July

2023

East and North Hertfordshire NHS Trust

Annual Report and Accounts 2022-23

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Performance Report

Introduction

Welcome to the Trust's annual report and accounts for 2022/23. I would like to formally thank all who work at the Trust, for all that you have done over the last year as we continue to make progress on waiting lists after the pandemic.

Political visits

Our progress in areas such as diagnostics, day case procedures and vascular surgery were the topics of visits by senior politicians – including the most senior trio of prime minister, chancellor, and health secretary in April 2022 as they visited the New QEII Hospital.

Labour party leader, Sir Keir Starmer, paid a visit to the Lister in December 2022 with the shadow health secretary Wes Streeting and spoke to junior doctors, and we have welcomed local MPs and councillors to our sites.

Working together for patients

Working together with our health and care colleagues in Hertfordshire and West Essex continues to be a priority, and we welcome the statutory footing of the integrated care board since July 2022.

We have welcomed new ways of working more closely within the system, to benefit our patients. For example, through the Hertfordshire Community Trust Hospital at Home programme, which has enabled many of our patients to leave hospital and be cared for at home, and which has also prevented patients from being admitted to hospital.

Our pilot heart failure service builds on this work and with funding from NHS England allows specialist nurses to identify patients at risk of heart failure and monitor them remotely.

Looking ahead, we will continue to work closely with our partners on delivering care closer to home, rather than in hospital. Multidisciplinary services will consist of a core, integrated community and primary care team led by complex care coordinators, with specialist support from secondary care, public health, mental health and voluntary sector co-opted in as required.

Charity flying high

Our charity has continued with outstanding fundraising work, including a new event last July – the Rainbow Run. Over 280 participants raised £16,000 for our patients and staff – with many making it a family event!

And the return of our charity abseil in March was more popular than ever, with 99 people dropping down the outside of the tower block at Lister, raising over £48,000.

Part of the Trust's Sunshine Appeal, I am pleased that we will start works in the summer for the terrace for our critical care patients to have access to safe outdoor space, aiming for completion by September.

Thank you to the charity team, and all those who have generously sponsored or donated over the year – you have made a real difference.

Board changes

This year we have bid farewell to Biraj Parmer, who has sadly stepped down as a non-executive director.

And we welcome Dr David Buckle who is now a non-executive director after holding the role of associate non-executive director.

Ellen Schroder

Chair

24 July 2023

Performance Overview

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

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

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

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

Chief Executive's Statement

Firstly, as always, I'd like to thank everyone who works at the Trust for your hard work and commitment in the last year. Covid has eased and no longer drives our daily business, but I know that pressure has continued to be felt and I don't underestimate the dedication of everyone who works here, including those from our partner and contract organisations.

Our people

I'd like to welcome Theresa Murphy to the Trust as our chief nurse. Theresa started her role in September 2022, following the departure of Rachael Corser, and I'm grateful for the benefit of her knowledge and experience.

I'd also like to welcome Dr Justin Daniels who has joined us this April as medical director, following the stepping down of Dr Michael Chilvers who will continue to work clinically at the Trust. We are all very grateful for the work of Dr Chilvers and delighted that Dr Daniels has chosen to join us.

I'm pleased that the Trust remains an attractive place to work, with almost no nurse vacancies in our emergency department and recent appointments to our midwifery team.

We launched new values for the Trust in July 2022 – include, respect and improve – and these have been rolled out across the organisation, with teams discussing what those words mean for them in practice.

And in July we also held our first staff awards since 2019, celebrating those going above and beyond – and the event was once again funded by the hospitals' charity via generous sponsors.

Our patients

I'm pleased to tell you that for the first half of last year, we were the 7th best Trust in the country – out of 168 Trusts – for growth in planned activity, delivering 110% of the elective activity compared to the year before COVID.

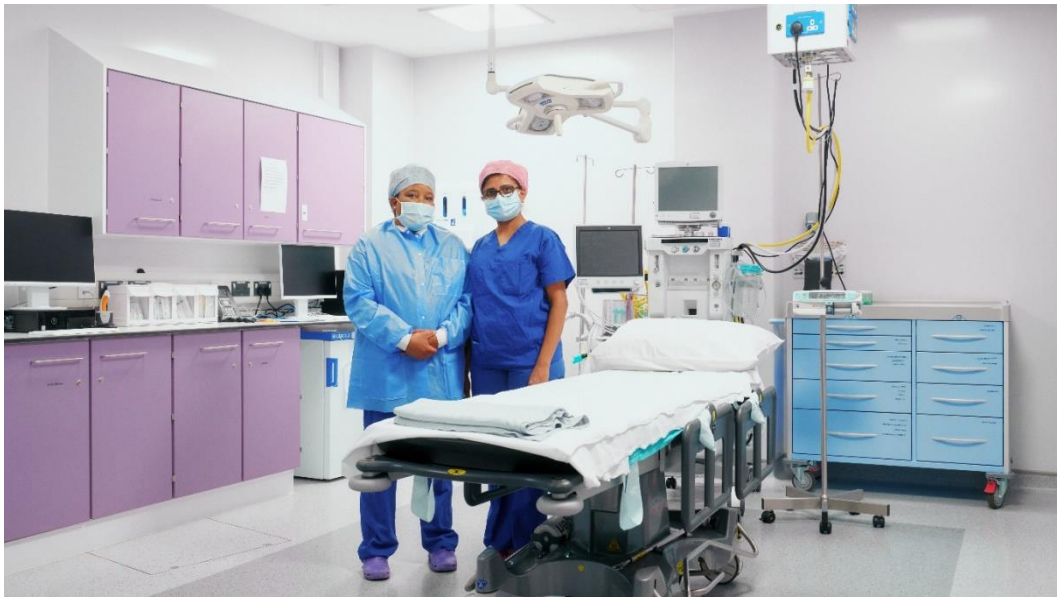
Our focus is now on reducing the number of people waiting for more than 65 weeks for a procedure.

We continue to see over 300 patients most days in the emergency department at Lister, and our urgent treatment centre at the New QEII Hospital in Welwyn Garden City sees an average of over 183 patients each day.

Improving now and for the future

Following our CQC report on maternity services, published in January, we have made a number of improvements in maternity including in staff numbers and training (with over 23 new midwives recruited), a replace and refurbishment programme of equipment and estate, and improved processes. We look forward to the Care Quality Commission (CQC) visiting again.

Planning permission has been granted for, and we await funding approval for, construction of a state-of-the-art hybrid vascular theatre at Lister Hospital. As a combined operating theatre and interventional radiology suite, it will allow patients to undergo complex procedures such as inserting stents using minimally invasive techniques to treat Aneurysms (EVAR), and leg arteries that can help reduce hospital stay.



Two procedure rooms have been created at Lister, creating capacity for day-case procedures, and a third will be completed at the New QEII Hospital by the end of the year.

And finally, our refurbished same day emergency care (SDEC) area reopened in December, supporting patients who may not need to attend the emergency department.

Adam Sewell-Jones

Chief Executive

24 July 2023

About the Trust

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

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

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

The area served by the Trust for acute hospital care covers a population of just over 600,000 people and includes south, east and north Hertfordshire, as well as parts of Bedfordshire. The Mount Vernon Cancer Centre provides specialist cancer services to some three million people from across Hertfordshire, Bedfordshire, Luton, north-west London and parts of the Thames Valley. The Trust's main catchment is a mixture of urban and rural areas that are in close proximity to London. The population is generally healthy and affluent compared to England averages, although there are some pockets of deprivation – most notably in parts of Cheshunt, Hatfield, Letchworth, Stevenage and Welwyn Garden City. From 2018 to mid-2021, the Trust saw a consistent reduction in mortality, with rates that were consistently lower than our national peers. While the last eighteen months have seen an upward trend, this has been mirrored nationally, the Trust remains well positioned compared to national peers.

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

Through the Lister, QEII and Hertford County, the Trust provides a wide range of acute inpatient, outpatient, diagnostic, ambulatory and urgent care services – including an emergency department and maternity care – as well as regional and sub-regional services in renal medicine, urology and plastic surgery. Approximately 6,750 staff are employed by the Trust. The Trust's annual turnover is approximately £610.6 million.

Organisational Structure

During the year, the Trust moved to a clinical operational structure of four Divisions consisting of Planned Care; Unplanned Care; Women's and Children; and Cancer. Prior to this the Trust had two operational Divisions: Planned Care, and Unplanned Care.

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

Hertfordshire and West Essex ICS

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

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

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

Strategy overview and objectives

The Trust's Vision is "To be trusted to provide consistently outstanding care and exemplary service".

The Trust has four guiding themes that shape its annual objectives:

- Quality – Consistently deliver quality standards, targeting health inequalities and involving patients in their care
- Thriving People – Support our people to thrive be recruiting and retaining the best, and creating an environment of learning, autonomy and accountability
- Seamless Services – Deliver seamless care for patients through effective collaboration and coordination of services within the Trust and with our partners
- Continuous Improvement – Continuously improve services by adopting good practice, maximising efficiency and productivity and exploiting transformation opportunities.

These themes and objectives are underpinned by our Trust Values: Include, Respect and Improve.

Within the context of this framework, the Trust has concentrated improvement activity upon a number of high impact strategic transformation programmes. Key emphasis has been placed around enhancing the productivity, efficiency and effectiveness of our surgical pathways and outpatient services as well as streamlining and strengthening the processes to support the

delivery of urgent and emergency care pathways. In addition, the Trust has also looked to review and improve the timeliness and effectiveness of its patient complaints processes.

Work did continue as far as possible on the Mount Vernon Cancer Centre (MVCC) Strategic Review, led by NHS England (NHSE). This work is in response to the strategic decision that the future of the MVCC was best served by becoming part of a tertiary cancer centre. University College Hospitals London (UCLH) was selected in January 2020 as the preferred provider by a panel of stakeholders following expressions of interest. Work has continued throughout 2022/23 with UCLH, the Trust, NHSE and key stakeholders, including HealthWatch, to develop a recommended future clinical model for MVCC, which best meets future patient and service needs.

Due diligence assessment has taken place. UCLH put in an Expression of Interest for capital funding as part of the New Hospitals Programme, for the re-provision of the cancer services at the Watford General Hospital site. This also included funding for networked radiotherapy in the north of the MVCC catchment – improving access to radiotherapy for patients in the north of the MVCC catchment areas has been a long-term strategic objective of the Trust. A decision on the capital funding has not yet been made.

The Trust has further invested in expanding its planned service capacity during 2022/23, completing the construction of two new surgical procedures rooms. This has significantly expanded capacity to perform elective operations at the Lister site. In addition, the Trust has now secured funding to support the construction of a new hybrid theatre. Construction will begin in 2023/24 and this will help to boost capacity and quality of services provided through the Hertfordshire and West Essex Vascular Surgery Network.

In addition, the Trust has been able to move forward during 2022/23 with the development and deployment of additional community diagnostic services based at the New QEII hospital and Hertford County Hospital. These expanded facilities will greatly extend access to important diagnostic tests for our patients.

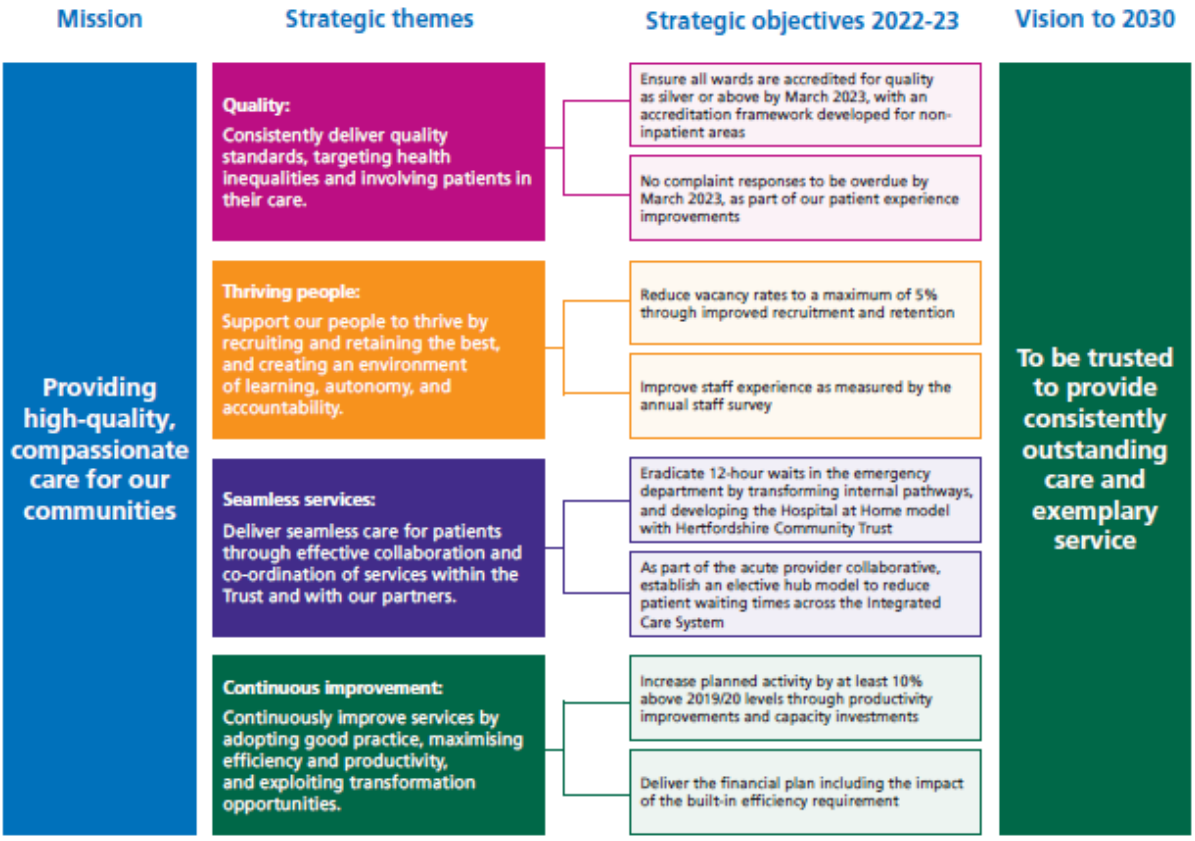
The Trust has continued to work with system partners more locally through the East & North Hertfordshire Integrated Care Partnership (ICP). This reinforces the Trust's commitment to play a leading role in working with our partners to develop integrated pathways of care for our local community and collaborate to find ways to enhance corporate efficiency and reduce back-office costs. The ICP Partnership Board includes representation from our county council, primary care and mental health colleagues, who will together oversee the strategic development of the ICP, informed by input from our people, patients and community. During the course of 2022/23 the Trust has worked closely with its place partners to extend the scope of virtual hospital arrangements and to develop a new heart failure service model.

Strategy and Values refresh

During 2022/23, the Trust undertook an extensive refresh of its strategy, including a bottom-up review of service ambitions and a strategic review of the Trust's vision, mission and strategic objectives. This work will be concluded with the publication of our ten-year Integrated Business Plan. The Trust has also refreshed its values and behaviours following a large engagement programme which now incorporate Include, Respect and Improve. These reflect the spirit for how we intend to work together and with system partners, to deliver our new strategic vision.

Our 2022/23 objectives

The Trust identified eight key objectives for 2022/23 designed to support delivery of our strategic priorities. They were deliberately ambitious and whilst not all were fully achieved, good progress has been made, despite various post-pandemic challenges throughout the year. These are summarised below.



Ward Accreditation

In July 2022 the Trust achieved the prestigious Pathway to Excellence® designation from the American Nurses Credentialing Centre. The Trust was the first Trust within the national cohort of fourteen NHS providers selected by the Chief Nursing Officer for England, to become designated with this internationally recognised programme. Pathways to Excellence embeds three pathways: **Nursing and midwifery excellence** (pathway standards of: shared decision making, leadership, safety, quality, wellbeing, professional development)**; local accreditation and shared decision making.**

The Trust's strategic objective aimed to ensure all wards were accredited for quality as silver or above by March 2023. During 2022/23 we were able to celebrate seven ward accreditations at silver and gold level, with all other inpatient wards continuing to work towards achieving accreditation and focusing on improving compliance with fundamental standards.

Building on these foundations a comprehensive review of the Clinical Excellence Accreditation Framework was undertaken. A revised model for 2023/24 will ensure future assessment processes align more closely with the Trust's current objectives and priorities and are in line with CQC compliance standards. The new accreditation framework will launch from April 2023. Accreditation will be split into two parts, the first part being sustainable achievement of all fundamental standards. To enable wards to monitor their progress with the fundamental standards, a new accreditation dashboard is being developed on the

ENHance platform. Individual wards will not progress to the second 'excellence' part of the accreditation process until all fundamental standards are consistently achieved. Following completion of both parts of the assessment process, an accreditation award level will be agreed. The priority moving forward will be for wards to focus on improving compliance with fundamental standards rather than achieving an accreditation award.

Complaint Responses

In response to the pandemic NHS providers prioritised efforts to support direct clinical care and front-line duties and responsiveness to COVID. For a brief period, extended timeframes for complaint responses were agreed in line with many other NHS organisations, which led to a general deterioration in overall response performance.

As part of a wider Patient Advice and Liaison Service (PALS) and Complaints Improvement Programme the Trust therefore aimed to increase both the timeliness and quality of responses to complainants, in addition to focusing on earlier PALS resolution. A refreshed training and awareness education programme was launched and is ongoing, with an emphasis on early local intervention and resolution of issues as they arise in local wards and department areas. Simultaneously we applied a lean thinking (process improvement) approach to our current way of working. This involved streamlining and standardising complaints pathways and processes making them simpler, by helping staff involved in complaints handling, eliminate all kinds of waste and allowing resources to be used more efficiently.

Whilst the Trust has not yet fully met our target for overdue responses, performance has improved by 52% during the last 12 months. This work will therefore continue into 2023/24 where we will also introduce routine sharing of our learning with complainants in our response letters and undertake regular complainant satisfaction surveys to monitor our ongoing progress.

Vacancy Rates

The Trust benchmarks favourably with national vacancy levels with a baseline 2022/23 position reported as 6.5%. This strategic objective aspired to drive towards a 5% vacancy factor, which would have placed the Trust in upper quartile performance. The Trust programme targeted improvements in both recruitment and retention of staff and focused across three main areas involving the onboarding of new staff, the ongoing socialisation of staff in their career journey and development of a new continuous feedback and review model. Improvements using a lean-based approach have streamlined and simplified processes enabling a seamless journey to support new joiners, with a refreshed offer of specialist support for international staff to smooth their transition to a new country. An improved digital solution allows new recruits to access more easily and rapidly a range of resources to support their recruitment and onboarding process. A range of surveys (joiner, pulse and the annual staff survey) then provide a wealth of material which the People team will use to monitor and demonstrate the impact of the programme.

During 2022/23 the Trust made significant progress and recruited 1270 whole time equivalent (WTE), increasing our substantive workforce by 166 WTE including 154 WTE more registered nurses and midwives. The ability to meet the target was complicated by additional staffing requirements as part of wider NHS national initiatives that increased service demand i.e. the Elective Recovery Programme and a change in the headroom allowance for rota based staff. The Trust vacancy position at the end of March 2022/23 was 9%. The programme itself will run through to July 2023/24 at which stage all programme milestones should be delivered, this includes a trajectory for how we will meet our overall ambition by quarter three 2023/24.

Staff Survey

The Trust's objective was to improve overall experience as measured by the staff survey. To achieve this the Trust focused heavily on staff engagement and morale. In response to the previous year's survey results a 'team talk' framework was designed for teams to explore themes from within their department and jointly design plans for improvement which were presented to the Trust's People Committee with actions taken forward within the divisional accountability structure.

An organisation wide engagement exercise was carried out to develop and design the Trust's new values which were launched in quarter one. This was followed up by the development of team charters for each team aligned to the values and associated behaviours to ensure the values became embedded within all that we do. With a key part of our values being respect, a civility and respect tool kit and development material was shared widely across the organisation. Emphasis was on creating increased psychological safety and encouraging people to speak out about their experiences. To support achieving this, the Trust has expanded its Freedom to Speak Up resources as well as utilising the staff networks, created the 'ask Adam' (Chief Executive) inbox, set up coffee roulette and launched the healthy leadership walk arounds.

Positively the engagement in the staff survey increased by 5%, from 42% to 47% against a national average of 44%. The results overall did not improve but remained broadly in line with national average for most domains except for 'We are always learning' which dropped due to lower uptake of appraisals at the time. There was a positive shift in staff reporting concerns and indicators from the workforce race equality standards did improve for black, Asian and minority ethic staff although more needs to be done to close the relative gap in experience.

Urgent & Emergency Care

To reduce 12 hour waits in the Emergency Department (ED) the Trust worked to improve the internal flow through the department; ensuring patients could be seen in good time with more efficient processes to discharge patients from hospital earlier and safely ensuring access to quality care at home.

This objective was supported by several transformation programmes and partnership working with system partners. The local 'Hospital at Home' (HAH) service which is ran by Hertfordshire Community NHS Trust provides high quality care for patients in the comfort of their own home, allowing patients to recover better and leave hospital earlier, or even avoid being admitted to hospital in the first instance.

HAH colleagues now have access to clinical information about patients who are receiving a response from the ambulance service, but who could be supported at home with rapid in-person medical care and remote monitoring – instead of coming into ED. An initial pilot showed that 66% of contacts were not brought into hospital, with 71 fewer patients needing to come into ED. Remote monitoring and early intervention is also being trialled for patients living with heart failure, as part of a developing integrated heart failure service.

If patients do need to come into the ED, we want to ensure that they receive the care they need in good time, and this year the Trust focused on ambulance handover times. These times reduced by 40% - from an average of 72 minutes in Nov-Dec 2022, to 43 minutes in Jan-Mar 2023.

The Trust's Urgent and Emergency Care improvement programme tested and implemented new ways of working to improve these times, with a new 'pull model' helping to move patients through the department more rapidly.

Finally, the Trust made strides in our discharge programme, aimed at improving the discharge process so that patients can go home earlier in the day, allowing those who require admitting get into a bed more quickly. Significant improvements were made in holding early board and ward rounds, and we are rolling out 'criteria-led' discharge to make further strides in increasing weekend discharges. A pilot in Cardiology showed an improvement from 1.26% to 41% of discharges taking place before 12pm noon.

Elective Hub Model

In 2022/23 the Hertfordshire and West Essex ICS successfully bid for national capital funding to support the development of a system-wide elective surgical hub. Based at St Alban's City Hospital and operated by West Herts Teaching Hospitals, the hub will provide vital surgical capacity for the ICS to recover elective services and keep pace with future demand. Focused on high volume low complexity surgery the hub will deliver ring-fenced elective capacity accessible to the whole system.

ICS partners, including the Trust have established a programme board to support the rapid development of the business case and joint operating model. Approval of the business case is anticipated in early 2023/24 with building work planned to enable the hub to be operational during 2024/25.

Elective Activity Productivity & Efficiency

To meet increased planned activity targets by at least 10% we implemented a range of productivity improvements to support new ways of working and release capacity. This has included the roll-out of patient-initiated follow-up (PIFU) pathways as part of a wider

transformation programme. PIFU empowers patients to take control of their care, providing pre-agreed self-management support and resources, with triggers ensuring patients can still see a specialist sooner than planned if they need to, as well as avoid unnecessary trips to hospital if they have no need to be seen. For patients, this means more choice and flexibility around when they access care. For clinicians, it means fewer appointments of low clinical value, freeing up time to support the patients most in need.

The implementation of PIFU has required new operational and digital processes, with intense operational and clinical engagement, and targeted communication activities to help introduce a new way of working. A total of 6,241 patients have already moved onto these new pathways this year and we anticipate by March 2024 we will record 17,905 patients, representing 4.2% of all outpatient activity. Whilst we have not fully met the national target of 5%, we benchmark with average national performance, and we will continue supporting teams into 2023/24 through robust plans to further increase uptake.

As part of Trust work to increase diagnostic capacity and reduce patient waiting times, we were successful in our bid to become part of the first wave of new Community Diagnostic Centres (CDC). Since the launch of new services within the Queen Elizabeth II hospital in Welwyn Garden City we have delivered 14,000 additional diagnostic examinations. Elective diagnostic waiting lists have been reduced for MRI, ultrasound and ECHO, and new clinical pathways have been developed including non-acute fatty liver disease (Gastro) and Direct Access cardiology pathways (ECHO and Holter).

One of the major challenges we have faced in the first phase of the programme is recruitment of appropriately qualified staff. This has been significantly supported by a very successful international recruitment campaign, and we are delighted to welcome and support our international colleagues to the Trust and this exciting new service. Patient feedback regarding the new CDC has been extremely positive with patients favouring increased availability of evening and weekend appointments to help balance busy family and work commitments.

Improvements within theatres to support our elective recovery focused on the surgical pathway experience for our patients, facilitating safe, efficient care to as many people as possible within the theatre capacity we have available. COVID had a significant impact on our ability to deliver this aim, and 2022/23 has been a year of recovery.

National data covering the first six months of 2022/23 identified the Trust as seventh best performance for elective recovery, and the Trust continues to report upper quartile performance that exceeds national averages for ‘overall’ and ‘in session’ theatre efficiency at 84% and 78% respectively. However, we recognise we have not yet returned to pre-pandemic activity levels, and still have an opportunity to improve our performance to meet the 85% national target for both. Our Surgical Care Programme has worked on all the areas that impact this efficiency (late starts, turnaround times, cancellations, and early finishes) to identify ways of reducing the time wasted and create time for additional patients to be treated. Our average case per list (ACPL) metric is also upper quartile and exceeds peer and national averages and will continue to be our primary focus as part of our elective recovery plan.

The Trust has benefited from the provision of two new procedure rooms this year, built on site at the Lister with another planned in 2023/24 at the Queen Elizabeth II hospital. These facilities provide the opportunity to treat less-complex cases in greater numbers, releasing space in our operating theatres for more complex operations.

We were also very fortunate to receive national funding and install a new Theatre Management System which enables our theatre teams to input and access information more

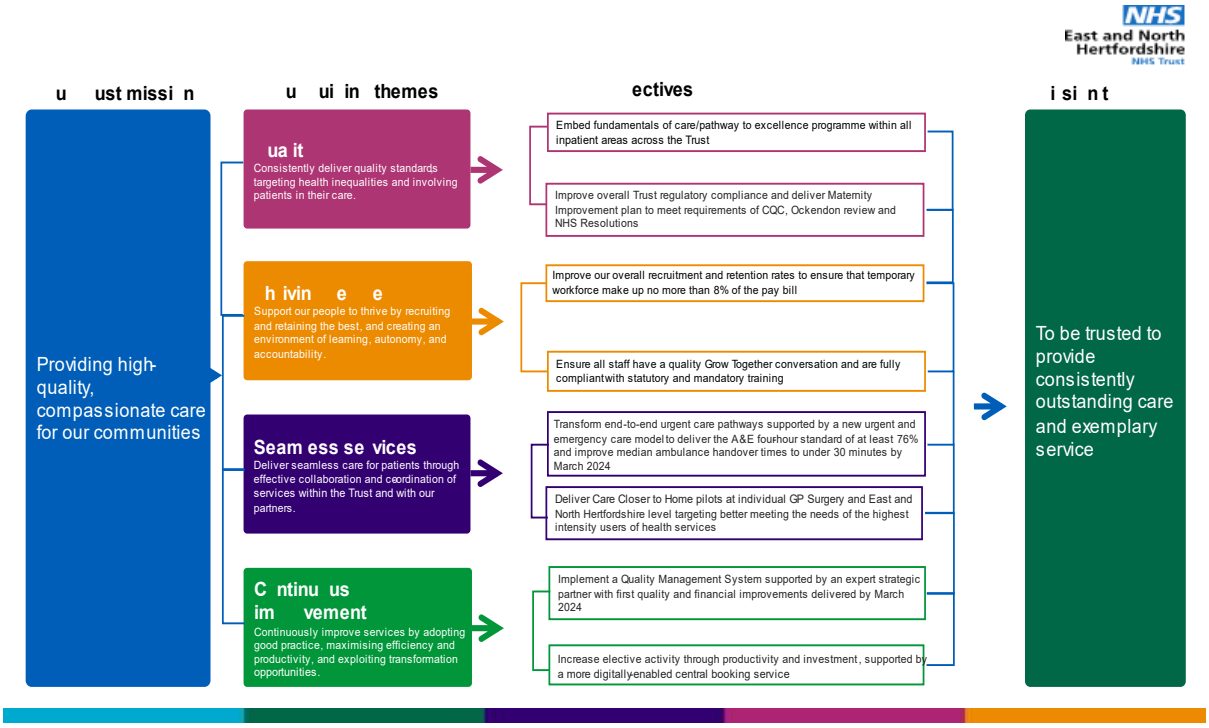
easily across the patient pathway and give us clarity on previous performance and future planning.

The workforce in theatres is crucial for our success, with recruitment a nationwide challenge. This year we have reviewed and redesigned our team structure enabling a greater emphasis on continual professional development and training, so we can grow our own stars and future leaders.

The surgical care and CDC programmes were audited as part of the Trust's internal assurance process in 2022/23 and both were assessed as providing substantial assurance.

Our 2023/24 Objectives

The Trust's 2023/24 strategic priorities build on our successful local recovery from the pandemic last year, expanding our response to urgent and emergency care pathway pressures, and increased national waiting lists and extended wating times for our patients to be seen and treated. We recognise and value our people and will continue to support their health and well-being and provide the best possible environment for our staff so that they are equipped to deliver high-quality, compassionate care.



We will continue to work collaboratively with our partners across the health and care system seeking to innovate, improve and integrate pathways and services for the communities we serve. At the very heart of our plans for 2023/24 is our intent and ambition to start the next stage of our improvement journey, which over the next three years will see us embed a new world class daily management system that drives improvement into every staff members day-to-day work.

Within our quality domain we aim to respond to the CQC findings and wider learning from our maternity review in 2022/23. We want to consistently deliver high quality standards and will continue to work tirelessly on the improvement actions as part of our maternity

improvement plan. This will be supported through a comprehensive programme to improve the fundamentals of care across our clinical areas and introduction of a new pro-active approach to managing and assuring our wider regulatory compliance requirements.

Our ambitions for our thriving people focus on increasing our substantive workforce through improved retention and less reliance on high-cost temporary staffing; this work will also support patient safety through consistency and continuity of care for our patients. This will run alongside our commitment to ensure all managers have a quality Grow Together (appraisal) conversation with their staff as part of everyone's personal development plans.

In response to our commitment to seamless services we will transform our urgent and emergency care pathways and significantly reduce the length of time patients have to wait within our Emergency Department, working alongside community and primary care colleagues to ensure patients are directed and can access the right care, in the right place. This will also involve working collaboratively with partners and Integrated Neighbourhood Teams so that multidisciplinary care is wrapped around patients, closer to their homes.

