearer communication and feedback on study results, which are being used to inform ongoing improvements. Patient and Public Involvement is supported through a dedicated Research Patient and Public Involvement Panel and through accessible information on the Trust website, including signposting to the national Be Part of Research service.



Strategic Approach: In 2024/5, we published our [four-year research strategy](#), developed in conjunction with patients, the public, and our wider healthcare partners, setting out our ambition to embed research as a core component of high-quality patient care. The strategy supports the Trust's mission to provide consistently outstanding care and exemplary service and focuses on aligning research with local need, improving inclusivity and access, strengthening collaboration, embedding research into service design, building workforce research capability, and making best use of data, digital systems and AI in a trusted way.

During the second year of the strategy, the Trust continued to build on existing research strengths, address identified areas for improvement, implement national initiatives and develop plans to support sustainable growth in research activity. The Trust also maintained a leadership role across the local system, regionally and nationally through its research and innovation partnerships and collaborative roles.

Research Activity: Based on 2025/26 information up to 16th March 2026 (i.e. not full year data) the Trust has recruited a total of 4,062 research participants across 103 projects covering 15 different clinical specialties.

In 2025, the Trust had 321 research publications authored by Trust staff, including 34 jointly published with the [University of Hertfordshire](#). The publications encompass a diverse array of research fields and are disseminated in several high-impact journals.

Future Plans: Our focus in 2026/27 is to deliver the third 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. This will be supported by additional funding to increase our research capacity and offer research access in the evenings and at weekends.

Social matters

Stakeholder engagement

The Trust has hosted a number of visits from our local MPs, including briefing meetings and visits to clinical areas.

The Trust continues to attend meetings of the Hertfordshire Health Overview and Scrutiny Committee on request, to provide briefings on topics of interest or concern. In addition, Trust representatives have attended joint scrutiny committees specifically on the topic of the proposed relocation of the Mount Vernon Cancer Centre.

Patient groups continue to drive improvement across the Trust. For example, 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.

Since July 2024 Trust Board meetings have been livestreamed, with just under 1,500 views of the Board meetings in 2025/26.



Public membership

A quarterly newsletter is shared with the Trust's 460 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.

A programme of updating patient leaflets began in 2025, with the aim of improving accessibility particularly for people with lower literacy, with member volunteers acting as a readers panel to check for understanding.

Annual General Meeting (AGM) 2025

The Trust held its AGM in September 2025 as a virtual event, with the offer of spaces to attend in person. [The 2025 AGM can be viewed here on YouTube.](#)

Over 300 people watched the 2025 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 the Trust's clinicians – answering an average of 148 queries per month.

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

A Consultant-GP partnership group is held monthly, and a WhatsApp group for GPs has been created with around 100 members – sharing Trust news.

A new podcast for GPs was launched in March 2026, providing expert updates on particular conditions.

Risk Profile

As of 31 March 2026, the Trust had 11 principal strategic 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 2025 with three new risks added (Workforce morale whilst making necessary staffing savings; System instability; and Change management) plus six existing BAF risks descriptions were 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 & estates challenges (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 morale whilst making necessary staffing savings	People & Culture
5	Leadership and engagement	People & Culture
6	Compliance culture 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 instability	Finance, Performance & Planning
8	Improving flow and performance	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	Digital Committee
11	Change management	People & Culture

Workforce morale whilst making necessary staffing savings (BAF 4) was added in the context that recruitment and retention have improved to such an extent that establishment numbers and controls on growth of establishment numbers was the emerging risk. System instability (BAF 7) reflects the significant national and local NHS England and ICB changes and managing the likely impact on the Trust. Change management (BAF 11) replaced ENH Production System and reflected the Board's focus on the need to prioritise change management.

At 31 March 2026 the highest rated BAF risks were rated a '20'. The first, financial constraints (BAF 3), reflected that whilst the Trust reached financial balance for a further year, significant savings were non-recurrent (see the finance performance section). The second, system instability (BAF 7) reflected the rapid development of changes included within the 10-year plan, ICB distraction with restructuring coupled with lost local East and North Hertfordshire memory with limited East Central ICB senior leadership coming from the existing ICB (see the local system section).

For comparison, there were no 20 rates risks at year-end in the previous two years, one '20' rated risk in 2022-23 (BAF 3: Financial Constraints), one in 2021/22 (BAF 1: Operational Performance) and two at the end of 2020/21 (BAF 4: Capital and BAF 10: Estates and Facilities).

One other risk score increased; Leadership and engagement (BAF 6) increased from 9 to 12. Two risks scores reduced over the course of the year (BAF 4) Workforce morale whilst making necessary staffing savings (16 to 12) and (BAF 5) Compliance culture and accountability (15 to 12). 6 of the 11 risks were red-rated, scoring 15 or above, at the end of the year.

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 2025/26 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

1 Introduction

While overall health outcomes are relatively strong, this masks significant variation in deprivation, ethnicity, age and wider determinants such as housing, employment, transport, digital access and health literacy. These factors influence access, treatment timeliness and outcomes, contributing to higher reliance on urgent care in some communities.

In 2025/26, the Trust focused on strengthening understanding and governance:

- Established a **Health Equity Group**
- Completed a **health inequalities self-assessment**
- Began developing an **organisation-wide action plan (implementation from 2026/27)**

Progress has been made; however, further work is required to systematically monitor equity of access, identify variation and embed learning.

2 Our Population

2.1 Demographic Overview

2.1.1 Population age and growth

Most residents are aged 30–60 (6–7% per 5-year age bracket). The population is ageing, with growth concentrated in older age groups. The population is projected to grow by 2.3% between 2025–2031, but healthcare demand by 5.7%, reflecting higher utilisation in older

groups (around 7x higher). Growth in **10–19-year-olds (+2.3%)** highlights the importance of effective transition between paediatric and adult services.

2.1.2 Deprivation and life expectancy

Life expectancy varies by **9 years within 6 miles**: Central Hatfield: 75 years and Welwyn East: 84 years

2.1.3 Ethnicity

Ethnic minority population: **10.4% (vs 14.0% nationally)** with highest diversity in Stevenage and Welwyn Hatfield. Within Hertfordshire 4.3% of households do not have English as a main language (barrier to access).

2.1.4 Population Health

Population Health Management (PHM) analysis shows that:

- 42.6% of the East and North Hertfordshire (enH) population is “generally healthy”
- Average: **1.4 long-term conditions per person** across the population
- 10% have complex needs
- 47.5% live with lower-level illness
- Complex groups account for **~50% of emergency care spend**.

Table 1: Health needs and utilisation across the ENH population segments.

	Living with Illness	Low Complexity	Advance Disease & Complexity	End of life, Severe Frailty & Dementia	ENH & Population
People	148,522	166,629	54,221	11,197	662,607
Average (Av) Age	37.2	49.7	68.4	74.9	40.7
Av Long Term Conditions	1.0	2.6	5.6	5.3	1.4
People from ethnic minority backgrounds %	10.8%	8.1%	5.1%	3.5%	12%
Acute spend per person per year	£387	£800	£2,260	£4,495	£641
% total acute spend on emergency care	29%	28%	44%	63%	38%
Av ED attendances	0.3	0.4	0.7	1.0	0.3
Av emergency admissions	0.0	0.1	0.2	0.6	0.1
Av elective admissions	0.1	0.3	0.6	1.2	0.2
Av first outpatient	0.6	1.1	2.3	2.2	0.7
Av outpatient follow-ups	0.6	1.4	3.1	4.3	0.9
Av community contacts	0.3	0.6	4.2	17.9	1.0
Av mental health contacts	0.2	0.6	1.6	1.4	0.4

Av GP contacts	3.2	6.1	12.1	15.8	4.2
Av medications	2.0	3.1	5.7	6.3	3.7

The health needs and utilisation table shows that:

- Emergency spend rises from **29% → 63%** across segments
- GP contacts rise from **3.2 → 15.8 per year**
- Acute spend rises from **£387 → £4,495 per person**

2.1.5 Other key characteristics of our population



Overall, smoking rates within our catchment area are reducing (**8% of over 18s smoke compared to 10.4% nationally**), although Welwyn and Hatfield have higher rates (**18.5%**) higher than the national average.



Alcohol related hospital admissions (narrow definition) are in line with the national average (**504 per 100,000 population**). However, **Stevenage** has a significantly higher rate (**668 per 100,000**).



Physical activity levels within our core catchment area are in line with those nationally, with nearly **three quarters of adults stating they are physically active**. However, physical activity amongst children and young people are lower in Stevenage (46.4% compared to 47.8% nationally). Nearly **two-thirds of adults** are classified as overweight or obese, with the highest prevalence in Stevenage (71.8%)



Under 75 preventable mortality rates (3-year range) for all causes across our population fare better than the national average ranging from **797 to 991 per 100,000** and compared to 952 nationally. Stevenage is the only area higher than the national and regional figures. There are some significant differences within the geographical area. Preventable mortality from liver disease is highest in Stevenage and Hatfield (19.0 and 17.9 per 100,000 compared to 14.7 in East Hertfordshire).



1.4 in 5 people within the core catchment area have a long-term (chronic) condition, with 9.7% of these individuals having 5 or more co-morbidities. This is expected to **increase to 15.2% by 2030**. It is also expected that there will be an increase in the number of years an individual lives in poor health.



The prevalence of key diseases will significantly increase over the coming years. It is anticipated that **diabetes will affect 10.0% of the population** by 2035 compared to 7.1% currently; **Chronic Kidney Disease will affect 8.5%** of our core catchment compared to 3.3% currently.

2.2 Demographics of those accessing acute care

The Trust has a breadth of knowledge regarding the population it serves and is now working to understand how this reflects the patients that we see. One way in which this is being done

is by strengthening the use of **disaggregated data (deprivation, ethnicity, age, sex)**, with a focus on improving data quality.

2.2.1 Ethnicity reporting

The Trust monitors the completeness of ethnicity data across divisions, services, and patient groups (inpatient/outpatient, past and future patients).

At 31 March 2026 the following recording data had been achieved:

Table 2: Ethnicity Completeness

Patient Type	Date range	Threshold	Exc. not stated	Inc. not stated	Missing
Future Inpatients	24/04/26 – 20/07/26	95.70%	85.84%	91.05%	4.97%
Future Outpatients	24/04/26 – 20/07/26	95.70%	83.67%	90.75%	4.60%
Past Inpatients	24/01/26 – 31/03/26	95.70%	85.67%	93.27%	2.61%
Past Outpatients	24/01/26 – 31/03/26	95.70%	84.15%	91.53%	3.61%

Analysis identified that most missing ethnicity data for past patients is within the Cancer division. An improvement plan has been developed and will be implemented in 2026/27 to address this.

2.2.2 RTT waiting list

The Trust has developed a report view for the demographics of the RTT waiting list to monitor waiting times by gender, ethnicity and age. Image 2 reflects the population distribution (For example, most of the population resides within IMD 6 and this is the majority of patients waiting), and can be analysed by wait length, service, division and booking status to identify inequalities. This will be used by the Health Equity Group in 2026/27 to support monitoring of equitable access.

2.2.3 Wider Trust waiting list

Analysis outside RTT pathways is currently limited. Work is planned with Business Information teams to extend this capability.

3. Progress in 2025/26

Health inequalities are embedded within governance through:

- Board oversight
- Equality & Health Inequalities Impact Assessments
- Integration into planning and service change

The Trust recognises that direct access to healthcare only accounts for at most 20% of an individual's health and wellbeing, and that more influential are the areas in which we live and work, our education, employment, and wider socio-economic factors.

3.1 Healthy Hospital Framework

Partnership work addressing wider determinants included:

- Public Health - Hertfordshire County Council
- Talking Therapies (mental health provided by Hertfordshire Partnership Foundation Trust)
- Stevenage Healthy Hub
- Hertfordshire Better Health Bus
- Change, Grow, Live (CGL) – Drug and Alcohol Recovery Service
- Hertfordshire Health Walks

Alcohol harm (notably in Stevenage) remains a priority; CGL engagement will expand in 2026/27. This work around promoting healthier lifestyles to both patients and staff has been used as a case study within the revised Healthy Hospitals Enhanced Framework and toolkit, published in November 2025.

3.2 Smoke-free sites

As part of the move to promote healthier lifestyles, the trust implemented its smoke-free sites policy from 1st April 2025. The policy supports Core20PLUS5 priorities and prohibits smoking on any acute site and promotes actively encouraging patients to quit smoking. This is the first step in a joint plan with Public Health Hertfordshire support patients and staff to stop smoking.

3.3 CYP Transition

Using health inequalities insights, the Trust identified variation in transition from paediatric to adult services, particularly by age, deprivation and ethnicity. National evidence highlights fragmented pathways, with poor transition linked to worse outcomes and increased inequalities.

Within ENHT, only diabetes had a clear transition pathway, with variation noted for 16–17-year-olds. A working group has since developed into a structured improvement programme, reviewing pathways across specialties. Progress includes the introduction of epilepsy transition clinics and a revised Trust-wide transition policy, aligned to updated national guidance and due for implementation in 2026/27.

3.4 HIV programme

ENHT implemented the national emergency department HIV opt-out testing programme in February 2026, in partnership with Public Health Hertfordshire. The initiative aims to identify undiagnosed HIV earlier, addressing the issue of late diagnosis despite low local prevalence.

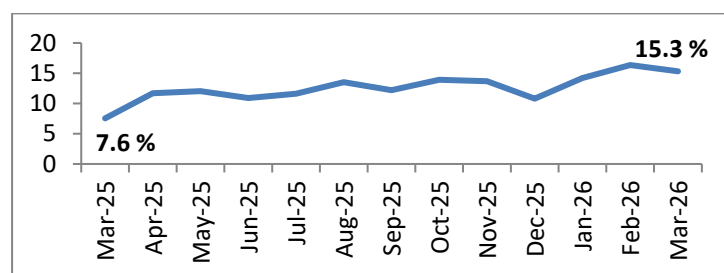
By routinely testing adults attending ED, the programme provides an effective “safety net,” enabling earlier treatment, improving long-term health outcomes, and reducing the risk of progression to AIDS.

3.5 Transform Advanced Kidney Care

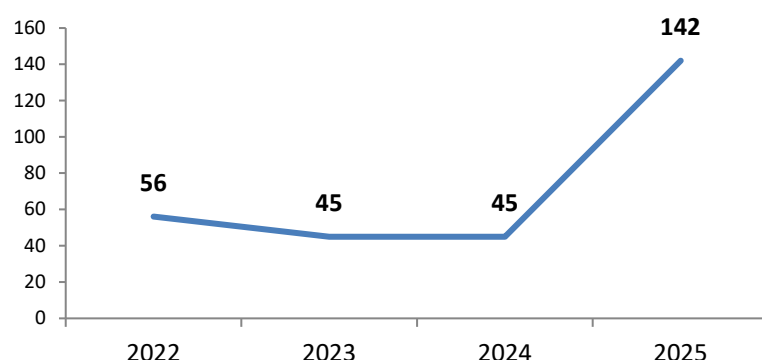
As one of 12 national pilot sites, ENHT is:

- Expanding home-based dialysis
- Improving transplant access
- Tailoring care across diverse populations

The graph below highlights the progress made in 12 months (percentage of patients with kidney function <15% activated on the Tx list).



