OUR VALUES
Commitment
Care Quality

NHS
West Hertfordshire Hospitals
NHS Trust

Annual Report and Accounts 2017/18

1. THE PERFORMANCE REPORT

OVERVIEW

Welcome to our 2017/18 annual report which looks back at another year of significant and sustained improvement. The high point was the official news in January that we had been taken out of special measures following a full inspection of our three hospitals by the Care Quality Commission. This was a huge boost to our staff and a very welcome public recognition of how much we have achieved. Although our overall rating remains 'requires improvement' there is a positive change in the ratings and we no longer have any service at Hemel Hempstead or St Albans City Hospitals rated as inadequate. This reflects our commitment to quality and that we are becoming a more clinically-led organisation. Although urgent and emergency care at Watford General retained an 'inadequate' rating, we are beginning to see enhanced levels of performance in this service and a recently approved substantial investment to increase staffing will improve this further.

During 2017/18 the emergency department was expanded, which had the double benefit of providing an eight bedded area for patients who need further investigation as well as a move to a more suitable community setting for the outpatient physiotherapy service. Like many hospitals across the country, we experienced a very difficult winter and despite a robust approach to patient flow, we regularly had to use additional 'surge' beds in some of our assessment areas.

A strategic outline business case seeking funding for the redevelopment of Watford and St Albans hospitals was submitted to NHS Improvement (NHSI) in September 2017. We are also pursuing investment for local services for the population of Dacorum and are working closely with NHSI to bring our plans to fruition as part of our commitment to achieving a long-term sustainable solution for all local residents. In the meantime, we will continue to improve our current buildings and in 2017/18 we celebrated the opening of the West Herts Cardiac Centre; a vastly expanded endoscopy suite; the new physiotherapy unit and a state-of-the-art cardiac MRI and CT suite.

The 12 months covered by this report also include some fantastic feedback from external assessors. Our expanded and refurbished endoscopy unit passed a stringent accreditation with flying colours, our impressive mortality rates were presented at conferences, the stroke service was 'A' rated in an annual audit and we won a Health Service Journal award for our work on maternity staffing. There are also many other individual accolades too numerous to mention in this report but collectively they characterise a workforce that is committed to providing the very best care for our patients.

Our performance against access targets (waiting times) is published each month in our Board papers. We now regularly meet six out of the seven cancer treatment time standards and detailed work on simplifying patient pathways has reduced waiting times and resulted in a better patient experience. We work closely with our health and social care partners to achieve this and are playing an active role in the Hertfordshire and west Essex Sustainability and Transformation Partnership. Our evolving clinical partnership with the Royal Free will also be of benefit to our patients.

While finances remain challenging, we spent £8 million less (compared to 2016/17) on agency staffing. This is a positive development and is due to concerted efforts to recruit staff permanently and improve the use of our in-house temporary staff. Staffing remains an issue for us, especially as our proximity to London – where NHS wages are higher – leads to stiff competition.

We would like to conclude by paying tribute to our outstanding team of staff and volunteers whose commitment to our patients, and appetite for learning and continuous improvement make West Herts such a great place to work and learn.

Professor Steve Barnett, Chair **Katie Fisher, Chief Executive Officer**

This report is divided into three sections, as follows:

- ***The Performance* Report**– a summary of the Trust's performance against key national and local standards in 2017/18

- ***The Accountability Report*** - an accountability report that sets out how the Trust's governance has ensured full compliance with all relevant guidance and legislation and details of the remuneration of directors and senior managers

- ***The Financial Statements*** – a summary of the Trust's financial performance in 2017/18

The report covers all the areas that the Trust is required to formally report on an annual basis.

The Trust's vision is to provide *"the very best care for every patient, every day".*

The vision is underpinned by values:

More specifically, the Trust sets itself the four aims below.

Aim One	**To deliver the best quality care for our patients**
Aim Two	**To be a great place to work and learn**
Aim Three	**To improve our finance sustainability**
Aim Four	**To develop a strategy for the future**

The aims are underpinned by a set of strategic objectives. This report demonstrates the measures taken by the Trust during 2017/18 to achieve its aims and objectives.

THE SERVICES

The Trust provides acute healthcare services to a core catchment population of approximately half a million people living in west Hertfordshire and the surrounding area. The Trust also provides a range of more specialist services to a wider population, serving residents of north London, Bedfordshire, Buckinghamshire and east Hertfordshire. With around 4,800 staff and 400 volunteers across the three hospitals in Watford, St Albans and Hemel Hempstead, the Trust is one of the largest employers locally.