Finally, within our continuous improvement journey we will start implementation of a new quality management system that will embed improvement as part of everyone's day-to-day job making everyone in our workforce a quality inspector. This work will support how we improve efficiency and productivity within our Theatre and Outpatient areas ensuring we can see more patients, as safely and timely as possible enabling us to address the demands of our increasing waiting lists. We will also seek to optimise digitally enabled services bringing benefits to both our patients and our staff.

It will be another year of change and challenge; our 2023/24 strategic objectives are therefore deliberately stretching and ambitious to meet those expectations and requirements. The objectives also reflect the next steps in our ongoing continuous improvement journey as an organisation and are set against one of the most financially challenging years within the NHS.

Performance Appraisal

As the NHS and the Trust has transitioned into a post pandemic environment during 2022/23 consistent performance against key national access and other operational targets has proved challenging. Over the year the Trust has continued to focus its efforts upon delivering high quality and responsive emergency care services recognising the importance of reducing ambulance and patient waiting times.

The expansion of elective service capacity to respond to waiting time targets has also been a key area of emphasis during 2022/23. The Trust has been able to deliver higher levels of day-case, inpatient elective and outpatient activity in 2022/23 than the previous year. This expansion will be continued into 2023/24, together with a drive to reduce waiting times further in line with national targets.

Performance against cancer treatment targets has continued to be strong during 2022/23.

The key performance headlines from the year are:

Financial performance:

- The financial performance and delivery environment has proved challenging for the Trust during the course of the 2022/23 financial year. The Trust has experienced significant challenges in respect of the delivery of its planned savings programme,

this has combined with a range of other material cost pressures over the course of the year.

- These factors have resulted in the reporting of a deficit financial position at the conclusion of 2022/23. The adjusted deficit performance for the Trust totalled £6.1m.

Operational performance:

- In 2022-23 we welcomed 180,583 patient attendances to our emergency departments, we cared for 50,412 inpatients and saw 590,794 patients in our outpatient settings.
- The focus in 2022-23 has been to return to business as usual following the COVID pandemic and work towards the achievement of elective and non-elective target performance. This includes the development of and delivery against the elective recovery plan, including eradication of patient waits over 104 weeks from referral to treatment. The Trust delivered on time against this metric. There was also a target of eradicating patient waits over 78 weeks by March 2023; this was achieved in all bar three specialties: trauma and orthopedics, gastroenterology and community paediatrics.
- Patient initiated follow up (PIFU) continues to be rolled out throughout the Trust. 12 specialities are now using PIFU and 8 additional specialities went live in April 2023.
- The Trust has continued to underperform against the four hour wait time target from arrival to the Emergency Department to being admitted, discharged or transferred. This is a key Trust objective in 2023/2024 and will remain a focus for the Board.
- There has been a real and sustained improvement in ambulance handover times due to focus of executives, the emergency department, inpatient wards and improved system working.
- Delivery against the cancer targets has continued to remain a priority, with the end of year performance being 83.2% for the Trust against a target of 85% for the 62 day urgent referral to treatment. Further work will be undertaken to ensure this is met in 2023-24 alongside the other seven standards. The Trust focussed well on and reduced the proportion of patients waiting over 62 days.
- Diagnostic waiting times remain a challenge due to increasing demand. Detailed analysis of capacity and demand has been completed. Additional pressure has been experienced due to an increase in cancer referrals and emergency attendances requiring scans.
- Stroke performance nationally is monitored on the calendar year rather than the financial year. The Trust remains at level D against the performance metrics in the national audit. There have been some improvements in the domains of occupational therapy and physiotherapy support, but more work is required and planned on access to a stroke bed within four hours of arrival and access to speech and language therapy in particular.

Quality and safety performance:

- The Trust continued to implement a range of safety and quality interventions in response to the recovery phase of the COVID pandemic. It is recognised that there was a significant risk to the delivery of high-quality care during these periods, particularly an increased risk associated with ongoing high operational activity and management of waiting lists.
- The Trust treated 3387 patients with COVID across April 2022 to March 2023.

- In terms of the Trust's mortality performance over the period, this remained favourable when benchmarked:
    - Summary Hospital-level Mortality Indicator (SHMI) – 0.9074 for the 12 months to December 2022, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stood at 20th out of all acute non-specialist Trusts (121).
    - Hospital Standardised Mortality Ratio (HSMR) – 96.1 for the 12 months to February 2023, which statistically is in the mid-range of Trusts (further information regarding the mortality metrics is provided in the performance analysis section below).
- During 2022-23, the Trust formally declared 63 Serious Incidents (SIs). Three incidents met serious incident 'never event' criteria (compared to five the year before). This number was a reduction on 2021-22 when 147 SIs were declared. However 57 of these 147 were attributable to the hospital onset hospital acquired COVID cases being declared as SIs, which was a new requirement from 2021.
- In 2022/23, 750 formal complaints were received across all services (a slight decrease since 2021/22 where 777 were received). There was also a total of 3499 PALS enquiries received (a slight reduction from 3614 the previous year).
- One MRSA case was reported in 2022/23, this is one more than 2021/22.

People performance:

- Work has continued to fill vacancies and reduce agency and bank spend. By the end of the year the Trust had a 9.1% vacancy overall and achieved a 7.6% vacancy for qualified nursing and midwifery and 6.0% for medical and dental.
- In September 2022 the establishment was adjusted due to an increase in headroom, there was also growth in the overall establishment of 135 whole time equivalent.
- The Trust ended the year with an increase of 55 full time equivalent (FTE) nurses and 8 FTE medical staff.
- Days lost in 2022/23 due to sickness absence were 26% higher than in 2021/22 and the erratic nature of the sickness trend reflects the circulation of COVID at different times of the year.
- On-going work has continued in offering support to staff to remain well and at work.
- Turnover rates have remained steady for most of 2022/23 and began to reduce toward the end of the year and continue to remain higher than pre-pandemic levels.

Statement on adopting Going Concern basis

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

In accordance with IAS 1 (the requirements for presentation, structure and content of financial statements), management has made an assessment of the Trust's ability to continue as a going concern. In making this assessment management has taken into account the Trust's income and expenditure plan for 2023/24, and the current cash position of the Trust. Whilst the Trust does forecast a small deficit of £2.5m, this is set within the context of a balanced financial plan for the Hertfordshire and West Essex ICS, of which it is a part. The system plan is supported by a memorandum of understanding that sets out a framework for financial risk and opportunity management and a joint schedule of work to underpin both system and individual organisation plan delivery.

The Trust's current cash plan for 2023/24 is not reliant on Department of Health and Social Care (DHSC) funding for cash financing with a forecast cash balance of £64.0m at 31st March 2024. The Board concludes there to be no material uncertainty around going concern for the period to 31 July 2024.

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

As directed by the Department of Health and Social Care Group Accounting Manual 2022/23, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future in the public sector. On this basis, the Trust has adopted the going concern basis for preparing the accounts.

Performance Analysis

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

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

Key performance indicators

The Trust's key performance metrics are collated on a monthly basis into an 'integrated performance report', which is reviewed by the Board and a number of its 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 2022/23 objectives can be found in the strategy and objectives sections earlier in the report.

Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'requires improvement'. The Trust is not fully compliant with the registration requirements of the Care Quality Commission. The CQC has not taken enforcement action against the Trust during 2022/23. The following conditions remain on the Trust's registration following the 2019 Inspection:

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

On 4 and 5 October 2022, the CQC carried out an inspection of our maternity services looking only at the safe and well-led key questions. This announced short notice focused inspection was carried out as part of the CQC's national review of maternity services.

The CQC rated our Maternity Service as 'Inadequate' and has served the Trust with a section 29A notice and recommendations on the immediate improvements that must be made within the service.

In its report, the CQC recognised that staff worked well with women in the community to plan services, there was a culture for improvement and innovation, and the team achieved good outcomes for women. However, there were concerns noted around insufficient staffing levels, mandatory training was below the Trust target, equipment needed more regular servicing, and cleanliness standards must improve.

The Trust has participated in other planned reviews by the CQC during 2022/23 relating to the following areas:

- a system Inspection of Hertfordshire local authority children's services by CQC and Ofsted to review Special Educational Needs and Disabilities compliance (SEND). This review rated the services outstanding across the health and social care system. Areas for improvement included the timeliness and quality of some referrals, including the establishing of parental consent by partner agencies; supervision and management oversight of practice in care leavers services and support to enable care leavers to access and understand their health histories.
- Virtual CQC reviews were undertaken through 'direct monitoring approach' workshops, where ease of access, safety and well- led enquiries were undertaken across Medicine, Surgery and Pharmacy services.

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

During 2022/23 the Trust reviewed the quality assurance framework and accountability performance review framework. Actions to improve good governance standards include the review of reporting structures, a review of published analytical data and internal and external peer review for assurance.

In-depth performance review

This section of the annual report sets out in more detail the Trust's performance in 2022/23 in relation to key areas including clinical, operational, financial and workforce performance.

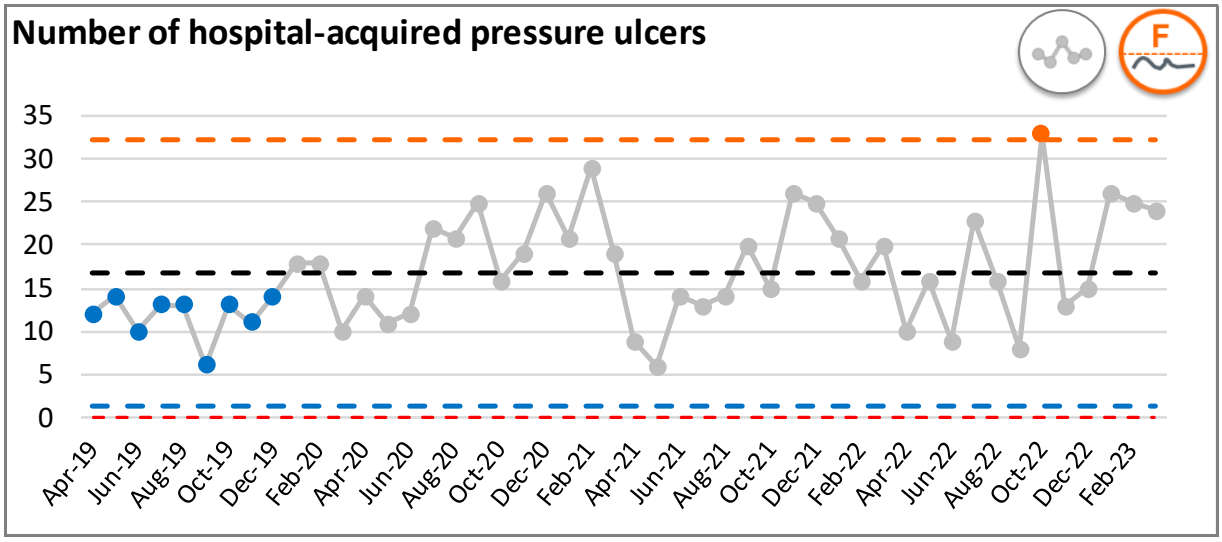
Quality and Safety

The Trust has implemented multiple operational and quality interventions in response to the sustained response and the ongoing management of risk related to recovery phase of the pandemic.

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

1. **Reducing pressure ulcers**

The Trust has reported 210 Hospital Acquired Pressure Ulcers (HAPU) for 2022-23 which is a 2.4% increase on our previous year's data.



Every HAPU is investigated by a Tissue Viability Nurse (TVN) to enable identification of gaps in care so that learning can be identified and improvements delivered. A Root Cause Analysis (RCA) investigation is performed at the time of validation and outcomes are fed back directly to ward staff. Our most prevalent themes are device care (26%) and repositioning (18%).

Progress against the 2022/23 priorities:

1. The reduction of medical device related HAPU within critical care has been sustained as has reduced further from 37 PU per year to 36.
2. Repositioning and skin inspection improvement is ongoing with the recent addition of the assessment to NerveCentre and visual oversight by way of the newly updated (PSSAG) screens within the ward areas. Measurement of improvement is still ongoing.
3. Documentation improvement has been delivered. All Tissue Viability Team documentation was reviewed and updated to be digitised as part of the Keeping Our Patients Safe (KOPS) digital programme. Periodical reviews of content are an ongoing Tissue Viability Team priority

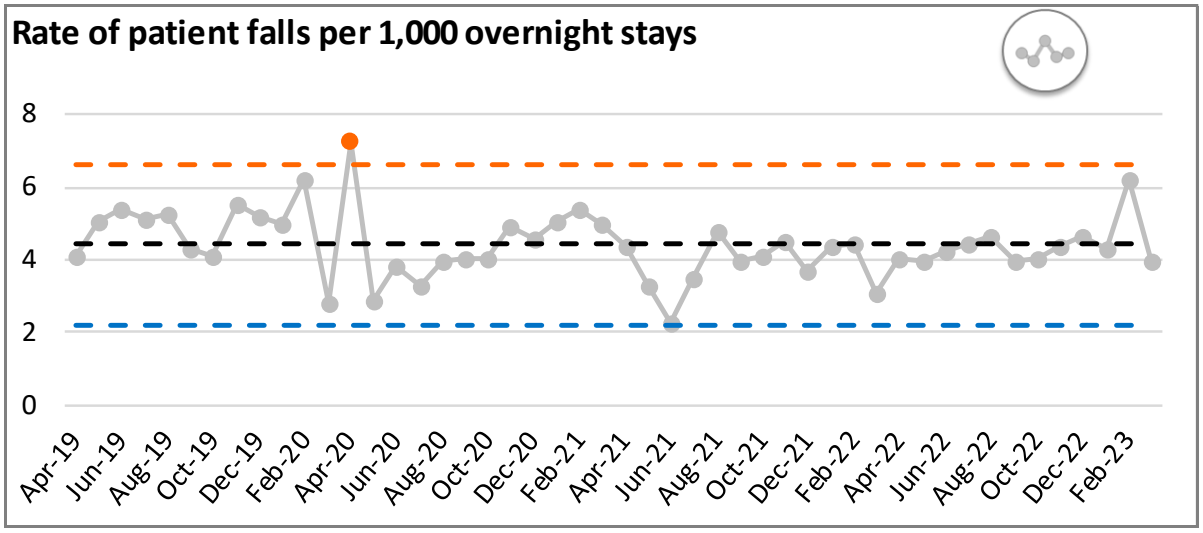
The Tissue Viability Team identified three priorities for improvement work over the coming year:

1. Engage with and deliver improvement alongside the National Commissioning for Quality and Innovation (CQUIN) programme. 2023 sets a target for timely risk assessment and care planning to prevent HAPU in adult inpatients.
2. Implement the new pressure ulcer (PU) clinical pathway and recommendations from the national Wound Care Strategy Programme as advised by NHS England (NHSE). This will include changes to the categorisation of and reporting of some PU and the implementation of a new PU risk assessment tool.
3. Support 10b in their HAPU reduction Quality improvement project as subject matter experts.

We have set a target to reduce our mean reported pressure ulcers from 15 to 10. The above priorities should accomplish this aim.

2. Preventing inpatient falls

In 2022-2023, the Trust has an average falls rate of 4.3 per 1000 bed day, higher than the previous year (3.78). Despite of the increase in falls rate, the Trust is still recording a lower falls rate compared to the national average of 6.6 (NHSE).



In 2022-2023 797 inpatient falls were recorded. This represents an 18.6% increase compared with the previous year. The Trust's occupied bed days has also increase by 4% which has contributed to the increase of inpatient falls incidence. Falls with serious harm is lower this year (16) compared to the previous year (19). Preventing falls with harm remains the Trust's priority.

In the later part of previous year, we have digitised the falls documentation which improves our documentation compliance. This follows an improvement in actioning falls prevention recommendation and gives the ward a better insight on their high falls risk patients with the use of PSAAG screen. We have completed quality improvement in assessment areas on the previous year and will continue to do quality improvement project to support areas with increased incidence of falls.

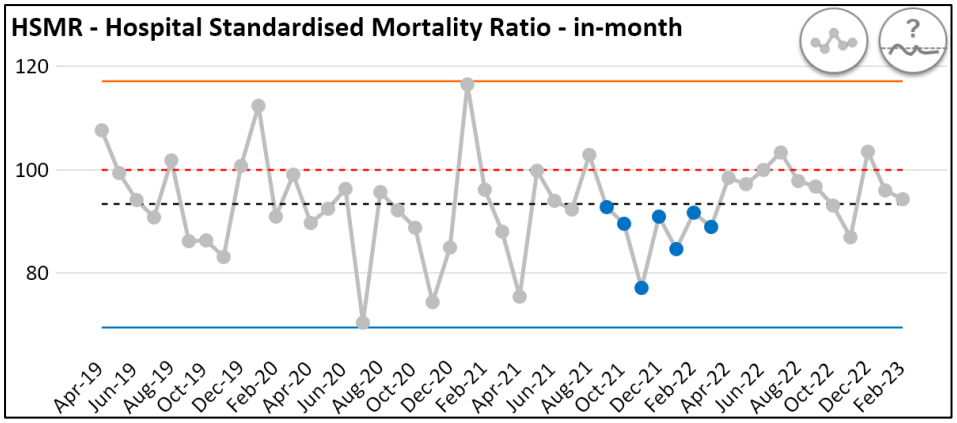
3. Mortality rates and learning from deaths

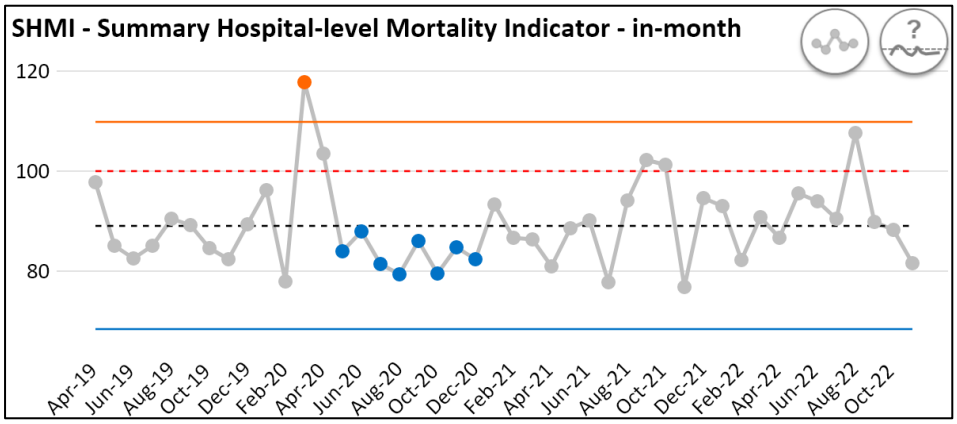
Mortality rates

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

- Hospital Standardised Mortality Ratio (HSMR) – 96.1 for the 12 months to February 2023, which statistically is in the mid-range of Trusts.
- Summary Hospital-level Mortality Indicator (SHMI) – 0.9074 for the 12 months to December 2022, which places the Trust within Band 2, the 'as expected' range. Our position relative to our national peers stood at 20th out of all acute non-specialist Trusts (121).

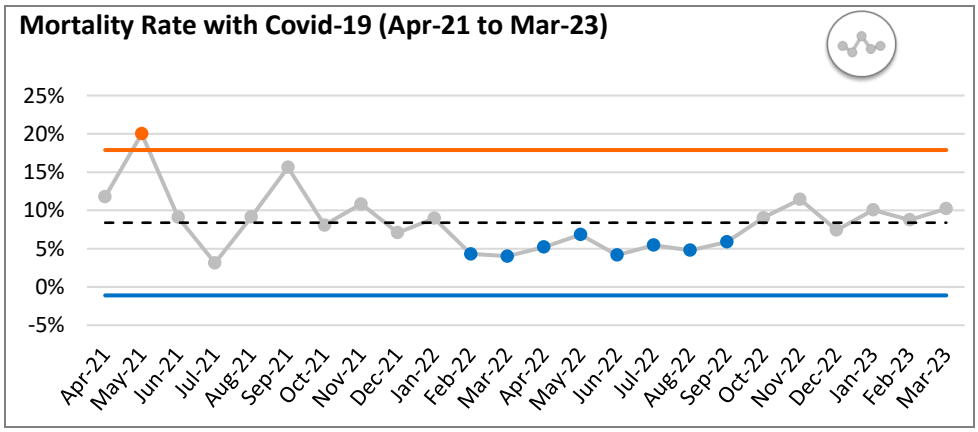
The Trust is committed to continuously seeking ways to strengthen our governance and quality improvement initiatives to support our learning from deaths framework.

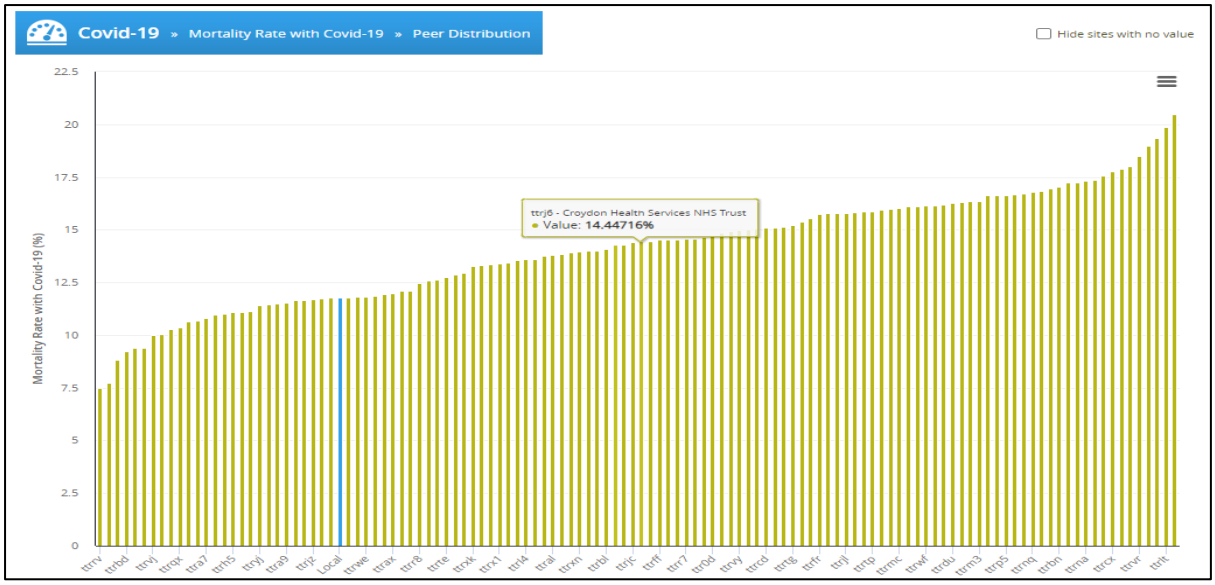




COVID

The multi-layered effects of the COVID pandemic have made meaningful analysis and comparisons regarding mortality data challenging. For example, in-patient numbers and case-mix have varied during the pandemic. The Trust has remained well-placed versus our national peers.





COVID Deaths 1 Apr-22 to 31 Mar-23	Definition
229	Patients who had a positive test or were clinically coded as COVID. These deaths are reported to NHS Digital so underpin our publicly reported mortality rates.
183	Patients who had a laboratory confirmed positive COVID test and died within 28 days of the first positive specimen date. This is the Public Health England national reporting definition.

Learning from deaths

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

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

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

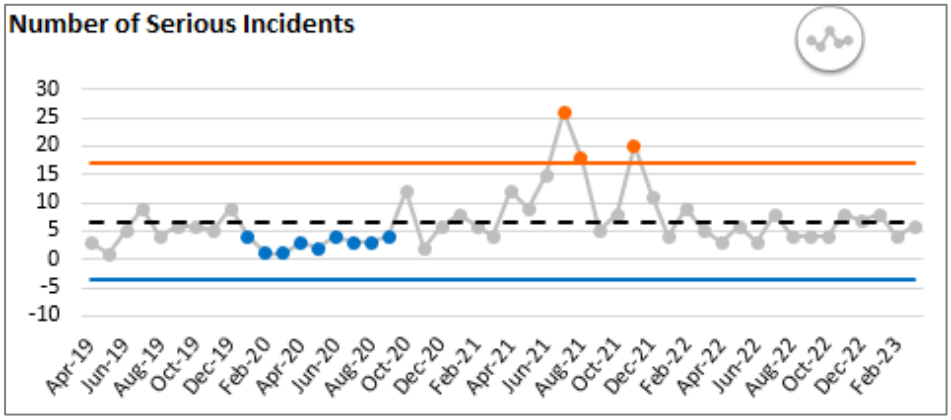
Following a review of our processes work began on a number of reforms aimed at building on the solid mortality review processes already embedded at the Trust.

Central to this work was the adoption in July 2022 of the Structured Judgement Review Plus format for review, developed by the “Better Tomorrow” Future NHS collaborative. This change also necessitated significant changes to peripheral processes, with updates now completed to attendant policies and procedures. Work remains ongoing regarding the adoption of associated reporting tools designed by the NHSE’s Making Data Count team, which align with wider Trust data reporting initiatives.

To provide focus for the ongoing development work, for the first time a Learning from Deaths Strategy has been created covering 2022-2024, assisting in our drive to further improve our learning framework and subsequently the quality of the care we provide.

4. Serious Incidents and Never Events

During 2022-23, the Trust formally declared 63 Serious Incidents (SIs). This number was a reduction on 2021/22 when 147 were declared however 57 of these were attributable to the hospital onset hospital acquired COVID cases being declared as SIs, which was a new requirement from 2021. In 2020-21 the Trust formally declared 55 SIs.



Of the 63 SIs declared in 2022/23, three were Never Events. Never Events are serious, largely preventable patient safety incidents that should not occur if existing national guidance or safety recommendations are in place. All the Never Events were classified as minimum or no harm. All three of the Never Events were cases of wrong site surgery; one in Ears Nose and Throat (ENT) and two in Plastic Surgery.

The Never Events were investigated by a dedicated team of Patient Safety Managers working in collaboration with clinical staff and the divisional quality teams to identify causes and learning. The findings have informed a range of learning and actions:

- Procurement of additional polaroid cameras for use in minor operations department
- Trust-wide communications reminding staff to ensure that the Waba medical image manager application must be used for clinical photographs
- Launch of new training video for all users of the Waba application
- Reminder to staff that the local anaesthetics operations checklist should be completed by two members of the clinical team
- Within Planned Care, a programme of simulation training across theatres in recognition of the Human Factors elements influencing Never Events.

A u t an chi en ’s safe ua i n se vices

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

Safeguarding is most effectively delivered through strategic and organisational multi-agency arrangements with key partners working collaboratively to achieve a shared vision. The Trust safeguarding team, along with the Chief Nurse (as the executive lead for safeguarding) are key members of the Hertfordshire safeguarding boards and partnerships.

Work in 2022/23 included a redesign of our maternity safeguarding processes which was undertaken during quarters 3 and 4. Throughout 2022/23 our safeguarding team led on the development and launch of enhancements to the Trust’s electronic patient records systems (EPR) which includes improved systems for logging and alerting staff to safeguarding risks relating to specific vulnerable service users. The changes were also designed to improve the safeguarding team’s ability to communicate real-time case management instructions directly to various members of the Trust’s patient facing multidisciplinary team.

In January 2023, the Trust employed a Children's Independent Sexual Violence Advisor to support our service user population under the age of 18 who have been victims of sexual assault this advisor works in close conjunction with our existing Independent Sexual Violence Advisor for adults.

The Trusts safeguarding committee through its associated clinical governance processes continues to ensure that learning from various types of safeguarding reviews is incorporated into practice Trust wide. The Trust’s safeguarding team continues to provide staff with direct supervision on case management and support staff in learning and debriefing exercises relating to safeguarding incidents.

Safeguarding caseload activity in the Trust remained above pre-COVID levels during 2022/23 however there has been a slight decrease in activity when compared to 2021/22 which is in keeping with reported activity nationally.

The Trust continues to demonstrate on-going commitment to safeguarding training ensuring all staff receive the required levels of training.

Moving forward into early 2023/24 the Trust safeguarding and education department will continue to work on the development of an electronic validation system for level 3 safeguarding adults training this is to ensure that compliance data is accurately recorded.

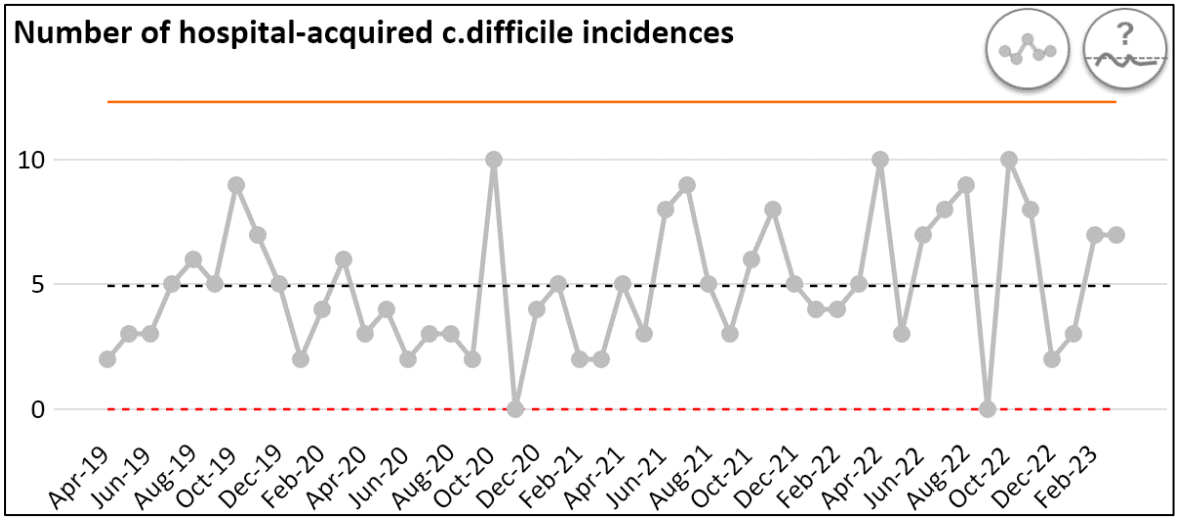
The Trust will be advertising a lead nurse for learning disabilities position to deliver training and to ensure learning from Learning Disability and autistic people (LeDeR) reviews are incorporated into practice.