The table below illustrates the progress made in increasing referrals for transplant assessment.



3.6 Addressing care needs of patients with Learning Disability and Neurodiversity

ENHT has established a monthly multi-agency working group, co-chaired by the Director of Quality and Deputy Medical Director, to improve the care of patients with learning disabilities and neurodiversity.

Key initiatives include:

- Developing a bespoke pain assessment tool and a modified bowel chart to enhance person-centred care
- Implementing digital inpatient identification and improved monitoring (aligned with Martha's Rule) to support early recognition of deterioration
- Strengthening collaboration across health and social care to better meet complex needs

The Trust is also exploring simulation training and shared learning from carers and multidisciplinary teams to increase staff awareness and improve care quality.

4. Equality of service delivery conclusion

The Trust has exercised its functions consistently with NHS England's latest statement on the exercise of functions relating to inequalities, as required under the Health and Care Act 2022.

This includes the continued focus on reducing health inequalities through service redesign, targeted interventions to improve access for disadvantaged groups, and the use of data to identify and address variation in outcomes.

The Trust works collaboratively with system partners to ensure alignment with Integrated Care System priorities on tackling inequalities, and to embed these considerations within operational, clinical and strategic decision-making.



Public Sector Equality Duty

The Trust remains committed to:

- Eliminating discrimination
- Advancing equality of opportunity
- Fostering good relations

Key progress in 2025/26:

- Targeted recruitment improving representation
- Accessibility enhancements (estates and digital)
- Strengthened reasonable adjustment processes
- Launch of refreshed EDI Strategy with measurable outcomes

Governance and Board oversight ensures accountability, with continued focus on addressing discrimination and improving inclusion outcomes.

Sustainability statement

Task Force on Climate Financial Disclosure (TFCFD)

Due to the patient focused 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 monthly 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 has now published their Green Plan Refresh 2025-28. The refresh incorporates 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: Four years on

Four years on from the publication of our first Green Plan, which covered the period 2021 to 2024, we have made some good progress across key areas, working towards greener hospital sites and reducing our environmental impact.

As our largest site, Lister Hospital has been the main focus with LED and solar panel installation and an upgrade to our building management system. Our heat decarbonisation plan is also now complete and sets out how we will transition to low carbon technologies.

Ongoing work with our digital team on energy saving projects has included switching off non-essential and idle equipment overnight and the introduction of an electronic document management system project which will digitise patient records.

To support a drive to offer sustainable food options, our catering team is working towards SOIL Association accreditation and has made the switch to recycled wooden cutlery and food waste is now sent to a bio digestion tank diverting it from landfill or incineration.

Our electric vehicle charging scheme for staff is established and we now have electric vehicles in our internal transport fleet with tracking software to help more efficient route planning.

Green Plan Refresh 2025–28

The refreshing of the Trust's Green Plan has involved engagement with a wide range of stakeholders. This engagement period enabled an honest review and reflection of Green Plan commitments and what has been achieved as an organisation since the launch in January 2022.

Looking forward, we have taken a pragmatic approach to what we hope to achieve, the most effective way to monitor our progress and to ensure progress is shared and celebrated with our colleagues and community.

Our Trust has identified 11 key areas of focus. Each area has an overarching aim, details the work the Trust has carried out to date, details what we will do in the next three years and how we plan to monitor and measure progress against these objectives.

The areas of focus are:

- Workforce and leadership.
- Net zero clinical transformation.
- Digital transformation.
- Medicines.
- Energy and water.
- Travel and transport.
- Food and nutrition.
- Waste.
- Biodiversity.

- Supply chain and procurement.
- Adaptation.

The Trust's sustainability governance structure has changed to better reflect the work required for delivering our Green Plan. The previous eight workstreams have been consolidated and structured into three workstreams: Estates & Facilities, Clinical, Digital & Medicines and Integrated Care Board (ICS), however the third external workstream remains subject to change.

As part of aligning with the Task Force on Climate-related Financial Disclosures (TCFD) framework, the Trust is strengthening its approach across the Governance, Risk Management, and, Metrics and Targets pillars. While full carbon foot printing remains at a national level, we will continue to track key metrics and targets related to emissions reduction and sustainability performance. To support this, we will develop action plans within each workstream and agree KPI's to help guide delivery of our Green Plan. Progress against the action plans will be shared at the Sustainability Board.

We will also be undertaking a review of our baseline carbon emissions as well as aligning our data collection with the existing Estates Returns Information Collection (ERIC) reporting, Sustainability Reporting Portal (SRP) and the new Greener NHS reporting requirements. The following table summarises our reporting plan

Annual	Bi-Annually	Quarterly
• Sustainability section in Annual Report. • Board-level progress report on annual Green Plan. • ERIC. • Greener NHS Sustainability Reporting Portal – format to be agreed with the regional greener NHS team. • TCFD. • Annual Fleet Return	• Progress reports to Sustainability Board • Progress reports up to Finance, Planning and Performance Committee.	• Data collection – including utilities, waste data and other data required for KPI's. • Workstream updates, performance tracker and action plan. • Greener NHS Data Collections.

What we have achieved over 2025/26

Workforce and Leadership

- Published Trust Green Plan Refresh 2025 – 2028 achieving the NHSE submission deadline of July 2025.
- Appointed a Net Zero Board Lead and Non-Executive Director.
- Bi-annual Trust Sustainability Board with Chair and Deputy Chair.
- Ongoing communications led promotion of green initiatives (local and national).
- Trust Green Plan features on Trust Corporate Induction Programme.
- Sustainability Plans Audit Review (by RSM) undertaken – rated *Reasonable Assurance*.
- Director of Estates & Facilities is a permanent Board member (non-voting).

Net Zero Clinical / Medicines Transformation

- Nursing Times Awards - Sustainability in Nursing and Midwifery Award for innovative Greener Emergency Response System – led by the Trust Resuscitation Service.

- Medicines were previously delivered to wards in single use plastic bags. The system is now updated to deliver medicines in reusable bags.
- We are educating and encouraging patients using insulin, by Novo Nordisk to use the PenCycle program. This is a free recycling scheme which enables patients to return their empty pens to the manufacturer for recycling.

Researchers at the East and North Hertfordshire Teaching NHS Trust have published 11 significant studies in 2025, highlighting the intersection of healthcare and climate change. These studies underscore the environmental impact of medical practices.

Digital transformation

- The new eConsent platform was rolled out across the Trust, digitising the process for signing patient consent forms. This has reduced the need for approximately 60,000 pieces of paper per annum from consent forms alone.
- Patient Engagement Portal (PEP) continues to be rolled out across the Trust's wards. Patients are given the option to replace postal appointment letters with a digital link, allowing patients to view, confirm, or cancel appointments online. This system is helping to reduce 'Did Not Attend' (DNA) rates and supports a reduction in emissions from postal services and unnecessary hospital visits.
- The Electronic Document Management System (EDMS) project has started with the aim of digitising the Trust's patient records. Digitisation brings huge sustainability benefits in terms of less papers and reduced transportation, the Trust currently print circa 20 million pages per year, which equates to 140 tonnes of CO2. Digital storage has a fraction of that footprint.

Estates & Facilities

- The Trust secured significant external funding with project works being completed across 2025/26.
 - o **£748k**: Installation of solar PV panels on the Treatment Centre, Maternity, and Endoscopy buildings at Lister Hospital
 - o **£1.1m**: LED lighting upgrades, bringing our LED coverage at Lister to 90%.
 - o **£25k**: Building Management System (BMS) improvements, and heat meter installations at Lister Hospital.
 - o **£100k**: Additional electrical and heat metering.
 - o **£2.1m** awarded in March 2025 to deliver a 726 kWp solar carport array at the Lister site, and solar PV panels on the Emergency Department building, Strathmore and New Ward Block.
- Renewal of the Combined Heat and Power (CHP) is well underway, to ensure an increased level of reliability and enhanced energy efficiency, while enabling the rollout of the Trust's Heat Decarbonisation Plan.
- Heat Decarbonisation Plan (HDP) has been completed, in partnership with Veolia Energy and critiqued by Bell Rock. The HDP will set out a roadmap for Lister to transition from existing CHP to low carbon technologies. Application for funding is currently on hold due to withdrawal of Government Public Sector Decarbonisation Scheme (PSDS) Funding.

Food and nutrition

- Introduced crockery and china on wards, which has reduced single-use items and supported both sustainability and a better patient experience.
- Catering Team is actively working towards bronze accreditation with the Soil Association, intending to achieve Food for Life awards for staff catering services.
- Catering Department is in process of switching to a single main supplier for food procurement to help improve supply chain transparency and reduce emissions.



Travel and transport

- A target set for 20% of the Trust's vehicle fleet to be electric or hybrid by 2025 has been achieved, with five fully electric vehicles now embedded within the non-patient transport fleet.
- The Trust has made a significant investment in electric vehicle charging infrastructure, with seven new EV charging points now operational for staff and two additional points available for visitors in the main car park.
- Work is underway to develop the Trust Net Zero Travel and Transport Strategy 2026
- Funding secured for 10 additional EV chargers as part of car-port solar panels project, with potential capacity for up to 50.

Greenspace and biodiversity

- Nature Recovery Ranger successfully recruited and in post at the Mount Vernon Hospital site for two years, funded from the National Lottery.
- Smoke Free Hospital Site: The Trust has officially become a smoke free site. The removal of the smoking shelter has enabled an accessible space to be completely landscaped and transformed into a green space for our Staff, Patients and Visitors.

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 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.

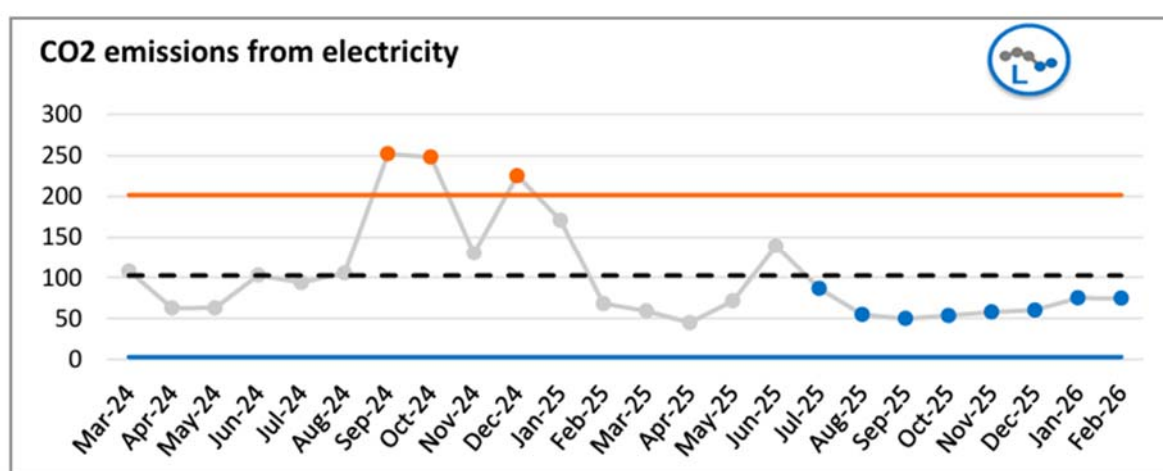
“There are currently no requirements for NHS Trusts or Integrated Care Boards (ICBs) to develop and publish their own carbon footprints. The time and resources spent on foot-printing needs to be proportionate and should not distract from acting. Organisations that have the capacity and skills may choose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

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

The essential focus for Trusts is to achieve key actions outlined in NHS Key Milestones for 2025-2026, 2027-2028 and 2029 and beyond. Our Trust has progressed extremely well against these milestones as highlighted above against the respective focus areas.

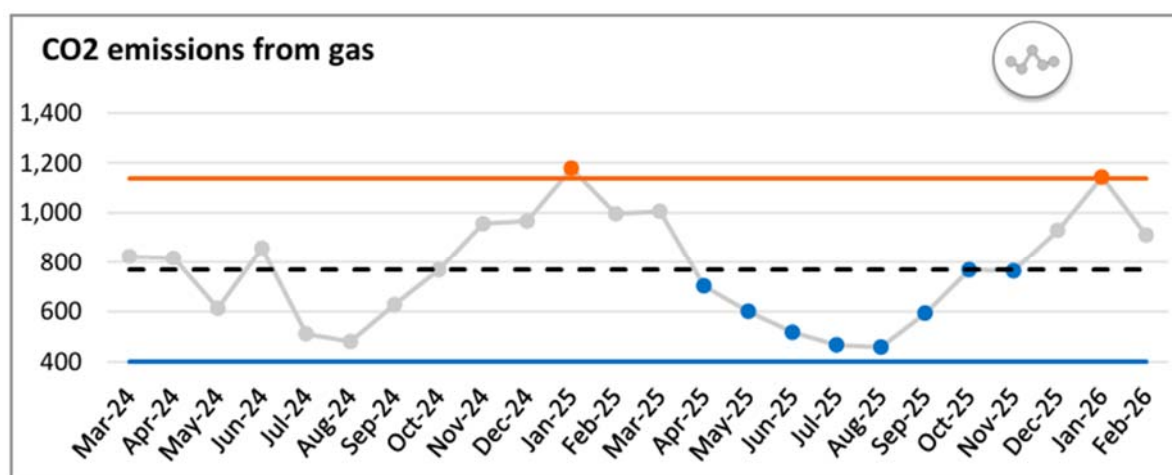
Carbon footprint – internal monitoring

The Trust has developed a methodology for data collection that can be used by 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 July – December 2024, and then slight peak in June 2025 are due to Energy Centre down-time, resulting in increased reliance from main-grid.



CO2 emissions from gas (graph 2.)

Shows seasonal variation, higher usage over winter months.