Hemel Hempstead Hospital

The clinical services offered at Hemel Hempstead include:

- antenatal and community midwifery
- outpatients
- urgent care
- medical care, including endoscopy and cardiac lung function testing
- diagnostic support, including x-ray, CT, MRI, ultrasound and non-urgent pathology

St Albans City Hospital

St Albans is an elective care centre. The clinical services offered include:

- antenatal and community midwifery
- outpatients
- minor injuries
- elective and day surgery
- diagnostic support, including x-ray, ultrasound, mammography, blood and specimen collection

Watford General Hospital

Watford is the main site for emergency and specialist care. The clinical services include:

- women's and children's services
- emergency care
- ambulatory care
- acute wards and frailty
- intensive care and emergency surgery
- planned care, including outpatients and complex surgery
- medical care, including endoscopy, cardiology and chemotherapy
- diagnostic support, including x-ray, CT, MRI, ultrasound and urgent and non-urgent pathology

In 2017/18:

- 41,000 emergency patients (including ambulatory care) and 48,350 elective patients were admitted
- 138,800 attendances A&E, urgent care centre and minor injuries unit
- 472,500 attendances outpatient appointments
- 4,900 babies were born under the care of the Trust (including home deliveries)

Key achievements

- Improved CQC inspection and being moved out of special measures
- Consistently achieved the national diagnostic waiting times standard with performance above the national average
- Sustained either below expected or expected mortality rates
- Opening new clinical decision unit
- Meeting national agency staffing target
- Installing a new MRI/CT scanner at St Albans
- Opening new cardiac centre
- Receiving a positive JAG inspection for the endoscopy service
- Winning an award in the workforce category of the 2017 Health Service Journal Awards for a successful drive to recruit and retain midwives

Aim One	To deliver the best quality care for our patients

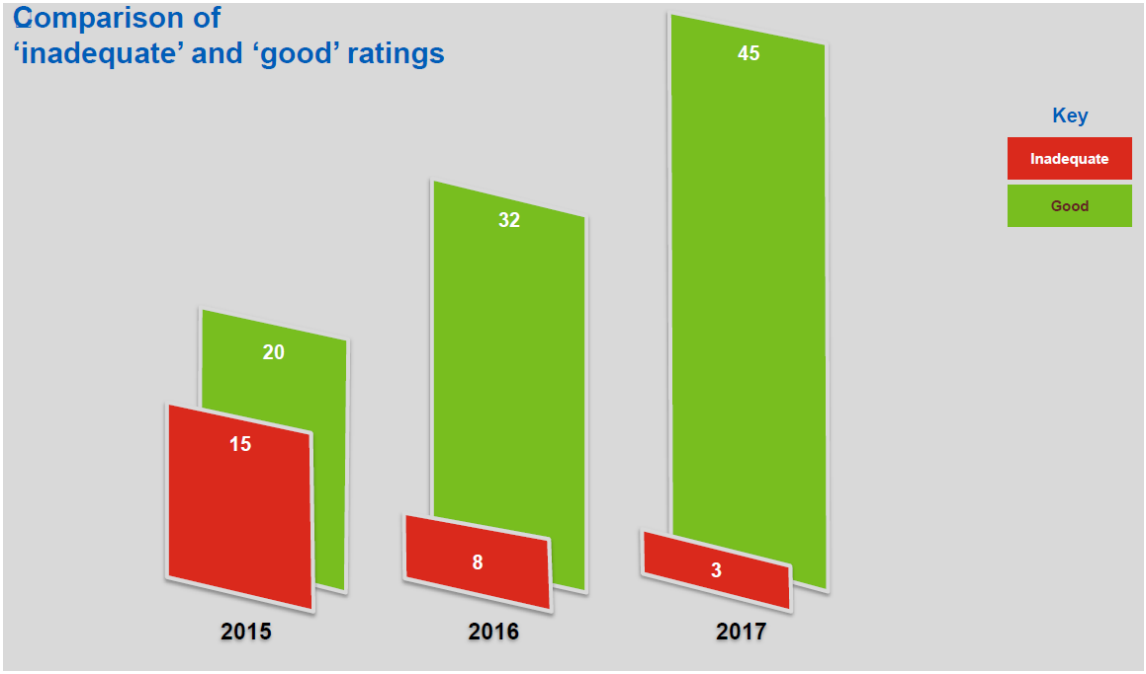
Quality commitment

A key focus in the reporting year has been on the development of a quality commitment. The commitment sets out the 'West Herts Way' and will drive the provision of excellent services to patients which are safe, compassionate and innovative and help to create a supportive environment for staff. The Trust will be supported over the forthcoming year by the Institute for Healthcare Improvement (IHI) to develop a structured approach to assess what leadership capability and capacity are needed in order to successfully deliver the quality commitment.

Care Quality Commission's inspection

The Trust underwent a third Care Quality Commission (CQC) inspection in August and September 2017 and was rated as 'good' for caring and 'requires improvement' for safe, effective, responsive and well led, with an overall rating of 'requires improvement'. This was a significant improvement in ratings from previous inspections and led to the Trust being moved out of special measures.

Comparisons from the last three inspections of inadequate and good ratings are shown below and clearly demonstrate the significant improvement over the past two years.