5. Infection prevention and control

Non-COVID key infection control performance indicators for 2022/23

Month	C.difficile 22-23	MRSA 22-23	MSSA 22-23	Pseudomonas aeruginosa 22-23	E.coli 22-23	Klebsiella 22-23
April	10	0	5	2	4	0
May	3	0	2	1	6	1
June	7	0	4	0	9	2
July	8	1	1	1	6	3
August	9	0	2	0	1	1
September	0	0	4	1	7	2
October	10	0	3	1	3	2
November	7	0	1	2	5	4
December	2	0	2	1	4	1
January	3	0	0	1	3	2
February	7	0	3	2	4	0
March						
	Total	**Total**	**Total**	**Total**	**Total**	**Total**
	66	**1**	**27**	**12**	**52**	**18**
	Threshold number 2022 -2023	**Threshold number 2022 -2023**	**Threshold number 2022 -2023**	**Threshold number 2022 -2023**	**Threshold number 2022 -2023**	**Threshold number 2022 -2023**
	59	**0**	**N/A**	**11**	**46**	**22**

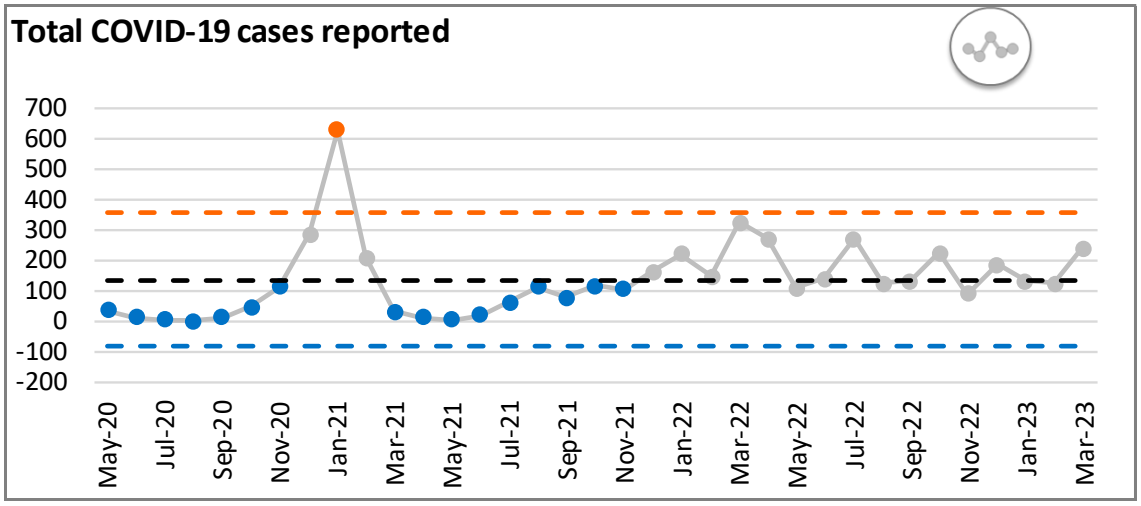
The Trust reported one hospital onset MRSA bacteraemia (blood infections) which is above the threshold of zero (compared to zero in 2021/22). The Trust managed an MRSA colonisation outbreak within the neonatal patient group in September 2022. From 15th November 2022 - 22nd February 2023, no cases of colonisation were identified as part of twice weekly screening.

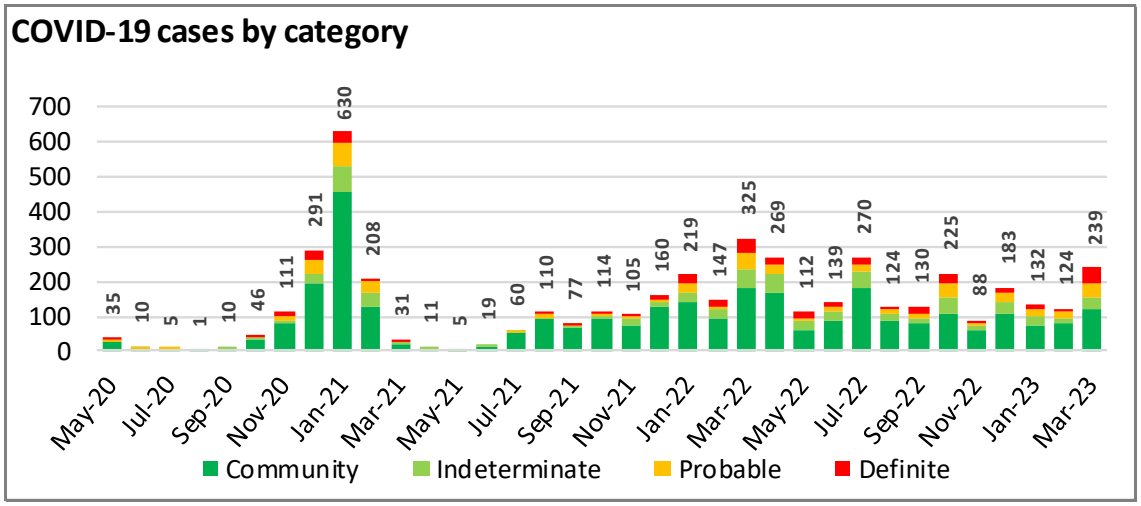


All Clostridioides Difficile cases have undergone review in real time to identify areas for learning and improvement locally in the context of 66 cases against a threshold of 59.

The Trust reported one Influenza A case identified in Feb 2023 which was community acquired. There were no Influenza B (flu) cases.

COVID key infection control performance indicators for 2022/23





The Infection Prevention and Control (IPC) Team continues to review all positive COVID probable and definite healthcare-associated cases, carrying out post-infection reviews (PIRs) to identify any learning and to ensure that recommended actions are implemented. There is also active engagement with wards and department to monitor asymptomatic tests and provide reminders to maintain reporting levels.

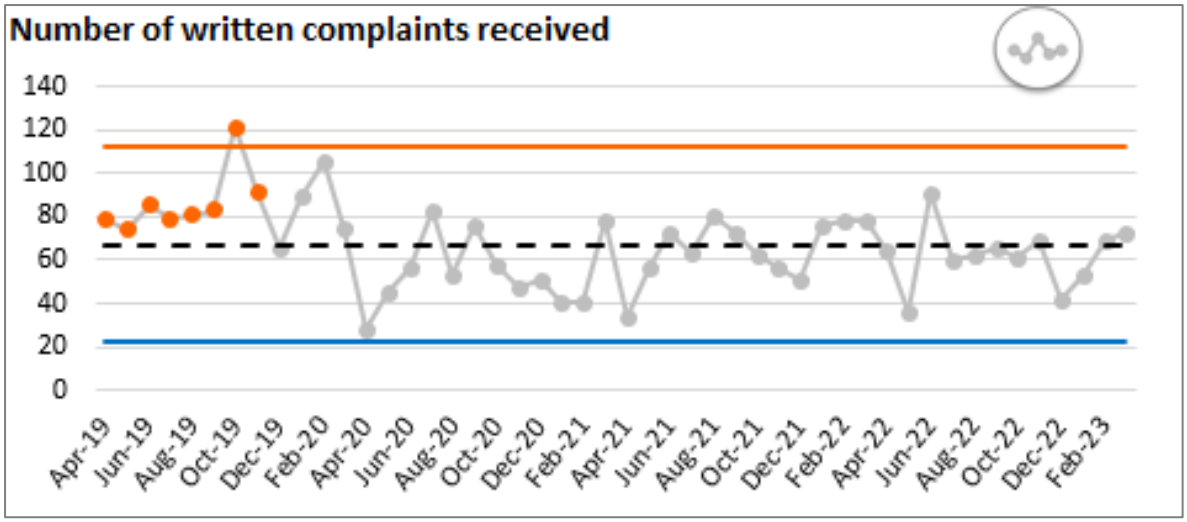
Patient Experience

In 2022/23 22,363 patients responded to our friends and family test (FFT) survey, an improvement on the previous year of 19,733. The Trust's FFT responses for inpatient and day cases are consistently higher than the national average for both the response rate and the proportion of patients who would recommend the Trust to their friends and family.

Throughout 2022/23 the Trust has been working extremely hard to re-establish the network of support that we provide to our carers, ensuring that by taking it back to basics we are able to improve and grow on what we offer.

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

In 2022/23, 750 formal complaints were received across all services (a slight decrease since 2021/22 whereby 777 received). There was also a total of 3499 PALS enquiries received (a slight reduction from 3614 the previous year).



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

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

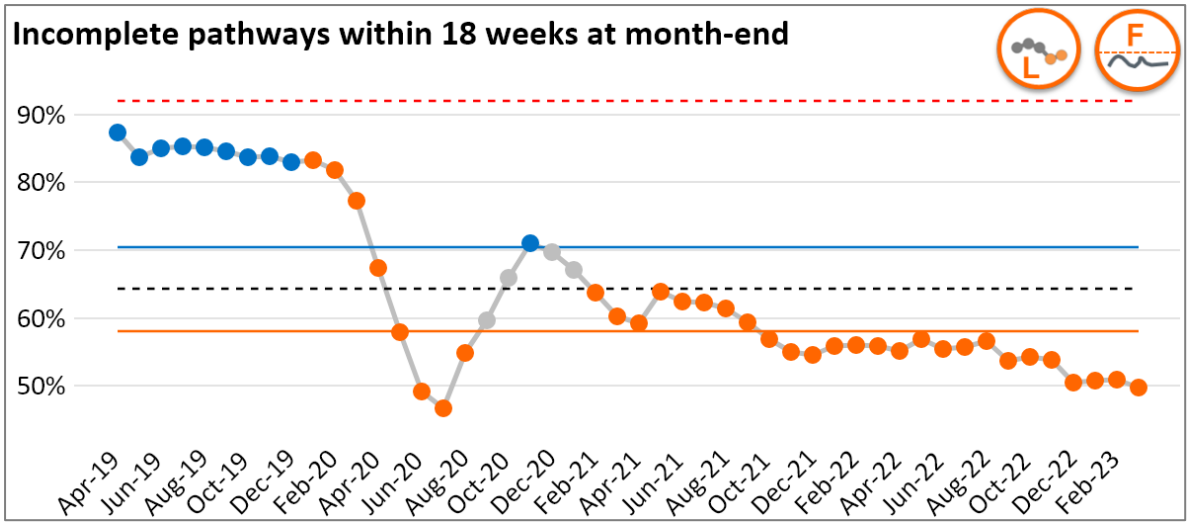
- The Admiral Nurse, a dementia nurse specialist, worked in partnership with carers on a project whose loved ones had spent time as an inpatient. A webpage on the Trust website was co-produced to provide comprehensive information for people with dementia and their carers
- The Trust has been linking in with Hospital Guide volunteers for patient experience improvements (e.g. signage project, wheelchairs, appointment letters)
- Two carer forums were held virtually and face to face for the Trust to hear experiences and learn key areas of improvement
- Establishing patient stories back into the Trust Board meetings
- A Complaints and PALS transformation project. This is aimed at eliminating overdue complaints as per the Trusts' strategic objectives. As a result, the number of overdue complaints has decreased, and the quantity of cases closed within the allocated timeframe has improved. This has been achieved by the streamlining, standardisation, and simplification of the complaint's pathways

Operational Performance

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

18 weeks referral to treatment (RTT)

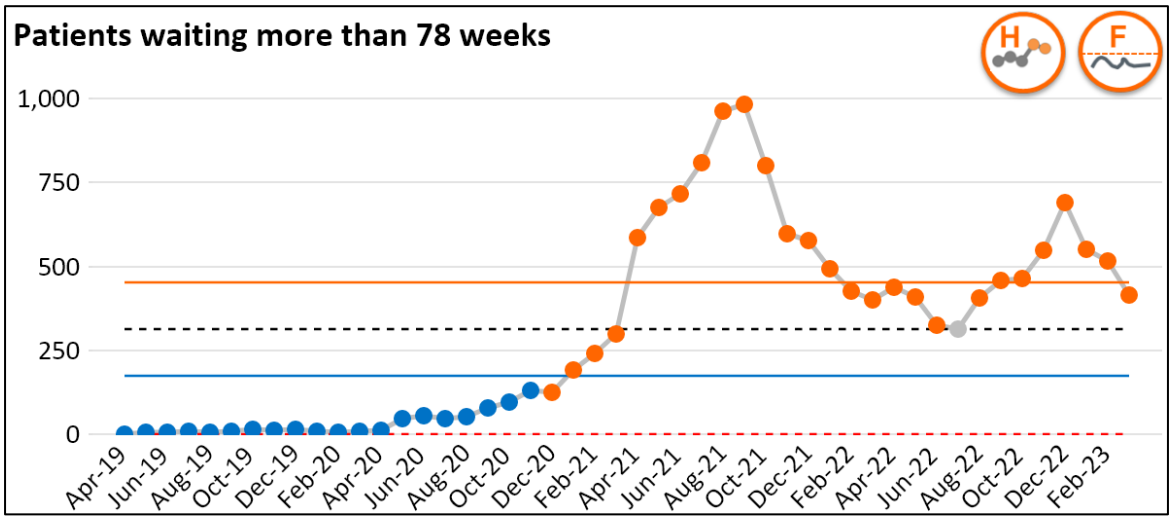
Despite the Trust performing well in the first half of 2022/23, performance dropped in the second half due to medical workforce issues including substantive recruitment and extra contractual pay rate challenges. Progress has now been made on pay rates and the Trust is working on delivery against trajectory as well as substantive recruitment to reduce the need for waiting list initiatives.



The Trust met the target that no patient waits more than 104 weeks for their treatment by the end of June 2023.

The Trust ended the year with 405 patients waiting over 78 weeks against the original trajectory of 554. The majority of the breaches were known capacity challenges in Community Paediatrics, Trauma and Orthopaedics and Gastroenterology. 24 patients were delayed due to patient choice and complexity of the patient pathway.

The number of patients waiting 78+ weeks for an appointment was 0.66% of the total RTT Patient Tracking List.



The three areas which did not meet the 78 week target continue to be monitored weekly, with a trajectory for gastroenterology to be achieved by the end of May 2023 and trauma and orthopaedics by the end of September 2023. Community paediatrics will not achieve the target due to a higher demand for this service than can be provided. Mutual aid has been requested via NHS England and work will continue with system partners and the independent sector to find solutions to meet these children's needs.

The Trust finished the year ahead of trajectory. The focus is now to achieve the 65 week target by March 2024 as well as meet the elective recovery target of 115% new outpatient and inpatient activity episodes against 2019/2020 activity; and a reduction of follow up patients to 75% of 2019/20 activity.

The Trust invited the Elective Intensive Support Team to review its processes and pathways to follow up on the work which was commenced prior to the pandemic. The demand and capacity work which the Trust undertakes was reviewed by the team and the feedback was that this was a very comprehensive piece of work and no actions required to change process.

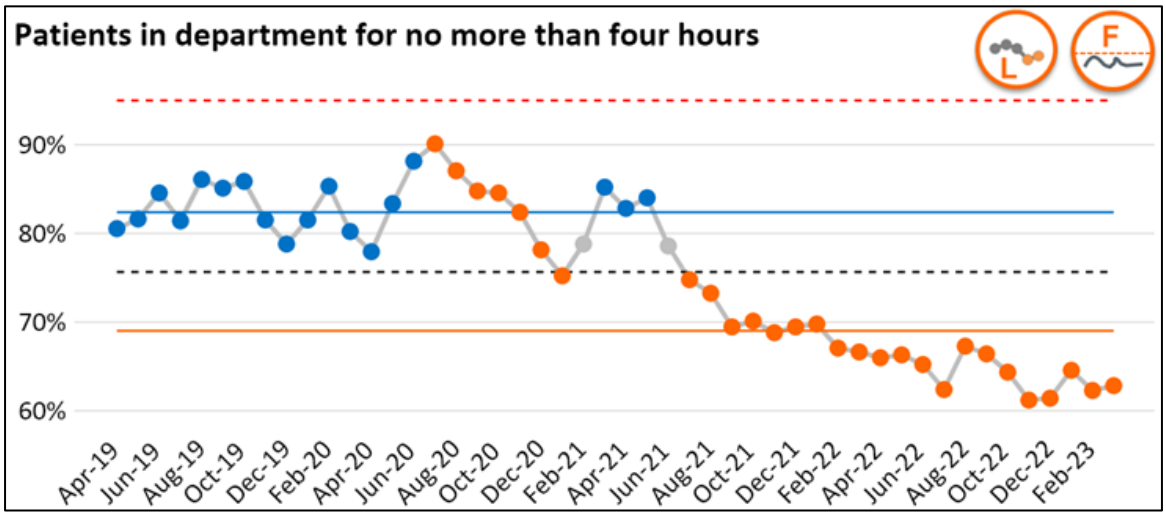
Further work is scheduled to continue with the team in 2023-24.

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

The end of year position saw the Trust achieving 64.2%. The target for 2023/2024 is set at 76% so the Trust has already started a series of actions to work towards achieving and exceeding this to get back towards performance of 95%.

During 2022 the Trust undertook major capital work within its emergency department, both adult and paediatric and the Same Day Emergency Care (SDEC) department. This work while underway prevented expansion of alternative pathways, direct access by GP and ambulances to assessment space and adequate flow of patients to meet their needs and achieve the targets. Better space is now open and will support improved performance. The establishment of the surgical assessment unit and new patient pathways will be a focus for 2023/24.

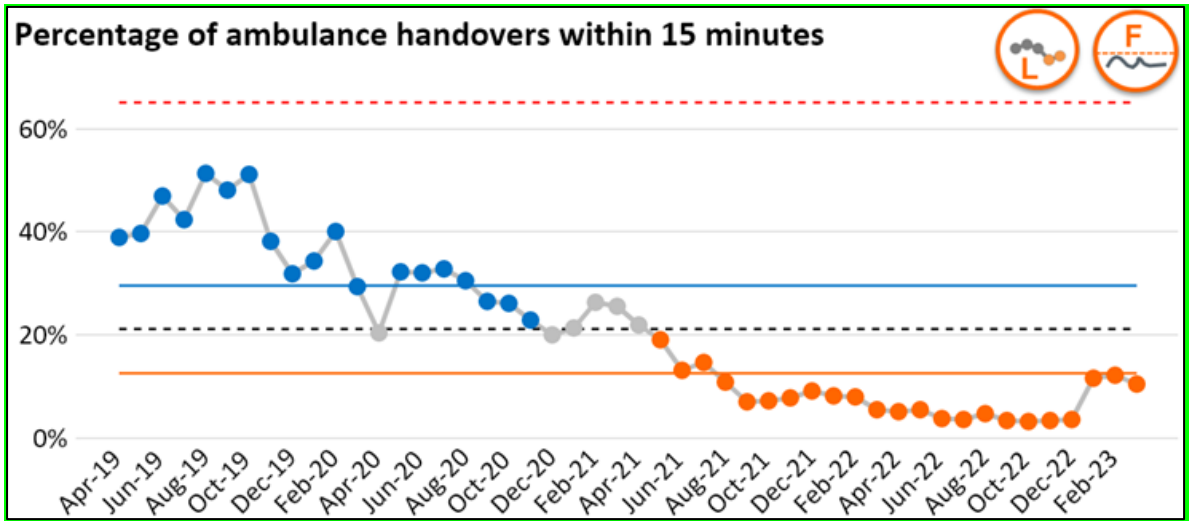
The Trust through comprehensive planning ensured that the department was safely managed during the March 2023 non-consultant medical staff industrial action.



Month	Lister Atts	QEII Atts	TOTAL Atts	TOTAL Breaches	Trust
Apr-22	9307	5419	**14726**	**5013**	**65.96%**
May-22	10288	6119	**16407**	**5519**	**66.36%**
Jun-22	9618	5841	**15459**	**5378**	**65.21%**
Jul-22	9874	5782	**15656**	**5884**	**62.42%**
Aug-22	9022	5610	**14632**	**4785**	**67.30%**
Sep-22	9076	5336	**14412**	**4840**	**66.42%**
Oct-22	9816	5847	**15663**	**5580**	**64.37%**
Nov-22	9771	5636	**15407**	**5974**	**61.23%**
Dec-22	10000	5977	**15977**	**6160**	**61.44%**
Jan-23	8605	5067	**13672**	**4840**	**64.60%**
Feb-23	8492	4793	**13285**	**5004**	**62.33%**
Mar-23	9719	5562	**15281**	**5674**	**62.87%**

Ambulance handover

With the completion of the capital build of the ambulance handover area and the focus on patient offloads and turn around of ambulances, there was a marked improvement in the performance in the last quarter of the year. This was also supported with the 'pull for safety' model which sees Assessment pulling suitable patients from the emergency department to enable both self-presenting patients as well as ambulance arrivals to be seen more promptly. This work will continue to ensure improvements are sustained. The work with system partners is essential to improve the emergency department pathways including prevention of admission, call before convey which enables ambulance crews to call for advice before transporting the patient to the emergency department, direct referrals to Same Day Emergency Care (SDEC) and emergency clinics.



Cancer performance

Cancer performance was not sustained fully over the course of 2022/23. The 62-day cancer target was achieved for four months out of twelve months, and our performance against this standard remains one of the best regionally. Across all the cancer standards, the year-end

position was compliant with three of the eight standards and within 0.5% of achieving a further two standards.

Report Pathway	Performance	Target
Two week wait (2WW) GP Referral to First Outpatient	93.9%	93%
2WW Breast Symptoms - Cancer not initially suspected	92.8%	93%
31 Day Second or Subsequent Treatment - Anti-Cancer Drug	99.7%	98%
31 Day Second or Subsequent Treatment - Surgery	89.8%	94%
31 Day Second or Subsequent Treatment - Radiotherapy	93.6%	94%
31 Day DTT to First Definitive Treatment	96.7%	96%
62 Day Referral to Treatment from Screening	75.4%	90%
62 Day Urgent Referral to Treatment of All Cancers	83.2%	85%

A factor for this underperformance was the high number of 2 week wait referrals putting substantial pressure on the Trust capacity in Endoscopy, Radiology and Histopathology.

Staffing issues in Anaesthetic, radiology and radiotherapy departments caused delays in the cancer pathways; these all have remedial plans in place to improve this in 2023/24.

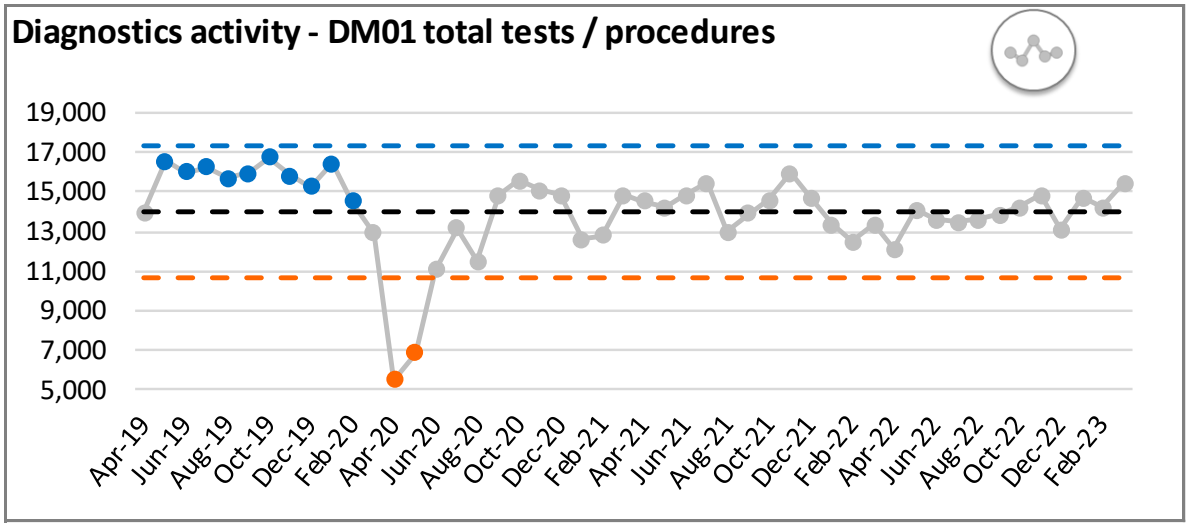
Demand and capacity exercises to confirm what resources and capacity we need to deliver the increased demand and sustain performance have been completed alongside a workforce plan which will include clarity on actual additional staff needed to meet the demand.

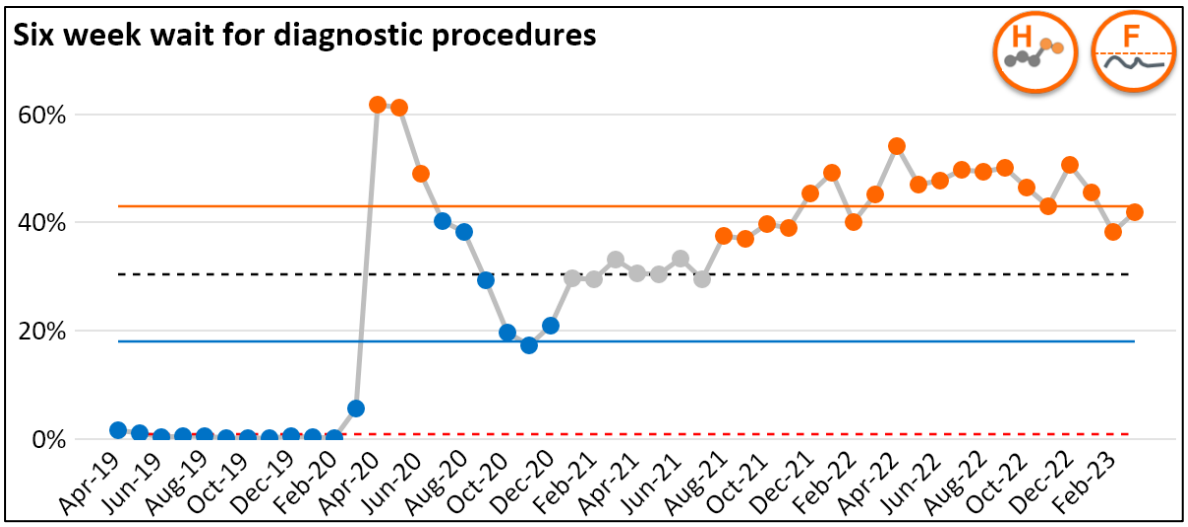
The medical extra contractual pay issue has been largely resolved which supports the additional capacity needed to meet demand.

The Elective Intensive Support Team is supporting pathway analysis for all Tumour Sites so we can clearly identify delays and make changes to improve the pathway. The 2 week wait pathway was flagged by this external team as being a show case for other Trusts due to its grip and control and achievement of the target.

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

As mentioned previously the demand on services has exceeded capacity. The Trust is working with system partners to manage this demand alongside the increase in activity through the community diagnostic hubs.





Stroke performance

The Trust's performance continues at level D despite there being some improvements to some of the domains.

The four hour performance target continued to be a challenge initially due to the requirement for COVID testing prior to bed placement, but in the latter part of the year this is generally due to stroke bed capacity. Further work will take place to protect bed capacity for stroke patients.

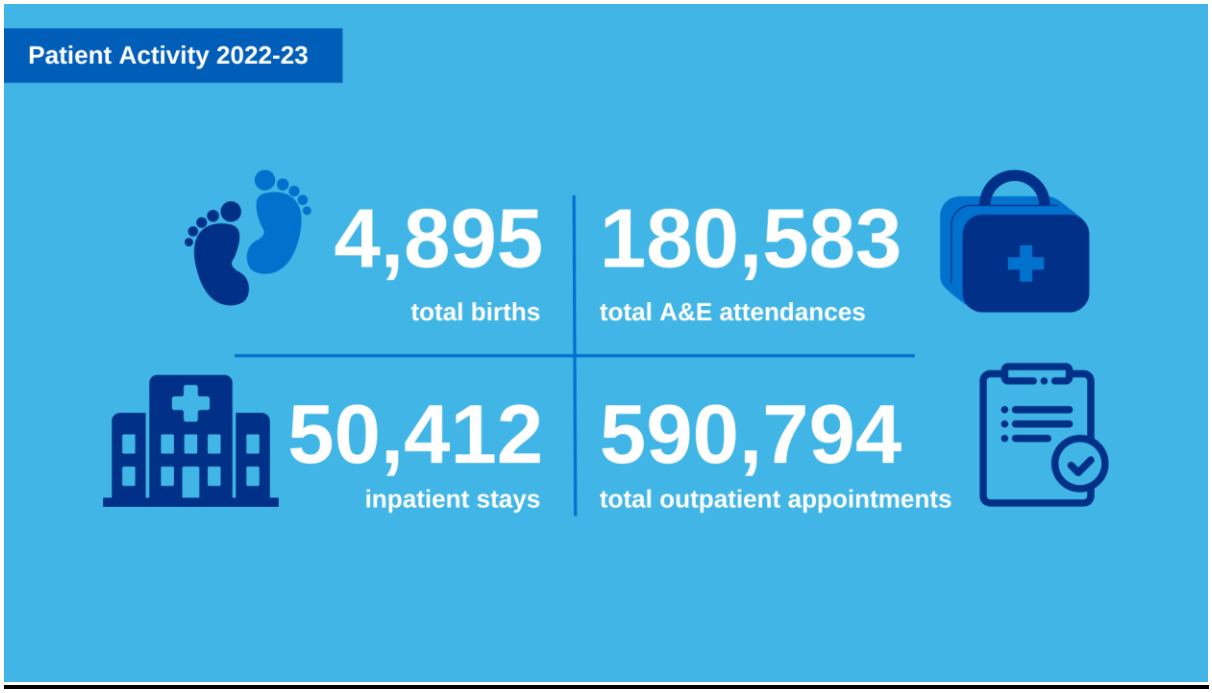
There have been improvements in the provision of both occupational therapists and physiotherapists; recruitment continues as well as reviewing their input and documentation.

Speech and language therapy input continues to be an area of concern and the Trust alongside its system partners are reviewing different models of care and delivery to mitigate staffing shortfalls.

The initial scanning of patients with suspected stroke remains at the highest score meaning that stroke can be diagnosed and appropriate treatment commenced as early as possible.

Thrombolysis remains at level D due to the low number of eligible patients although there has been a change in the clinical guidelines which the Trust has implemented and will be reviewing the impact of. The Trust is also completing a missed opportunity audit and undertaking visits to other stroke units with better performance to develop our learning.

Patient Activity 2022/23:



Financial Performance

The Trust reported a deficit before technical adjustments of £8.5 million. Including technical adjustments, the Trust reported a deficit of £6.1 million against a planned breakeven position.

The Trust's financial performance during 2022/23 needs to be set within the context of the overall NHS funding framework. This year NHS providers have continued to receive fixed block allocations of core funding that were further supplemented by specific additional COVID allocations. This additional supplement was intended to allow the Trust to mitigate against anticipated pandemic impacts, including income shortfalls, compliance with enhanced infection control measures and to support increased levels of staff absences impacting upon operational performance. For the Trust in 2022/23 specific COVID funding totalled £11.7 million. A significant reduction compared with the previous year.

The 2022/23 financial framework also made provision for NHS providers to access additional allocations in order to cover the costs of initiatives to recover the levels of elective activity delivered. This was facilitated through the terms of an Elective Recovery Fund (ERF) mechanism.

The material reduction in COVID income funding received in 2022/23 necessitated the Trust setting a significant cost improvement programme (CIP) for the financial year to remove additional cost levels that had become embedded within expenditure baselines during the

course of the pandemic. The Trust CIP plan for 2022/23 totalled £18.8m. During the course of the year the Trust has reported material delivery slippage against this target, this totalled £6.9m across the year. This has been a defining feature of financial performance for the Trust across 2022/23.