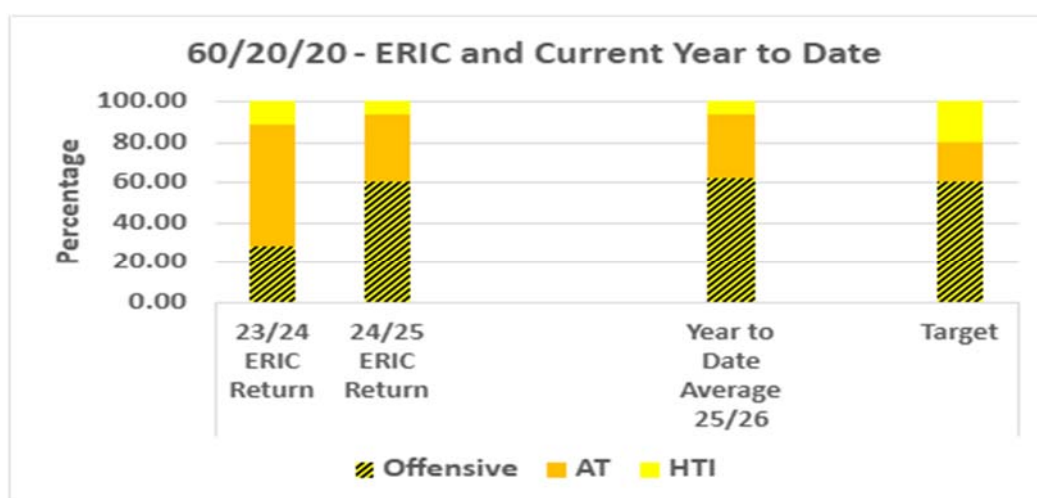
Waste reporting

2025/26 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
To achieve 0% waste to landfill across all waste streams by end 2023.	This target was achieved ahead of schedule - 1 st June 2023 and continues to be maintained. This includes both clinical and non-clinical waste
To achieve the clinical waste segregation targets set in the NHS England Clinical Waste strategy (20% incineration waste; 20% AT*/Infectious waste; 60% offensive waste.)	This target was achieved in May 2024, ahead of the 2026 deadline and has continued to be maintained. The 2025 ERIC return showed that the target had been met for the whole year. The 2026 return will also show this.
To ensure full compliance with Healthcare Technical Memorandum 07-01 – Safe and Sustainable Management of Healthcare Waste	Sharpsmart trend audits have continued with good engagement from colleagues in wards and departments. Waste management training in some wards and departments has taken place
To minimise, reduce and avoid waste where possible, encouraging the organisation to move away from waste disposal to resource management.	The waste manager is working with a furniture refurbishment provider to identify where padded furniture could be “made good” and reused rather than disposed of and new furniture bought to replace. The refurbishment of broken IT equipment also contributes to this aim. Usable pharmaceutical products are returned to main pharmacy where safe to do so.

Clinical Waste Segregation

The offensive waste stream is well established in all clinical areas throughout the Trust. In the 2023/2024 Estates Returns Information Collection (ERIC) return, ENHT reported some progress toward but did not achieve the target in year. The 2024/2025 return showed the target was achieved throughout the year. The 2025/2026 reporting will also show the target having been achieved throughout the year.

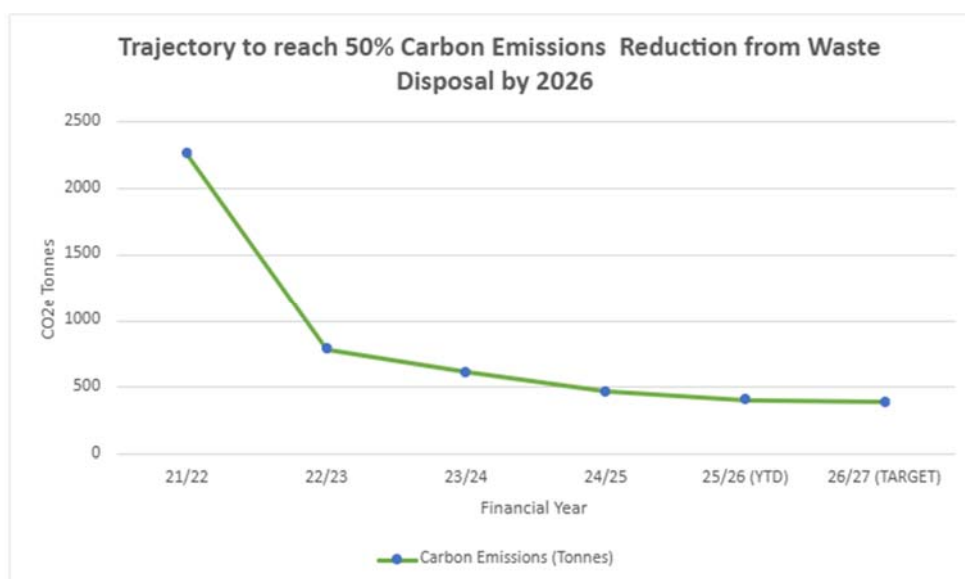


AT – anatomical waste, **HTI** - high temperature incineration.

Reduction in Carbon Emissions from waste disposal

Working with Sharpsmart to ensure that the most carbon efficient means of waste disposal are used in addition to using reusable sharps containers has resulted in a significant reduction in carbon emissions from ENHT's waste disposal. A further reduction of 13.83 tonnes of CO₂e during the next year will be needed to achieve this target.

By 2028, the target of 80% reduction in CO₂ emissions will be required. A significant reduction in the total quantity of waste disposed of will be required to achieve this target. Potential waste reduction / avoidance schemes could involve increased use of reusable items instead of single use/disposables where feasible, effective stock rotation, and exploring furniture renovation/reuse providers.



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.

Martin Armstrong, Chief Executive
26 June 2026

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 – roles and responsibilities

The Trust's Board of Directors ('the Board') functions according to corporate governance best practice and operates as a unitary Board, with collective accountability for all aspects of Trust performance, from clinical quality to financial performance and sustainability. Key responsibilities of the Board are:

- Setting the strategic direction for the Trust
- Setting the Values of the Trust and promoting the desired culture for the organisation
- Monitoring resource requirements and performance and overseeing the delivery of our Annual Plan
- Ensuring that the services we provide to patients are high quality, safe and caring
- Ensuring that we are governed by a robust system of internal control and risk management
- Ensuring effective engagement with stakeholders to ensure effective dialogue with the communities it serves
- Ensuring that we are compliant with the conditions of our Provider licence and the Code of Governance
- Overseeing our performance and ensuring that all organisational, local and national
- performance targets are met
- Continuously seeking further improvement and innovation

The Board is responsible for exercising all the powers of the Trust; however, it has the option to delegate these powers to senior management and committees of the Board. The Board has several committees which support the seeking of assurance in relation to quality, performance, and risk management throughout the Trust. These committees as of 31 March 2026 are: Audit & Risk Committee; Remuneration & Appointments Committee; Quality & Safety Committee; Finance; Finance, Performance & Planning Committee; People & Culture Committee; Digital Committee; Charity Trustee Committee and ENH Health Care Partnership Committee.

The Trust has a Scheme of Reservation and Delegation, along with a set of Standing Financial Instructions, which outlines when approval for a decision is required from the Board or one of its committees, such as for a high-value business case, and decisions which the Executive team are permitted to make without further approval.

The Board is jointly and severally responsible for scrutinising and constructively challenging the performance of the Trust to ensure we deliver our strategy, continuously improve, and deliver high quality care.

Board composition

Led by an independent chair, Anita Day, 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 Executive Team during 2025-26 was led by Adam Sewell-Jones, Chief Executive Officer.

As of 31 March 2026, the Board consisted of a non-executive chair, six 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 four further executive directors – the Chief People Officer, Chief Information Officer, Chief Kaizen Officer, Director of Estates & Facilities – participate in Board meetings, but do not have voting rights. 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 2025/26, there was one formal change to the non-executive membership of the Board, with a representative from the University of Hertfordshire, Zoe Aslanpour, formally joining the Board when the Trust gained Teaching Hospital status from 1 April 2025.

During 2025/26 no executive director left the Trust. The former Chief People Officer, Tom Pounds, left on 31 March 2025. Penny St Martin joined as the Chief People Officer in July 2025. Amanda Marcus was the Acting Chief People Officer between April and July 2025. However, Adam Sewell-Jones finished as Chief Executive on 31 May 2026, with Martin Armstrong being appointed as the permanent Chief Executive.

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. The Board believes it has the appropriate balance and completeness in its composition to meet the requirements of an NHS 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
David Buckle	Non-Executive Director Associate*	17 September 2018	N/A	N/A
	Non-Executive Director (SID)	1 December 2022	Four years	30 November 2026
Nina Janda	Non-Executive Director Associate*	1 September 2023	Two years + four years	31 August 2029
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
Zoe Aslanpour	Non-Executive Director	1 April 2025	Three years	31 March 2028
Tichafara Phiri	NExT Non-Executive Director*	12 March 2025	1 year + extended until 31 April 2026	31 April 2026
Adam Sewell-Jones	Chief Executive	1 January 2022	N/A	31 May 2026
Martin Armstrong	Finance Director & Deputy Chief Executive during 2025-26	31 October 2016	N/A	N/A
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
Amanda Harcus	Acting Chief People Officer*	1 April 2025	N/A	6 July 2025
Penny St Martin	Chief People Officer*	7 July 2025	N/A	N/A
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.

Biographical details of each director, including their skills, experience and expertise, are available on the Trust website at link [on the Trust's website, in line with the NHS Trust Code of Governance.](#)

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 2025/26.

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

Directors' appointment and appraisal

The Chair and non-executive directors are appointed by NHS England, on behalf of the Secretary of State for Health and Social Care (non-voting associate and NExT non-executive directors are appointed directly by the Trust 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 person" condition set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. This is undertaken on appointment and reviewed annually and includes a self-declaration process.

Directors' responsibility for Equality & Diversity

To assist in the development of our equality and involvement understanding we are introducing a clear Equity & Inclusion objective for each Director, both Executive and Non-Executive, that is assessed at appraisal.

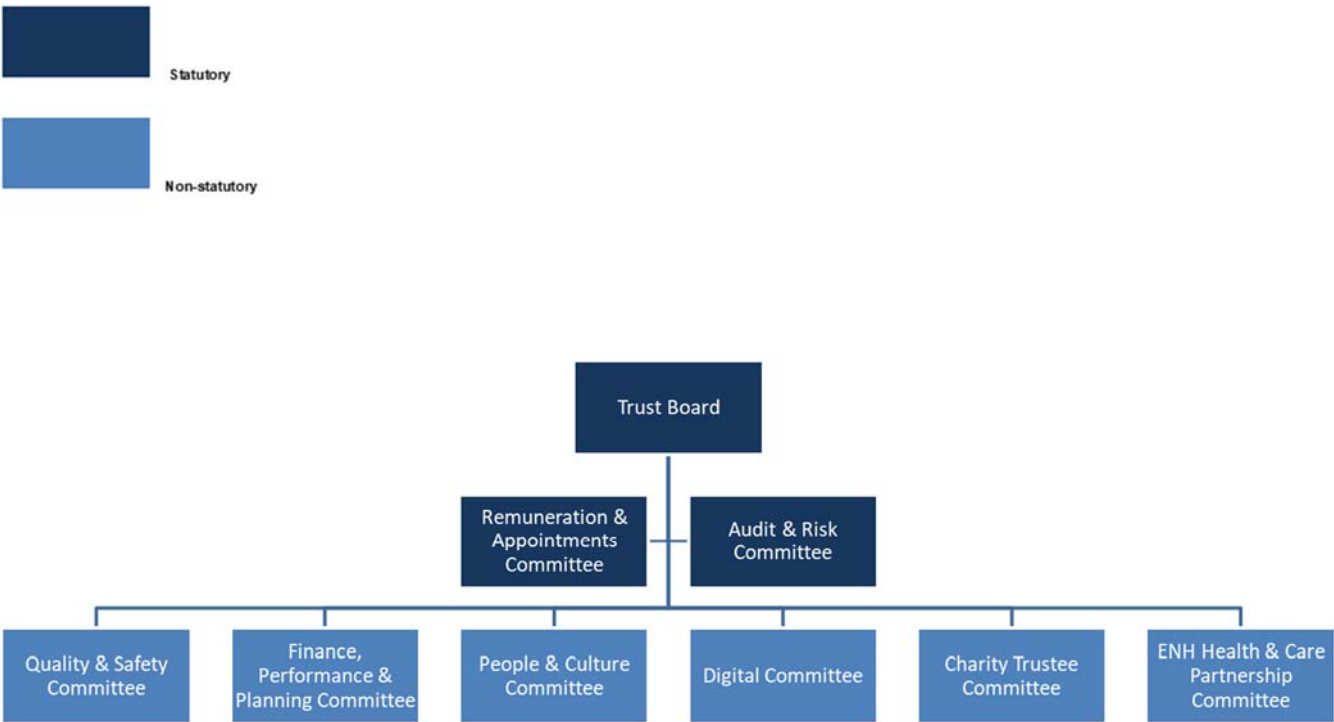
Well-Led Framework

An independent review was completed in 2023 by the Good Governance Institute. The Board’s development programme and an action plan was created and implemented to address areas for improvement identified from the review.

Governance structure and effectiveness review

The Trust Board has a number of formal Board assurance committees (see the diagram below for the committee structure on 31 March 2026) 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 the Board and each committee is undertaken annually to ensure that it continues to meet its terms of reference and operate effectively. The results were presented at each relevant committee as well as at a Board Seminar on 15 April 2026.



Attendance of Directors at Public Board Meetings 2025-26

The Board met in formal public session on seven occasions during 2025/26. The Board met on a further six occasions for Board development sessions.

Trust Board members	14 May 25	30 June 26*	9 July 25	10 Sept 25	19 Nov 25	14 Jan 26	11 Mar 26	Total attendance
Anita Day, Chair of the Trust Board	✓	✓	✓	Apologies	✓	✓	✓	6 out of 7
Karen McConnell, Non-Executive Director	✓	✓	✓	✓	✓	Apologies	✓	6 out of 7
David Buckle, Non-Executive Director	✓	Apologies	✓	✓	✓	✓	✓	6 out of 7
Richard Oosterom, Associate Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	6 out of 7
Nina Janda, Associate Non-Executive Director	✓	✓	✓	✓	Apologies	✓	✓	6 out of 7
Diana Skeete, Non-Executive Director	✓	✓	✓	Apologies	✓	✓	✓	6 out of 7
Janet Scotcher, Non-Executive Director	Apologies	✓	✓	✓	✓	✓	✓	6 out of 7
Zoe Aslanpour, Non-Executive Director	Apologies	Apologies	Apologies	Apologies	✓	Apologies	Apologies	1 out of 7
Gillian Hooper, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Tichafara Phiri, NEXt Non-Executive Director	✓	✓	✓	Apologies	Apologies	✓	✓	5 out of 7
Adam Sewell-Jones, Chief Executive	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Martin Armstrong, Deputy Chief Executive & Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Justin Daniels, Medical Director	✓	Apologies	Apologies	✓	✓	✓	✓	5 out of 7
Lucy Davies, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Mark Stanton, Chief Information Officer	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Theresa Murphy, Chief Nurse	✓	Apologies	✓	✓	✓	✓	✓	6 out of 7
Kevin Howell, Director of Estates and Facilities	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Kevin O'Hart, Chief Kaizen Officer	✓	✓	✓	✓	✓	✓	Apologies	6 out of 7
Amanda Harcus, Interim Chief People Officer	✓	✓	✓					3 out of 3
Penny St Martin, Chief People Officer			✓	✓	✓	✓	✓	5 out of 5
	Not a board member		*Extraordinary Board meeting – 24 Mar 25					

Disclosures set out in the NHS Trust Code of Governance 2023

The Trust has applied the principles of the NHS Trust Code of Governance on a comply or explain basis. 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.