In addition, the Trust has experienced a further range of additional unplanned cost pressures during the course of the year that have supplemented this challenging financial environment. Medical staffing costs have increased significantly across the period, £9.9m (9.5%), reflecting the impact of the national pay award, increased costs to deliver elective activity and also the management of urgent and emergency care pressures.

Furthermore, the Trust has experienced higher levels of inflation and cost in respect of both drug and pathology spend categories and also in relation to utility prices.

In response to the financial deficit position that emerged as the financial year progressed, the Trust designed and implemented a 'financial reset' programme to manage and mitigate cost pressures. This allowed the Trust to stabilise its in-year financial performance and deliver a deficit outturn position that was consistent with requirements to allow the Hertfordshire and West Essex ICS to achieve an overall balanced position.

Further key features of financial performance during 2022/23 were:

- Income from patient care activities

Income from patient care activities increased from £529.9 million in 2021/22 to £566.6 million in 2022/23 (£36.7 million / a 6.9% increase). The overwhelming element of this increase represents the effect of additional allocations to support both the expected cost uplift impact on the Trust for 2022/23 and resources required to deliver key service priorities for the year. The elective recovery fund mechanism remained in place during 2022/23 to incentivise the expanded delivery of planned services. The Trust increased the amount of income earned through this course, rising from £13.6m in 2021/22 to £19.9m in 22/23. Elective performance was especially strong in the first half of the year and tailed off significantly in the final quarter as a consequence of a dispute related to rates of pay for out of hours activity sessions.

- Other income receipts

During the course of the COVID pandemic other income receipts to the Trust were significantly lower as patient and visitor activity was dramatically reduced. An improvement in these levels was reported in 2021/22 and this pattern has continued over the course of 2022/23. Research and Development (R&D) income increased by £0.4m to £6.0m, and private patient income also increased significantly by £1.0m to £4.4m in 2022/23. Furthermore, changes to rules for visitors and improved access to the Trust during 2022/23 has meant increased footfall that has helped to boost both car parking and catering income levels. Whilst other income levels have improved materially compared with 2021/22 it is worth noting that they still remain below pre-pandemic levels.

- COVID pandemic expenses

The Trust continued to incur direct revenue expenditure associated with the pandemic in 2022/23. This expenditure was incurred through enhanced staffing rotas, backfilling staff that had tested COVID positive or were required to self-isolate, expanded bed capacity, the segregation of patient pathways enhanced cleaning and infection control regimes and much more. The Trust received COVID income funding of £11.7m as reimbursement against this

specific pandemic costs. This was a reduction in funding levels of £16.5m compared with the funds received in 2021/22.

- Spend on Pay (including temporary staff)

Pay costs increased year on year by £39.1 million from £347.4 million to £387.1 million. The majority of the increase was driven by national pay awards (£26.9 million) and increased costs (£4.5 million) due to increased activity across the Trust year-on-year, as the Trust responded to the need to deliver significantly increased levels of elective activity. Some of the pay savings schemes that the Trust intended to achieve during the year to mitigate increased pay costs did not deliver to the scale anticipated.

Expenditure on temporary staff increased year on year by £5.0 million from £43.2 million to £48.2 million. Again, a significant element of this increase related to the Trust's need to expand elective recovery activity at speed during the year. In addition, the level of sickness absence across the Trust remains higher than levels experienced before the pandemic.

- Spend on Non-Pay

Expenditure on non-pay (excluding financing costs) decreased year on year by £5.1 million from £224.2 million to £219.1 million. The main reason for the reduction is due to a non-recurrent increase in dilapidations in 2021/22 at a number of properties the Trust leases.

- PPE impact

A major impact of the pandemic has been the increase in the use of personal protective equipment (PPE). From an early stage of the pandemic the Department of Health and Social Care (DHSC) decided that PPE would be purchased centrally and 'pushed' out to healthcare organisations daily on a needs basis. This continued in 2022/23. The Trust was required to account for the cost of this PPE in its accounts, with matching income to offset, thereby meaning a nil effect on the Trust's bottom line in year. The cost of PPE donated to the Trust by the DHSC was £1.3 million.

- Capital investment / donated equipment

The Trust expended £24.5 million on capital investments in 2022/23. Significant investments were made establishing two new surgical procedure rooms on the Lister site to enable an expansion of elective activity delivery, in addition the Trust continued with the refurbishment of its ward-based care environment. Furthermore, significant capital expenditure was incurred in respect of both scheduled medical equipment replacement and also the enhancement of the Trust's digital infrastructure.

- Cash

The Trust's cash balance has decreased by £8.9 million from £84.9 million to £76.0 million. The decrease in cash is primarily a consequence of the reduction in the Trust operating surplus as a consequence of the significant financial challenges and pressures that have been set out above.

- IFRS 16 impact

The implementation of IFRS 16 had a significant impact on the Trust's balance sheet. ROU assets totalling £111.1m were created with corresponding lease liabilities. At 31.03.23 the Trust's ROU asset balance was £108.8m and the lease liability balance was £108.9m.

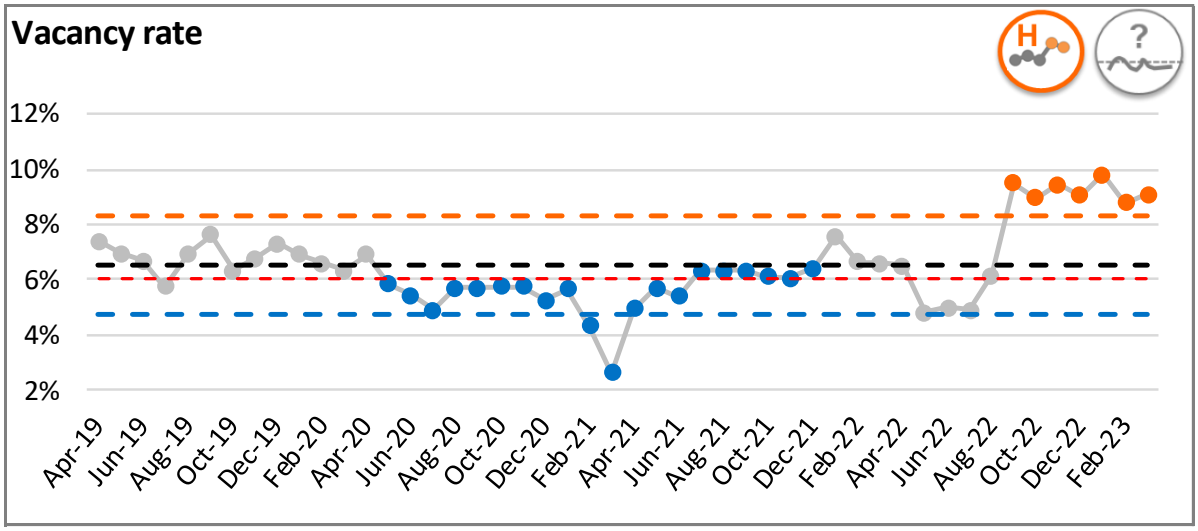
People Performance

The Trust continues to deliver against the key objective set out within its People Strategy and the four pillars of: work, grow, thrive and care, which link to the NHS People Promise.

Work Together

Recruitment

During 2022/23, the Trust worked to recruit to vacancies across all staff-groups and ends the year with an overall vacancy rate of 9.1% (4.1% above our Trust target), with successes in Nursing & Midwifery qualified and Medical staff groups, with a 7.6% and 6% respective vacancy rate, both showing significant progress against the previous year towards our ambition for ‘drive for 5%’ vacancy rate overall.



Over 1,860 qualified staff were in post at the end of March 2023, the highest number of qualified staff in post for 3 years, supported by a very successful overseas recruitment campaign alongside active domestic recruitment activity. The Trust was one of 12 awarded the NHS Pastoral Care Quality Award - recognising our work in international recruitment and commitment to providing high-quality pastoral care to internationally educated nurses and midwives.

Ensuring inclusive recruitment practices remain a key priority for the Trust and through the implementation of our inclusion ambassador scheme we ensure equity and accessibility to roles championing equality, diversity and inclusion throughout the selection process.

Temporary Staffing

Overall demand for temporary staffing reduced by 3% compared to the previous financial year. Bank fill improved by 4% and agency placements reduced by 5% across the year, however, agency spend exceeded the Trust's agency ceiling target by £786k.

Bank spend (as a percentage of total whole time equivalent (WTE) spend) averaged at 9.5% across 2022/23 (consistent with 2021/22 levels) and remained under the Trust's 10% target throughout. Agency spend (as a percentage of total WTE spend) averaged under target for 2021/22 at 3.6%. The Trust ranked first (best-performing) for agency spend across the ICS region for the second year running. Overall bank fill rate performance averaged at 87% across the year.

The Trust hosts a temporary staffing division across the ICS ensuring consistent governance processes and procedures are in place, along with transparent cost controls focusing on all staff-groups. Ambitious work remains underway to mobilise a doctor's shared bank within the ICS hosted by NHS Professionals.

As at Quarter 3 2022/23, the Trust achieved savings of £261,165 under the tri-party contract (alongside West Hertfordshire and Hertfordshire Community Trust) through NHS Professionals managed service compared to the previous standalone contract.

Electronic Rostering

Currently 87% of clinical staff are on the e-roster providing a holistic overview across the organisation and supporting better deployment and decision making.

The Trust procured new medical rostering software and commenced full implementation throughout 2022/23, this resulted in all our junior doctor workforce on a roster with compliance rates of 84%. 90% of our consultant workforce are on eroster and implementation activities continue for remaining medical workforce onto the eroster system. The ambition is both junior and consultant workforce activity fully system based for activity and annual leave management by Quarter 3 2023.

Medical Workforce

The Local Clinical Excellence Awards (CEA) for 2021/22 were deployed as per national guidance and paid in March 2022 to all eligible consultants and a review of CEAs will take place once revised national guidance is issued in 2023/24.

Since December 2021, the medical workforce team retained a 95% success rate for publishing work schedules and rotas on time as contractually required to junior doctors. The variants arising are primarily due to external factors, Health Education England errors or late appointments.

Medical Revalidations and Appraisal continued to be a focus and the Trust averaged 83% for medical appraisals completed in 2022/23.

With the demands on elective recovery increasing, the Trust reviewed its policy guidance and pay-rates to ensure a consistent approach with clear definitions of additional to contract activity and rates of pay are applied. The Waiting List Initiative (WLI) policy refresh was undertaken with extensive input from Clinical, Operational and Finance colleagues and supported by the People Directorate and applies to funded WLI activity. For clarity WLI is defined as additional sessions outside the normal timetable to deliver additional activity and a refreshed WLI policy came into effect at the Trust on 1st November 2022.

Internal Bank Rates for Consultants have also been reflected at the same amount to ensure consistency, although wider pay modelling is underway within the ICS for Trusts to consider a longer term/sustainable model with the pressures of the British Medical Association (BMA) rate card.

Grow together

Clinical and Medical Education

During 2022/23 the Trust has continued its focus on providing an exceptional clinical learning environment for our students and trainees, as well as increasing the numbers of registered staff within the organisation through training.

Educational placement capacity for students remains high with a regular cohort of International nurses undergoing training to register with the Nursing and Midwifery Council (NMC). The Trust has also been able to demonstrate a high clinical examination (OSCE) pass rate in 2022/23, with approximately 75% of international staff achieving their Nursing & Midwifery registration (pin) at the first attempt, and 100% at second resit. This has supported the Trust in successfully reducing the timeframe from nursing staff arriving to being able to work as registrants.

In 2022/23 we saw a continued increase in our Clinical Support Workers undertaking apprenticeships at the Trust (117 in total). A significant number of these staff progress onto the Nurse Associate Programmes leading to qualified nursing routes, with approximately 50 staff accepted onto Nurse degree programmes each year.

The Trust placements for fourth year Cambridge, fifth and final year University College London (UCL) and Cambridge medical students, continues to be rated highly by students, with students regularly requesting to undertake Foundation years at the Trust.

Core Staff training and Development

The Trust continues to develop the use of a single Learning Management System (LMS), the ENH Academy. Essential Training including mandatory training is available on this system, with new non-mandatory online and in person bookable programmes, such as management and personal development skills, being added during 2022/23. Since Go live, over 320 individual courses have been created available to staff on the system. Upgrades to the system planned for the coming year include development of collaborative learning spaces and peer supported learning.

Compliance with mandatory training elements across the Trust has averaged at 86% against a target of 90%.

Talent Management & Leadership Development

Grow Together, our approach to ensuring continuous feedback is provided to colleagues, is fully embedded within the Trust. The process culminates each year with 'Grow Together Review' which is an appraisal being undertaken for all staff within a defined April–August window. Built into this is a system to support talent, career conversations and succession planning which is being further developed for 2023/24.

The Trust's *Healthy Leadership Rhythm* creates a series of required leadership, team and culture initiatives and establishes them as concurrent practices with the delivery of our services. These further enhance our approach to healthy conversations and feedback.

Future workforce

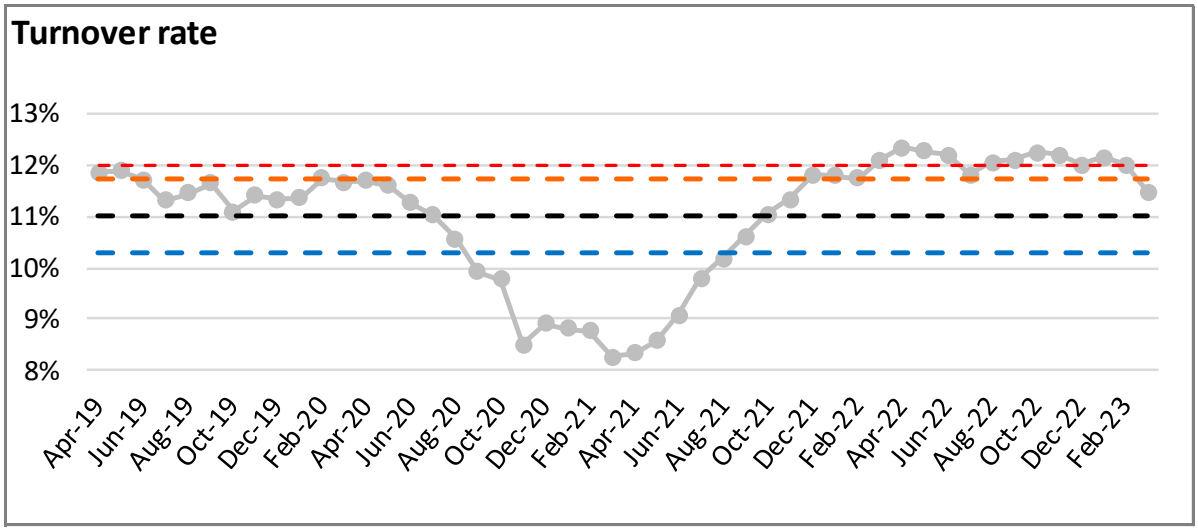
In 2022/23 the Trust had over 281 staff undertaking apprenticeships both in clinical and in non-clinical roles (level 2-7) an increase of over 30 from the previous year, with new apprenticeships offered in Health care science roles, mammography and ophthalmology.

The Trust has been able to offer around 96 work experience placements to young people in and around Hertfordshire since September 2022, as part of its widening participation programme. This includes Trust staff (our ambassadors) visiting schools and colleges to support career events.

Thrive Together

Retention

The overall turnover rate in March 2023 was 11.5% and has remained steady for most of the year having slowed following "the Great Resignation" seen across the NHS during 2021/22. The main reasons for voluntarily leaving is consistent with previous years with 30% of staff stating voluntary resignation (other), Relocation (21%) and Work/life Balance (17%).



Staff survey

We used a different approach in cascading and understanding staff survey results with a programme of Team Talks, followed by action plans, a 'you said, we did' engagement and co-ordinated interventions for identified hot spot areas. This has contributed to the 2022 results completion rate increasing by 5% (42% to 47%), above the national average of 44%.

Inclusion and engagement

A board development programme 'cultural intelligence' happened during the year and our Civility Matters video and team talks have been focused on people's development and understanding to make us more inclusive. Our values refresh also included wide engagement with our workforce and has been further embedded through teams developing their own team and behaviour charters.

There are clear action plans arising from mandated equality reports (WRES/WDES, Gender Pay and EDS2022) and these continue to link to the NHS people promises.

The Trust continued to focus on increased representation in leadership and decision-making roles and the number of colleagues in roles 8a and above has increased marginally with more success in recruitment and promotion for black, Asian and minority ethnic consultants [20] during the year.

The Trust ran its big week of thanks to celebrate the contribution of all our staff with fun engagement and information giving sessions, staff celebration with food and culminated in the staff awards.

Flexible Working

The flexible initial pilot showed a 9% increase in requests being made by susbstantive staff yet the review showed less positivity than expected due to feelings of unfairness and added workload for rota managers. Lessons from the pilot will roll into wider work to continue to build flexible working approaches in the Trust during 2023/24.

Care Together

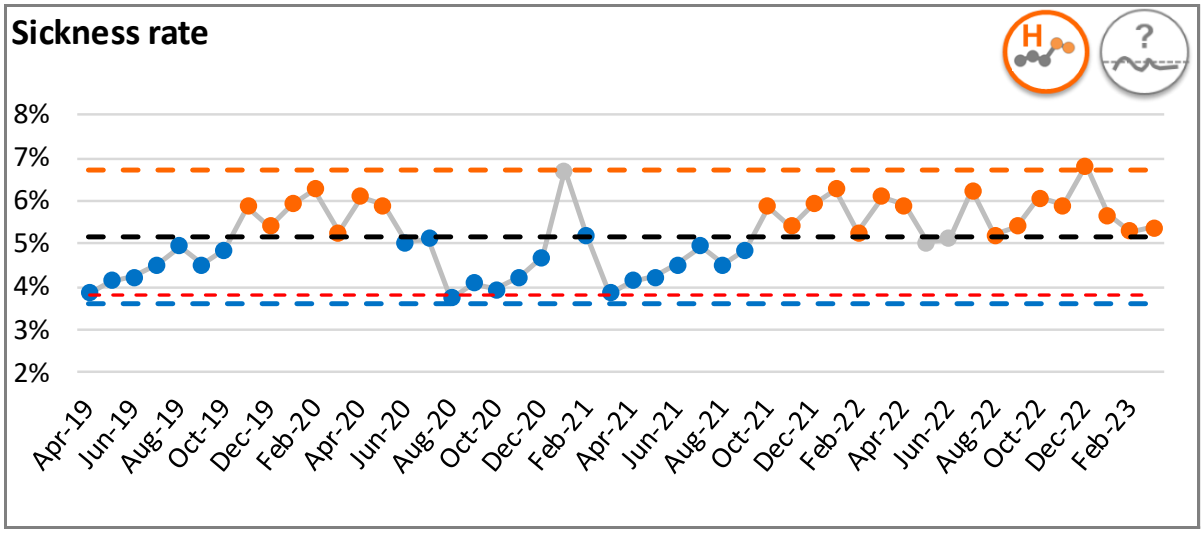
During 2022/23 work continued on health leadership programmes of work with managers and leaders and a focus has been on supporting staff during the increased cost of living

crisis, we made several offers to staff including increasing mileage rates, providing free Blue Light discount cards as well as opening a staff hub shop and running events such as a winter coat and jumper jumble. The services have been well received and are supported by our charity and other donations.

Health at Work

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

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



Wellbeing is promoted by the network of wellbeing champions, mental health first aiders, wellbeing events, webinars and on the intranet. Team and individual reflection sessions have provided regular opportunities for colleagues to explore the emotional aspects of their role, and the menopause network has been a popular new peer support group. Access to information and support is available from the Health at Work advice line, has been enhanced by Enquire, the new virtual assistant giving access to advice 24/7.

East and North Hertfordshire Hospitals Charity

2022/23 was an excellent year for the East and North Hertfordshire Hospitals' Charity thanks to the incredible generosity, kindness and hard work of supporters, volunteers, colleagues and benefactors. As visiting restrictions eased, the charity has successfully returned to pre-pandemic levels of activity. The highlights include: record breaking mass participation events; a new public lottery; multiple staff thank you and celebration events and raising 64% of the income needed to deliver the Sunshine Appeal and create new outside spaces for staff and patients.

Digital performance

The Digital programme during the year had a focus on Optimising existing System to deliver solutions to support Clinicians in delivering safe patient care in our medical wards.

- Digital assessment forms and care plans removed 100 individual forms from the wards, cutting out duplication and enabling clinical information to be readily available on ward rounds and across the Trust.
- Implementing digital consent forms.
- Moving the Venous thromboembolism (VTE) from paper to digital to help manage the tracking of blood clots in patients.
- A new theatre system was implemented to improve the efficiency and management of our theatres.
- New handheld devices have been provided to Doctors and Nurses to allow better access to the Trust systems.

The Trust has now fully joined the Integrated Care System (ICS) shared care record, patient information from the Trust is now being shared with clinicians across the ICS (who has a clinical at another organisation need to access the data). Trust clinicians caring for patients can also access relevant patient information from other ICS healthcare providers.

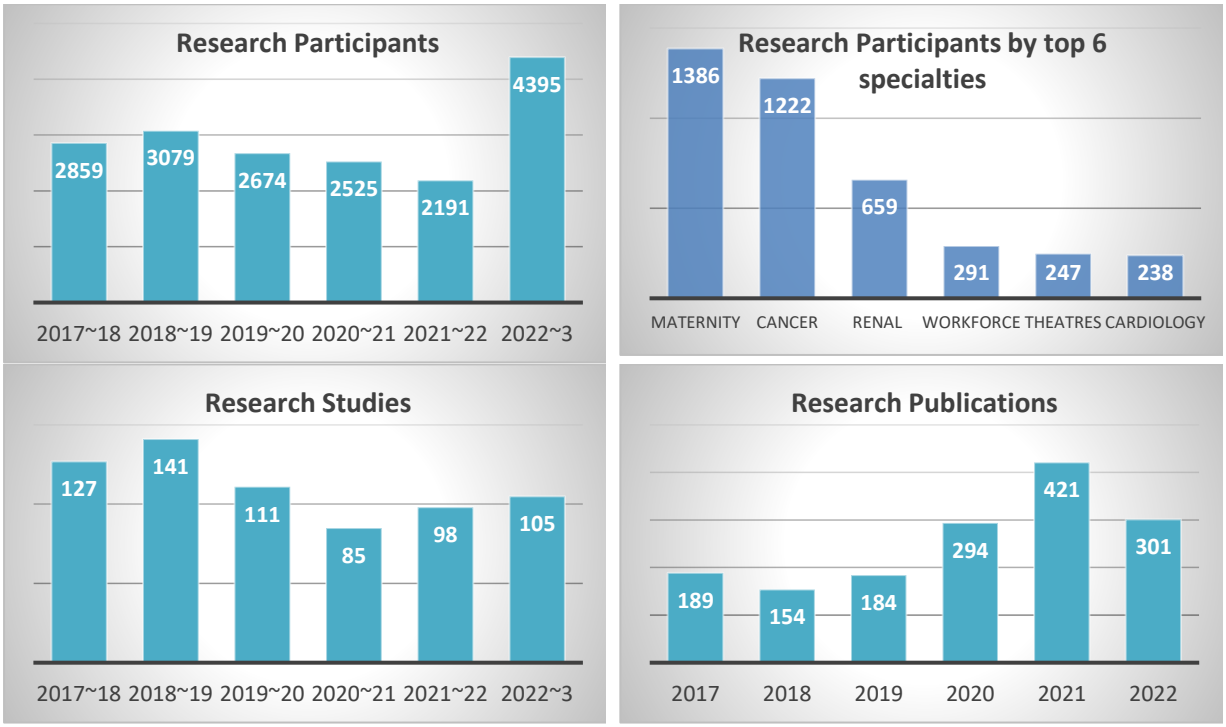
Research and Development

In 2022/23 4,395 patients were recruited to participate in research at the Trust which is an increase from 2191 in the previous year. All research at the Trust is approved by a designated NHS research ethics committee. The more than doubling of research activity has come about due to the embedding of research into service provision.

The Trust is part of the National Institute for Health and Care Research (NIHR) and supports research of national and international importance. We work in partnership with the University of Hertfordshire, the life science industry and non-commercial research funders to enhance patient and experience through research and innovation.

During 2022/23 the top six areas of highest research activity by participation were: maternity (1,386), cancer (1,222), renal (659), organisational research (291), theatres (247) and cardiology (238). Other areas of research included nursing research, robotic surgery, biomarker development and use of data and artificial intelligence.

Research trends over the last six years and top six research areas are given below.



Embedding research into practice for the benefit of patients

The following illustrate the breadth and research we undertake for patient benefit:

- **Routine testing for Group B Streptococcus** (1,362 participants). Sometimes pregnant mothers with GBS can pass this infection to their babies with potentially harmful effects. This research is seeing if a bedside test to detect GBS infection is better than using a risk-based approach without the test.
- **Preventing hospitalizations due to viral infection in infants** (100 participants) This study is looking at how babies can be protected from serious illness due to respiratory syncytial virus by giving them antibodies.
- **Use of Artificial Intelligence to detect prostate cancer** (398 participants). This research is looking to use artificial intelligence to detect prostate cancer from routine scans, enabling faster and more accurate cancer detection.
- **FibroScan assessment and outcomes in a renal dialysis population** (296 participants) The purpose of this study is to gain a better understanding of liver impairment and its relationship with inflammation in dialysis patients. This study involves analysis of some blood tests, a painless ultrasound scan of the liver called a FibroScan and an assessment of the amount of fluid in the body.
- **Magnet4Europe** (291 participants). The Magnet4Europe intervention transfers, changes, scales up, and evaluates an evidence-based model of organizational redesign of clinical work environments to enhance workers' wellbeing, retention and productivity. This is being run at the Lister hospital and supports our nursing workforce colleagues.
- **Perioperative Quality Improvement Programme: Patient Study** (224 participants). This study gathers and analyses patient data to improving perioperative care. It

measures complications after major planned surgery and looks to improve these outcomes through feedback of data to clinicians.

- **Lung Cancer Detection using Blood Exosomes and HRCT** (201 participants). This project aims to decide whether a blood test can detect future lung cancer progression and treatment response.
- **New blood thinner, with lower risk of bleeding, in patients with heart attack and atrial fibrillation**. The cardiology team were the first to recruit and recruited the largest number of patients in the UK into two large trials assessing a new class of blood thinning medication (Factor XI inhibitor) against usual blood thinner (apixaban). The new blood thinner appears to have a lower risk of bleeding, than current medication, with the findings published in the Lancet.

Public involvement and research participation

We continually ask research participants about their experience. During 2022/23 all 91 people who took part in our survey strongly agreed or agreed with the statement "Research staff have always treated me with courtesy and respect". The Trust is leading a programme across the Hertfordshire and West Essex Integrated Care System to develop a more inclusive participation in research.

Social matters

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

Public membership

The Trust currently has 565 public members – people who have expressed an interest in:

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

Over the last year, a quarterly newsletter for members has been developed – Members Update. The newsletter features news from the Trust and our charity, and opportunities to get involved.

Members have also been asked how they would best like to be involved in the Trust – with options from only receiving the newsletter, to filling out surveys and attending project meetings.

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

- Our Trust stakeholder survey
- Patient-led assessments of the care environment (PLACE)
- Our patient and carer experience group
- The Trust's annual general meeting in 2022

Annual General Meeting (AGM) week 2022

The Trust's AGM in 2022 took place once again as a virtual event.

The 2022 AGM can be viewed here on YouTube.

Work with GPs

The Trust continues to deliver a successful GP query helpline, providing a link between primary care and our clinicians – with an average of 100 queries per month.

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

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

Risk Profile

As of 31 March 2023, the Trust had 11 principal risks defined on the Board Assurance Framework (BAF) (set out below) each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified. The BAF sets out the principal risks identified by the Board to delivering the Trust's strategy. In 2022, the Board carried out an in-depth review of the risks on the BAF. In particular, workforce and culture were identified as an emerging key risk area, in the context of the legacy of COVID.

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.	**Workforce requirements**	Quality & Safety
2.	**Population/stakeholder expectations**	Quality & Safety
3.	**Financial constraints**	Finance, Performance & Planning
Strategic priority 2: Support our people to thrive by recruiting and retaining the best, and creating an environment of learning, autonomy, and accountability		
4.	**Workforce shortages and skills mix**	People
5.	**Culture, leadership and engagement**	People
Strategic priority 3: Deliver seamless care for patients through effective collaboration and co-ordination of services within the Trust and with our partners		
7.	**Immature place and system collaborative processes and culture**	Finance, Performance & Planning
8.	**Improving performance and flow**	Finance, Performance & Planning
9.	**Trust and system financial flows and efficiency**	Finance, Performance & Planning
Strategic priority 4: Continuously improve services by adopting good practice, maximising efficiency and productivity, and exploiting transformation opportunities		

10.	**Technology, systems and processes to support change**	Quality & Safety
11.	**Enabling Innovation**	People
12.	**Clinical engagement with change**	Quality & Safety

Over the course of the 2022-23 BAF year, six risks have not seen their score change.

Seven risks of the 11 risks were red-rated (scoring 15 and above) during the last year. Four risks remain red-rated at the end of the year. Risk 7 (performance and flow) started scored 12 and increased and has stayed at 16. Risk 3 (financial constraints) started at 16 and increased to 20, which is the only risk rated as high as 20 on the BAF. Risk 5 (Culture, leadership and engagement) and Risk 7 (Immature place and system collaborative processes and culture) were scored 16 a year ago and remain scored 16. Three red-rated risks reduced risk scores to an amber rating through effective mitigation work (Risk 9 financial flows; Risk 11 enabling innovation; Risk 12 clinical engagement).

The Board and its committees receive regular reports on BAF risks to assure that the mitigations are operating (where this is within the Trust's ability to do so) and that those mitigations are effective or further actions are identified. In addition, the Audit and Risk Committee monitors progress and the efficacy of the BAF.

Statements Relating To Social Matters

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

Respect for human rights and anti-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 June 2020. The policy is due for review in June 2023.

At the time of writing, the Trust is anticipating reporting an overall outcome of green for the 2022/23 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.

TIAA 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 Director of Finance, as the Trust's Accountable Officer for fraud.

Equality of service delivery

The Trust is committed to ensuring equality of service delivery throughout the organisation and to ensuring the Public Sector Equality Duty (PSED) is fulfilled more broadly. We are committed to provide a comprehensive service to all irrespective of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.

The Public Sector Equality Duty (PSED) main aims and objectives are:

I. To eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.
II. To advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
III. To foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The Trust Board agreed to merge the Equality and Inclusion Committee (EIC) with the new People Committee in May 2022, having responsibility for both people (staff) matters and equality and inclusion to ensure a co-ordinated approach. Additionally, the Kings Fund supported a Trust Board development session regarding equality and diversity in March 2022.

The Trust engaged with colleagues from national, regional and system partners to address inequalities and eliminate discrimination, recognising the importance of partnership working and collaboration to advance the equity and inclusion agenda.

The Trust continued to review its policies and procedures as well as mark and celebrate diversity. Trust services aspire to improve, prevent, diagnose, and treat both physical and

mental health problems with equitable regard. Furthermore, wider social duty to promote equality through the services and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.

Initial analysis of the patient treatment lists undertaken in the year indicated that the ethnicity of patients on the list mirrored that of the local population. This will be re-checked regularly.

The Trust is in the process of producing new Equity and Inclusion Strategy and established more robust mechanisms and use of data to monitor and measure performance of our key objectives in relation to action plans derived from the Workforce Disability Equality Standard, Workforce Race Equality Standard, Gender Pay Gap, and new Equality Delivery System (EDS2022).

The Trust has established an internal inclusion ambassadors' scheme that aims to foster diversity and representation within the Trust at all staff levels. The Trust endeavours to achieve a just and restorative culture, paying particular attention to growing compassion in the workplace, modelled by leaders. As part of this approach the Trust works with partners such as local union representatives, the Freedom to Speak Up Guardian, employee engagement leads, and health and wellbeing leads and staff network chairs and leads.

Sustainability statement

Sustainability: One year on.

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

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

One year on the Trust continues to work towards the NHS Long Term plan of achieving Net Zero by 2040, through embedding sustainability at the heart of decision making across the Trust. A key project within this work is the commencement of the Trust's decarbonisation strategy which will outline a roadmap for the Trust to follow and ultimately operate a Net Zero estate through structural fabric improvements, installing low carbon heating sources and explore future carbon offset initiatives.

In addition to the decarbonisation strategy, work is well underway to ensure the eight key focus areas within the plan are being progressed through individual workstreams.

These eight workstreams are listed below:

Each workstream has a developing team of responsible members of staff that are key to driving forward actions and ensuring that the workstream delivers on its aims and objectives. Updates from these workstreams are monitored via the Trust Sustainability Board. Five out of the eight workstreams have nominated leads, however three do not.

The complexity of attempting to deliver a 16-year, multi-work stream, unfunded programme underpinned by a 3-year strategy (the Green Plan) should not be underestimated. Achieving Net Carbon Zero is the most significant non-clinical policy agenda in the NHS, and the policy and protocols are developing and evolving alongside expected delivery. There are significant opportunities and challenges associated with delivering the Green Plan, despite it being a strategy in its infancy.

What we have done already?

Corporate approach

- Develop eight individual workstreams which underpin the Trust Green Plan
- Appoint a Net Zero board lead
- Create a Sustainability Board meeting
- Carbon footprint monitoring; initiated assessing, measuring and recording carbon footprint

Our People

- Carbon Literacy training – attended by sustainability leads; cascade training is planned for 2023
- A Green Ambassadors Network established (30 members) with Trust-wide representation which is open to all staff who are interested in enhancing sustainability across the Trust
- A staff inductions training programme – with a sustainability section in development, rolled out is planned for May 2023
- A Sustainability Communication Lead – supporting monthly communications

Sustainable care models

- An inhaler usage reduction project (high steroid usage and metered dose inhalers) - Glaxo Smith Kline and Trust clinicians initiated
- A reusable theatre hats/caps project being led by the Anaesthetic Team
- A reusable PPE project being led by Mount Vernon and the Trust's clinical team
- Nitrous Oxide reduction demand and capacity in progress
- Desflurane anaesthetic gas removed from both Lister and Mount Vernon sites
- Hospital@Home modelling and assessment made using the Sustainability in Quality Improvement (SusQI) framework. Opportunities identified show reduced carbon impact and cost savings

Travel and logistics

- Electric vehicle charging points have been fully commissioned with a go-live date end of March 2023
- Electric internal fleet conversion – rolling renewal programme is underway with eight electric vehicles due onsite by May 2023
- Sustainable Transport and Travel workstream collaboration between the Trust and Stevenage Borough Council has commenced

Estates & Facilities

- Energy Manager appointment
- Decarbonisation Strategy in development (published May 2023)
- A consolidated utility tracker, enabling control and measurement of energy usage at the Lister site
- Building Management System (BMS) internal upgrade carried out to improve controllability of mechanical and electrical equipment
- Sub-metering installation site-wide commenced
- LED lighting survey

Climate change adaptation

- Emergency Planning Core Standards in 2019 – fully compliant

Greenspace and biodiversity

- Mount Vernon appointment of a new Nature Recovery Ranger

- Mount Vernon launched ‘Space to Breathe’ map identifying ancient woodland, wildflower meadow and wildlife ponds
- Hertfordshire County Council and the Trust supported the Green Space and Biodiversity think tank, hosted by the Trust. A key focus is progressing a clean air initiative trial in 2023
- The Trust mapped the Green Space across the Lister Hospital to create a ‘Green Space’ baseline so further creation can be recorded and help improve our external spaces for staff

Procurement

- This is at the early stages of development, being led by the Integrated Care System (ICS)

Estates compliance

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

Carbon emissions and waste reporting

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

A number of influencing factors contribute towards our overall footprint. A key impact over the last five years has been the general increase in clinical activity with both Emergency Department and patient admissions. This has an impact throughout the Trust increasing the use of utilities, equipment and travel. As previously mentioned, the Trust has taken a major step towards taking action against climate change with the development of our decarbonisation strategy. This provides the Trust with a clear plan of action in how to achieve Net Zero by 2040.

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:

- The Sustainable Development Unit’s ‘Sustainability Reporting Framework Template’
- Greener NHS Data Collection
- NHS Estates Net Zero Carbon Delivery Plan

NHS England has indicated that from 2023 stricter reporting and greater scrutiny will be expected from Trusts. Rather than report flat data (as previously done), there is now a need to evidence and triangulate actions taken and their associated impacts.

The Trust’s Energy Manager has started to consolidate and request data flows from various departments to ensure it captures the necessary data to complete the table below. These data flows are currently being used to produce a summary ‘master’ spreadsheet that will provide a more accurate carbon footprint oversight.

To convert the various data flows into the respective carbon emissions, the current energy manager uses the latest UK Government Green House Gas (GHG) reporting conversion

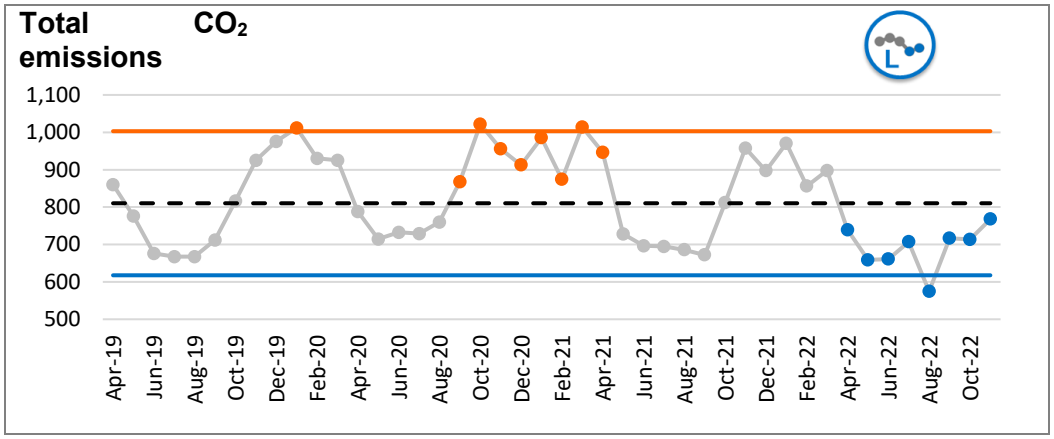
factors. The GHG conversion factors will vary depending on the data flow for example electricity (in 2023) equates to 0.207 kg CO_2e for every 1 kWh consumed and gas equates to 0.182 kg CO_2e for every 1 kWh. As the NHS guidance reports in tonnes a further conversion is made within the data from kg CO_2e to $tC0_2e$. These data flows are received monthly and automatically uploaded into the 'master' spreadsheet to ensure the overall carbon footprint of ENHT is continually monitored and reviewed. When reporting on historical data to review progress against targets from previous year's, the energy manger uses the respective conversion factor from that given year. This is essential to confirm that progress is monitored accurately.

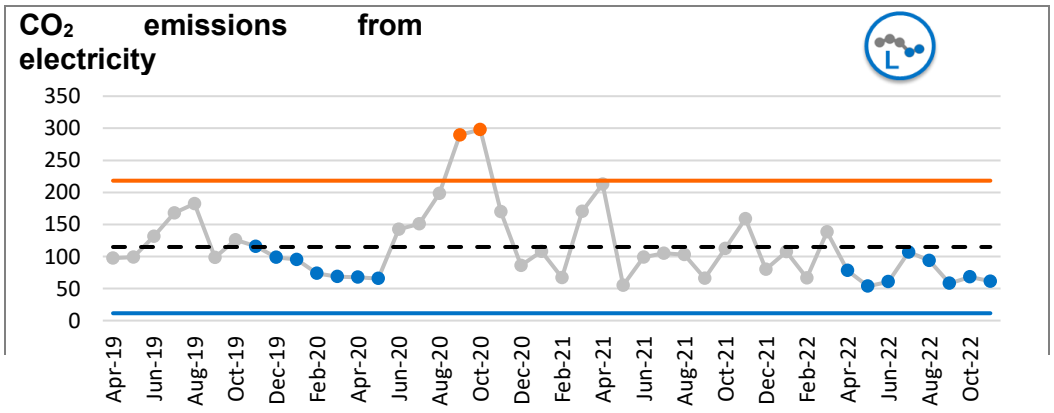
The scope of the ENHT carbon footprint is aligned with the NHS Carbon Footprint (seen in the table below) which is outlined within the 'Delivering a 'Net Zero' National Health Service report'. The sustainability team is currently working on increasing this scope to cover the NHS Carbon Footprint Plus which focuses more on the Scope 3 emissions of staff commuting, patient visitor travel, food, and catering, amongst others.

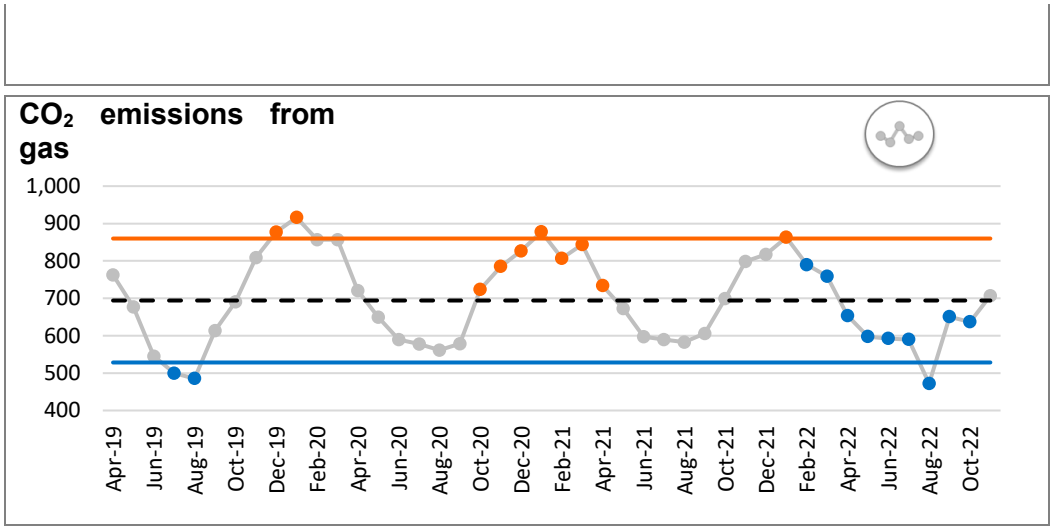
Carbon footprint for the Trust (Lister Hospital and all satellite sites) 2022-23

NHS Carbon Footprint	**6,355**	**tCO_2e**
Building Energy	5,643	tCO_2e
Waste	570	tCO_2e
Water		
Anaesthetic gases		
Inhalers		
Business travel and fleet	142	tCO_2e

Once the data flows are established, these will be feed into a Carbon Footprint Dashboard as seen below. Being able to analyse trends within these data flows can be invaluable in implementing targeted carbon efficiency projects.







Developing such a dashboard will enable the Trust to align with its Green Plan and its aim of becoming Net Zero by 2040. As the Trust continues to invest capital and secure further external government funding in energy efficiency projects, the Trust is expecting to be able to track accurately the reduction in carbon emissions. This will allow the Trust to measure whether it is projected to achieve its annual carbon emissions reduction targets.

One of the key aims of the current carbon emission dashboard is to expand the data sources so the Trust can include emissions associated to water, anaesthetic gases and inhalers. Having visibility of all these sources will provide a more comprehensive oversight of the carbon emissions currently being emitted on an annual basis. Being able to have sight of this data this will ensure the Trust can include the potential carbon emissions benefits when considering future strategic decisions.

Waste

- Clinical waste quantities have decreased overall against 2021/2022 quantities by 4.07%*.
- Domestic waste (non-recyclable energy from waste) has reduced by 11.45%*, with recyclable domestic waste (food, dry mixed recyclables, and confidential waste) showing an increase of 9.37%*. Showing a combined reduction of 6.73%* of domestic waste against 2021/2022.
- Whilst the quantities of waste disposed of show an overall decrease, it should be noted that the cost of disposal combined with fuel and transport costs have continued to increase.
- Work has taken place to encourage a return to pre-COVID processes. A dry mixed recycling (DMR) scheme has taken place in some administration areas, which has contributed toward the overall increase in the recyclable waste streams.
- The domestic waste stream remains at zero waste to landfill, with non-recyclable waste being burnt to provide energy from waste.
- The waste tender process concluded with a total waste management contract being awarded to Sharpsmart. The key aims of this contract are:

    - To achieve 0% waste to landfill across all waste streams by end 2023
    - To achieve the clinical waste segregation targets set in the NHS England Clinical Waste strategy (60% offensive waste, 20% AT/infectious waste, 20% incineration waste)
    - To ensure full compliance with Health Technical Memorandum 07-01-Safe Management of Healthcare Waste

- To minimise, reduce and avoid waste where possible, encouraging the organisation to move away from waste disposal to resource management

** 2022/2023 data forecast -11 months data averaged to 12 months.*

Accountability Report

The accountability report consists of three sections:

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

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

Adam Sewell-Jones, Chief Executive
Date: 24 July 2023

Corporate Governance Report

This part of the annual report consists of:

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

Di ect s' Re t

The Trust Board

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

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

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

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

The Board met in formal session on seven occasions during 2022/23. The Trust reverted holding meetings in person, where meetings had to be held remotely during COVID restrictions. Members of the public were able to attend the Board in person. The Board met on a further five occasions for Board Development sessions.

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

As of 31 March 2023, the Board consists of a non-executive chair, five non-executive directors and five executive directors – the Chief Executive, Medical Director, Chief Nurse, Director of Finance and Chief Operating Officer. In addition, four further executive directors – the Chief People Officer, Chief Information Officer, Director of Improvement and Director of Estates & Facilities – participate in board meetings, but do not have voting rights. The executive and non-executive members function as a team, working closely together, although with different responsibilities.

During 2022/23, there was one personnel change in terms of the Trust's non-executive director Board members. Mr Biraj Parmar stepped down from the Board in September 2022 and Dr David Buckle replaced Mr Parmar as a voting non-executive, having been serving on the Board as a non-voting associate non-executive director.

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

During 2022/23 there has been two changes to the executive director team. Ms Theresa Murphy joined the Trust as Chief Nurse, replacing Ms Rachael Corser. Ms Lucy Davies joined the Trust as Chief Operating Officer replacing Ms Julie Smith. Both Ms Corser and Ms Smith moved to roles outside of the Trust.

The Chair and non-executive directors are appointed by NHS England, on behalf of the Secretary of State for Health and Social Care (associate non-executive directors can be appointed following local recruitment policies). The normal term of office served by the chair and non-executive directors is either two or four years, renewable for a further four-year period. The maximum term is 10 years.

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

The executive directors are appointed by the Board on permanent contracts. All executive and non-executive directors undergo an annual performance evaluation and appraisal. The Chair conducts the annual performance evaluation and appraisal of the Chief Executive and non-executive directors. The Chief Executive, in turn, conducts the annual performance evaluation and appraisal of the Trust's executive directors. The Chair is appraised by NHS England. The outcomes of the appraisals of executive directors and the Chief Executive are discussed by the non-executive directors at the Board's Remuneration and Appointments Committee. The Chief Executive is not present when his appraisal is being considered by the Committee. Each Board member is required to meet the Fit and Proper Persons test. This is undertaken on appointment and reviewed annually and includes a self-declaration process. Board performance is evaluated further through focussed discussions at Board development days, meetings, observation, annual evaluation of the Board committees and an ongoing in-year review of the board assurance framework and delivery of the Trust's strategic objectives.

The role of the NHS Trust Chair

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

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

The role of Non-Executive Directors

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

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

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

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

The Trust Board 2022/23

This section of the annual report provides details of Board members as well as of other non-voting directors, including the Board committee membership during 2022/23.

Key to principal committee membership:
ARC – Audit and Risk Committee
RC – Remuneration Committee
FPPC – Finance, Performance and Planning Committee
QSC – Quality and Safety Committee
PC – People Committee
CTC – Charity Trustee Committee

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

2. The Board members have been deemed as having attended a meeting if they attended for a majority of the agenda items. Partial attendance at a meeting is also recorded but not reported here.
3. This report includes attendance at the statutory/mandatory Board or Committee meetings. Namely, the Board of Directors, Audit & Risk Committee and Remuneration & Appointments Committee.

Board members

Ellen Schroder, Trust Chair

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

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

Committee membership: FPPC, QSC, CTC, RC, PC

Adam Sewell-Jones, Chief Executive

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

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

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

Meeting membership core attendee: QSC, FPPC, RC

Karen McConnell, Non-Executive Director and Vice Chair

Karen, who lives in St Ippolyts (near Hitchin), studied Bacteriology at Newcastle University before joining the Northern Regional Health Authority as a finance trainee in 1983. In 1985 she joined the Audit Commission where she completed her accountancy training. Karen held a variety of senior positions at the Audit Commission, including her role as a district auditor and regional director, before leading the Audit Practice and its 900 staff through the transition of outsourcing the Commission's work to the private sector during 2011 and 2012. Karen was appointed as the Comptroller and Auditor General (C&AG) for Jersey in January 2013 and completed her 7 year term in December 2019. In her role as C&AG she provided the States of Jersey with independent assurance that the public finances of Jersey were being regulated, controlled and accounted for in accordance with the law. Karen currently acts as an adviser to Public Sector Audit Appointments limited.

Committee membership: FPPC (Chair), ARC, RC

Val Moore, Non-Executive Director

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

Committee membership: QSC, RC, CTC, PC (Chair)

Jonathan Silver, Non-Executive Director

Jonathan is the Senior Independent Director (SID) for the Trust. Jonathan, who lives in Aldenham, studied operational research and accountancy at Strathclyde University, graduating in 1978. On qualifying as a chartered accountant with Grant Thornton in 1981, he moved to Fisons plc. After five years, Jonathan joined Laird plc – now a global technology company providing systems, components and solutions that protect electronics from electromagnetic interference and heat, and that enable connectivity in wireless applications and antennae systems. Following 29 years with Laird, the last 21 of which had been as its chief financial officer and main board director, Jonathan retired in 2015. He is a Non-Executive Director and Audit Committee Chairman of Henderson High Income PLC and of Spirent Communications PLC. Jonathan is also a Non-Executive Director of ENH Pharma Ltd, the Trust's wholly owned subsidiary company.

Committee membership: FPPC, ARC (Chair), RC (Chair), PC

Peter Carter OBE, Non-Executive Director

Peter was chief executive at the Royal College of Nursing from January 2007 to August 2015. Prior to his role at the RCN, he was chief executive of the Central and North West London NHS Foundation Trust for 12 years. Now an independent healthcare consultant, Peter was awarded an OBE for services to the NHS in 2006.

Committee membership: QSC (Chair), RC

David Buckle, Non-Executive Director

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

David has been a member of the Society for the Assistance of Medical Families for over three decades, becoming a director of this charity in 2017 before being voted its President in May 2018. He is also a trustee and Vice-Chair for the Stroke Association, the country's largest stroke charity.

Committee membership: QSC, RC, CTC (Chair), ARC

Biraj Parmar, Non-Executive Director (until September 2022)
Biraj graduated from Aston Business School and has spent over 25 years mainly in the investment and commercial banking arena. Having started in corporate finance, Biraj moved into financial markets and worked at a senior level with a number of high profile banks, most recently with Lloyds Bank, until retiring from banking in 2019. Over his career, Biraj also co-founded and led two businesses, one in the healthcare sector and the other a consultancy focused on financial services. Biraj has a long family connection to medicine and healthcare. He is passionate about inclusion in its broadest sense and has proudly received inspiring leadership accolades when serving in the banking sector.

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

Committee membership: FPPC, PC (Chair until stepping down from the Board), RC

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

Committee membership: FPPC (core attendee), ARC (core attendee)

Michael Chilvers, Medical Director
Michael has been a consultant in the Trust since 1999, in the specialty of anaesthesia and critical care. He has trained in Nottingham, Brisbane and London – including The Royal Free, University College London Hospitals, Great Ormond Street and Harefield Hospital. Michael was appointed as medical director in December 2017 and prior to this was divisional chair of the Trust's surgery division for five years.

Committee membership: PC (core attendee), FPPC (core attendee), QSC (core attendee)

Rachael Corser, Chief Nurse (until September 2022)
Rachael joined the Trust in January 2018 from West Hertfordshire Hospitals NHS Trust, where she was the deputy director of nursing and governance for just over two years. She has had previous experience of working in acute, community, integrated care and independent sector healthcare settings, at board and sub-board level. With an extensive and varied clinical background, including working as an advanced clinical practitioner, Rachael has published her own research and evaluation of developing integrated healthcare services. Rachael has an MSc in nursing research and practice innovation and is a Florence Nightingale Scholar.

Committee membership: QSC (core attendee), FPPC (core attendee), CTC (core attendee)

Theresa Murphy, Chief Nurse (from September 2022)
Theresa joined the Trust on 2 September 2022 with over 30 years' experience in complex health and care settings.

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

Theresa holds an LLB and was a London scholar for Florence Nightingale Foundation; she is currently studying for an MA in leadership and has previously attended Oxford University for global executive studies.

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

Committee membership: QSC (core attendee), FPPC (core attendee), CTC (core attendee)

Julie Smith, Chief Operating Officer (until April 2022)

Julie qualified as a diagnostic radiographer in 1989 and as an ultra-sonographer in 1993. She has worked in a number of NHS Trusts, including North West Anglia NHS Foundation Trust and Princess Alexandra Hospital NHS Trust. Julie joined our Trust in 2018 from Cambridge University Hospitals NHS Foundation Trust, where she worked for 19 years and held a number of roles – including executive intern, associate director and operations director. She was also interim chief operating officer for a three month period.

Committee membership: FPPC (core attendee), QSC (core attendee).

Lucy Davies, Chief Operating Officer (from April 2022)

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

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

Lucy is a mum to two teenage boys and lives in north London.

Committee membership: FPPC (core attendee), QSC (core attendee), PC (core attendee)

Thomas Pounds, Chief People Officer (non-voting Board member)

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

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

Committee membership: PC (core attendee), FPPC, QSC, RC (core attendee), CTC

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

Committee membership: FPPC

Kevin 'Ha t, Di ect f Im ve ment (n n-voting Board member)
Kevin moved from an early career in finance and capital markets and qualified as a registered nurse in 2000. He has since worked clinically in a number of NHS trusts including University College Hospitals London and East Suffolk and North Essex NHS Foundation Trust.

Kevin initially joined East and North Hertfordshire NHS Trust as programme management office director in April 2017, before been recruited into a new position as director of improvement in November 2019.

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

Committee membership: FPPC (core attendee), QSC, PC

Kevin Howell, Director of Estates and Facilities (non-voting Board member)
Kevin joined the Trust in January 2020. With nearly 40 years' experience in the NHS, Kevin has held several senior and executive Estates and facilities roles in the London area – including the PRU Hospital, Barnet and Chase Farm, Watford, North Middlesex and St Georges. He has led on the development of two new hospitals and a new midwifery led unit in north London.

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

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

Committee membership: FPPC

Name	Title	Appointment Date	Term(s) of Office	Term of Office ends
Ellen Schroder	Trust Chair	1 April 2016	Four Years + Four Years	31 March 2024
Adam Sewell-Jones	Chief Executive	1 January 2022	N/A	N/A
Val Moore	Non-Executive Director	1 September 2016	Four Years + Four Years	31 August 2024
Jonathan Silver	Non-Executive Director Designate*	16 October 2017	N/A	N/A
	Non-Executive Director	1 February 2018	Two Years + Four Years	31 January 2024
Peter Carter	Non-Executive Director	3 September 2018	Four Years + Four Years	2 September 2026
David Buckle	Non-Executive Director Associate*	17 September 2018	N/A	N/A
	Non-Executive Director	8 September 2022	Four years	7 September 2026
Karen McConnell	Non-Executive Director	7 January 2019	Four Years + Four Years	6 January 2027
Biraj Parmar	Non-Executive Director Associate*	1 April 2021	N/A	N/A
	Non-Executive Director	6 January 2022	Four Years	7 September 2022
Martin Armstrong	Finance Director & Deputy Chief Executive	31 October 2016	N/A	N/A
Michael Chilvers	Medical Director	18 December 2018	N/A	N/A
Rachael Corser	Chief Nurse	2 January 2018	N/A	11 September 2022
Theresa Murphy	Chief Nurse	2 September 2022	N/A	N/A
Julie Smith	Chief Operating Officer	25 June 2018	N/A	1 May 2022
Lucy Davies	Chief Operating Officer	19 April 2022	N/A	N/A
Tom Pounds	Chief People Officer*	1 April 2021	N/A	N/A
Mark Stanton	Chief Information Officer*	9 February 2021	N/A	N/A
Kevin O'Hart	Director of Transformation*	Joined the Board from July 2022	N/A	N/A
Kevin Howell	Director of Estates & Facilities*	Joined the Board from July 2022	N/A	N/A

*****_Attends and participates in Trust Board meetings, but without voting rights_

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

Declarations of Interests of the Board of Directors

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

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

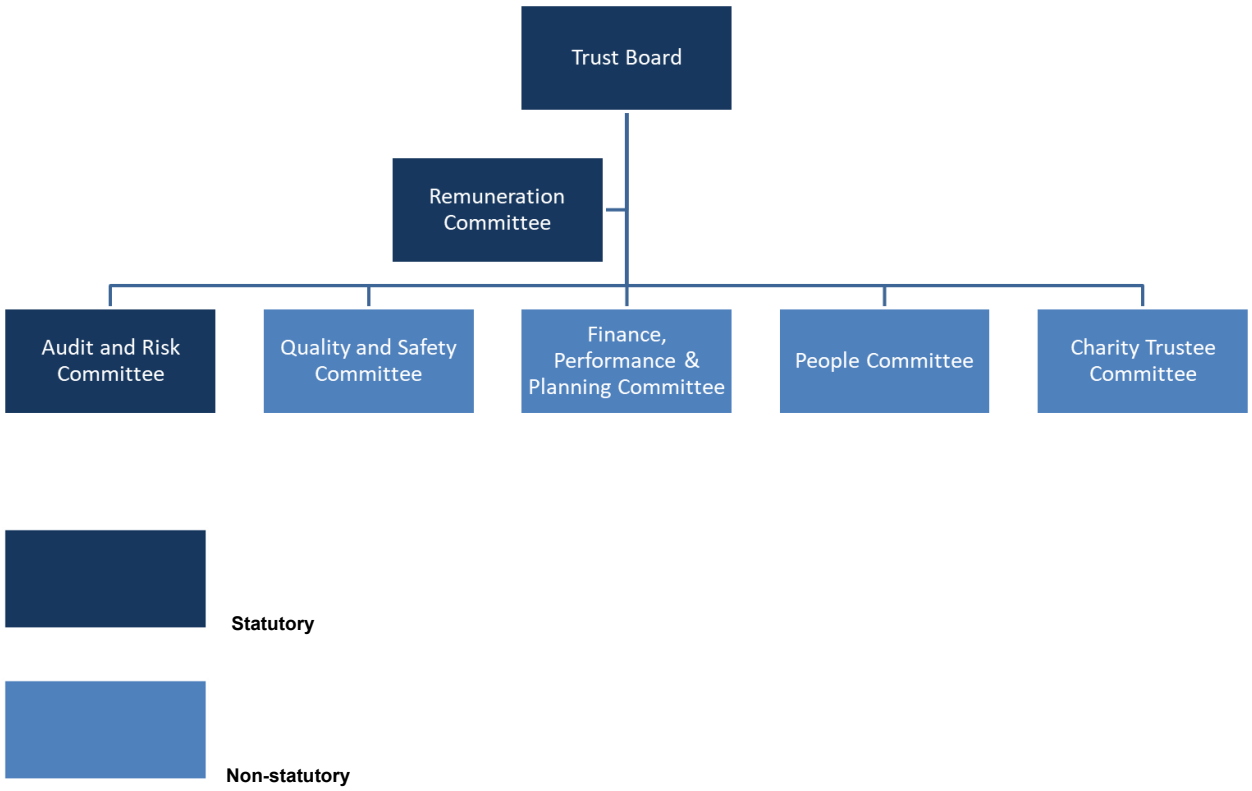
The Register of Interests is published on the Trust's website (here: https://www.enherts-tr.nhs.uk/about/board/introduction/).

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

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

Governance structure

The Trust Board has a number of formal board assurance committees (see diagram below for the committee structure on 31 March 2023) that are supported by a system of line accountability through executive directors, often supported by further operational assurance groups. Each Board assurance committee provides a summary report to the next Trust Board meeting. An internal review of each committee is undertaken annually to ensure that it continues to meet its terms of reference and operate effectively.