Code of Governance compliance statement

The Board considers that it was fully compliant with the provisions of the Code in 2025/26, apart from those set out below.

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.

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.

The Code of Governance sets out a number of disclosure requirements to be included in the Annual Report and these are provided below.

Ref	Summary of requirement	Disclosure
A2.1	Partnerships & sustainability	Our local system and objectives sections See Sustainability statement section
A2.3	Culture, staff well-being	The Trust's 2025-26 Staff Survey results can be found at: NHS staff survey results . Also see wider commentary in the Annual Governance Statement including the Developing Workforce Safeguards section; the Risk Profile; and Other Employee Matters in the Staff Report.
A2.8	Stakeholders and system working	An "Impact section" was added to Board and Committee coversheet template in 2022. ICS & Strategy overview and objectives sections
B2.6 and 2.7	NEDs are independent	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. The Chair holds meetings with the non-executive directors without the executive directors being present.
C4.2	Director's skills & expertise	This is covered in The Trust Board section of the report above and within the Annual Governance Statement.
C4.7	Well-led external review	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	Succession-planning diversity and inclusion	This is covered in the terms of reference and on the annual cycle for the Remuneration Committee.
D2.4	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 is fair and balanced	The Annual Report is emailed to Board members prior to approval and this duty is highlighted to Board members.
D2.8	Risk management	Internal audit reviews risk management annually – see the annual governance statement section.

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 Audit Committee ensures there is an effective internal audit function established by management that met Public Sector Internal Audit Standards and provided appropriate independent assurance. The Trust receives its internal audit service from RSM.

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England 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.

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

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: Martin Armstrong, Chief Executive

Date: 26 June 2026

East and North Hertfordshire Teaching NHS Trust Annual Governance Statement 2025/26

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 Teaching 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 Teaching NHS Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board provides clear and visible leadership for risk management by setting the Trust's risk strategy, risk appetite and expectations for robust internal control. The Chief Nurse is the Executive Lead for risk management, supported by the Head of Corporate Governance who oversees the Board Assurance Framework (BAF). Each Executive Director is accountable for risks within their portfolio and acts as the lead for strategic BAF risks.

Staff capability to identify, assess and manage risk is supported through structured training, guidance and oversight. The Compliance and Risk Team provides targeted risk management and risk register training to help ensure staff understand their risk responsibilities. Divisions and corporate teams receive ongoing coaching on the application of the Trust's risk assessment tools, scoring matrix and escalation pathways.

The Trust promotes a culture of continuous learning by systematically reviewing internal and external sources of assurance—including incidents, complaints, clinical audit, internal audit, patient and staff feedback, and thematic reviews. Learning is disseminated via governance sessions, safety newsletters, daily bulletins, divisional risk clinics and multidisciplinary review forums, ensuring good practice is shared and embedded across services.

Leadership capacity is strengthened through Board development sessions covering strategy, governance, risk, financial sustainability, digital transformation and system collaboration. The Board and its Committees also receive periodic training on the BAF, risk appetite and the operation of assurance systems, ensuring directors are equipped to scrutinise risk effectively.

The risk and control framework

The Trust's Risk Management Strategy sets out the systems for identifying, assessing, escalating and controlling risks across clinical, operational, financial, workforce, digital and strategic domains. Risks are assessed using the Trust's standard risk matrix, with defined controls, assurance sources, gaps and mitigation plans documented on local and corporate risk registers. The Board routinely reviews its risk appetite to ensure alignment with strategic priorities, external context and regulatory requirements.

The Board Assurance Framework (BAF) provides the overarching structure for monitoring strategic risks to the Trust's objectives. Executive Leads review BAF risks bi-monthly, and Board Committees receive regular reports on risk movement, assurance strength and mitigation effectiveness. The Corporate Risk Register is aligned to the BAF through established escalation processes overseen by the Risk Management Group, which reports directly to the Trust Management Group where executives review and approve changes to the Corporate Risk Register (CRR), enabling visibility of high-impact risks and emerging themes.

Quality governance is delivered through an established framework that includes the Quality and Safety Committee, divisional governance structures, real-time reporting and triangulated assurance. The quality of performance information is assessed through internal audit, data quality reviews and clinical audit processes. The Trust maintains routine oversight of compliance with CQC regulatory requirements through self-assessment, thematic reviews, clinical governance panels and continuous monitoring of quality indicators.

The governance framework contains 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.

Risks to data security and digital resilience are managed through the Trust's information governance framework, cyber-security controls, DSP Toolkit compliance processes, system monitoring and regular internal audit. Digital safety processes ensure new systems, upgrades and configuration changes are risk-assessed and introduced safely.

The Trust's major risks include operational performance and flow, financial sustainability, workforce capacity, change culture, health inequalities, capital investment constraints and digital transformation. Several risks relate to system-wide interdependencies where outcomes depend on collaboration across the Integrated Care System. Mitigations include strengthened governance, enhanced data and digital capability, targeted workforce initiatives, flow and productivity programmes, and capital planning aligned to clinical priorities. Outcomes are monitored through the BAF, Corporate Risk Register, Board Committees and divisional governance reviews.

The Internal Auditor annual review of risk management and the Board Assurance Framework concluded a 'reasonable assurance' rating in 2023/24, 2024/25 and 2025/26.

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.
- Regular 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 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. 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. In addition, the website provides a separate Board register of interests. The online system helps significantly in tracking compliance and progress, with 82% of staff expected to make an annual declaration having done so by 31 March 2026.

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.

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. 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.

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

East and North Hertfordshire Teaching NHS Trust reported an adjusted financial surplus of £5 million against a planned breakeven position, thereby continuing to meet its statutory duty to break even.

The NHS financial framework for 2025/26 built on arrangements established to support recovery of core services and productivity following the COVID-19 pandemic, including the prior baseline reset of contract values and allocations. However, the framework reflected a significantly more constrained financial environment, with a stronger emphasis on financial discipline and system balance. Systems were required to operate within fixed resource limits, deliver substantial efficiency and productivity improvements (including c.4% productivity growth and at least a 1% cost base reduction), and achieve financial balance at system level. While greater flexibility was afforded to Integrated Care Systems (ICSs) through reduced ringfencing, this was accompanied by strengthened expectations that organisations live within their means and prioritise delivery of key operational standards.

The national payment mechanism for 2025/26 comprised a combination of variable activity-based payments for elective care, incorporating national expectations linked to the Elective Recovery Fund (ERF), and blended payment mechanisms for non-elective services. Within this framework, the Trust agreed a block contract with its main commissioner, Hertfordshire and West Essex ICB, covering both elective and non-elective activity. Full receipt of contract income was contingent upon delivery against key performance requirements, including reductions in patient waiting times and progress against national operational standards, particularly Referral to Treatment (RTT) targets.

The year was characterised by continued service and financial disruption arising from sustained industrial action across medical staffing groups. The Trust worked proactively to mitigate the impact on patient safety and financial performance. Financial impacts included increased staffing costs and reduced activity levels due to disruption to planned elective care. These effects were partially mitigated through the block income arrangement with the ICB and additional funding to offset the direct costs of industrial action.

Progress against delivery of the financial plan was overseen by the Finance, Performance and Planning Committee (FPPC) and reported regularly to the Board. The Trust continued to build on prior year improvement themes, with a focus on addressing areas of adverse performance and strengthening delivery.

Operating within a financially challenged system, the Trust worked closely with Hertfordshire and West Essex ICS to deliver a range of system-wide workstreams aimed at improving efficiency and restoring financial balance. Through these collaborative efforts, the Trust contributed to the achievement of an overall balanced system position.

As part of ICS-wide financial management arrangements, the Trust continued to operate within the requirements of the Deficit Control Regime, including adherence to expenditure controls such as the “Triple-lock” approval process in line with NHS England’s Outturn Variance Protocol.

The Trust utilised its Cost Improvement Programme (CIP) delivery framework to identify and deliver against a challenging £35.8 million efficiency target for 2025/26. Delivery was supported by continued strong performance against key performance indicators to ensure achievement of the full value of contractual income alongside a mix of recurrent and non-recurrent cost reduction schemes.

The Trust continued to work with its internal audit provider, RSM, to ensure robust financial processes and controls were in place. The 2025/26 internal audit programme included independent reviews of key financial controls and payroll processes, resulting in reasonable assurance over financial controls and partial assurance over payroll.

The Trust maintained its Executive Programme Board structure to coordinate delivery of key transformation initiatives aimed at improving value for money. This was complemented by continued investment in business intelligence capabilities, enhancing the quality and timeliness of information available to support operational and financial decision-making.

During 2025/26, the Trust further strengthened governance arrangements relating to the development, approval and documentation of business cases. This, alongside a continued focus on strategic infrastructure planning, has improved assurance over the prioritisation and management of resources within the capital programme. The impact of which has seen the Trust deliver a £35m capital plan in year and secure funding for a £50m capital plan in 2026/27

The Trust recognises that sustained delivery of cost improvement plans is critical to achieving long-term financial balance. Accordingly, there is a clear focus on developing savings programmes with a strong recurrent basis, reducing reliance on non-recurrent measures. To support this, the Trust has increased its emphasis on sustainable productivity improvement. This has been underpinned by regular productivity reporting to FPPC, enhanced analytical capability to identify opportunities, and the development of targeted improvement schemes overseen by the Project Management Office (PMO).

Looking ahead to 2026/27, demand for urgent and emergency care services is expected to remain high during 2026/27. The Trust will continue the work commenced in 2025/26 with system partners to improve patient flow, reduce delayed discharges and strengthen community-based care pathways through the continued development of the East & North Hertfordshire Health and Care Partnership and neighbourhood working arrangements.

Key risks to future performance include workforce shortages in key staff groups, the potential for industrial relations disruption, inflationary cost pressures and the delivery of a challenging productivity and efficiency programme. These risks are monitored through the Board Assurance Framework and supporting governance processes, with mitigating actions regularly reviewed by the Board and its committees.

The Trust recognises the scale of the financial challenge and has taken steps to strengthen delivery capability. This includes the restructuring and refocusing of the PMO under a newly

appointed Transformation Director, alongside the identification of requirements for external delivery support. These developments have informed the design and underpinning of the 2026/27 financial plan and associated savings programme.

The Trust's external auditor, BDO, identified a significant weakness in arrangements for securing economy, efficiency and effectiveness, specifically in relation to financial sustainability. In response, the Trust has taken decisive action to strengthen its approach to CIP delivery. This includes implementation of an enhanced governance and delivery framework, and incorporation of learning from prior years. Investment has been made in a strengthened PMO function and senior delivery leadership, alongside the introduction of improved reporting tools (including Power BI) and the continuation of monthly Board-level assurance meetings to provide strategic oversight and support effective delivery.

Information governance

The Trust successfully achieved a DSPT 'Standards Met' rating for 2024/2025, demonstrating that it is practising good data security and that personal information is handled correctly. Independent audit assurance for 2024/25 was rated as 'High', indicating strong confidence in the accuracy and robustness of the Trust's submission. This maintains the position achieved in 2023/2024, where the Trust also received a 'Standards Met' rating with 'High' independent assurance.

For 2025/2026, the DSPT submission is in progress. For 2025-26, initial feedback indicated there will be some learning in relation to the Cyber Assessment Framework (CAF). The Trust met the required baseline submission deadline of 31 December 2025. The final outcome will be reported in next year's Annual Governance Statement.

As at 31 March 2026, positively, no data breaches have met the threshold for reporting to the Information Commissioner's Office (compared to four reportable breaches in 2024/2025), indicating an improvement in incident profile.

There are no cyber security governance issues to report. The Trust continues to monitor sector-wide threats, incorporating learning from cyber incidents affecting other NHS organisations. Cyber security remains a principal risk on the Corporate Risk Register, reflecting the increasing frequency and sophistication of threats. The current risk score is 16, reduced from 20 in the previous year, indicating an improving risk position while maintaining appropriate oversight.

Data quality and governance

The Data Quality Strategy and Data Quality Policy support the quality of the trust's data. These two documents set out the ten key values to support the production and assurance of high-quality data and its management across the organisation.

To ensure that the quality of the data is dependable, the Trust upholds the five data quality principles: Accuracy, Completeness, Reliability, Relevance and Timeliness.

The Data Quality strategy has been written supporting the aspiration of 'get it right first time' when recording data (good quality data is everyone's responsibility) and the policy defines the individual responsibilities for specific roles across the organisation for its delivery. The strategy is operationalised through the Data Quality Assurance Group and supported by a rolling monthly audit and governance programme.

The Data Quality team collaborate with the Digital team to ensure that our systems have the correct validation and mandatory rules that enforce 'Get it Right first time.'

Key workstreams include supporting the Trust's Demand and Capacity programme, continued 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 dashboards drive action because of the defined thresholds and tolerances which allow immediately to see what is being breached and what may need action, underpinned by clear escalation protocols and training.

The quality and accuracy of elective waiting time data

The Trust assures the quality and accuracy of elective waiting time data through the use of Patient Tracking Lists (PTLs), available via Power BI, the Trust's business intelligence platform. A dedicated team of Referral to Treatment (RTT) validators, with service-specific and pathway expertise, is responsible for ensuring RTT pathways are compliant with national RTT rules. This includes the routine review and correction of patient pathways for those waiting to commence first definitive treatment. Oversight of RTT validation activity is supported by a dedicated Validation Dashboard in Power BI, which provides daily visibility of the validation status of the RTT PTL. The dashboard highlights potential data quality issues and records the date each pathway was last validated. These data quality indicators align with the nationally available LUNA system, which enables benchmarking of PTL data quality across NHS trusts. The Trust's RTT PTL has a 98.51% overall confidence level which increases to over 99.2% for patients waiting over 26 weeks.