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

Attendance of Directors at Board Meetings 2022-23

Trust Board member	May-22	Jul-22	Sep-22	Nov-22	Dec-22*	Jan-23	Mar-23	Total attendance
Ellen Schroder, Chair of the Trust Board	Apologies	✓	✓	✓	✓	✓	✓	6 out of 7
Karen McConnell, Vice-Chair of the Trust Board	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Val Moore, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Peter Carter, Non-Executive Director	✓	✓	✓	Apologies	✓	✓	✓	6 out of 7
Jonathan Silver, Non-Executive Director	✓	Apologies	✓	Apologies	✓	✓	✓	5 out of 7
David Buckle, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Biraj Parmar, Non-Executive Director	✓							1 out of 1
Adam Sewell-Jones, Chief Executive	✓	✓	✓	✓	Apologies	✓	✓	6 out of 7
Martin Armstrong, Deputy Chief Executive & Director of Finance	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Lucy Davies, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Thomas Pounds, Chief People Officer	✓	✓	✓	✓	✓	✓	✓	7 out of 7
Michael Chilvers, Medical Director	✓	✓	Apologies	✓	✓	✓	✓	6 out of 7
Mark Stanton, Chief Information Officer	✓	✓	✓	✓	✓	Apologies	Apologies	5 out of 7
Rachael Corser, Chief Nurse	✓	✓	✓					3 out of 3
Theresa Murphy, Chief Nurse			✓	✓	✓	✓	✓	5 out of 5
Kevin Howell, Director of Estates and Facilities		Apologies	Apologies	✓	✓	✓	✓	4 out of 6
Kevin O'Hart, Director of Improvement		✓	✓	✓	✓	✓	Apologies	5 out of 6

Dec-22: Extraordinary Board*

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

Attendance of Members at Remuneration Committee Meetings 2022-23

Remuneration Committee member	May-22	Jul-22	Nov-22	Jan-23	Total attendance
Jonathan Silver, Chair and Non-Executive Director	✓	Apologies	✓	✓	3 out of 4
Ellen Schroder, Chair of the Trust Board	✓	✓	✓	✓	4 out of 4
Karen McConnell, Vice-Chair of the Trust Board	✓	✓	✓	✓	4 out of 4
Val Moore, Non-Executive Director	✓	Apologies	✓	✓	3 out of 4
Peter Carter, Non-Executive Director	✓	✓	Apologies	✓	3 out of 4
David Buckle, Non-Executive Director	✓	✓	✓	✓	4 out of 4
Biraj Parmar, Non-Executive Director	✓	Apologies			1 out of 2

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

Attendance of Members at Audit and Risk Committee Meetings 2022-23

Audit & Risk Committee member	Apr 22	June 22	Jul 22	Oct 22	Dec 22	Jan 23	Total attendance
Jonathan Silver, Chair and Non-Executive Director	✓	✓	✓	✓	Apologies	✓	5 out of 6
Karen McConnell, Non-Executive Director	Apologies	✓	✓	✓	✓	Apologies	4 out of 6
David Buckle, Non-Executive Director	Apologies	✓	✓	✓	✓	✓	5 out of 6

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

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

The *Finance, Performance and Planning Committee* also meets monthly (excluding August) and has a membership of three non-executive directors. The purpose of the Committee is to

provide assurance to the Board that appropriate arrangements are in place to support the delivery of the financial, operational and planning objectives which contribute to the delivery of the Trust Strategy. Through this work, the Committee plays a key role in ensuring the sustainability of the Trust.

The *People Committee* meets bi-monthly and has a membership of three non-executive directors plus relevant officers. The Committee started in May 2022. The Committee provides assurance to the Board that appropriate arrangements are in place to deliver the Trust's People Strategy and enhance equality and inclusion for The Trust's staff.

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

Information governance

The Trust achieved a status of 'Approaching Standards' for its 2021/22 Data Security and Protection Toolkit (DSPT) submission. This was due to one mandatory requirement not being met, which was the 95% target for staff taking their annual NHS data security awareness training (88.15% achieved). This target applied to training completed in the 12 months period leading up to the submission deadline. All other mandatory DSPT requirements were met. The Internal Auditor's assurance level for the requirements in scope of the audit was 'Substantial'.

For this year's DSPT, the requirements for network connected medical devices and medical devices with the capability to connect to the network, have become mandatory. Work is progressing to review the Trust's medical device registers to ensure they are complete and that data security assurance requirements for medical devices are met.

There have been two incidents reported through the DSPT in this financial year - one was an email incident due to human error, and the other was a disclosure of patient level data in a response to a Freedom of Information request. A set of recommendations were provided in both cases to help prevent similar incidents occurring.

A new Trust wide Privacy Notice was published on the Trust website. The requirements under the NHS National Data Opt out were met ahead of the national deadline and the process for checking for patient opt outs is well embedded. The Health Information Exchange (HIE) is being successfully rolled out.

The Trust's Information Governance Steering Group has oversight of information governance, meeting bi-monthly, and reports to the Quality and Safety Committee.

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.

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

Internal auditor

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

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

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

Statement of the Acc unta e ff ice ’s Res nsi i ities

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

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

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

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

Signed: Adam Sewell-Jones, Chief Executive

Date: 24 July 2023

East and North Hertfordshire NHS Trust Annual Governance Statement 2022/23

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East and North Hertfordshire NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East and North Hertfordshire NHS Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Board of Directors set the policy framework and strategy and provides leadership for the management of risk across the organisation. In 2022/23 the Chief Nurse was the Executive Lead for risk management with the Head of Corporate Governance leading on the Board Assurance Framework (BAF). The executive team lead on the areas of risk within their portfolios and are nominated as the lead for specific strategic risks on our Board Assurance Framework.

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

During 2022/23 the Board reviewed and updated the Risk Management Strategy, including amending the risk appetite to reflect the post-COVID environment. We have made progress in implementing our Risk Management Strategy, Board Assurance Framework and Accountability Framework structure to ensure these provide clear and comprehensive risk management and fully support the corporate governance systems. During 2022/2023 the Board and Audit Committee have regularly reviewed progress of risk management including undertaking deep dives and focused reviews on those risks rated 20.

The operational responsibility for risk management is managed by the relevant clinical division or corporate directorate. To enhance risk management a Risk Management Group,

chaired by the Deputy Chief Executive was established during the year. A process of review, challenge and escalation of divisional and corporate directorate risks, as contained in the risk register, is now conducted through the Risk Management Group. This has improved accuracy of risk scoring and enabled easier identification and escalation of the biggest corporate risks.

Areas of high risk are escalated to the Audit Committee, Quality and Safety Committee (QSC), Finance Performance (FPPC), People Committee and the Trust Board. The Board Committees have continued to strengthen their scrutiny of the risks through the use of deep dives into specific areas.

The Board receives support and training on risk management and the Board had two risk management workshops during the year. The first reviewed the risk strategy and appetite. The second considered the BAF and ways to maximise its effectiveness. The Compliance and Risk Team provide support and training to staff and leadership teams on risk management and the risk register. The Health, Safety and Security Team provide mandatory training on health, safety and security and fire to all staff across the organisation.

During 2022/23 the Board had five development sessions to consider key areas of strategic significance, including our strategic priorities, system-working, performance, culture, well-led review findings and patient safety. The expectation is that these sessions provide strategic focus to the organisation, enabling it to proactively respond to and support the achievement of strategic priorities for the local health economy in ways which are commercially and clinically effective for the Trust.

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

The Chief Executive and Trust Chair continue to monitor the size and the balance of skills and experience of the Board to ensure it is appropriate for the requirements of the business and the future direction of the Trust. During 2022/23, there was one personnel change in terms of the Trust's non-executive director Board members. Mr Biraj Parmar stepped down from his role for personal reasons. Dr David Buckle replaced Mr Biraj as a voting non-executive, having been serving on the Board as a non-voting associate non-executive director. There have been two changes to the executive director team. Ms Rachael Corser, Chief Nurse, left the Trust with Theresa Murphy appointed as the new Chief Nurse. Ms Julie Smith, Chief Operating Officer left the Trust with Ms Lucy Davies appointed as the new Chief Operating Officer.

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

We seek to learn from good practice in a number of ways including from internal and external reviews, clinical audit programme, incidents, feedback from complaints and patient and carer experiences. Good practice in risk management, sharing good practice and learning the lessons is shared with all staff though governance half days, monthly patient safety newsletter, Trust daily bulletin, staff forums and the organisational development

programme. Divisions use local methods including newsletters, posters, virtual staff meetings, message of the week and safety huddles. In addition, to support identifying learning from serious incidents as soon as possible, bi-weekly serious incident review panels and divisional risk clinics are held to support the management and scrutiny of organisational risk.

The risk and control framework

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

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

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

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

We will do this by:

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

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

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

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

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

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

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

The Internal Auditor annual review of the Board Assurance Framework concluded 'substantial assurance' for the BAF which indicates strong strategic risk management. Internal Audit concluded a 'limited assurance' opinion for corporate risk. In addition to taking into account the recommendations from internal auditors, a number of enhancements have been made to corporate risk management during the year with external expertise brought in to review corporate risk and make recommendations including establishing a Risk Management Group, corporate risk ownership transferring from QSC to Audit & Risk Committee and Audit Committee being renamed the Audit and Risk Committee. In addition, two risk development sessions were held with the Board and the Risk Strategy was robustly reviewed and significantly updated.

Led by the Compliance and Risk team, a risk clinic for each division and a review of the corporate risks has continued through 2022/23. This work was informed by the revised risk appetite that the Board approved during the year. The major incident command and control structures enabled early discussion on new and emerging risks, clear escalation and mitigating actions to be agreed.

Board Assurance and Reporting

Our Trust Board has four established committees to discharge its responsibilities on Board assurance. These are the Audit and Risk Committee, Quality and Safety Committee, the Finance Performance and Planning Committee and People Committee. These are constituted as key assurance mechanisms and an annual review of each of the committees is undertaken to ensure they continue to meet their terms of reference and the new requirements of the Code of Governance and requirements of the Provider Licence that apply from 1 April 2023. They are each chaired by a Non-Executive Director. In addition, the Board has the Charity Trustee Committee to provide assurance and support for its responsibility as a Corporate Trustee. Directors' attendance at the Board and its Committees is recorded and monitored. A review of attendance during 2022/23 has not highlighted any issues. These are reported in full in the Trust's Annual Report.

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

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

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

The People Committee provides assurance to the Board that appropriate arrangements are in place to deliver the Trust's People Strategy and improve equality and inclusion for the Trust's people.

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

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

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

COVID Pandemic

The challenges posed by the COVID pandemic required temporary changes to some of the governance structures. The business continuity structures and command and control structure have remained flexible and responsive to support the organisation. Whilst operationally COVID continued to have an impact, by the end of 2022/23, bar infection control, governance arrangements had reverted to pre-pandemic processes.

Principal Strategic Risks

The BAF underwent a significant review during 2022/23 with a number of the BAF risks changed and a particular increased focus on workforce risks. A People Committee was established by the Board in May 2022, reflecting the Board's increased workforce focus.

The Trust at the end of 2022/23 had 11 principal risks defined on the Board Assurance Framework each with key controls, assurance levels, gaps in controls and assurance and mitigating action identified.

At the end of 2022/23 one risk remained rated a '20' (Risk 3: Financial constraints). This compared to one risk rated '20' in 2021/22 (Risk 1: Operational Performance) and two risks rated '20' at the end of 2020/21 (Risk 4: Capital and Risk 10: Estates and Facilities).

In 2022/23, two risk scores reduced:

- Risk 10 (Technology, systems and processes to support change) reduced in November 2022 to a '12'.
- Risk 12 (Clinical engagement) reduced from '16' to '12' in September 2022.

And two risk scores increased:

- Risk 3 (Financial constraints), highlighted above, increased from '16' to '20' which reflected the increased financial challenges.
- Risk 8 (Improving performance and flow) increased from '12' to '16' in September 2022 to reflect known challenges such as ambulance waiting times and referral to treatment.

In addition, Risk 9 (Financial flows and efficiency) increased from '12' to '16' but reverted to a '12' in March 2023.

The Board and the lead committees for BAF risks receive reports at every meeting on progress with the BAF to assure that the mitigations are operating (where this is within the Trust's ability to do so) and that those mitigations are effective or further actions are identified. During 2022/23 the Audit and Risk Committee undertook a deep dive review of specific risks on the BAF.

Conflicts of Interest

During the year the Trust introduced an online Declaration of Interests system for the first time that makes both declaring interests easier and monitoring compliance more effective. The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

Quality governance

The Trust's quality and safety governance structure and arrangements enable the Trust to maintain and continually improve quality from 'ward to board'. There are clearly defined corporate and local indicators for quality and safety. This structure delivers the well-led CQC framework and provides clear assurance from wards upwards, and from the board to the clinical areas.

Quality governance has a number of elements. These include the QSC which reports to the Board. The QSC is responsible for ensuring that effective arrangements are in place for the oversight and monitoring of all aspects of clinical quality and safety, including identifying potential risks to the quality of clinical care. The board relies on the committee to provide advice on clinical quality, patient safety and risk, and for assurance on areas of clinical governance and audit. It focuses on promoting a culture of openness and organisational

learning. On behalf of the board, the QSC reviews compliance and receives assurance in meeting regulatory standards set by the CQC. Performance is also monitored via FPPC and Accountability Review Meetings.

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

CQC rated the Trust's Maternity Service as Inadequate and served the Trust with a section 29A notice published in January 2023. Following this notice, the Trust have made a number of improvements in maternity including increasing staff numbers and training (with over 23 new midwives recruited), a replace and refurbishment programme of equipment and estate, and improved processes. There is ongoing work to ensure all areas of concern noted by the CQC are being addressed. A weekly maternity improvement senate was created to oversee this work. A formal response to the section 29A notice has been provided to CQC.

There were three never events during 2022-23 and the Serious Incidents and Never Events section earlier in this Annual Report sets out what happened and the actions taken to ensure learning and these events never happen again.

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 incorporates new ways of working, including the growth of roles such as nursing associates, trainee nurse associates, hybrid Allied Health Professionals and nursing support role and physician associate. The plan is reviewed by the People Committee and Finance, Performance and Planning Committee (FPPC). Nursing establishment reviews take place annually to ensure service needs are met with oversight and approval at the Quality and Safety Committee (QSC) and at Board.

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

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

As well as staff skills and qualifications being assessed during recruitment and appointment, staff have access to a range of Continuing Professional Development (CPD) programmes, clinical skills development, mandatory training and apprenticeships to support upskilling including developing new and retaining existing competences. Clinical and medical registration is checked with the relevant professional bodies regularly and during Grow Together conversations (annual appraisals) which in 2022/23 moved to a fixed cycle, staff development and further training is discussed. An annual training needs analysis taking place between October and December identifies additional training needs, which informs our procurement of CPD and apprenticeship programmes.

Staff competences are reviewed on a daily basis as part of good rostering management using the Trust's Health roster system. Daily meetings take place to review the effective

deployment of the workforce and provide mitigation where required. The eroster systems automatically interface with the temporary staffing systems to ensure there is mitigation for staffing shortfalls and maintain safer staffing standards.

NHS Pensions

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

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

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

The Trust reported a deficit before technical adjustments of £8.5 million. Including technical adjustments, the Trust reported a deficit of £6.1 million against a planned breakeven position. This performance saw the Trust fail to meet the duty to break even for the first year since 2018-19.

The NHS financial framework for 2022/23 continued to be significantly impacted by arrangements put in place to allow the service to manage the impact of the COVID pandemic. Funding received by the Trust was predominantly allocated under fixed block arrangements, although this was supplemented by some specific COVID monies to manage direct financial impacts of the pandemic upon the Trust and also by access to recovery fund monies to support the costs of restoring elective activity levels. The levels of COVID income support received by the Trust reduced significantly in 2022/23 compared with the previous year.

Progress against the delivery of the financial plan was monitored by the Finance, Performance and Planning Committee (FPPC) and reported to Board. During the course of the year as financial performance and forecast outturn varied from the expected breakeven target the Trust designed and implemented a 'Financial Reset' programme. This was intended to mitigate and improve areas of adverse performance. The themes of financial improvement covered by the reset programme were reviewed and monitored by an Executive Steering group with regular reports of progress to both the FPPC and the Trust Board. In addition, the Trust implemented a required double lock expenditure approval process as required by the NHS England Outturn Variance protocol. The Trust worked with Hertfordshire and West Essex ICS to deliver a financial outturn position that supported the achievement of an overall balanced position for the system as a whole.

During 2022/23 the Trust undertook a HFMA financial sustainability review, as required by NHS England. This process was based around a detailed self-assessment of eight elements of financial governance. The assessment was subsequently reviewed by the Trust's internal auditors alongside evidence provided. The Trust was assessed to have a strong environment of financial control and governance in place; however it was acknowledged that the process for the development, delivery and monitoring of cost improvements needed to be strengthened. As a consequence, a revised CIP delivery protocol was designed and approved by the Trust Management Group for implementation going forward.

In addition, the Trust's annual Internal Audit programme provides an independent review of our key financial controls and this year they have reviewed our systems and processes for our core financial systems and provided reasonable assurance.

NHS Improvement undertook a Use of Resources assessment in August 2019 and rated the Trust as 'requires improvement.' This has not been reviewed in this reporting year. The Trust has during 2022/23 implemented an Executive Programme Board structure intended to co-ordinate the delivery of key transformation activities which will contribute to the achievement of improved value for money arrangements. Furthermore, the Trust has continued to focus upon improving the quality of business intelligence reporting available across the Trust as a means of improving the quality of business and financial decision making.

The Trust recognises that the ongoing achievement of its targeted cost improvement plans represent a key element in the delivery of ongoing financial balance. During the course of the 2022/23 financial year the Trust reported material slippage against the savings schemes that it had set out to deliver for the year. It is clear that this materially contributed to the Trust's overall reported deficit position.

Acknowledging the ongoing challenge of savings and efficiency delivery, the Trust has responded to this slippage through a number of steps.

During the course of 2022/23 a 'financial reset' programme was introduced that placed focus and emphasis upon in year savings delivery recovery. Furthermore, the Trust also reviewed, agreed and implemented a strengthened CIP Development, Delivery and Monitoring Framework. This has been used to designed and plan the 2023/24 savings plan.

Information governance

The Trust's assurance framework and risk register include the risks associated with the management and control of information. In this respect, the Trust has established a framework to support compliance with the ten data security and protection standards and the Data Protection Act 2018.

The Trust achieved a status of 'Approaching Standards' for its 2021/22 Data Security and Protection Toolkit (DSPT) submission. This was due to one mandatory requirement not being met, which was the 95% target for staff taking their annual NHS data security awareness training (88.15% achieved). This target applied to training completed in the 12 month period leading up to the submission deadline. All other mandatory DSPT requirements were met. The Independent Auditor's assurance level for the requirements in scope of the audit was 'Substantial'.

For 2023/24's DSPT, the requirements for network connected medical devices and medical devices with the capability to connect to the network, have become mandatory. Work is progressing to review the Trust's medical device registers to ensure they are complete and that data security assurance requirements for medical devices are met.

There were two incidents reported through the DSPT in this financial year - one was an email incident due to human error, and the other was a disclosure of patient level data in a response to a Freedom of Information request. A set of recommendations has been provided in both cases to help prevent similar incidents occurring.

The requirements under the NHS National Data Opt out were met ahead of the national deadline and the process for checking for patient opt outs is well embedded.

The Health Information Exchange (HIE) is being successfully rolled out.

A new Trust wide Privacy Notice has been published on the Trust website. A redesign and expansion of information governance section on the Trust Intranet is evolving as a valuable staff resource, to supplement the data protection mailbox as a resource to resolve advice and guidance queries from staff. The largest numbers of requests for advice and guidance concern information sharing agreements and contracts, DPIA, audit, research and service evaluation approvals, registries, surveys and questionnaires, and participation in pilots, including in evolving areas of research and diagnostics, such as genomics and Artificial Intelligence.

The internal audit for the Data Security and Protection Toolkit (DSPT) provided a substantial assurance rating.

Data quality and governance

Our data quality continues to improve and is supported by the Data Quality Strategy and Policy. The strategy sets out the 10 key principles to support the production and assurance of high-quality data and its management across the organisation. The most important of these is that good data management and quality of data is everyone's responsibility. The strategy is built around the aspiration of 'get it right first time' when recording data and defines responsibilities for specific roles across the organisation for its delivery. The strategy is implemented through the Data Quality Steering Group and supported by a monthly audit programme. The Audit and Risk Committee receives a quarterly update on all the key workstreams to continue to improve data quality, to progress and improve patient experience, service delivery and patient flow which include accuracy of data recording.

Key workstreams include: the development of the data quality key performance indicators dashboard, the development of the Ethnicity Capture and Monitoring dashboard and supporting the specialty operational teams.

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 2022/2023.

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 2023, the head of internal audit opinion for East and North Hertfordshire NHS Trust is as follows:

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

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

Internal audit carried out 19 reviews during 2022/23. Five audit reviews produced a substantial assurance rating; ten produced a reasonable assurance rating; four produced a limited assurance rating and none were rated as no assurance. The four limited assurance reviews were: Discharge Summaries Deep Dive; Clinical Dataset Emergency Standards Emergency Department; Referral to Treatment and Risk Management (noting the Board Assurance Framework which monitors strategic risks received a substantial assurance rating). Robust actions have been agreed for all limited assurance audit reviews and the implementation of these actions is monitored closely by the Audit and Risk Committee.

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

- The Board regularly reviews the Trust's objectives and receives reports on key matters of concern.
- The Audit and Risk Committee provides an independent and objective review of the Trust's system of internal control and on the progress of the implementation of the risk management strategy and procedure.
- 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.
- Commissioning the Good Governance Institute during the year to assist with review and improvements to the risk framework and constitutional documents to maximise efficacy and compliance.
- An independent well-led developmental review, as part of NHSE best practice, was commissioned by the Trust and carried during the year.
- The Finance, Performance and Planning Committee highlights the major financial, performance and strategy risks to the Board and refers potential risks to quality to the Quality and Safety Committee for further scrutiny, while providing proactive risk management within the areas of activity covered by its own remit.
- The Board provides oversight of risks relating to the Trust's Strategy and supporting strategies.
- The new People Committee provides enhanced oversight of the related plans and risks relating to the workforce.
- Clinical Audit – the annual clinical audit programme is reviewed and approved through the Clinical Effectiveness Committee and progress is monitored through the Divisions and QSC. The Audit and Risk Committee receives the annual self-assessment against the assurance framework.
- Internal Audit, through its annual audit plan, provides assurance and comment on matters related to internal control.

- The annual review of the Trust's Standing Orders, Scheme of Reservation and Delegation and the Standing Financial Instructions has identified improvements that the Audit and Risk Committee reviewed and endorsed, prior to Board approval.
- The Board has appointed a Senior Information Risk Owner, who is supported by the Data Protection Officer and an Information Governance Steering Group, to provide information governance assurance via the Data Security and Protection toolkit submission and IGSoC.
- The Board endeavours to ensure that all senior staff, clinical and other, through various meetings and review processes, including attending the Board Committees as required are held to account in all areas for delivery against finance, performance, people, quality, governance and risk issues. The Accountability Framework Structure and Integrated Performance Report support this.
- We commission and support external reviews and expertise to review and strengthen our governance. Examples include regarding the BAF and risk management. This has provided assurance and additional recommendations, which have been progressed.
- We provide programme and enhanced governance support to areas under pressure or where additional support is required. Examples include Maternity, Emergency Department, Paediatrics, Audiology, Gastroenterology and Mortuary.
- We have Authorised Engineers who provide an independent review of our compliance and effective management of safety against a number of statutory requirements including water, electrical, fire, decontamination, ventilation and medical gases.
- Executive Directors, Senior Managers of the Trust and identified risk leads are proactively engaged in maintaining and reviewing the effectiveness of the system of internal control. This is supported by positive engagement with CQC and recent Internal Audit reports.

Conclusion

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

Signed:

Adam Sewell-Jones, Chief Executive Date: 24 July 2023

Modern Slavery Act Statement

The Modern Slavery Act 2015 establishes a duty for commercial organisations with a turnover in excess of £36 million to prepare an annual slavery and human trafficking statement. This is a statement of steps taken to ensure that slavery or human trafficking is not taking place in its business or its supply claims.

The Trust's income from government sources is publicly funded and outside the scope of these requirements. The Trust does not receive income from non-governmental sources e.g. private patients, in excess of £36 million and hence does not qualify as a commercial organisation for the purpose of the requirements of making this statement under the Modern Slavery Act 2015.

Equally, clearly the Trust is opposed to any actions that could be construed as slavery or human trafficking. Referrals for suspected victims of modern-day slavery are managed by the Trust's safeguarding team and duty social worker through a process in keeping with HMSP adult victim referral pathway. Suspected victims of modern-day slavery must not be discharged until a management plan is agreed with the duty social worker or a registered nurse practitioner working for the Trust's safeguarding adults team.

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 2022/23)
- Remuneration tables
- Pension entitlement table
- Pension benefits table

Remuneration policy

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

The Remuneration and Appointments Committee is a committee of the Trust Board, consisting of the Chair and all the non-executive directors. It is chaired by Mr Jonathan Silver (who is also the chair of the Audit Committee). The Committee is supported by the Chief Executive, Chief People Officer and the Trust Secretary. The Remuneration and Appointments Committee aims to meet four times a year but will schedule additional meetings if needed. It met five times in total during 2022/23. Details of directors' remuneration are given later in this section of the report.

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

Executive Director pay is based on the following agreed principles;

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

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

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

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

The remuneration and terms of office of non-executive directors are those set out by NHS England/Improvement. In September 2019 NHS England & NHS Improvement published a structure to align remuneration for chairs and non-executive directors of NHS Trusts and NHS foundation Trusts. These recommendations have been implemented by the Trust. The level of remuneration is paid for a minimum of two and a half days per month for non-executive directors and three and a half days per week for the Trust's Chair. Pay awards agreed nationally for other staff groups working at the Trust and the wider NHS, including staff on Agenda for Change contracts, medical and dental staff and very senior managers are determined by the Senior Salaries Review Body, which looks at senior salaries and pay conditions across the public sector.

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

Staff sharing scenarios

Mrs Sarah Brierley (Director of Strategy) has fulfilled a secondment since October 2021 on a part time basis to Hertfordshire Community NHS Trust and has taken on the role of Director of Strategy for both Trusts. East and North Hertfordshire NHS Trust funded 87% of the role during 2022/23.

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

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

Remuneration tables

Name and title	2022/23							2021/22						
	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 (from 01.01.22) Chief Executive	195-200	24	0	0	0	0	200-205	45-50	0	0	0	0	0	45-50
Nick Carver (to 31.12.21) Chief Executive	0	0	0	0	0	0	0	145-150	1	0	0	0	0	145-150
Martin Armstrong Director of Finance	155-160	22	0	0	2.5-5	0	160-165	155-160	0	0	0	22.5-25	0	180-185
Rachael Corser (to 11.09.22) Director of Nursing	60-65	8	0	0	7.5-10	0	65-70	125-130	0	0	0	10-12.5	0	135-140
Theresa Murphy (from 02.09.22) Director of Nursing	75-80	0	0	0	0	0	75-80	0	0	0	0	0	0	0
Michael Chilvers Medical Director	205-210	0	0	0	0	0	205-210	200-205	0	0	0	0	0	200-205
Julie Smith (to 01.05.22) Chief Operating Officer	10-15	1	0	0	0	0	10-15	140-145	0	0	0	7.5-10	0	150-155
Lucy Davies (from 19.04.22) Chief Operating Officer	130-135	0	0	0	87.5-90	0	220-225	0	0	0	0	0	0	0

Thomas Pounds	125-130	23	0	0	37.5-40	0	165-170	115-120	0	0	0	80-82.5	0	195-200
Chief People Officer														
Mark Stanton	125-130	23	0	0	30-32.5	0	160-165	120-125	0	0	0	27.5-30	0	150-155
Chief Information Officer														
Kevin O' Hart (from 01.07.22)	90-95	17	0	0	0	0	90-95	0	0	0	0	0	0	0
Director of Improvement														
Kevin Howell (from 01.07.22)	115-120	18	0	0	0	0	120-125	0	0	0	0	0	0	0
Director of Estates & Facilities														

Name and title	2022/23						2021/22					
	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL	Salary	Expense payments (taxable) total	Performance pay and bonuses	Long term performance pay and bonuses	All pension related benefits	TOTAL
	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	Rounded to the nearest £100	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
Non-executive directors												
Ellen Schroder Chair	50-55	0	0	0	0	50-55	40-45	0	0	0	0	40-45
Bob Niven (to 05.01.22)	0	0	0	0	0	0	5-10	0	0	0	0	5-10
Val Moore	10-15	5	0	0	0	10-15	10-15	1	0	0	0	10-15

Jonathan Silver	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Peter Carter	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
David Buckle	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Karen McConnell	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Biraj Parmar (to 07.09.22)	5-10	0	0	0	0	5-10	15-20	0	0	0	0	15-20

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

- The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual. The Trust's contribution to directors' pensions was 14.3% of salary for 2022/23 (this was topped up to 20.6% by NHSE) (20.6% in 2021/22). 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 2021/22 and 2022/23.

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 2023	Lump sum at pension age related to accrued pension at 31 March 2023	Cash equivalent transfer value at 1 April 2022	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2023	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*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Chief Executive								
Martin Armstrong	0-2.5	0	50-55	90-95	867	5	919	0
Director of Finance								
Rachael Corser (to 11.09.22)	0-2.5	0	35-40	55-60	531	10	577	0
Director of Nursing								
Theresa Murphy (from 02.09.22)	0	0	45-50	140-145	1,219	0	1,136	0
Director of Nursing								
Michael Chilvers*	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Medical Director								
Julie Smith (to 01.05.2022)	0	0	50-55	100-105	975	1	1,016	0
Chief Operating Officer								
Lucy Davies (from 19.04.22)	5-10	5-10	55-60	115-120	962	89	1,105	0
Chief Operating Officer								
Thomas Pounds	2.5-5	0-2.5	30-35	50-55	375	19	423	0
Interim Chief People Officer								
Mark Stanton *	0-2.5	0	15-20	0	224	21	268	0
Chief Information Officer								
Kevin O'Hart (from 01.07.22) *	0-2.5	0	35-40	55-60	581	18	634	0
Director of Improvement								
Kevin Howell (from 01.07.22)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Director of Estates & Facilities								

- Michael Chilvers left the pension scheme with effect from 1st April 2019.
- Adam Sewell-Jones opted out of the pension scheme in June 2020 before joining the Trust on 1st January 2022.
- Kevin Howell opted out of the pension scheme prior to joining the Trust board on 1st July 2022.
- There is no mandatory lump sum available for Mark Stanton.

Notes to pensions table

As non-executive members of the Board do not receive pensionable remuneration, there are no entries in respect of pensions for these individuals. A cash-equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued

benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

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

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

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 2022/23. This information is subject to audit by the Trust's auditors, BDO LLP.

Payments to past directors

There were no such payments in 2022/23. This information is subject to audit by the Trust's auditors, BDO LLP.

Pay multiples (fair pay disclosure) for 2022/23

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 2022/23 was £207,500 (2021/22 – £202,500). This was 5.9 times (2021/22 – 6.0 times) the median remuneration of the workforce, which was £35,068 (2021/22 – £33,688).

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

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

Further fair pay disclosures required for 2022/23

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 2022/23 was £205k-£210k (2021/22, £200k-£205k). The relationship to the remuneration of the organisation's workforce is disclosed in the below table along with the percentage change in remuneration of highest paid director.