For non-RTT pathways, the PTL is segmented by waiting time for new and follow-up patients, those with booked appointments, and those awaiting appointment scheduling. Identified data quality issues are further categorised into defined subsets to support risk stratification and to inform potential use of automation to close unnecessary or inappropriate referrals. However, the non-RTT follow-up waiting list remains significantly inflated, in part due to legacy data quality issues.

In February 2026, at the Trust's request, the national GIRFT Elective Team undertook a high-level review of the Trust's waiting lists and its approach to waiting list data quality improvement. The review was intended to provide independent advice and support the prioritisation of improvement actions. GIRFT advised the development of a structured and appropriately resourced validation programme to systematically identify and address pathway data issues, thereby enabling more effective management of all pathways via the Trust's PTLs. For independent assurance, the Trust's Audit and Risk Committee has included PTL data quality and accuracy for audit by the Trust's internal auditors in 2026-27.

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 2025/2026.

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 2026, the Head of Internal Audit opinion for East and North Hertfordshire Teaching 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 eleven reviews during 2025/26. Positively, the three areas audited annually because they are central to determining confidence in the system of internal controls all achieved reasonable assurance ratings - for core financial controls, risk management and DSPT information governance (as was the case the previous year) with a caveat relating to improvements identified in the 2025-26 CAF. Change management and divisional governance were also rated reasonable assurance.

The following one-off audits were rated as partial assurance: Health and Safety Part 1: Water and electricity; Part 2: Fire; PSIRF; Payroll and EPPR. There was one minimal assurance for medical appraisals.

The context for these ratings is important. The Trust intentionally identified areas for audit that the Trust already knew were or were likely to be areas with some control issues but was seeking independent assurance that there were no other unidentified control issues within these areas. For example, in last year's Annual Governance Statement estates critical engineering functions was identified as a governance development area, which was why the health and safety audits were prioritised. PSIRF was chosen precisely because it is a new process.

All actions arising have been allocated to accountable executives, with progress monitored through the Trust Management Group and Audit and Risk Committee. The majority of issues identified in these audits have already been addressed and are therefore no longer control issues. In the context set out, whilst the need for improvement is recognised, the Trust does not believe these represent a significant internal control failure within the meaning of the Annual Governance Statement.

The Trust's external auditor, BDO, identified significant deficiencies in controls in relation to IT general controls. These primarily related to privileged access roles and the absence of audit trails for one system.

BDO also identified significant weakness in respect of financial sustainability and the Trust's ability to manage its medium-term budget gaps. The non-recurrent CIP challenge is covered in the financial performance and review of economy section above. In 2024/25, BDO, similarly identified a significant weakness in arrangements for securing economy, efficiency and effectiveness, specifically in relation to financial sustainability. This is a recognised challenge. In the context the Trust achieved financial balance in 2024/25 and this year, the ability to deliver CIPs was highlighted as a governance development area in 2024/25's Annual Governance Statement and whilst progress has been made, it remains a governance development area, with CIPs delivery being a top risk on the Corporate Risk Register and financial constraints a highest scoring risk on the BAF at year-end.

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.
- Internal auditors review risk management and gave a reasonable assurance rating for 2025/26 and 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.
- The People and Culture Committee provides oversight of the related plans and risks relating to the workforce.
- Quality & Safety Committee approves and reviews the annual clinical audit programme.
- Internal Audit, through its annual audit plan, provides assurance and comment on matters related to internal control.
- The Trust reviews the Standing Orders, Scheme of Reservation and Delegation and the Standing Financial Instructions annually, lastly in May 2026.
- The Senior Information Risk Owner, who is supported by the Data Protection Officer provide information governance assurance via the Data Security and Protection toolkit submission.
- The Trust has an Accountability Framework Structure and Integrated Performance Report process.
- 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.
- 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.
- External inspections, such as by CQC and MHRA, noting the November 2025 MHRA inspection identified a single significant deficiency within Lister Hospital Quality Control Laboratory, relating to ensuring analytical methods were properly validated. However, this issue was addressed and closed by the MHRA.
- Executive Directors, Senior Managers 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 Internal Audit reports.

Conclusion

My review has established that East and North Hertfordshire Teaching 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:

Martin Armstrong, Chief Executive

Date: 26 June 2026

Modern Slavery Act Statement

The Trust is committed to preventing modern slavery and human trafficking in its operations and supply chains. This statement is made in accordance with section 54 of the Modern Slavery Act 2015 and sets out the steps taken during 2025/26.

Our organisation and supply chains

The Trust procures a wide range of goods and services, the majority of which are sourced through NHS and government procurement frameworks or are subject to NHS Standard Contract and Terms and Conditions.

These arrangements require suppliers to comply with all relevant employment, labour, human rights and modern slavery legislation. Social value considerations are incorporated into procurements where lawful and appropriate.

Policies and governance

The Trust has a zero-tolerance approach to modern slavery and human trafficking. This commitment is supported by established policies and procedures including Freedom to Speak Up, Safeguarding, Procurement and Workforce policies. Responsibility for supply chain compliance sits with the Procurement function, with modern slavery risks overseen through corporate governance and safeguarding arrangements.

Due diligence and risk management

The Trust undertakes proportionate due diligence to mitigate the risk of modern slavery by:

- Applying NHS Employment Check Standards and robust pre-employment checks
- Using approved agency and framework suppliers subject to audit assurance
- Requiring suppliers to comply with the Modern Slavery Act via contracts and purchase orders
- Procuring extensively through NHS Supply Chain, whose Supplier Code of Conduct addresses forced labour
- Supporting professional procurement standards through Chartered Institute of Procurement and Supply membership

The Trust recognises that most goods and services are sourced from UK or EU-based suppliers operating within comparable legislative frameworks.

Training and awareness

Staff are supported through safeguarding policies, procedures and training to identify and respond to concerns relating to modern slavery and exploitation. Procurement staff are expected to remain alert to risks and escalate concerns where identified.

Ongoing commitment

The Trust will continue to review and strengthen its arrangements, taking proportionate and risk-based action to prevent slavery and human trafficking in its business and supply chains. All staff have a responsibility to act in accordance with Trust values and policies.

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 2025/26)
- 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, Vice-Chair, Senior Independent Director and the Chair of the People and Culture Committee. 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 four times in total during 2025/26. 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 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 the 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

During 2025/26, the Trust has continued to play an active role in supporting the effective operation of the Integrated Care Partnership (ICP). As part of this commitment, the Trust contributes to a proportion of the costs associated with several material key ICP staff roles. This includes a contribution towards the salary of Ruth Forbes, Development Director for the HCP (Health and Care Partnership)

This shared-funding approach reflects our commitment to collaborative system leadership and ensures that the HCP has the capacity and expertise required to deliver its strategic priorities across the local health and care system.

Remuneration tables

Name and title	2025/26							2024/25						
	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	220-225	0	0	0	45-47.5	0	265-270	215-220	2	0	0	7-5-10	0	225-230
Chief Executive														
Martin Armstrong	175-180	0	0	0	50-52.5	0	225-230	170-175	0	0	0	20-22.5	0	190-195
Director of Finance														
Theresa Murphy	150-155	0	0	0	42.5-45	0	195-200	145-150	1	0	0	15-17.5	0	165-170
Director of Nursing														
Justin Daniels	225-230	0	0	0	45-47.5	0	270-275	225-230	1	0	0	145-147.5	0	370-375
Medical Director														
Lucy Davies	155-160	0	0	0	60-62.5	0	220-225	150-155	1	0	0	17.5-20	0	170-175
Chief Operating Officer														
Thomas Pounds (to 31.03.25)	0	0	0	0	0	0	0	140-145	0	0	0	22.5-25	0	165-170
Chief People Officer														
Amanda Harcus (to 06.07.25) ****	30-35	0	0	0	0-2.5	0	30-35	0	0	0	0	0	0	0
Interim Chief People Officer														
Penny St Martin	105-110	0	0		0		105-110	0	0	0		0		0

(from 07.07.25)				0		0					0		0	
Chief People Officer														
Mark Stanton	145-150	1	0	0	40-42.5	0	185-190	140-145	3	0	0	37.5-40	0	180-185
Chief Information Officer														
Kevin O' Hart	140-145	0	0	0	62.5-65	0	205-210	130-135	0	0	0	20-22.5	0	150-155
Director of Improvement														
Kevin Howell	135-140	0	0	0	0	0	135-140	145-150	0	0	0	0	0	145-150
Director of Estates & Facilities														

Name and title	2025/26						2024/25					
	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												
Anita Day (from 02.01.24)	50-55	50	0	0	0	55-60	50-55	6	0	0	0	55-60
Chair												
Val Moore (to 31.08.24)	0	0	0	0	0	0	5-10	2	0	0	0	5-10
Jonathan Silver (to 31.07.24)	0	0	0	0	0	0	0-5	0	0	0	0	0-5

Peter Carter (to 20.09.24)	0	0	0	0	0	0	5-10	0	0	0	0	5-10
Nina Janda	10-15	20	0	0	0	15-20	10-15	0	0	0	0	10-15
David Buckle	10-15	3	0	0	0	10-15	10-15	0	0	0	0	10-15
Karen McConnell	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Janet Scotcher (from 01.09.24)	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Gillian Hooper (from 03.12.24)	10-15	10	0	0	0	10-15	0-5	0	0	0	0	0-5
Diana Skeete (from 01.09.24)	10-15	6	0	0	0	10-15	5-10	0	0	0	0	5-10
Richard Oosterom (from 01.09.24) **	0	0	0	0	0	0	0	0	0	0	0	0
Tichafara Phiri (from 11.03.25) ***	0-5	0	0	0	0	0-5	0	0	0	0	0	0
Zoe Aslanpour (from - 01.04.25) ****	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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 (CPI of 1.7% for the 2025 Greenbury exercise) and any increase or decrease due to a transfer of pension rights. This figure does not represent an amount that will be received by the individual. It is a calculated value intended to provide an indication of the potential benefit of membership of the pension scheme. 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 2025/26 (this was topped up to 23.7% by NHSE) (23.7% in 2024/25). 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 2024/25 and 2025/26.
- 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 £64,708.08 (£161,802.64 relates to his managerial role).
- ** Richard Oosterom is paid via invoice and has received £13,0000 during the year.

- *** Tichafara Phiri joined on 11.03.25 and was not paid in the 2024-25 financial year. He received £5,000 in September 2025 relating to the 2024-25 financial year.
- **** Amanda Marcus occupied the role of Interim Chief People Officer from 1st April 2025 – 6th July 2025.
- ***** Zoe Aslanpour is not remunerated by the Trust but is a voting member of the Board.

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 2026	Lump sum at pension age related to accrued pension at 31 March 2026	Cash equivalent transfer value at 1 April 2025	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2026	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*	2.5-5	0	65-70	165-170	1,432	53	1,533	0
Chief Executive								
Martin Armstrong	2.5-5	0-2.5	60-65	145-150	1,274	57	1,374	0
Director of Finance								
Theresa Murphy	2.5-5	0-2.5	65-70	165-170	1,563	0	0	0
Director of Nursing								
Justin Daniels	2.5-5	0	80-85	205-210	1,812	57	1,926	0
Medical Director								
Lucy Davies	2.5-5	2.5-5	70-75	175-180	1,525	73	1,644	0
Chief Operating Officer								
Amanda Harcus	0-2.5	0	25-30	0	368	4	392	0
Interim Chief People Officer (to 06.07.25)								
Penny St Martin (from 07.07.25) *	0	0	0	0	0	0	0	0
Chief People Officer								
Mark Stanton*	2.5-5	0	30-35	0	448	37	510	0
Chief Information Officer								
Kevin O'Hart*	2.5-5	2.5-5	40-45	100-105	894	69	994	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								

- 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.
- Penny St Martin opted out of the pension scheme prior to joining the Trust board on 7th July 2025.
- Amanda Harcus occupied the role of Interim Chief People Officer from 1st April 2025 – 6th July 2025

Notes to pensions table

Non-executive members of the Board do not receive pensionable remuneration and therefore no pension-related disclosures are made 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 include the member's accrued benefits and any contingent spouse's pension payable from the 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 include the value of any pension benefits in another scheme or arrangement which the individual has transferred into the NHS Pension Scheme, as well as any additional pension benefit accrued through the purchase of added years at the member's own cost.

CETV figures are calculated in accordance with guidance provided by HM Treasury.

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

The Public Service Pensions Remedy (McCloud) has been implemented to address age discrimination arising from the 2015 pension reforms. Eligible members had their membership during the remedy period (1 April 2015 to 31 March 2022) rolled back into the legacy schemes on 1 October 2023. The pension benefits and CETVs disclosed reflect the impact of the remedy, where applicable.

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 2025/26. This information is subject to audit by the Trust's auditors, BDO LLP.

Payments to past directors

There were no such payments in 2025/26. This information is subject to audit by the Trust's auditors, BDO LLP.

Pay multiples (fair pay disclosure) for 2025/26

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 2025/26 was £222,500 (2024/25 – £222,500). This was 5.2 times (2024/25 – 5.5 times) the median remuneration of the workforce, which was £43,098 (2024/25 – £40,795).

Regarding the ratio of highest paid director to median remuneration of the workforce, as the median pay has increased, the mid-point band of the highest paid director has remained the same, resulting in a slightly lower 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

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 2025/26 was £220k - £225k (2024/25, £220k-£225k). 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.

	25/26 Increase / (decrease)	24/25 Increase / (decrease)
Percentage change in salary in respect of highest paid director		
Change in salary and allowances from the previous year in respect of the highest paid director:	0.00%	12.66%
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):	3.83%	5.42%
Average change in performance pay and bonuses from the previous year in respect of all employees (excluding highest paid director):	N/A	N/A

2025-26	25th percentile	Median	75th percentile
Total remuneration (£)	30,404.13	43,098.07	56,213.96
Salary component of total remuneration (£)	30,307.56	42,726.75	55,759.07
Pay ratio information	7.32	5.16	3.96
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

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
25/26	7.32	7.34	5.16	5.21	3.96	3.99
24/25	7.64	7.64	5.45	5.49	4.14	4.18

In 2025/26, 31 employees (2024/25, 36 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £345 to £345,248 per annum (for 2024/25, – the reported range was £2,000 to £401,300).

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
- 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.

	2025/26	2025/26	2024/25	2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	455	563	1,019	971
Ambulance staff	-	-	-	-
Administration and estates	1,545	49	1,594	1,707
Healthcare assistants and other support staff	869	59	928	1,006
Nursing, midwifery and health visiting staff	1,899	33	1,932	1,859
Nursing, midwifery and health visiting learners	-	5	5	5
Scientific, therapeutic and technical staff	519	18	537	562
Healthcare science staff	129	8	136	167
Social care staff	-	-	-	-
Other	-	-	-	-
Total average numbers	5,416	735	6,151	6,275
Of which:				
Number of employees (WTE) engaged on capital projects	18	1	16	16

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.