Percentage change in salary in respect of highest paid director	**22/23 Increase / (decrease)**	**21/22 Increase / (decrease)**
Change in salary and allowances from the previous year in		
respect of the highest paid director:	2.47%	2.53%
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):	2.19%	5.87%
Average change in performace pay and bonuses from the previous		
year in respect of all employees (excluding highest paid director):	N/A	N/A

2022-23	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	25,318.92	35,068.13	47,672.00
Salary component of total remuneration (£)	25,278.24	34,864.26	47,169.64
Pay ratio information	8.20	5.92	4.35
2021-22	**25th percentile**	**Median**	**75th percentile**
Total remuneration (£)	23,983.03	33,687.66	45,921.50
Salary component of total remuneration (£)	23,881.02	33,398.55	45,839.00
Pay ratio information	8.44	6.01	4.41

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**
22/23	8.20	8.21	5.92	5.95	4.35	4.40
21/22	8.44	8.48	6.01	6.06	4.41	4.42

In 2022/23, 16 employees (2021/22, 27 employees) received remuneration in excess of the highest paid director. Remuneration ranged from £10,000 to £303,231 per annum (for 2021/22, – the reported range was £10,000 to £296,269).

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

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

Staff report

This section covers:

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

Staff numbers and costs

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

Average number of employees	2022/23			2021/22
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	938	58	**996**	973
Administration and estates	1,644	134	**1,779**	1,796
Healthcare assistants and other support staff	898	178	**1,076**	1,034
Nursing, midwifery and health visiting staff	1,816	237	**2,053**	2,020
Scientific, therapeutic and technical staff	467	57	**524**	491
Healthcare science staff	174	-	**174**	166
Total average numbers	**5,938**	**663**	**6,601**	6,479
Of which:				
Number of employees (WTE) engaged on capital projects	6	-	6	10

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

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

Staff costs	2022/23			2021/22
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	269,050	-	**269,050**	239,599
Social security costs	29,065	-	**29,065**	25,720
Apprenticeship levy	1,291	-	**1,291**	1,209
Employer's contributions to NHS pensions	43,291	-	**43,291**	41,044
Pension cost - other	107	-	**107**	85
Termination costs	-	-	**-**	-
Temporary staffing costs	-	48,175	**48,175**	43,177
Recoveries in respect of seconded staff	(3,509)	-	**(3,509)**	(2,881)
External financing				
Costs capitalised as part of assets	332	-	**332**	526

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

Staff composition

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

Gender	Headcount March 2023	FTE March 2023
Female	5156	4477.67
Male	1629	1551.86
Total	**6785**	**6029.54**

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

Gender	Headcount March 2023
Female	5
Male	10

Sickness absence data

Sickness absence rates have remained above 5% each month during 2022/23 with the highest rates around late autumn/wintertime. The absence rate for the 12-month period ending March 2023 was 5.4%. This peaked at 6.8% in December 2022 and on average over the last year has been 5.6%.

Trust sickness absence by month:

Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
5.9%	5.0%	5.1%	6.2%	5.2%	5.4%	6.1%	5.9%	6.8%	5.7%	5.3%	5.4%

The three highest levels of absence are attributable to cough/cold/flu, followed by gastrointestinal reasons and chest and respiratory problems. We will continue to promote a range of support for staff to remain well in work and encourage proper rest periods, taking of annual leave and continue to locally triangulate absence data with staff survey results, patient complaints and staff complaints to identify areas that may require higher levels of development and support to create healthy workplaces in those team areas.

Staff turnover percentage

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

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

Staff Engagement

The table below shows the Trust's staff engagement score over the last five years, as recorded in the NHS staff survey. The engagement score for 2022 shows an increase in staff responding, and an expected slight drop in overall engagement score based on the collated composition of answers in specific domains.

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

Staff policies regarding equality and diversity

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

In August 2020 the Trust introduced the role of inclusion ambassadors in the appointment process for all posts graded at Band 8a and above. The scheme has trained 31 ENHT staff and 15 from other ICS organisations. We have increased our ambassadors from 11 to 22. In the last year inclusion ambassadors have been involved in 116 out of 139 appointments to roles at 8a and above. A full review of the scheme and other aspects of equality, diversity and inclusion in recruitment and selection is currently underway.

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

Trade Union Facility Reporting Time

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

Table 1 - Relevant Union officials
What was the total number of our employees who were relevant union officials during the period April 2022 to March 2023?

Number of employees who were relevant union officials during the relevant period	Full time equivalent employee number
14	6029.54*

**March 2023*

Table 2 – Percentage of time spent on facility time
How many of your employees who were relevant unions officials employed during the relevant period spent a) 0%, b) 1- 50% c) 51-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	
1 – 50%	12
51 - 99%	
100%	2

Table 3 Percentage of pay bill spend on facility time

Provide the total cost of facility time	£165,541*
Provide the total pay bill	£373,897,799
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.04

**estimate*

Table 4 Paid trade union activities

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

Other employee matters

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

Expenditure on consultancy

In 2022/23 £480,637 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 2023, for more than £245 per day:

	Number
Number of existing engagements as of 31 March 2023	1
Of which the number have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

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

For all off-payroll engagements between 1 April 2022 and 31 March 2023, for more than £245 per day

	Number
No. of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	1
Of which…	
No. not subject to off-payroll legislation	0
No. subject to off-payroll legislation and determined as in-scope of IR35	0
No. subject to off-payroll legislation and determined as out of scope of IR35	1
No. of engagements reassessed for compliance or assurance purposes during the year	1
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 2022 and 31 March 2023

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year.	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements.	9

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

Reporting of compensation schemes - exit packages 2022/23

As part of the requirement to rationalise its administration areas, the Trust agreed with NHS England/Improvement the running of a mutually agreed resignation scheme, which led to several mutually agreed departures.

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages	Number of departures out of total number of exit packages where special payments have been made
	Number	Number	Number	Number
<£10,000	-	11	11	-
£10,001 to £25,000	-	3	3	1
£25,001 to 50,000	-	1	1	-
£50,001 to £100,000	-	1	1	-
£100,001 to £150,000	-	-	-	-
Total number of exit packages by type	**-**	16	16	1
Total resource cost (£)	£0	£205,402	£205,402	**£12,600**

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

Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

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

Reporting of compensation schemes - exit packages 2021/22

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

Exit packages: other (non-compulsory) departure payments	2022/23		2021/22	
	Payments agreed		Payments agreed	
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	3	123	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	13	70	19	194
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	13	-	-
Total	17	206	19	194
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the number in Note 6.1 which will be the number of individuals.

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

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

Parliamentary accountability and audit report

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

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

Fees and charges

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

Remote contingent liabilities

Details of the Trust's contingent liabilities are included within note 30 to the accounts.

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 37 of the financial statements.

During 2022/23 the Trust has no individual case of Losses and Special Payments in year that exceeded £300,000.

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board.

Date: 24 July 2023 Adam Sewell-Jones, Chief Executive

Date: 24 July 2023 Martin Armstrong, Finance Director

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

Opinion on financial statements

We have audited the financial statements of East and North Hertfordshire NHS Trust (the Trust) and its subsidiary (the Group) for the year ended 31 March 2023, which comprise the Group and Trust Statements of Comprehensive Income, Statements of Financial Position, Statements of Changes in Equity and Statements of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs), and as interpreted and adapted by the 2022-23 Government Financial Reporting Manual as contained in the Department of Health and Social Care's Group Accounting Manual 2022-23.

In our opinion the financial statements:

- give a true and fair view of the financial position of East and North Hertfordshire NHS Trust and the Group as at 31 March 2023 and of the expenditure and income of the Trust and the Group for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care's Group Accounting Manual 2022-23; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust and the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we

have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being the information described in that report as having been audited.

In our opinion the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care's Group Accounting Manual 2022-23.

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 identify any significant weaknesses in the arrangements that have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2023.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, we have identified the following significant weaknesses in the Trust's arrangements for the year ended 31 March 2023:

Significant weakness in arrangements	Recommendation
The Trust was reliant on achievement of £18.8m of savings from Cost Improvement Programmes (CIP) in order to meet its break-even obligations in 2022/23. This was not achieved, and underlying arrangements for CIP identification and monitoring were not sufficiently robust during the year to support this. *In our view this is evidence of a significant weakness in the Trust's arrangements for financial sustainability.*	*We recommend that the Trust closely monitor CIP outturn over the course of 2023/24, in particular the extent to which the revised CIP delivery framework is able to address areas of known weakness. Where delivery risk is identified, the Trust should ensure appropriate intervention takes place.*
In October 2022 the Care Quality Commission (CQC) inspected the maternity services at the Lister Hospital and rated it as 'inadequate'. CQC rated the service as inadequate primarily because: • *The service did not have enough staff to keep women safe from avoidable harm and to provide the right care and treatment* • *The service provided mandatory training in key skills to all staff, however not all staff completed this* • *The service did not have effective systems to ensure staff received adequate safeguarding training* • *The service did not control infection risk well*	*We recommend that the Trust continue to monitor and address findings arising from this report. We recommend that the Trust also consider the extent to which the root causes of issues identified may have a bearing on arrangements elsewhere in the Trust, so that remedial action can be taken.*

• *The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards* *Following this inspection the CQC issued a warning notice to the Trust under Section 29A of the Health and Social Care Act 2008. The CQC took this action as it believed a person would, or may be exposed to, the risk of harm if they had not done so.* *In our view this is evidence of a significant weakness in the Trust's governance arrangements for this service.*	

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

Report to the Secretary of State

On 27 May 2020 we reported to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 that the Trust had planned a cumulative deficit position and that as a result the Trust had begun to take a course of action that would be unlawful.

Other matters on which we report by exception

Except as reported above we have nothing to report in respect of the following matters which the Local Audit and Accountability Act 2014 requires us to report to you if:

- in our opinion the Annual Governance statement does not comply with the guidance issued by NHS Improvement; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

Responsibilities of the Directors and the Accountable Officer

As explained more fully in the Statement of Directors' 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 Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Our procedures included the following:

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

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

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

- in addressing the risk of fraud in revenue recognition, gaining an understanding of the Trust's internal control environment for recognising block contract income, including the adequacy of underlying documentation with commissioners, and for ensuring that non-block contract income is appropriately recognised under IFRS 15; substantively testing a sample of non-block income recognised throughout the year to evidence of services provided during the year; substantively testing a sample of deferred income balances to ensure that they related solely to non-block contract income for which performance obligations were not met during the financial year; substantively selecting receipts and invoices before and after year end and substantively testing a sample of block income to supporting documentation to ensure classification of block income and non-block is appropriate;
- in addressing the risk of fraud in relation to expenditure recognition, substantively selecting items of expenditure around year end based on a lower threshold that reflects the level of risk and testing an increased sample of payable accruals at year end to ensure that they are based on goods and services received prior to year end and, where amounts are estimated, the amounts accrued are accurate;
- in the case of unauthorised payments made to fictitious suppliers, testing a sample of amendments to bank details by agreeing to supplier confirmations and/or the banking system, and obtaining and reviewing the approval workflow of amending supplier bank details;
- engagement with the Trust, Local Counter Fraud Specialist and internal forensics specialists over the response to an alleged fraud;

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

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

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's 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 issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in January 2023.

Auditor's other responsibilities

As set out in the Other matters on which we report by exception section of our report there are certain other matters which we are required to report by exception.

Certificate - delay in completion of the audit

We cannot formally conclude the audit and issue an audit certificate for East and North Hertfordshire NHS Trust for the year ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

Use of our report

This report is made solely to the Board of Directors of East and North Hertfordshire NHS Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014.

Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Board of Directors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.

Rachel Brittain
Key Audit Partner

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

24 July 2023
BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

East And North Hertfordshire NHS Trust

Annual accounts for the year ended 31 March 2023

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2022/23	2021/22	2022/23	2021/22
	Note	£000	£000	£000	£000
Operating income from patient care activities	3.1	566,603	529,895	566,479	529,782
Other operating income	4	43,997	48,566	44,457	49,037
Operating expenses	6.1, 8	(606,237)	(571,582)	(607,414)	(572,918)
Operating surplus from continuing operations		**4,363**	**6,879**	**3,522**	**5,901**
Finance income		1,406	39	1,406	39
Finance expenses	10	(3,171)	(2,095)	(3,171)	(2,095)
PDC dividends payable		(5,121)	(4,666)	(5,121)	(4,666)
Net finance costs		**(6,886)**	**(6,722)**	**(6,886)**	**(6,722)**
Other losses		-	(479)	-	(479)
Corporation tax expense		(258)	(286)	-	-
Deficit for the year		**(2,781)**	**(608)**	**(3,364)**	**(1,300)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(8,340)	(187)	(8,340)	(187)
Revaluations	15	7,833	11,618	7,833	11,618
Total comprehensive (expense) / income for the year		**(3,288)**	**10,823**	**(3,871)**	**10,131**

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

Adjusted financial performance (control total basis):		
Deficit for the year	(2,781)	(608)
Remove net impairments not scoring to the Departmental expenditure limit	(4,042)	155
Remove I&E impact of capital grants and donations	578	182
Remove net impact of inventories received from DHSC group bodies for COVID response	109	153
Remove loss recognised on return of donated COVID assets to DHSC	-	479
Adjusted financial performance (deficit) / surplus	**(6,136)**	**361**

The Notes to the Accounts support the consolidated results above.

Statements of Financial Position

	Note	Group 31 March 2023 £000	Group 31 March 2022 £000	Trust 31 March 2023 £000	Trust 31 March 2022 £000
Non-current assets					
Intangible assets	11.1, 12.1	27,454	30,178	27,449	30,168
Property, plant and equipment	13.1 14.1	239,346	231,434	239,267	231,360
Right of use assets	16.1	108,376	-	108,376	-
Other investments	17	-	-	1,000	1,000
Receivables	19.1	2,562	1,581	2,562	1,581
Total non-current assets		**377,738**	**263,193**	**378,654**	**264,109**
Current assets					
Inventories	18	8,135	7,896	6,859	6,625
Receivables	19.1	29,722	24,627	29,060	23,933
Cash and cash equivalents	20.1	76,028	84,947	73,962	83,323
Total current assets		**113,885**	**117,470**	**109,881**	**113,881**
Current liabilities					
Trade and other payables	21	(85,287)	(79,393)	(85,047)	(78,985)
Borrowings	23	(10,403)	(2,973)	(10,403)	(2,973)
Other financial liabilities		(200)	(184)	(200)	(184)
Provisions	24	(7,987)	(696)	(7,987)	(696)
Other liabilities	22	(7,665)	(7,542)	(7,665)	(7,542)
Total current liabilities		**(111,542)**	**(90,788)**	**(111,302)**	**(90,380)**
Total assets less current liabilities		**380,081**	**289,875**	**377,233**	**287,610**
Non-current liabilities					
Trade and other payables	21	(3,597)	(3,799)	(3,597)	(3,799)
Borrowings	23	(139,406)	(40,860)	(139,406)	(40,860)
Other financial liabilities		(1,350)	(1,566)	(1,350)	(1,566)
Provisions	24	(7,171)	(14,249)	(7,171)	(14,249)
Total non-current liabilities		**(151,524)**	**(60,474)**	**(151,524)**	**(60,474)**
Total assets employed		**228,557**	**229,401**	**225,709**	**227,136**
Financed by					
Public dividend capital		373,703	371,259	373,703	371,259
Revaluation reserve		57,656	58,163	57,656	58,163
Income and expenditure reserve		(202,802)	(200,021)	(205,650)	(202,286)
Total taxpayers' equity		**228,557**	**229,401**	**225,709**	**227,136**

The notes on pages 121 to 177 form part of these accounts.

Name	Mr Adam Sewell Jones
Position	Chief Executive
Date	24th July 2023

Consolidated Statement of Changes in Equity for the year ended 31 March 2023

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2022	**371,259**	**58,163**	**(200,021)**	**229,401**
Deficit for the year	-	-	(2,781)	**(2,781)**
Impairments	-	(8,340)	-	**(8,340)**
Revaluations	-	7,833	-	**7,833**
Public dividend capital received	4,406	-	-	**4,406**
Public dividend capital repaid	(1,962)	-	-	**(1,962)**
Taxpayers' and others' equity at 31 March 2023	**373,703**	**57,656**	**(202,802)**	**228,557**

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

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

Statement of Changes in Equity for the year ended 31 March 2023

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022	**371,259**	**58,163**	**(202,286)**	**227,136**
Deficit for the year	-	-	(3,364)	**(3,364)**
Impairments	-	(8,340)	-	**(8,340)**
Revaluations	-	7,833	-	**7,833**
Public dividend capital received	4,406	-	-	**4,406**
Public dividend capital repaid	(1,962)	-	-	**(1,962)**
Taxpayers' and others' equity at 31 March 2023	**373,703**	**57,656**	**(205,650)**	**225,709**

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

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

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

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

Statements of Cash Flows

		Group		Trust	
		2022/23	2021/22	2022/23	2021/22
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus		4,363	6,879	3,522	5,901
Non-cash income and expense:					
Depreciation and amortisation	6.1	25,726	13,157	25,704	13,129
Net impairments	7	(4,042)	155	(4,042)	155
Income recognised in respect of capital donations	4	(143)	(405)	(143)	(405)
(Increase) in receivables and other assets		(5,967)	(1,498)	(5,999)	(1,457)
(Increase) in inventories		(239)	191	(234)	111
Increase in payables and other liabilities		6,672	21,983	6,813	22,040
(Decrease) / increase in provisions		(670)	12,860	(670)	12,860
Tax paid		(285)	(243)	-	-
Net cash flows from operating activities		**25,415**	**53,079**	**24,951**	**52,334**
Cash flows from investing activities					
Interest received		1,406	39	1,406	39
Purchase of intangible assets		(997)	(5,912)	(997)	(5,912)
Purchase of PPE		(17,308)	(33,220)	(17,286)	(33,214)
Receipt of cash donations to purchase assets		121	405	121	405
Net cash flows from investing activities		**(16,778)**	**(38,688)**	**(16,756)**	**(38,682)**
Cash flows from financing activities					
Public dividend capital received		4,406	26,518	4,406	26,518
Public dividend capital repaid		(1,962)	-	(1,962)	
Loans repaid to DHSC		(2,588)	(2,588)	(2,588)	(2,588)
Other loans repaid		-	(63)	-	(63)
Capital element of lease liability repayments		(8,663)	-	(8,663)	-
Capital element of PFI, LIFT and other service concession payments		(334)	(262)	(334)	(262)
Interest on loans		(1,096)	(1,177)	(1,096)	(1,177)
Other interest		(46)	(58)	(46)	(58)
Interest paid on lease liability repayments		(1,061)	-	(1,061)	-
Interest paid on PFI, LIFT and other service concession obligations		(982)	(873)	(982)	(873)
PDC dividend paid		(5,230)	(3,400)	(5,230)	(3,400)
Net cash flows (used in) / from financing activities		**(17,556)**	**18,097**	**(17,556)**	**18,097**
(Decrease) / increase in cash and cash equivalents		**(8,919)**	**32,488**	**(9,361)**	**31,749**
Cash and cash equivalents at 1 April		**84,947**	**52,459**	**83,323**	**51,574**
Cash and cash equivalents at 31 March	20.1	**76,028**	**84,947**	**73,962**	**83,323**

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 2022/23 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

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

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

The Trust has judged that the financial performance and position of its Charity is not material to the results of the Trust and, as a result, the decision has been made not to consolidate for 2022/23.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.4 Critical judgements in applying accounting policies
The Trust has no lease agreements for three of it's Right of Use Assets – Trust Management Corridor, Bedford Renal Unit and Harlow Renal Unit.

In relation to the Trust Management Corridor and in the absence of a lease agreement, the Trust has confirmed with Hertfordshire Partnership Foundation Trust that it enjoys the same rights and obligations as if an agreement was in place and the current expiry date of 2069 is reasonable. The Trust is committed to working with Hertfordshire Partnership Foundation Trust to formalise a lease agreement during 2023/24.

The Trust holds Right of Use assets relating to its satellite haemodialysis units. Although no formal lease agreements are in place, the Trust continues to enjoy the same rights and obligations as if an agreement were in place. Currently the Trust is out to tender for a 5 year contract for the provision of services in relation to these units and on that basis is content with the current lease term end dates of 2027 and 2028.

Note 1.5 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

Revaluations of property, plant and equipment and Right of Use Assets are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.
- Non specialised buildings (Right of Use Assets) - investment method

The current valuation exercise was carried out in March 2023. The values in the valuer report have been used to inform the measurement of property assets at valuation in these financial statements.

Significant uncertainty in valuation relates principally to land and our specialised buildings. The valuer, in arriving at the value of specialised buildings, estimates the build costs based on current market indices. A 5% change in estimated build costs will result in a 4.67% change in the carrying value of buildings. Land valuation is based on current market rate per Acre. A 5% change in the market rate will result in a 5% change in the carrying value of land.

The estimated useful economic lives of PPE and intangible assets is based on management's experience plus professional advice from experts. When management identifies that actual useful economic lives differ materially from the estimates used to calculate depreciation, that charge is adjusted prospectively. Due to the significance of PPE and intangibles investment, variations between actual and estimated useful economic lives could impact operating results both positively and negatively. As such, this is a key source of estimation uncertainty. The depreciation and amortisation expense for the year was £25.7m (11.4% of non-pay expenditure). A 10 per cent increase in average asset lives would have resulted in a £2.3m reduction in this figure and a 10 per cent decrease in average asset lives would have resulted in a £2.3m increase in this figure.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.6 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

A receivable is recognised when goods are delivered as this is the point in time that the consideration is unconditional and because only the passage of time is required before the payment is due.

Revenue from NHS contracts

The main source of income for the Trust are the contracts set with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level.

The 2022/23 National Financial Payment System aims to provide a transition out of the COVID-19 block payment into a payment approach known as aligned payment and incentive (API). The API approach is the preferred contract type by DHSC, however some Trusts have moved into other arrangements. The Trust has agreed block contracts with some of its Integrated Care Systems.

The funding for API payment system is a mixture of three elements: fixed, variable and pass through. The passthrough element is primarily applicable to Drugs and Devices and applies to the NHSE contact and the Cancer Drug Fund contract.

The variable element is primarily the Elective Recovery Fund Scheme (ERF). Elective recovery funding scheme provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. An over achievement of elective recovery targets resulted in a variable contribution by commissioners to the Trust.

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.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.7 Other forms of income

Revenue from education and training

Health Education England provide funding to maintain education and training capacity, retain students on education and training programmes, and enable students to provide their skills to the NHS to support the response. Income is recognised in line with the requirements of IFRS 15. Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.

Non-patient care services to other bodies

The Trust provides non-patient related services to other NHS bodies for which income is recognised in line with IFRS 15. Revenue is recognised when performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligation.

Note 1.8 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1.9 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 1.10 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.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.11 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 are determined as follows:

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

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

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

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

Note 1.11 Property, plant and equipment (cont)

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.

Note 1.11 Property, plant and equipment (cont)

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

Note 1.11 Property, plant and equipment (cont)

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as a finance cost as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

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

Note 1.12 Intangible assets

Recognition

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

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

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.

The Trust holds material intangible assets for its Electronic Patient Record (EPR) system Lorenzo. Two assets with a combined NBV of £14.77m and remaining amortisation period of 10 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.

Notes to the Accounts (continued) here and thereafter

Note 1.12 Intangible assets (cont)

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Development expenditure	5	10
Software licences	5	15
Licences & trademarks	5	10

Note 1.13 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.

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

Note 1.14 Cash and cash equivalents

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

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

Note 1.15 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.

Notes to the Accounts (continued) here and thereafter

Note 1.15 Financial assets and financial liabilities cont

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, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

The Trust determines expected credit losses using a matrix of percentage based on the class of financial asset and prior recoverability. The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.16 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 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

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 1.16 Leases (cont)
Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability and adjusted for prepaid and accrued lease payments and deferred lease incentives recognised in the statement of financial position immediately prior to initial application. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.
No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000.

The Trust as lessor
Leases of owned assets where the Trust is lessor were unaffected by initial application of IFRS 16. For existing arrangements where the Trust is an intermediate lessor, classification of all continuing sublease arrangements has been reassessed with reference to the right of use asset.

2021/22 comparatives
Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.17 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 2023:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.27%	0.47%
Medium-term	After 5 years up to 10 years	3.20%	0.70%
Long-term	After 10 years up to 40 years	3.51%	0.95%
Very long-term	Exceeding 40 years	3.00%	0.66%

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 2023:

	Inflation rate	Prior year rate
Year 1	7.40%	4.00%
Year 2	0.60%	2.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 1.70% in real terms (prior year: minus 1.30%).

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 29 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.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.2 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

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

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

Note 1.21 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 1.22 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 1.23 Third party assets

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

Note 1.24 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.

Notes to the Accounts (continued) here and thereafter

Note 1 Accounting policies and other information (continued) here and thereafter

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

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

IFRS 16 Leases - application of liability measurement principles to PFI and other service concession arrangements

From 1 April 2023, the measurement principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Such remeasurements will be recognised as a financing cost. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred.

Initial application of these principles will be on 1 April 2023 using a modified retrospective approach with the cumulative impact taken to reserves. This is expected to result in an increased PFI liability on the statement of financial position. DHSC are yet to publish any guidance and as such the effect of this has not yet been quantified.

Other standards, amendments and interpretations

There are no other standards that have been issued that will have material effect on the Trust.

Note 2 Operating Segments

The Trust has assessed that services provided by each of its Divisions or geographical locations all fall within the description of 'provision of healthcare' and operate as a single operating segment. There is no one unit with income of over 10% of total income that the chief operating decision maker, the Trust Board, would make operating decisions based on segmented reporting.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Income from commissioners under API contracts*	430,120	393,861	430,120	393,861
High cost drugs income from commissioners (excluding pass-through costs)	52,892	51,909	52,892	51,909
Other NHS clinical income	34,034	53,845	34,034	53,845
Private patient income	4,241	3,314	4,241	3,314
Elective recovery fund	19,946	13,632	19,946	13,632
Agenda for change pay offer central funding*	11,042	-	11,042	-
Additional pension contribution central funding*	13,264	12,559	13,264	12,559
Other clinical income	1,064	775	940	662
Total income from activities	**566,603**	**529,895**	**566,479**	**529,782**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National tariff payments system documentation.

https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/

* The Government has announced a formal pay offer to Agenda for Change unions for staff subject to Agenda for Change pay, terms and conditions. The full cost and related funding have been recognised in these accounts.

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

Note 3.2 Income from patient care activities (by source)	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	163,467	132,051	163,467	132,051
Clinical commissioning groups*	94,180	393,158	94,180	393,158
Integrated care boards*	303,605	-	303,605	-
Other NHS providers	46	597	46	597
Non-NHS: private patients	4,241	3,314	4,241	3,314
(chargeable to patient)	240	182	240	182
Injury cost recovery scheme	620	412	620	412
Non NHS: other	204	181	80	68
Total income from activities	**566,603**	**529,895**	**566,479**	**529,782**

* On 1st July 2022, integrated care boards (ICBs) became legally established through the Health and Care Act 2022, and CCGs were closed down.

Note 3 Operating income from patient care activities (Group) continued

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

	2022/23	2021/22
	£000	£000
Income recognised this year	240	182
Cash payments received in-year	176	111
Amounts added to provision for impairment of receivables	124	52
Amounts written off in-year	-	119

Note 4 Other operating income

	Group					
	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,965	-	**5,965**	5,646	-	**5,646**
Education and training	18,304	198	**18,502**	17,438	187	**17,625**
Non-patient care services to other bodies	14,665	-	**14,665**	17,908	-	**17,908**
Reimbursement and top up funding	1,247	-	**1,247**	3,871	-	**3,871**
Receipt of capital grants and donations and peppercorn leases	-	143	**143**	-	405	**405**
Charitable and other contributions to expenditure	-	1,231	**1,231**	-	1,688	**1,688**
Revenue from operating leases	-	169	**169**	-	110	**110**
Other income	2,075	-	**2,075**	1,313	-	**1,313**
Total other operating income	**42,256**	**1,741**	**43,997**	**46,176**	**2,390**	**48,566**

Note 4 Other Operating income (Trust) continued

	Trust					
	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	5,965	-	**5,965**	5,646	-	**5,646**
Education and training	18,304	198	**18,502**	17,438	187	**17,625**
Non-patient care services to other bodies	14,522	-	**14,522**	17,776	-	**17,776**
Reimbursement and top up funding	1,247	-	**1,247**	3,871	-	**3,871**
Receipt of capital grants and donations and peppercorn leases	-	143	**143**	-	405	**405**
Charitable and other contributions to expenditure	-	1,231	**1,231**	-	1,688	**1,688**
Revenue from operating leases	-	272	**272**	-	213	**213**
Other income	2,075	500	**2,575**	1,313	500	**1,813**
Total other operating income	**42,113**	**2,344**	**44,457**	**46,044**	**2,993**	**49,037**

Other contract income includes:

Car parking income of £840k (2021/22 £287k)

Catering (non-patient) of £1,152k (2021/22 £730k)

Note 4 Other Operating income continued

Note 4.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2022/23	2021/22
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	5,542	1,299

Note 4.2 Transaction price allocated to remaining performance obligations

	31 March 2023	31 March 2022
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000
within one year	7,665	7,542
Total revenue allocated to remaining performance obligations	**7,665**	**7,542**

Note 5 Fees and charges

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

Note 6.1 Operating expenses

	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	8,288	8,300	8,288	8,300
Purchase of healthcare from non-NHS and non-DHSC bodies	11,358	11,148	11,358	11,165
Staff and executive directors costs ***	383,952	344,318	382,429	342,952
Remuneration of non-executive directors	136	145	136	145
Supplies and services - clinical (excluding drugs costs)	40,343	40,092	40,458	40,193
Supplies and services - general	13,938	13,203	13,938	13,203
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	67,697	62,014	70,578	64,883
Inventories written down	293	317	293	317
Consultancy costs	481	842	473	834
Establishment	5,631	5,638	5,468	5,483
Premises	24,132	22,167	24,073	22,106
Transport (including patient travel)	1,305	1,242	1,305	1,242
Depreciation on property, plant and equipment*	22,564	10,155	22,547	10,135
Amortisation on intangible assets	3,162	3,002	3,157	2,994
Net (credit) / charge to impairments	(4,042)	155	(4,042)	155
Movement in credit loss allowance: contract receivables	207	30	207	30
Increase in other provisions	16	12,656	16	12,656
Change in provisions discount rate(s)	(116)	18	(116)	18
Fees payable to the external auditor audit services- statutory audit **	245	83	210	74
Internal audit costs	159	141	159	141
Clinical negligence	17,304	16,064	17,304	16,064
Legal fees	143	459	143	459
Insurance	287	324	278	316
Research and development	3,633	3,673	3,633	3,673
Education and training	1,998	1,888	1,998	1,888
Expenditure on short term leases (current year only)*	707	-	707	-
Operating leases expenditure (comparative only)*	-	10,785	-	10,785
Redundancy	78	-	78	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes	131	121	131	121
Car parking & security	595	478	595	478
Hospitality	36	3	36	3
Losses, ex gratia & special payments	12	45	12	45
Other services, eg external payroll	1,529	1,670	1,529	1,670
Other	35	406	35	390
Total	**606,237**	**571,582**	**607,414**	**572,918**

* Depreciation increase is directly related to the implementation of IFRS16. As does the movement in operating leases year on year.

** The audit fee is stated on a gross basis for the Trust and net for the subsidiary. The total amount NET of VAT is £210k

*** Employer pension contributions paid by NHSE on the Trusts behalf (£13.264m) and the Agenda for Change pay awar (£11.024m) are included within the Staff costs.

Note 6.2 Limitation on auditor's liability (Group)

The limitation on auditor's liability for external audit work is £1 million (2021/22: £1 million).

Note 7 Impairment of assets

	2022/23	2021/22
	£000	£000
Net impairments charged to operating (deficit) / surplus resulting from:		
Changes in market price	(4,042)	155
Total net impairments charged to operating (deficit) / surplus	**(4,042)**	**155**
Impairments charged to the revaluation reserve	8,340	187
Total net impairments	**4,298**	**342**

Impairments relating to Changes in Market Price and those Charged to the Revaluation Reserve relate to the Trust's Property, Plant and Equipment. This reflects the movements in value of properties based on their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis.

Note 8 Employee benefits

	Group		Trust	
	2022/23 Total £000	2021/22 Total £000	2022/23 Total £000	2021/22 Total £000
Salaries and wages	269,050	239,599	267,527	238,233
Social security costs	29,065	25,720	29,065	25,720
Apprenticeship levy	1,291	1,209	1,291	1,209
Employer's contributions to NHS pensions	43,291	41,044	43,291	41,044
Pension cost - other	107	85	107	85
Temporary staff (including agency)	48,175	43,177	48,175	43,177
Total gross staff costs	**390,979**	**350,834**	**389,456**	**349,468**
Recoveries in respect of seconded staff	(3,509)	(2,881)	(3,509)	(2,881)
Total staff costs	**387,470**	**347,953**	**385,947**	**346,587**
Of which				
Costs capitalised as part of assets	332	527	332	527
Included in Research & development	3,108	3,108	3,108	3,108
Included in Redundancy	78	-	78	-

Note 8.1 Retirements due to ill-health (Group)

During 2022/23 there were 3 early retirements from the Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £153k (£144k in 2021/22).

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

Note 9 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements of NHS Pensions 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 10 Finance expenditure

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

	Group and Trust	
	2022/23	2021/22
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	1,096	1,174
Interest on lease obligations	1,061	-
Interest on late payment of commercial debt	-	1
Main finance costs on PFI and LIFT schemes obligations	426	447
Contingent finance costs on PFI and LIFT scheme obligations	556	426
Total interest expense	**3,139**	**2,048**
Unwinding of discount on provisions	(14)	(10)
Other finance costs	46	57
Total finance costs	**3,171**	**2,095**

Note 10.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Group and Trust	
	2022/23	2021/22
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	1

Note 11.1 Intangible assets - 2022/23

Group	Software licences	Licences & trademarks	Internally generated assets	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022	**40,187**	**-**	**4,788**	**-**	**44,975**
Additions	826	-	-	171	**997**
Reclassifications	(730)	-	-	589	**(141)**
Derecognition	(649)	-	-	-	**(649)**
Valuation / gross cost at 31 March 2023	**39,634**	**-**	**4,788**	**760**	**45,182**
Amortisation at 1 April 2022	**11,142**	**-**	**3,655**	**-**	**14,797**
Provided during the year	2,999	-	163	-	**3,162**
Reclassifications	(11)	-	-	-	**(11)**
Derecognition	(220)	-	-	-	**(220)**
Amortisation at 31 March 2023	**13,910**	**-**	**3,818**	**-**	**17,728**
Net book value at 31 March 2023	**25,724**	**-**	**970**	**760**	**27,454**
Net book value at 1 April 2022	**29,045**	**-**	**1,133**	**-**	**30,178**

Note 11.2 Intangible assets - 2021/22

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

Note 12.1 Intangible assets - 2022/23

Trust	Software licences	Licences & trademarks	Internally generated assets	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022	**40,083**	**-**	**4,788**	**-**	**44,871**
Additions	826	-	-	171	**997**
Reclassifications	(730)	-	-	589	**(141)**
Derecognition	(649)	-	-	-	**(649)**
Valuation / gross cost at 31 March 2023	**39,530**	**-**	**4,788**	**760**	**45,078**
Amortisation at 1 April 2022	**11,048**	**-**	**3,655**	**-**	**14,703**
Provided during the year	2,994	-	163	-	**3,157**
Reclassifications	(11)	-	-	-	**(11)**
Derecognition	(220)	-	-	-	**(220)**
Amortisation at 31 March 2023	**13,811**	**-**	**3,818**	**-**	**17,629**
Net book value at 31 March 2023	**25,719**	**-**	**970**	**760**	**27,449**
Net book value at 1 April 2022	**29,035**	**-**	**1,133**	**-**	**30,168**

Note 12.2 Intangible assets - 2021/22

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

Note 13.1 Property, plant and equipment - 2022/23

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022	**33,168**	**159,352**	**7,247**	**62,820**	**15,098**	**2,646**	**280,331**
Additions	-	2,304	7,714	4,935	2,014	-	**16,967**
Impairments	(7,254)	(5,097)	-	-	-	-	**(12,351)**
Reversals of impairments	-	4,011	-	-	-	-	**4,011**
Revaluations	157	5,663	-	-	-	-	**5,820**
Reclassifications	-	3,681	(8,853)	5,215	69	-	**112**
Derecognition	-	-	-	-	(260)	-	**(260)**
Valuation/gross cost at 31 March 2023	**26,071**	**169,914**	**6,108**	**72,970**	**16,921**	**2,646**	**294,630**
Accumulated depreciation at 1 April 2022	**-**	**1,330**	**-**	**35,410**	**9,984**	**2,173**	**48,897**
Provided during the year	-	7,244	-	3,919	1,402	87	**12,652**
Impairments	-	370	-	-	-	-	**370**
Reversals of impairments	-	(4,604)	-	-	-	-	**(4,604)**
Revaluations	-	(2,013)	-	-	-	-	**(2,013)**
Reclassifications	-	(19)	-	-	1	-	**(18)**
Accumulated depreciation at 31 March 2023	**-**	**2,308**	**-**	**39,329**	**11,387**	**2,260**	**55,284**
Net book value at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,534**	**386**	**239,346**
Net book value at 1 April 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,114**	**473**	**231,434**

Note 13.2 Property, plant and equipment - 2021/22

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

Note 13.3 Property, plant and equipment financing - 31 March 2023

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	26,071	157,305	6,108	30,284	5,534	322	**225,624**
On-SoFP PFI contracts and other service concession arrangements	-	8,425	-	-	-	-	**8,425**
Owned - donated/granted	-	1,876	-	3,357	-	64	**5,297**
NBV total at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,534**	**386**	**239,346**

Note 13.4 Property, plant and equipment financing - 31 March 2022

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

Included in building are LINAC enabling work at Mount Vernon Cancer Centre with NBV of £2,593k, tenant improvement work at Luton renal unit £3,927k and other tenant improvement work £64k which are not revalued.

Note 13.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Group	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	25,011	-	-	-	-	**25,011**
Not subject to an operating lease	26,071	142,595	6,108	33,641	5,534	386	**214,335**
NBV total at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,534**	**386**	**239,346**

Note 14.1 Property, plant and equipment - 2022/23

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022	**33,168**	**159,352**	**7,247**	**62,820**	**15,029**	**2,490**	**280,106**
Additions	-	2,304	7,714	4,935	2,014	(22)	**16,945**
Impairments	(7,254)	(5,097)	-	-	-	-	**(12,351)**
Reversals of impairments	-	4,011	-	-	-	-	**4,011**
Revaluations	157	5,663	-	-	-	-	**5,820**
Reclassifications	-	3,681	(8,853)	5,215	69	-	**112**
Derecognition	-	-	-	-	(260)	-	**(260)**
Valuation/gross cost at 31 March 2023	**26,071**	**169,914**	**6,108**	**72,970**	**16,852**	**2,468**	**294,383**
Accumulated depreciation at 1 April 2022	**-**	**1,330**	**-**	**35,410**	**9,919**	**2,087**	**48,746**
Provided during the year	-	7,244	-	3,919	1,401	71	**12,635**
Impairments	-	370	-	-	-	-	**370**
Reversals of impairments	-	(4,604)	-	-	-	-	**(4,604)**
Revaluations	-	(2,013)	-	-	-	-	**(2,013)**
Reclassifications	-	(19)	-	-	1	-	**(18)**
Accumulated depreciation at 31 March 2023	**-**	**2,308**	**-**	**39,329**	**11,321**	**2,158**	**55,116**
Net book value at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,531**	**310**	**239,267**
Net book value at 1 April 2022	**33,168**	**158,022**	**7,247**	**27,410**	**5,110**	**403**	**231,360**

Note 14.2 Property, plant and equipment - 2021/22

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

Note 14.3 Property, plant and equipment financing - 31 March 2023

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	26,071	157,305	6,108	30,284	5,530	247	**225,545**
On-SoFP PFI contracts and other service concession arrangements	-	8,425	-	-	-	-	**8,425**
Owned - donated / granted	-	1,876	-	3,357	-	64	**5,297**
Total net book value at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,530**	**311**	**239,267**

Note 14.4 Property, plant and equipment financing - 31 March 2022

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

Note 14.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

Trust	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	25,011	-	-	-	-	**25,011**
Not subject to an operating lease	26,071	142,595	6,108	33,641	5,530	310	**214,255**
Total net book value at 31 March 2023	**26,071**	**167,606**	**6,108**	**33,641**	**5,530**	**310**	**239,266**

Note 15 Revaluations of property, plant and equipment

The Trust's land and buildings valuations were reviewed at 31 March 2023 by an independent, qualified valuer, using the Modern Equivalent Asset (MEA) methodology for specialised assets, in accordance with DHSC guidance and the NHS Group Accounting Manual.

A full valuation was carried out by Avison Young (previously known as Bilfinger GVA), 3 Brindley Place, Birmingham, B1 2JB. This was carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Current Value in Existing Use of the properties has been primarily derived using the Depreciated Replacement Cost (DRC) approach because the specialised nature of the asset means that there are no market transactions for this type of asset. The DRC method is a form of cost approach that is defined in the RICS Valuation – Global Standards 2022 (RB Global) Glossary as: 'The current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.'

For non-specialised properties, the investment method of valuation has been used.

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

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

The definition of MEA
Modern Equivalent Assets - a structure similar to an existing structure with an equivalent, productive capacity, which could be built using modern materials, techniques and designs. Replacement cost is the basis used to estimate the cost of constructing a modern equivalent asset. The MEA has been determined based upon a single build programme on a cleared site to modern design and arrangement.

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

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

The net decrease in the valuation of property, plant and equipment which was transferred to revaluation reserve during the year was £507k (shown in Other Comprehensive Income as gross impairments of £8,340k and revaluations of £7,833k), whilst impairment of £4,234k was credited to the statement of comprehensive income.

Note 16 Leases - East And North Hertfordshire NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee.
In addition to the freehold owned by the Trust, it also leases a number of other buildings in the South East of England to carry out its obligations as a healthcare provider. These are leased from other NHS Providers as well as other bodies external to government.

In addition, the Trust leases a large proportion of its medical equipment from Lifecycle, who act as a contract manager for the Trust.

The Trust has applied IFRS 16 to account for lease arrangements from 1 April 2022 without restatement of comparatives. Comparative disclosures in this note are presented on an IAS 17 basis.

Note 16 Leases - East And North Hertfordshire NHS Trust as a lessee (cont)

Note 16.1 Right of use assets - 2022/23

Group and Trust	Property (land and buildings) £000	Plant & machinery £000	Total £000	Of which: leased from DHSC group bodies £000
IFRS 16 implementation - adjustments for existing operating leases / subleases	104,404	6,669	**111,073**	79,697
Additions	1,997	344	**2,341**	1,997
Remeasurements of the lease liability	4,926	(757)	**4,169**	4,424
Movements in provisions for restoration / removal costs	897	-	**897**	631
Revaluations	(403)	-	**(403)**	-
Disposals / derecognition	(1,854)	(53)	**(1,907)**	(1,854)
Valuation/gross cost at 31 March 2023	**109,967**	**6,203**	**116,170**	**84,895**
Depreciation provided during the year	7,956	1,956	**9,912**	6,335
Impairments	192	-	**192**	-
Revaluations	(403)	-	**(403)**	-
Disposals / derecognition	(1,854)	(53)	**(1,907)**	(1,854)
Accumulated depreciation at 31 March 2023	**5,891**	**1,903**	**7,794**	**4,481**
Net book value at 31 March 2023	**104,076**	**4,300**	**108,376**	**80,414**
Net book value of right of use assets leased from other NHS providers				11,293
Net book value of right of use assets leased from other DHSC group bodies				69,121

Note 16 Leases - East And North Hertfordshire NHS Trust as a lessee (cont)

Note 16.2 Revaluations of right of use assets

The Trust's Right of Use assets were reviewed at 31 March 2023 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 considered on a case by case basis to determine whether a formal valuation is required. Following review of all ROU assets, a value was obtained for the Origin Housing ROU asset and its value at 31 March 2023 was £15.565m. The carrying value of all Right of Use assets classified as Buiildings at 31 March 2023 is £101.305m.

The net decrease (loss) in the valuation of Right of Use assets which was transferred to the statement of comprehensive income during the year was £192k.

Note 16.3 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 23.

	Group and Trust 2022/23 £000
Carrying value at 31 March 2022	-
IFRS 16 implementation - adjustments for existing operating leases	111,073
Lease additions	2,319
Lease liability remeasurements	4,169
Interest charge arising in year	1,061
Lease payments (cash outflows)	(9,724)
Carrying value at 31 March 2023	**108,898**

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 the Statement of Cash Flows. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments at 31 March 2023

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2023 £000	31 March 2023 £000
Undiscounted future lease payments payable in:		
- not later than one year;	8,487	4,843
- later than one year and not later than five years and	27,738	18,828
- later than five years.	87,940	64,865
Total gross future lease payments	**124,165**	**88,536**
Finance charges allocated to future periods	(15,267)	(7,857)
Net lease liabilities at 31 March 2023	**108,898**	**80,679**
Of which:		
- Current	7,408	4,114
- Non-Current	101,490	76,565

Note 16.5 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the Trust previously determined to be operating leases under IAS 17.

	Group and Trust 2021/22 £000
Operating lease expense	
Minimum lease payments	10,785
Total	**10,785**

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	9,898
- later than one year and not later than five years and	23,909
- later than five years.	74,769
Total	**108,576**

Note 16 Leases - East And North Hertfordshire NHS Trust as a lessee (cont)

Note 16.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 1.15.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	Group and Trust 1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	**108,576**
Impact of discounting at the incremental borrowing rate	(12,027)
IAS 17 operating lease commitment discounted at incremental borrowing rate	**96,549**
Less:	
Commitments for short term leases	(218)
Irrecoverable VAT previously included in IAS 17 commitment	(2,349)
Other adjustments:	
Differences in the assessment of the lease term	1,336
Public sector leases without full documentation previously excluded from operating lease commitments	12,233
Other adjustments	3,522
Total lease liabilities under IFRS 16 as at 1 April 2022	**111,073**

Note 17 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 2023 and for the period then ended.

ENH Pharma Ltd is 100% owned and was incorporated on 28 July 2014 in the United Kingdom. Its principal activity is outpatient pharmacy. As at 31 March 2023, the subsidiary's total profit for the year was £1,083k (2021/22: £1,192k), with gross assets of £6,009k (2021/22: £5,498k) and net assets of £3,851k (2021/22: £3,266k).

Note 18 Inventories

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Drugs	3,954	3,630	2,678	2,360
Consumables	4,034	4,114	4,034	4,113
Energy	147	152	147	152
Total inventories	**8,135**	**7,896**	**6,859**	**6,625**

Inventories recognised in expenses for the year were £69,335k (2021/22: £64,034k). Write-down of inventories recognised as expenses for the year were £293k (2021/22: £317k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2022/23 the Trust received £1,231k of items purchased by DHSC (2021/22: £1,688k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above. The closing balance of inventory included in Consumables was £56k (2021/22: £165k).

Note 19.1 Receivables

	Group		Trust	
	31 March 2023	31 March 2022	31 March 2023	31 March 2022
	£000	£000	£000	£000
Current				
Contract receivables	22,463	15,981	22,427	15,939
Allowance for impaired contract receivables	(1,540)	(1,342)	(1,540)	(1,342)
Prepayments (non-PFI)	3,089	4,493	3,089	4,493
PDC dividend receivable	327	218	327	218
VAT receivable	3,234	3,297	2,608	2,645
Clinician pension tax provision reimbursement funding from NHSE	5	-	5	
Other receivables	2,144	1,980	2,144	1,980
Total current receivables	**29,722**	**24,627**	**29,060**	**23,933**
Non-current				
Contract receivables	1,418	569	1,418	569
Allowance for impaired contract receivables	(352)	(404)	(352)	(404)
Prepayments (non-PFI)	899	949	899	949
Clinician pension tax provision reimbursement funding from NHSE	597	467	597	467
Total non-current receivables	**2,562**	**1,581**	**2,562**	**1,581**
Of which receivable from NHS and DHSC group bodies:				
Current	16,725	11,055	16,725	11,055
Non-current	597	467	597	467

Note 19.2 Allowances for credit losses - 2022/23

	Group and Trust Contract receivables £000
Allowances as at 1 April 2022	**1,746**
Changes in existing allowances	207
Changes arising following modification of contractual cash flows	(61)
Allowances as at 31 March 2023	**1,892**

Note 19.3 Allowances for credit losses - 2021/22

	Group and Trust Contract receivables £000
Allowances as at 1 April 2022	**1,844**
Changes in existing allowances	30
Changes arising following modification of contractual cash flows	(128)
Allowances as at 31 March 2023	**1,746**

Note 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
At 1 April	**84,947**	**52,459**	**83,323**	**51,574**
Net change in year	(8,919)	32,488	(9,361)	31,749
At 31 March	**76,028**	**84,947**	**73,962**	**83,323**
Broken down into:				
Cash at commercial banks and in hand	2,081	1,657	15	33
Cash with the Government Banking Service	73,947	83,290	73,947	83,290
Total cash and cash equivalents as in SoFP	**76,028**	**84,947**	**73,962**	**83,323**

Note 20.2 Third party assets held by the trust

East And North Hertfordshire NHS Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Monies on deposit	9	8
Total third party assets	**9**	**8**

Note 21 Trade and other payables

	Group		Trust	
	31 March 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
Current				
Trade payables	26,028	21,234	25,788	20,826
Capital payables	358	1,388	358	1,388
Accruals	46,588	45,080	46,588	45,080
Social security costs	3,995	3,854	3,995	3,854
Other taxes payable	4,062	3,797	4,062	3,797
Pension contributions payable	4,256	4,040	4,256	4,040
Total current trade and other payables	**85,287**	**79,393**	**85,047**	**78,985**
Non-current				
Other payables	3,597	3,799	3,597	3,799
Total non-current trade and other payables	**3,597**	**3,799**	**3,597**	**3,799**
Of which payables from NHS and DHSC group bodies:				
Current	10,439	5,745	10,439	5,745
Non-current	-	-	-	-

Note 22 Other liabilities

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Current		
Deferred income: contract liabilities	7,665	7,542
Total other current liabilities	**7,665**	**7,542**

Note 23 Borrowings

	Group and Trust	
	31 March 2023	31 March 2022
	£000	£000
Current		
Loans from DHSC	2,637	2,638
Lease liabilities*	7,408	-
Obligations under PFI service concession contracts	358	335
Total current borrowings	**10,403**	**2,973**
Non-current		
Loans from DHSC	32,862	35,449
Lease liabilities*	101,490	-
Obligations under PFI service concession contracts	5,054	5,411
Total non-current borrowings	**139,406**	**40,860**

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 16.

Note 23.1 Reconciliation of liabilities arising from financing activities

Group and Trust - 2022/23	Loans from DHSC	Other loans	Lease liabilities	PFI schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2022	**38,087**	**-**	**-**	**5,746**	**43,833**
Financing cash flows - payments and receipts of principal	(2,588)	-	(8,663)	(334)	**(11,585)**
Financing cash flows - payments of interest	(1,096)	-	(1,061)	(426)	**(2,583)**
Non-cash movements:					
IFRS 16 implementation - adjustments for existing operating leases / subleases	-	-	111,073	-	**111,073**
Additions	-	-	2,341	-	**2,341**
Lease liability remeasurements	-	-	4,169	-	**4,169**
Application of effective interest rate	1,096	-	1,061	426	**2,583**
Carrying value at 31 March 2023	**35,499**	**-**	**108,920**	**5,412**	**149,831**

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

Note 24 Provisions for liabilities and charges analysis (Group)

Group and Trust	Pensions: early departure costs	Legal claims	Redundancy	Lease dilapidations - amounts previously charged to revenue	Lease dilapidations - Cost capitalised under IFRS 16	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2022	**919**	**75**	**297**	**13,187**	**-**	**467**	**14,945**
Change in the discount rate	(132)	-	-	16	897	(529)	**252**
Arising during the year	113	57	457	-	-	654	**1,281**
Utilised during the year	(103)	(45)	(297)	(850)	-	(2)	**(1,297)**
Reversed unused	(21)	-	-	-	-	-	**(21)**
Unwinding of discount	(14)	-	-	-	-	12	**(2)**
At 31 March 2023	**762**	**87**	**457**	**12,353**	**897**	**602**	**15,158**
Expected timing of cash flows:							
- not later than one year;	95	-	457	6,934	496	5	**7,987**
- later than one year and not later than five years and	431	-	-	3,660	271	37	**4,399**
- later than five years.	236	87	-	1,759	130	560	**2,772**
Total	**762**	**87**	**457**	**12,353**	**897**	**602**	**15,158**

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

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

Redundancy provision relates to costs that are likely to be paid.

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

Other provision relates to clinician pension costs.

The discount rate applied to provisions above is 1.70%.

Note 25 Clinical negligence liabilities

At 31 March 2023, £345,482k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East And North Hertfordshire NHS Trust (31 March 2022: £540,945k).

Note 26 On-SoFP PFI service concession arrangements

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

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

Note 26.1 On-SoFP PFI service concession arrangement obligations

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

	Group and Trust	
	31 March 2023 £000	31 March 2022 £000
Gross PFI service concession liabilities	**7,914**	**8,674**
Of which liabilities are due		
- not later than one year;	757	761
- later than one year and not later than five years and	2,998	2,996
- later than five years.	4,159	4,917
Finance charges allocated to future periods	(2,502)	(2,928)
Net PFI service concession arrangement obligation	**5,412**	**5,746**
- not later than one year;	358	335
- later than one year and not later than five years and	1,680	1,560
- later than five years.	3,374	3,851

Note 26.2 Total on-SoFP PFI service concession arrangement commitments

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

	Group and Trust	
	31 March 2023 £000	31 March 2022 £000
Total future payments committed in respect of the PFI service concession arrangements	**20,097**	**20,680**
Of which payments are due:		
- not later than one year;	1,769	1,635
- later than one year and not later than five years and	7,528	6,960
- later than five years.	10,800	12,085

Note 26.3 Analysis of amounts payable to service concession operator

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

	Group and Trust	
	2022/23 £000	2021/22 £000
Unitary payment payable to service concession operator	**1,726**	**1,595**
Consisting of:		
- Interest charge	426	447
- Repayment of balance sheet obligation	335	263
- Service element and other charges to operating expenditure	131	121
- Capital lifecycle maintenance	278	338
- Contingent rent	556	426
Total amount paid to service concession operator	**1,726**	**1,595**

Note 27 Financial instruments

Note 27.1 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/I. 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/I. 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 2023 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 27 Financial instruments (cont)

Note 27.2 Carrying values of financial assets

	Group
Carrying values of financial assets as at 31 March 2023	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	24,133
Cash and cash equivalents	76,028
Total at 31 March 2023	**100,161**

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

Note 27.3 Carrying values of financial assets **Trust**

Carrying values of financial assets as at 31 March 2023	**Held at amortised cost**
	£000
Trade and other receivables excluding non financial assets	23,471
Cash and cash equivalents	73,962
Total at 31 March 2023	**97,433**

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

All financial assets are held at amortised cost.

Note 27 Financial instruments (cont)

Note 27.4 Carrying values of financial liabilities

	Group
Carrying values of financial liabilities as at 31 March 2023	**Held at amortised cost**
	£000
Loans from the Department of Health and Social Care	35,499
Obligations under leases	108,898
Obligations under PFI service concessions	5,412
Trade and other payables excluding non financial liabilities	78,883
Other financial liabilities	1,550
Total at 31 March 2023	**230,242**

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

Note 27.5 Carrying values of financial liabilities

	Trust
Carrying values of financial liabilities as at 31 March 2023	**Held at amortised cost**
	£000
Loans from the Department of Health and Social Care	35,499
Obligations under leases	108,898
Obligations under PFI service concessions	5,412
Trade and other payables excluding non financial liabilities	78,645
Other financial liabilities	1,550
Total at 31 March 2023	**230,004**

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

All financial liabilities are held at amortised cost.

Note 27 Financial instruments (cont)

Note 27.6 Fair values of financial assets and liabilities

The book value (carrying value) of financial assets and liabilities is considered a reasonable approximation of fair value.

Where the financial instrument is not linked to an inflationary index, and a nominal rate is required, 1.9% has been used, as advised by HM Treasury (PES). This has been applied to DH Loans.

PFI – we have applied a 3.76% discount factor

Note 28 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 2023 £000	31 March 2022 £000	31 March 2023 £000	31 March 2022 £000
In one year or less	88,385	76,422	88,147	76,014
In more than one year but not more than five years	45,884	18,606	45,884	18,606
In more than five years	121,082	37,461	121,082	37,461
Total	**255,351**	**132,489**	**255,113**	**132,081**

Note 29 Losses and special payments

	2022/23		2021/22	
Group and trust	**Total number of cases Number**	**Total value of cases £000**	**Total number of cases Number**	**Total value of cases £000**
Losses				
Bad debts and claims abandoned	99	60	70	129
Stores losses and damage to property	64	259	50	329
Total losses	**163**	**319**	**120**	**458**
Special payments				
Ex-gratia payments	29	57	36	267
Special severance payments	1	13	-	-
Total special payments	**30**	**70**	**36**	**267**
Total losses and special payments	**193**	**389**	**156**	**725**
Compensation payments received				

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

Special severance payments include any non-contractual payments made following judicial mediation, and non-contractual payments in lieu of notice.

Cases over £300,000

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

Note 30 Related parties

During the year none of the Department of Health and Social Security Ministers, Trust board members or key management staff, or parties related to them has undertaken any material transactions with East and North Hertfordshire NHS Trust. The Department of Health and Social Care is the Trust's parent department and there has been a number of material transactions with other public sector bodies, the most significant of which were with East and North Hertfordshire ICB, NHS England, Health Education England, the Hillingdon Hospitals NHS Foundation Trust, HMRC, the NHS Pension Scheme, NHS Resolution, West Essex ICB, Bedfordshire ICB, Hertfordshire Valleys ICB, NHS Hampshire and Isle of Wight ICB, NHS Hertfordshire and West Essex 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 2022-23 the Trust received £1,133k (2021-22 £1,446k) from the charity. The majority of these receipts were for the re-imbursement of running costs and donations made for the benefit of patients and staff. There was £304k (2021-22 £375k) receivable balance from the charity at the end of the financial year.

Note 31 Events after the reporting date

There have been no events after the Balance Sheet date that have materially impacted, or cast doubt on, the values and balances recorded within these Financial Statements. There is therefore no requirement for the Trust to adjust, or disclose potential impacts on, the values herein.

Note 32 Better Payment Practice code

Non-NHS Payables	2022/23 Number	2022/23 £000	2021/22 Number	2021/22 £000
Total non-NHS trade invoices paid in the year	74,426	241,874	68,930	219,118
Total non-NHS trade invoices paid within target	70,078	212,142	64,278	195,991
Percentage of non-NHS trade invoices paid within target	94.2%	87.7%	93.3%	89.4%
NHS Payables				
Total NHS trade invoices paid in the year	2,500	34,171	2,470	33,700
Total NHS trade invoices paid within target	1,748	25,549	1,683	24,894
Percentage of NHS trade invoices paid within target	69.9%	74.8%	68.1%	73.9%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

The Trust adopts the NHS Standard Terms and Conditions when entering into contractual arrangements, which requires invoices to be paid within 30 days of receipt. For the purpose of this disclosure, it has been assumed that all invoices which were paid within the 30 day target were due to be paid within that period.

Obligations for Late Payment Interest for failure to pay within the due terms are included within Note 10.1.

Note 33 External financing

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

	2022/23 £000	2021/22 £000
Cash flow financing	(222)	(8,883)
External financing requirement	**(222)**	**(8,883)**
External financing limit (EFL)	1,741	(8,883)
Underspend against EFL	**1,963**	**-**

Note 34 Capital Resource Limit

	2022/23 £000	2021/22 £000
Gross capital expenditure	24,474	37,366
Less: Disposals	(689)	(479)
Less: Donated, granted and peppercorn leased capital additions	(143)	(405)
Plus: Loss on disposal from capital grants in kind	-	479
Charge against Capital Resource Limit	**23,642**	**36,961**
Capital Resource Limit	25,605	37,082
Underspend against CRL	**1,963**	**121**

Note 35 Breakeven duty financial performance

	2022/23 £000
Adjusted financial performance (deficit) (control total basis)	(6,136)
Breakeven duty financial performance (deficit)	**(6,136)**

Note 35 Breakeven duty financial performance (cont)

Note 35.1 Breakeven duty rolling assessment

Each NHS trust board is responsible for planning and controlling the activities, costs and income of the NHS trust to ensure that it remains financially viable at all times. The board is accountable for financial control and for ensuring that the NHS trust meets its statutory duty to break even.

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
	£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)
Breakeven duty cumulative position	1,825	4,325	7,653	11,221	11,753	11,862	8,249	(7,977)
Operating income	-	331,312	340,309	346,402	350,543	365,313	376,050	384,712
Cumulative breakeven position as a percentage of operating income	-	1.3%	2.2%	3.2%	3.4%	3.2%	2.2%	(2.1%)

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	(29,533)	(24,424)	(13,543)	1,452	2,528	361	(6,136)
Breakeven duty cumulative position	(37,510)	(61,934)	(75,477)	(74,025)	(71,497)	(71,136)	(77,272)
Operating income	411,870	420,968	444,903	498,597	540,900	578,461	610,600
Cumulative breakeven position as a percentage of operating income	(9.1%)	(14.7%)	(17.0%)	(14.8%)	(13.2%)	(12.3%)	(12.7%)

The Trust first reported cumulative deficit in 2015-16 of £7,977k (-2.1% of operating income). The Trust is in the eighth year of consecutive break-even duty breach achieving a cumulative deficit of £77,272 (-12.7% of operating income) above the -0.5% permitted. The Trust recorded a deficit of £6,136k in 2022-23 and is working with NHS England & Improvement to develop a plan to achieve cumulative breakeven duty in future years.