	2025/26		2025/26	2024/25	2023/24
	Permanent		Other	Total	Total
	£000		£000	£000	£000
Salaries and wages	330,221		-	330,221	312,838
Social security costs	44,208		-	44,208	35,318
Apprenticeship levy	1,635		-	1,635	1,585
Employer's contributions to NHS pension scheme	63,820		-	63,820	60,559
Pension cost - other	54		-	54	65
Other post-employment benefits	-		-	-	-
Other employment benefits	-		-	-	-
Termination benefits	-		-	-	-
Temporary staff	-		41,941	41,941	48,770
NHS charitable funds staff	-		-	-	-
Total gross staff costs	439,938		41,941	481,879	459,135
Recoveries in respect of seconded staff	(5,792)		-	(5,792)	(4,856)
Total staff costs	434,146		41,941	476,087	454,279
Of which					
Costs capitalised as part of assets	1,612		-	1,612	1,041

Staff composition

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

Gender	Headcount March 2026	FTE March 2026
Female	5233	4582.3 FTE
Male	1724	1633.7 FTE
Total	6957	6216.0 FTE

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

Gender	Headcount 31 March 2026
Female	10
Male	9

Sickness absence data

Monthly Sickness absence rates have been between 4.3% and 5.3% during 2025/26 with the highest rates around wintertime, peaking in January 2026.

The absence rate for the 12-month period ending March 2026 was 4.76% against a target of 4.0%. This is an increase on the previous year's rate of 4.49%.

Trust sickness absence by month:

Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
4.3%	4.7%	4.9%	4.9%	4.5%	5.0%	4.9%	4.96%	5.0%	5.3%	5.1%	5.0%

The most common causes of absence are Anxiety/Stress/Depression, followed by Cold/Cough/Flu, and other musculoskeletal (MSK) problems.

We will continue to promote a range of support initiatives to help staff remain well at work. This includes encouraging appropriate rest, the taking of annual leave, and ongoing local triangulation of absence data with staff survey results, patient feedback, and staff complaints. This approach will help identify areas requiring additional development and support, enabling us to create healthier workplace environments across teams.

Staff turnover percentage

Voluntary turnover has remained consistently below the 10% target throughout 2025/26, ranging from 7.1% to 8.2%. Turnover reduced steadily through the first half of the year, reaching a low in September, before increasing slightly over the winter period.

Rates are stable and remain below 8%; overall, turnover is well controlled with performance consistently exceeding target levels.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Turnover (voluntary resignations only)	8.2%	7.5%	7.4%	7.2%	7.2%	7.3%	7.1%	7.5%	7.6%	7.9%	7.4%	7.1%
Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

Staff Engagement

The table below shows the Trust's staff engagement score since 2018, as recorded in the NHS staff survey. Although 2025 shows reduced responses, score remains stable, suggesting quality did not decline.

	2018	2019	2020	2021	2022	2023	2024	2025
Score	6.8	6.9	6.9	6.8	6.7	6.8	6.9	6.8
Number of responses	2373	2600	2641	2640	2955	2994	3338	2756

Staff policies regarding equality and diversity

During 2025/26, the Trust has continued to strengthen its commitment to inclusive recruitment and equitable employment practices. Candidates and staff with disabilities remain fully supported through our ongoing compliance with the Disability Confident (Two-Tick) standards, alongside the continued rollout of the Reasonable Adjustment Passport. This tool is now well-embedded and ensures that adjustments are consistently understood, recorded and applied throughout an individual's employment journey.

The Inclusion Ambassador Scheme has continued to play an important role in promoting fairness and equity during recruitment selection. Ambassadors provide an additional layer of assurance on interview panels, helping to mitigate bias and support inclusive decision-making.

The Policy to Protect Staff from Sexual Violence and Aggression at Work has continued to be a key area of focus throughout 2025/26. Communications promoting the confidential reporting email have been widely circulated to ensure staff know how to disclose incidents safely and discreetly.

The People Team continues to work closely with the hospital's domestic and sexual abuse specialist, ensuring that any staff member affected receives timely, trauma-informed support. This partnership also provides expert guidance to managers and investigators, helping to ensure that any subsequent processes are handled sensitively, consistently and in line with best practice.

Progress has been made regarding oversight of equality, diversity and inclusion. The impact of all relevant policies is reviewed through the EDI Steering Group, which monitors progress and is chaired by a Non-Executive Director, identifies where remedial action is required, and ensures that equality considerations remain embedded across Trust activity. Further work is required to strengthen governance arrangements and clarify accountabilities to support the effective and sustainable delivery of the Trust's EDI ambitions.

Other employee matters

There were no other significant employee matters to highlight.

Expenditure on consultancy

In 2025/26 £736,753.69 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 2026, for more than £245 per day:

The Trust engaged the below number of individuals off-payroll during 2025/26. All engagements complied with HMRC IR35 requirements. No engagements exceeded six months without review.

	Number
Number of existing engagements as of 31 March 2026	7
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	1
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	1
For four or more years at the time of reporting	4

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

For all off-payroll engagements between 1 April 2025 and 31 March 2026, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	7
Of which...	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	4
No. subject to off-payroll legislation and determined as out of scope of IR35	3
No. of engagements reassessed for compliance or assurance purposes during the year	5
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 2025 and 31 March 2026

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

Reporting of compensation schemes - exit packages 2025/26

Exit packages agreed during 2025/26 are disclosed below in accordance with HM Treasury guidance:

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	16	16
£10,000 - £25,000	-	12	12
£25,001 - 50,000	-	6	6
£50,001 - £100,000	-	3	3
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	37	37
Total cost (£)		705,170	£705,170

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 2025/26.

Reporting of compensation schemes - exit packages 2024/25

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages 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

Exit packages: other (non-compulsory) departure payments					
	2025/26		2024/25		
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements	
	Number	£000	Number	£000	
Voluntary redundancies including early retirement contractual costs	12	368	-	-	
Mutually agreed resignations (MARS) contractual costs	18	298	-	-	
Early retirements in the efficiency of the service contractual costs	-	-	-	-	
Contractual payments in lieu of notice	7	40	2	21	
Exit payments following Employment Tribunals or court orders	-	-	3	185	
Non-contractual payments requiring HMT approval	-	-	-	-	
Total	37	706	5	206	
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 Teaching 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 2025/26.

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 29 of the financial statements.

During 2025/26 the Trust has no individual case of Losses and Special Payments in year that exceeded £300,000.

Gifts

There were no gifts made over £300,000 during 2025/26.

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, are 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: 26 June 2026

Martin Armstrong, Chief Executive

Date: 26 June 2026

Barry Jenkins, Interim Finance Director

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

Report on the audit of the financial statements

Opinion

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 2026 and of the Group's and of the Trust's expenditure, income and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025-26; 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 Teaching NHS Trust ("the Trust") and its subsidiary ("the Group") for the year ended 31 March 2026, which comprise the Consolidated Statement of Comprehensive Income, the Statements of Financial Position, the Statements of Cash Flows and the Statements 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 UK-adopted International Financial Reporting Standards as adapted and interpreted by the Government Financial Reporting Manual 2025-26 as contained in the Department of Health and Social Care Group Accounting Manual 2025-26 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

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 2025-26 that entities prepare their accounts on a going concern basis where it is anticipated that the

services they perform will continue to be provided 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 and Supplementary Guidance Note 01 issued by the Comptroller and Auditor General in November 2024.

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 2025-26, 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 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2026:

Significant weakness in arrangements	Recommendation
The Trust has identified a £37.9 million savings target for 2026/27. As at May 2026, the Trust had not identified detailed plans for how it will make £16.6 million (44%) of these savings. 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.	We recommend that the Trust strengthens its efficiency programmes and cost-saving initiatives to ensure they are robust, effective, and capable of mitigating identified financial risks. These measures should be identified and developed at an early stage to allow sufficient time for implementation.

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 that on 25 June 2026 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 2026 and not having credible plans that would enable it to return to a breakeven position by 31 March 2029.

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 the financial statements are prepared in a format directed by the Secretary of State and 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.

However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the Trust and management.

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:

- Enquires of management whether there were any litigations and claims;
- Enquires of the Trust's legal team;
- Review of minutes of meeting 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 experts 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 forensics 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 management override of controls, expenditure recognition and revenue recognition.

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;
- Performing unpredictability procedures by changing the nature, timing or extent of some of our tests;
- Assessing significant estimates made by management for accrued receivables and accrued liabilities for bias,

- Testing pre- and post-year end transactions for 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; 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 certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for East and North Hertfordshire Teaching NHS Trust for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice 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 of Audit Practice. 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 Teaching 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

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

East And North Hertfordshire Teaching NHS Trust

Annual accounts for the year ended 31 March 2026

Consolidated Statement of Comprehensive Income

		Group and Trust	
		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3	699,386	656,767
Other operating income	4	62,642	60,513
Operating expenses	6,8	(778,533)	(719,276)
Operating (deficit) from continuing operations		(16,505)	(1,996)
Finance income	9	1,859	2,602
Finance expenses	10	(3,266)	(3,394)
PDC dividends payable		(4,908)	(5,981)
Net finance costs		(6,315)	(6,773)
Other (losses) / gains	11	(630)	(85)
Corporation tax income / (expense)		133	(289)
Deficit for the year		(23,317)	(9,143)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(23,601)	(655)
Revaluations	16	7,615	1,544
Other reserve movements		(939)	(17)
Total comprehensive expense for the period		(40,242)	(8,271)

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	12	16,121	22,215	16,121	22,215
Property, plant and equipment	14	219,158	251,966	219,121	251,923
Right of use assets	17	93,256	95,866	93,256	95,866
Other Investments	18	-	-	1,000	1,000
Receivables	20	1,206	2,394	1,206	2,394
Total non-current assets		329,741	372,441	330,704	373,398
Current assets					
Inventories	19	10,176	9,833	8,699	8,515
Receivables	20	50,872	38,929	50,304	38,061
Cash and cash equivalents	21	42,900	49,720	41,069	47,674
Total current assets		103,948	98,482	100,072	94,250
Current liabilities					
Trade and other payables	22	(87,807)	(85,908)	(88,023)	(86,152)
Borrowings	24	(10,877)	(10,902)	(10,877)	(10,902)
Other financial liabilities		(412)	(412)	(412)	(412)
Provisions	25	(2,598)	(5,179)	(2,598)	(5,179)
Other liabilities	23	(3,790)	(4,328)	(3,790)	(4,328)
Total current liabilities		(105,484)	(106,729)	(105,700)	(106,973)
Total assets less current liabilities		328,205	364,194	325,076	360,675
Non-current liabilities					
Borrowings	24	(122,133)	(127,706)	(122,133)	(127,706)
Other financial liabilities		(3,703)	(4,124)	(3,703)	(4,124)
Provisions	25	(6,382)	(6,413)	(6,382)	(6,413)
Total non-current liabilities		(132,218)	(138,243)	(132,218)	(138,243)
Total assets employed		195,987	225,951	192,858	222,432
Financed by					
Public dividend capital		400,443	390,166	400,443	390,166
Revaluation reserve		36,294	52,280	36,294	52,280
Income and expenditure reserve		(240,750)	(216,495)	(243,880)	(220,014)
Total taxpayers' equity		195,987	225,951	192,857	222,432

The notes on pages 99 to 154 form part of these accounts.

Name	Martin Armstrong
Position	Chief Executive
Date	26 June 2026

Statements of Cash Flows

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating deficit		(16,505)	(1,996)	(15,987)	(2,885)
Non-cash income and expense:				-	-
Depreciation and amortisation	6.1	30,588	28,846	30,569	28,827
Net impairments	7	28,859	10,411	28,859	10,411
Income recognised in respect of capital donations	4	(320)	(96)	(320)	(96)
(Increase) / decrease in receivables and other assets		(9,819)	1,693	(10,119)	552
(Increase) in inventories		(343)	(1,076)	(184)	(1,041)
Increase / (decrease) in payables and other liabilities		2,802	(11,796)	2,342	(10,145)
(Decrease) in provisions		(2,714)	(4,852)	(2,714)	(4,852)
Tax paid		(317)	(287)	-	-
Other movements in operating cash flows		(939)	-	(939)	-
Net cash flows used in operating activities		31,292	20,847	31,507	20,771
Cash flows from investing activities					
Interest received		1,859	2,602	1,859	2,602
Purchase of intangible assets		(54)	(676)	(54)	(676)
Purchase of PPE and investment property		(28,163)	(26,414)	(28,163)	(26,414)
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(17)	(107)	(17)	(107)
Receipt of cash donations to purchase assets		320	96	320	96
Net cash flows used in investing activities		(26,055)	(24,499)	(26,055)	(24,499)
Cash flows from financing activities					
Public dividend capital received		10,277	7,600	10,277	7,600
Movement on loans from DHSC		(2,588)	(2,588)	(2,588)	(2,588)
Capital element of lease liability repayments		(9,267)	(9,118)	(9,267)	(9,118)
Capital element of PFI		(815)	(734)	(815)	(734)
Interest on loans		(887)	(954)	(887)	(954)
Other interest		(4)	(19)	(4)	(19)
Interest paid on lease liability repayments		(1,299)	(1,196)	(1,299)	(1,196)
Interest paid on PFI		(738)	(770)	(738)	(770)
PDC dividends (paid)		(6,724)	(5,153)	(6,724)	(5,153)
Cash flows (used in) other financing activities		(13)	(20)	(13)	(20)
Net cash flows (used in) financing activities		(12,058)	(12,952)	(12,058)	(12,952)
Decrease in cash and cash equivalents		(6,820)	(16,604)	(6,605)	(16,680)
Cash and cash equivalents at 1 April - brought forward		49,720	66,324	47,674	64,354
Cash and cash equivalents at 31 March	21	42,900	49,720	41,069	47,674

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	390,166	52,280	(216,495)	225,951
(Deficit) for the year	-	-	(23,317)	(23,317)
Impairments	-	(23,601)	-	(23,601)
Revaluations	-	7,615	-	7,615
Public dividend capital received	10,277	-	-	10,277
Other reserve movements	-	-	(939)	(939)
Taxpayers' and others' equity at 31 March 2026	400,443	36,295	(240,750)	195,987

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 2026

Trust	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	390,166	52,280	(220,014)	222,432
(Deficit) for the year	-	-	(23,865)	(23,865)
Impairments	-	(23,601)	-	(23,601)
Revaluations	-	7,615	-	7,615
Public dividend capital received	10,277	-	-	10,277
Other reserve movements	-	-	-	-
Taxpayers' and others' equity at 31 March 2026	400,443	36,294	(243,879)	192,857

Consolidated 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

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 2025/26 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, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. 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 capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

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

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

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 2025/26.

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

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at Integrated Care System (ICS) level, within which commissioners' contract with providers for the delivery of healthcare services. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at an agreed fixed baseline in addition to the price of the related service.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pensions' 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

NHS 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.

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.

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 Years	Max life Years
Land	N/A	N/A
Buildings, excluding dwellings	10	83
Plant & machinery	5	15
Information technology	5	10
Furniture & fittings	5	20

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, eg 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 £10.3m and remaining amortisation period of 7 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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

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 1.8 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, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model, estimates current value in existing use as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.

An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust.

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

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

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.

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.

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 GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

The Trust determines expected credit losses using a matrix of percentage based on the class of 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 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

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 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

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 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

The Trust has undertaken an assessment of potential contingent assets and contingent liabilities at the reporting date and has concluded that there are no items requiring disclosure. No probable contingent assets have been identified, and there are no possible or present obligations arising from past events that meet the definition of a contingent liability.

Note 1.16 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 of the audit of the annual accounts.

Note 1.17 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 1.18 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 1.19 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 2025/26.

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 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and 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.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE currently subject to revaluation have a total book value of £156m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £14m at 31 March 2026. The Trust is not able to quantify the impact at this time.

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) - fair value

A full valuation exercise was carried out in March 2026. 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 the valuation relates principally to land and specialised buildings. In arriving at the value of specialised buildings, the valuer estimates build costs based on current market rates. A 5% change in estimated build costs would result in a £7.1m change in the carrying value of buildings. A 5% change in market rates would result in a £0.7m 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.

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

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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)	2025/26	2024/25
	£000	£000
Income from commissioners under API contracts - variable element*	205,380	179,703
Income from commissioners under API contracts - fixed element*	350,094	344,643
High cost drugs income from commissioners	69,273	64,773
Other NHS clinical income	41,340	33,457
Private patient income	6,402	6,967
National pay award central funding***	-	1,507
Additional pension contribution central funding**	25,446	24,062
Other clinical income	1,451	1,655
Total income from activities	699,386	656,767

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 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%, 2024/25: 23.7%) and related NHS England funding (9.4%, 2024/25: 9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 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)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England	92,838	104,141
Integrated care boards	598,695	543,962
Non-NHS: private patients	6,402	6,967
Non-NHS: overseas patients (chargeable to patient)	265	433
Injury cost recovery scheme	1,045	1,013
Non NHS: other	141	251
Total income from activities	699,386	656,767

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

	2025/26	2024/25
	£000	£000
Income recognised this year	265	433
Cash payments received in-year	270	248
Amounts added to provision for impairment of receivables	404	450
Amounts written off in-year	363	381

Note 4 Other operating income (Group)

	2025/26	2024/25
	£000	£000
	£000	£000
Research and development	7,930	7,923
Education and training	24,326	22,331
Non-patient care services to other bodies	26,613	26,761
Receipt of capital grants and donations and peppercorn leases	320	96
Revenue from operating leases	298	270
Other income	3,155	3,132
Total other operating income	62,642	60,513

Other contract income includes:

Car parking income of £1,153k (2024/25 £1,471k)

Catering (non-patient) of £1,333k (2024/25 £1,295k)

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

	2025/26	2024/25
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,000	2,000

Note 5.2 Transaction price allocated to remaining performance obligations

	31 March	31 March
	2026	2025
	£000	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	1,790	3,879
Total revenue allocated to remaining performance obligations	1,790	3,879

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)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	7,589	8,856
Purchase of healthcare from non-NHS and non-DHSC bodies	10,848	10,881
Staff and executive directors costs **	473,827	452,853
Remuneration of non-executive directors	169	146
Supplies and services - clinical (excluding drugs costs)	57,017	49,051
Supplies and services - general	16,838	16,386
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	83,574	78,768
Inventories written down	204	222
Consultancy costs	737	617
Establishment	6,063	5,607
Premises	30,875	29,111
Transport (including patient travel)	1,058	1,259
Depreciation on property, plant and equipment	24,744	25,503
Amortisation on intangible assets	5,844	3,343
Net impairments	28,859	10,411
Movement in credit loss allowance: contract receivables / contract assets	295	467
Change in provisions discount rate(s)	(17)	2
Fees payable to the external auditor		
audit services- statutory audit *	332	268
Internal audit costs	144	203
Clinical negligence	22,978	20,193
Legal fees	800	596
Insurance (as a policy holder)	308	118
Research and development	648	385
Education and training	1,599	1,895
Expenditure on short term leases	192	429
Redundancy	807	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	(680)	(699)
Car parking & security	919	798
Hospitality	37	34
Losses, ex gratia & special payments	2	19
Other services, eg external payroll	1,622	1,534
Other	301	20
Total	778,533	719,276

* The audit fee is stated on a gross basis for the Trust and net for the subsidiary. The total amount NET of VAT for the Trust is £211k.

** Employer pension contributions paid by NHSE on the Trusts behalf £25.446m (24/25: £24.062m).

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 7 Impairment of assets (Group)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	28,859	10,411
Total net impairments charged to operating surplus / deficit	28,859	10,411
Impairments charged to the revaluation reserve	23,601	655
Total net impairments	52,460	11,066

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. In 2025/26 the Trust reviewed the MEA model which resulted in a significant reduction in the land and buildings area required for the provision of services resulting in a significant net impairment.

Note 8 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	330,221	312,188
Social security costs	44,208	35,318
Apprenticeship levy	1,635	1,585
Employer's contributions to NHS pensions	63,820	60,559
Pension cost - other	54	65
Temporary staff (including agency)	41,941	49,420
Total gross staff costs	481,879	459,135
Recoveries in respect of seconded staff	(5,792)	(4,856)
Total staff costs	476,087	454,279
Of which		
Costs capitalised as part of assets	1,612	1,041
Total employee benefits excl. capitalised costs	474,475	453,238

Please note, the £474,475k is made up of Staff and executive director costs £473,827k and Research and development staff costs £658k.

Note 8.1 Retirements due to ill-health (Group)

During 2025/26 there were 6 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £177k (£43k in 2024/25).

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.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,859	2,602
Total finance income	1,859	2,602

Note 10.1 Finance expenditure (Group)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	887	954
Interest on lease obligations	1,299	1,196
Interest on late payment of commercial debt	4	19
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	738	770
Remeasurement of the liability resulting from change in index or rate	330	451
Total interest expense	3,258	3,390
Unwinding of discount on provisions	8	4
Total finance costs	3,266	3,394

Note 10.2 The late payment of commercial debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	4	19

Note 11 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Losses on disposal of assets	(630)	(85)
Total gains / (losses) on disposal of assets	(630)	(85)

Note 12.1 Intangible assets - 2025/26

Group	Software licences £000	Development expenditure £000	Total £000
Cost at 1 April 2025 - brought forward *	40,868	4,794	45,662
Additions	42	12	54
Reclassifications	(276)	227	(49)
Disposals / derecognition	(5,219)	(2,880)	(8,099)
Cost at 31 March 2026	35,415	2,153	37,568
Amortisation at 1 April 2025 - brought forward	19,576	3,871	23,447
Provided during the year	5,492	352	5,844
Reclassifications	(35)	22	(13)
Disposals / derecognition	(4,983)	(2,848)	(7,831)
Amortisation at 31 March 2026	20,050	1,397	21,447
Net book value at 31 March 2026	15,365	756	16,121
Net book value at 1 April 2025	21,292	923	22,215

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

*Development expenditure is software that has been developed internally by the Trust.

Note 12.2 Intangible assets - 2024/25

Group	Software licences £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	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 - brought forward	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

*Development expenditure is software that has been developed internally by the Trust.

Note 13.1 Intangible assets - 2025/26

Trust	Software licences £000	Development expenditure £000	Total £000
Cost at 1 April 2025 - brought forward *	40,764	4,794	45,558
Transfers by absorption	42	12	54
Additions	925	-	925
Disposals / derecognition	(661)	(305)	(966)
Cost at 31 March 2026	41,070	4,501	45,571
Amortisation at 1 April 2025 - brought forward	19,472	3,871	23,343
Provided during the year	5,492	352	5,844
Disposals / derecognition	(424)	(274)	(698)
Amortisation at 31 March 2026	24,540	3,949	28,489
Net book value at 31 March 2026	16,530	552	17,082
Net book value at 1 April 2025	21,292	923	22,215

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

*Development expenditure is software that has been developed internally by the Trust.

Note 13.2 Intangible assets - 2024/25

Trust	Software licences £000	Development expenditure £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	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 - brought forward	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

*Development expenditure is software that has been developed internally by the Trust.

Note 14.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	24,025	175,354	2,644	81,503	16,787	1,332	301,645
Additions	-	15,001	5,659	5,819	1,103	51	27,633
Impairments	(9,111)	(23,960)	-	-	-	-	(33,071)
Reversals of impairments	-	9,470	-	-	-	-	9,470
Revaluations	(531)	(26,375)	-	-	-	-	(26,906)
Reclassifications	-	1,839	(3,384)	235	1,359	-	49
Disposals / derecognition	-	-	-	(16,154)	(5,250)	(723)	(22,127)
Valuation/gross cost at 31 March 2026	14,383	151,329	4,919	71,403	13,999	660	256,693
Accumulated depreciation at 1 April 2025 - brought forward	-	3,768	5	35,096	9,703	1,106	49,678
Provided during the year	-	6,435	-	6,718	2,046	70	15,269
Impairments	564	39,906	-	-	-	-	40,470
Reversals of impairments	(33)	(11,578)	-	-	-	-	(11,611)
Revaluations	(531)	(33,990)	-	-	-	-	(34,521)
Reclassifications	-	5	(5)	-	13	-	13
Disposals / derecognition	-	-	-	(15,791)	(5,250)	(723)	(21,764)
Accumulated depreciation at 31 March 2026	-	4,546	-	26,023	6,512	453	37,534
Net book value at 31 March 2026	14,383	146,782	4,919	45,380	7,487	207	219,158
Net book value at 1 April 2025	24,025	171,585	2,639	46,407	7,084	226	251,966

Note 14.2 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	171,585	2,639	46,407	7,084	226	251,966
Net book value at 1 April 2024	21,780	167,156	13,828	44,563	6,126	309	253,762

Note 14.3 Property, plant and equipment financing - 31 March 2026

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,383	137,701	4,700	43,422	7,487	186	207,879
On-SoFP PFI contracts and other service concession arrangements	-	7,497	-	-	-	-	7,497
Owned - donated/granted	-	1,584	219	1,958	-	21	3,782
NBV total at 31 March 2026	14,383	146,782	4,919	45,380	7,487	207	219,158

Note 14.4 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 and other service concession arrangements	-	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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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 (£5,804k).

¹ All PPE buildings are owned.

Note 15.1 Property, plant and equipment - 2025/26

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 2025 - brought forward	24,025	175,354	2,644	81,503	16,717	1,153	301,396
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	15,000	5,659	5,819	1,106	55	27,639
Impairments	(9,111)	(23,960)	-	-	-	-	(33,071)
Reversals of impairments	-	9,470	-	-	-	-	9,470
Revaluations	(531)	(26,375)	-	-	-	-	(26,906)
Reclassifications	-	1,839	(3,384)	235	1,359	-	49
Transfers to / from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(16,154)	(5,250)	(723)	(22,127)
Valuation/gross cost at 31 March 2026	14,383	151,328	4,919	71,403	13,932	485	256,450
Accumulated depreciation at 1 April 2025 - brought forward	-	3,768	5	35,096	9,636	968	49,473
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	6,435	-	6,718	2,046	70	15,269
Impairments	564	39,906	-	-	-	-	40,470
Reversals of impairments	(33)	(11,578)	-	-	-	-	(11,611)
Revaluations	(531)	(33,990)	-	-	-	-	(34,521)
Reclassifications	-	5	(5)	-	13	-	13
Transfers to / from assets held for sale	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	(15,791)	(5,250)	(723)	(21,764)
Accumulated depreciation at 31 March 2026	-	4,546	-	26,023	6,445	315	37,329
Net book value at 31 March 2026	14,383	146,782	4,919	45,380	7,487	170	219,121
Net book value at 1 April 2025	24,025	171,586	2,639	46,407	7,081	185	251,923

Note 15.2 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
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 15.3 Property, plant and equipment financing - 31 March 2026

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	14,383	137,701	4,700	43,422	7,487	149	207,842
On-SoFP PFI contracts and other service concession arrangements	-	7,497	-	-	-	-	7,497
Owned - donated / granted	-	1,584	219	1,958	-	21	3,782
Total net book value at 31 March 2026	14,383	146,782	4,919	45,380	7,487	170	219,121

Note 15.4 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 and other service concession arrangements	-	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

1

¹ All PPE buildings are owned.

Note 16 Revaluations of property, plant and equipment

The Trust's land and buildings valuations at 31 March 2026 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 2025 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 32% of its current land, while Hertford County Hospital's was modelled as a three-storey building occupying 26% of its current land. In 2025/26 the Trust reviewed the MEA model which resulted in a significant reduction in the land and buildings area required for the provision of services resulting in a significant net impairment.

During the year, the Trust recognised a net decrease in the valuation of property, plant and equipment amounting to £15,986k (comprising net impairments of £23,601k and revaluations of £7,615k). An impairment charge of £28,859k was recognised in the statement of comprehensive income. This primarily relates to the reviewed MEA model and reduction in the land and buildings area required for the current service provision and other backlog maintenance incurred during 2025/26.

Note 17 Leases - East And North Hertfordshire Teaching 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 - 2025/26

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	108,213	9,921	118,133	81,585
Additions	1,365	543	1,908	1,365
Remeasurements of the lease liability	4,348	515	4,863	2,555
Movements in provisions for restoration / removal costs	94	-	94	36
Disposals / derecognition	(1,365)	(951)	(2,316)	(1,365)
Valuation/gross cost at 31 March 2026	112,654	10,028	122,681	84,176
Accumulated depreciation at 1 April 2025 - brought forward	17,852	4,415	22,267	13,388
Provided during the year	7,626	1,849	9,475	5,964
Disposals / derecognition	(1,365)	(951)	(2,316)	(1,365)
Accumulated depreciation at 31 March 2026	24,113	5,313	29,426	17,987
Net book value at 31 March 2026	88,541	4,715	93,256	66,189
Net book value at 1 April 2025	90,361	5,506	95,867	68,197
Net book value of right of use assets leased from other NHS providers				8,186
Net book value of right of use assets leased from other DHSC group bodies				58,003

Note 17.2 Right of use assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	107,432	8,923	116,354	81,316
Additions	1,588	2,071	3,659	1,365
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	108,213	9,921	118,133	81,585
Accumulated depreciation at 1 April 2024 - brought forward	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	90,361	5,506	95,867	68,197
Net book value at 1 April 2024	95,089	5,078	100,167	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 17.3 Revaluations of right of use assets

The Trust's Right of Use assets were reviewed at 31 March 2026 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 2026 is £88.506m (31 March 2025: £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	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	98,622	102,484
Lease additions	1,891	3,552
Lease liability remeasurements	4,862	1,704
Interest charge arising in year	1,299	1,196
Lease payments (cash outflows)	(10,565)	(10,314)
Carrying value at 31 March	96,108	98,622

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 2026

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	8,380	5,002
- later than one year and not later than five years;	25,081	19,057
- later than five years.	76,389	50,000
Total gross future lease payments	109,850	74,059
Finance charges allocated to future periods	(13,741)	(5,932)
Net lease liabilities at 31 March 2026	96,109	68,127
Of which:		
Leased from other NHS providers		8,897
Leased from other DHSC group bodies		59,230

Note 17.6 Maturity analysis of future lease payments at 31 March 2025

	Group and Trust	
	Total	Of which
		leased from
		DHSC group bodies:
	31 March	31 March
	2025	2025
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	8,622	4,838
- 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 finance 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 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 2026 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 2026, the subsidiary's total profit for the year was £608k (2024/25: Loss of £94k (restated)), with gross assets of £6,159k (2024/25: £6,479k) and net assets of £3,696k (2024/25: £3,588k).

The risk of the MVCC out-patient pharmacy moving to another provider in the short term has reduced over the last couple of years. This risk is being continually monitored and in the event of it occurring ENH Pharma would commercially pursue maintaining the supply of service with the new third party, actively look to increase the parent Trust activity and would look for new opportunities to supplement any potential loss of income.

The Trust therefore do not feel it to be an impairment risk.

Note 19 Inventories

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Drugs	4,273	3,979	2,796	2,661
Consumables	5,715	5,643	5,715	5,643
Energy	188	211	188	211
Total inventories	10,176	9,833	8,699	8,515

Inventories recognised in expenses for the year were £83,778k (2024/25: £78,796k). Write-down of inventories recognised as expenses for the year were £204k (2024/25: £222k).

Note 20.1 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Contract receivables	36,634	27,763	36,636	27,699
Allowance for impaired contract receivables / assets	(1,929)	(1,426)	(1,929)	(1,426)
Prepayments (non-PFI)	6,925	6,352	6,925	6,352
PDC dividend receivable	936	-	936	
VAT receivable	3,517	3,201	2,947	2,397
Clinician Pension	26	21	26	21
Other receivables	4,763	3,018	4,763	3,018
Total current receivables	50,872	38,929	50,304	38,061
Non-current				
Contract receivables	-	1,418	-	1,418
Allowance for impaired contract receivables / assets	-	(353)	-	(353)
Prepayments (non-PFI)	749	799	749	799
Clinician Pension	457	530	457	530
Total non-current receivables	1,206	2,394	1,206	2,394
Of which receivable from NHS and DHSC group bodies:				
Current	21,579	21,112	21,579	21,112
Non-current	457	530	457	530

Note 20.2 Allowances for credit losses - 2025/26**Group and Trust****Contract
receivables and
contract assets****£000****Allowances as at 1 Apr 2025 - brought forward****1,779**

New allowances arising

295

Utilisation of allowances (write offs)

(144)

Allowances as at 31 Mar 2026**1,929****Note 20.3 Allowances for credit losses - 2024/25****Group and Trust****Contract
receivables and
contract assets****£000****Allowances as at 1 Apr 2024****1,469**

New allowances arising

467

Utilisation of allowances (write offs)

(157)

Allowances as at 31 Mar 2025**1,779**

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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	49,720	66,324	47,674	64,354
Net change in year	(6,820)	(16,604)	(6,605)	(16,680)
At 31 March	42,900	49,720	41,069	47,674
Broken down into:				
Cash at commercial banks and in hand	1,851	2,070	20	24
Cash with the Government Banking Service	41,049	47,650	41,049	47,650
Total cash and cash equivalents as in SoCF	42,900	49,720	41,069	47,674

Note 22.1 Trade and other payables

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Trade payables	30,691	23,632	30,538	23,916
Capital payables	1,770	2,300	1,770	2,300
Accruals	36,983	42,060	36,983	42,060
Annual leave accrual	2,711	2,477	2,711	2,477
Social security costs	5,139	4,403	5,127	4,388
Other taxes payable	5,243	4,964	5,204	4,949
PDC dividend payable	-	880	-	880
Pension contributions payable	5,208	5,192	5,196	5,182
Other payables	62	-	62	-
Total current trade and other payables	87,807	85,908	87,591	86,152
Of which payables from NHS and DHSC group bodies:				
Current	8,096	11,773	8,096	11,773

Note 23 Other liabilities

	Group and Trust	
	31 March	31 March
	2026	2025
	£000	£000
Current		
Deferred income: contract liabilities	3,790	4,328
Total other current liabilities	3,790	4,328

Note 24.1 Borrowings

	Group and Trust	
	31 March	31 March
	2026	2025
	£000	£000
Current		
Loans from DHSC	2,623	2,626
Lease liabilities	7,275	7,480
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	979	796
Total current borrowings	10,877	10,902
Non-current		
Loans from DHSC	25,097	27,685
Lease liabilities	88,834	91,142
Obligations under PFI, LIFT or other service concession contracts	8,202	8,879
Total non-current borrowings	122,133	127,706

Note 24.2 Reconciliation of liabilities arising from financing activities (Group and Trust)

Group - 2025/26	Loans from DHSC £000	Lease liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	30,311	98,622	9,675	138,608
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,588)	(9,267)	(815)	(12,670)
Financing cash flows - payments of interest	(887)	(1,299)	(738)	(2,924)
Non-cash movements:				
Additions	-	2,214	-	2,214
Lease liability remeasurements	-	4,539	-	4,539
Remeasurement of PFI / other service concession liability resulting from change in index or rate			330	330
Application of effective interest rate	884	1,299	738	2,921
Other changes	-	-	(9)	(9)
Carrying value at 31 March 2026	27,720	96,108	9,181	133,009

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

Note 25.1 Provisions for liabilities and charges analysis (Group and Trust)

Group	Pensions: early departure costs £000	Legal claims £000	Re- structuring £000	Pay-related claims (including Agenda for Change) £000	Lease dilapidation s - amounts previously charged to revenue £000	Lease dilapidation s - cost capitalised under IFRS16 £000	Redundancy £000	Other £000	Total £000
At 1 April 2025	740	75	66	358	6,894	2,908	-	551	11,592
Change in the discount rate	(17)	-	-	-	-	-	-	(37)	(54)
Arising during the year	90	29	-	-	-	94	614	-	827
Utilised during the year	(103)	(24)	(66)	(358)	(1,556)	(1,230)	-	(26)	(3,363)
Reversed unused	(25)	-	-	-	-	-	-	(36)	(61)
Unwinding of discount	8	-	-	-	-	-	-	31	39
At 31 March 2026	693	80	-	-	5,338	1,772	614	483	8,980
Expected timing of cash flows:									
- not later than one year;	92	80	-	-	616	1,170	614	26	2,598
- later than one year and not later than five years;	423	-	-	-	-	-	-	80	503
- later than five years.	178	-	-	-	4,722	602	-	377	5,879
Total	693	80	-	-	5,338	1,772	614	483	8,980

Early Departure costs relate to a constructive obligation with the NHS Pensions Agency to refund it the costs of pensions paid to staff who have retired due to ill-health in earlier years. The value of the obligation is assessed using actuarial tables and the uncertainty relates to the length of time these pensions will be payable.

Legal claims relate to claims made under the Trust's Employer Liability and Public Liability Schemes, for which the Trust is responsible for the payment of an excess should the claim be successful. Uncertainty relates to the potential for success and an amount has been included for all those assessed at a probability of over 50% by NHS Resolution.

The redundancy provision relates to the estimated costs of redundancy payments expected to be made in the following financial year to individuals affected by the restructure of the Health Records department.

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.

Pay-related claims 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, the remainder has been settled in 25/26.

Other provision relates to clinician pension costs.

The discount rate applied to provisions above is 2.95%.

Note 26 Clinical negligence liabilities

At 31 March 2026, £331,645k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire Teaching NHS Trust (31 March 2025: £346,416k).

Note 27 On-SoFP PFI, LIFT or other service concession arrangements

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

The Trust pays a monthly contractual unitary payment, which covers the cost of facilities management services, financing and lifecycle replacement of assets components. Further information on the nature and value of these payments is included below.

Note 27.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group and Trust	
	31 March 2026	31 March 2025
	£000	£000
Gross PFI, LIFT or other service concession liabilities	12,124	13,233
Of which liabilities are due		
- not later than one year;	1,652	1,509
- later than one year and not later than five years;	6,561	6,226
- later than five years.	3,911	5,498
Finance charges allocated to future periods	(2,942)	(3,558)
arrangement obligation	9,181	9,675
- not later than one year;	979	796
- later than one year and not later than five years;	4,647	4,062
- later than five years.	3,555	4,817

Note 27.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

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

	Group	
	31 March 2026	31 March 2025
	£000	£000
PFI, LIFT or other service concession arrangements	16,926	18,869
Of which payments are due:		
- not later than one year;	2,199	2,123
- later than one year and not later than five years;	9,362	9,036
- later than five years.	5,365	7,710

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	
	2025/26	2024/25
	£000	£000
Unitary payment payable to service concession operator	1,274	1,192
Consisting of:		
- Interest charge	738	770
- Repayment of balance sheet obligation	815	734
- Service element and other charges to operating expenditure *	(680)	(699)
- Capital lifecycle maintenance	401	387
Total amount paid to service concession operator	1,274	1,192

* The Trust has continued to make deductions against poor service performance in 2025-26 and this has resulted in a further 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 2026 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 2026	
Trade and other receivables excluding non financial assets	39,951
Cash and cash equivalents	42,900
Total at 31 March 2026	82,851

	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

Note 28.3 Carrying values of financial assets (Trust)

	Held at amortised cost £000
Carrying values of financial assets as at 31 March 2026	
Trade and other receivables excluding non financial assets	39,383
Cash and cash equivalents	41,069
Total at 31 March 2026	80,452

	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

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 2026	
Loans from the Department of Health and Social Care	27,720
Obligations under leases	96,109
Obligations under PFI, LIFT and other service concessions	9,181
Trade and other payables excluding non financial liabilities	69,506
Other financial liabilities	4,115
Total at 31 March 2026	206,631

	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, LIFT and other 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

Note 28.5 Carrying values of financial liabilities (Trust)

	Held at amortised cost £000
Carrying values of financial liabilities as at 31 March 2026	
Loans from the Department of Health and Social Care	27,720
Obligations under leases	96,109
Obligations under PFI, LIFT and other service concessions	9,181
Trade and other payables excluding non financial liabilities	69,290
Other financial liabilities	4,115
Total at 31 March 2026	206,415

	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, LIFT and other 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

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 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	83,417	83,263	83,201	83,509
In more than one year but not more than five years	45,948	45,467	45,948	45,467
In more than five years	102,052	106,837	102,052	106,837
Total	231,417	235,567	231,201	235,813

Note 29 Losses and special payments

	2025/26		2024/25	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Group and trust				
Losses				
Bad debts and claims abandoned	136	394	101	420
Stores losses and damage to property	5	195	54	240
Total losses	141	589	155	660
Special payments				
Compensation under court order or legally binding arbitration award	-	-	3	124
Ex-gratia payments	15	26	34	119
Total special payments	15	26	37	243
Total losses and special payments	156	615	192	903
Compensation payments received				

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 Care, Trust board members or key management staff, or parties related to them has undertaken any material transactions with East and North Hertfordshire Teaching 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, 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 2025-26 the Trust received £1,300k (2024-25 £1,028) from the charity. The majority of these receipts were for the reimbursement of running costs and donations made for the benefit of patients and staff. There was £254k (2024-25 £58k) receivable balance from the charity at the end of the financial year.

Note 31 Better Payment Practice code

	2025/26	2025/26	2024/25	2024/25
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	70,027	265,173	69,881	275,739
Total non-NHS trade invoices paid within target	64,562	240,422	66,171	243,546
Percentage of non-NHS trade invoices paid within target	92.2%	90.7%	94.7%	88.3%
NHS Payables				
Total NHS trade invoices paid in the year	2,400	52,833	2,618	43,036
Total NHS trade invoices paid within target	1,644	38,002	1,738	29,607
Percentage of NHS trade invoices paid within target	68.5%	71.9%	66.4%	68.8%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

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 10.1.

Note 32 Capital Resource Limit

	2025/26	2024/25
	£000	£000
Gross capital expenditure	34,457	29,649
Less: Disposals	(631)	(85)
Less: Donated, granted and peppercorn leased capital additions	(320)	(96)
Charge against Capital Resource Limit	33,506	29,468
Capital Resource Limit	33,506	29,468
Under / (over) spend against CRL	-	0

Note 33 Adjusted financial performance

	2025/26	2024/25
	£000	£000
(Deficit) for the period per SOCI	(23,317)	(9,143)
Remove net impairments not scoring to the departmental expenditure limit	28,859	10,411
Remove I&E impact of capital grants and donations	39	390
Remove I&E impact of IFRIC 12 schemes on an IFRS 16 basis	581	846
Add back I&E impact of IFRIC 12 schemes on former UK GAAP basis	(1,135)	(1,053)
Remove net impact of DHSC centrally procured inventories	-	28
Adjusted financial performance surplus	5,027	1,479

Note 34 Breakeven duty financial performance

	2025/26
	£000
Adjusted financial performance surplus	5,027
IFRIC 12 breakeven adjustment	554
Breakeven duty financial performance surplus	5,581

Note 35 Breakeven duty rolling assessment

	1997/98 to 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	2025/26
	£000	£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	5,581
Breakeven duty cumulative position	(61,934)	(75,477)	(74,025)	(71,497)	(71,136)	(77,271)	(73,969)	(72,284)	(66,703)
Operating income	420,968	444,903	498,597	540,900	578,461	610,600	658,584	717,280	762,028
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%)	(8.8%)

* The Trust's adjusted financial performance for 2025-26 was £5,028k. There are technical adjustments relating to PFI remeasurement accounting that has improved the breakeven duty by £554k.

The Trust first reported cumulative deficit in 2015-16 of £7,977k (-2.1% of operating income). The Trust is in the eleventh year of consecutive break-even duty breach achieving a cumulative deficit of £66,702 (-8.8% of operating income) above the -0.5% permitted. The Trust recorded a surplus of £5,582k in 2025-26.