The CQC highlighted some areas of outstanding practice, including innovations in the children's emergency department to tackle mental health and suicide awareness, an "iSeeU" initiative enabling women to use face-time technology to see their baby on the neonatal care unit and enhanced recovery care pathways which were helping patients to recover more quickly after surgery.

One area which remained with an overall rating of 'inadequate' was the emergency department. Since the inspection, the Trust has made many improvements to this service, the most significant is the establishment of the emergency department (ED) as a service in its own right, the appointment of new staff, the expansion of ED and the adoption of new ways of working. The full inspection reports are available on the CQC website (http://www.cqc.org.uk/).

Quality account

The Trust is required to prepare a quality account for each financial year. This has been produced in accordance with the Department of Health and Social Care's (DHSC) guidance. Progress made against achieving identified priorities for 2016/17 has been monitored by the Trust throughout the year and the 2017/18 quality account will be published in June 2018. For further details please see page 28.

Improving services

During the reporting year, a wide range of large and small service changes have been achieved to improve services for patients, staff, volunteers and visitors. A small selection are list below:

- An enhanced patients' lounge at Watford hospital.
- The adoption of the national 'Red2Green' approach.
- Supporting the national #endPJparalysis initiative.
- The patient discharge summary has been reviewed and updated.
- A new lung function lab opened in Watford hospital.
- The establishment of a beads of courage programme which offers a child a glass bead to add to a chain when they have an operation, an overnight stay or a procedure.
- The installation of a bell in the children's ward for patients to ring at the end of their treatment.
- The launch, with CGL Spectrum, of an ambulatory pathway for alcohol detoxification.
- The relaunch of a noise at night campaign to reduce overnight disturbances for patients.
- Longer visiting hours were introduced on all adult wards.
- A project to allow mothers to see their babies in the neonatal unit by the use of a tablet device
- The establishment of a dedicated specialist diabetes podiatry service.
- Introducing a number of measures to improve end of life care.
- The development of a new library of healthcare literature on conditions, treatments and services.

Changes to clinical services

In response to national guidance, the urgent care centre in Hemel Hempstead hospital became an urgent treatment centre on 01 December 2017. The underlying issue of insufficient numbers of GPs to work overnight at the urgent treatment centre remains and Herts Valleys Clinical Commissioning Group (HVCCG) has launched a project group to consider the future provision of urgent care services across west Hertfordshire and possible care models.

On 01 August 2017, the management of Simpson ward at Hemel Hempstead hospital transferred to Hertfordshire Community NHS Trust (HCT). Simpson ward, which has 21 beds, is used to care for patients who no longer require acute care and are being assessed prior to deciding where their longer term care needs will best be provided.

There was also a change to the configuration of surgical elective beds at Watford in order to create a ring fenced orthopaedic elective ward. The outpatient physiotherapy service was also consolidated into the West Hertfordshire Therapy Unit, located in a former rehabilitation unit in Jacketts Field, Abbots Langley.

In line with a national focus on driving more efficiencies and increasing the level of consolidation across NHS pathology services, in November 2017 the Board approved a strategic outline case for the modernisation of pathology services. The case has been submitted to NHSI for review and approval and work on an outline business case has commenced.

In addition to the service changes reported above, in 2017/18 the Trust established a range of working groups which focused on improving emergency care, workforce, ICT, environment, bed reconfiguration, and planned care.

Serious incidents

The Trust reported four never events in 2017/18. All never events are subjected to intense investigation and scrutiny, with action plans drawn up with the multi-disciplinary teams to ensure that there are changes in practice to prevent these occurring again. In line with new guidance, the Trust has requested the de-escalation of three of the four never events as they relate to categories of incidents which the revised list no longer includes. There were 40 serious incidents declared in 2017/18.

Work to improve the quality of serious incident reports and investigation processes continues, including taking early decisions on whether an incident should be discussed by the serious incidents panel and whether it meets the national serious incident criteria. The table below shows a selection of actions taken as a result of learning from serious incidents and never events.

Serious Incidents and Never Events	Actions taken
Maternity/obstetric and neonatal incidents	▪ Maternity safety alert posters to remind staff of correct clinical management processes ▪ Infant feeding guidelines developed ▪ Risk assessment completed following the delivery of a baby
Surgical invasive procedures	▪ Escalation procedure for inpatient orthopaedic referrals ▪ Monitoring of the World Health Organisation's surgical checklist ▪ Sharing lessons learnt at divisional quality governance meetings ▪ Learning from a thematic review at 'Stories around Safety' event. ▪ Strengthening the post-take process for surgical patients ▪ Programme of nursing staff engagement and awareness
Hospital acquired pressure ulcers	▪ Ward based training on pressure area care to transitional nurses ▪ Daily patient safety huddles undertaken on wards
Sub-optimal care of the deteriorating patient	▪ Learning included in the trust-wide patient safety newsletter ▪ Implementation of 'hands on' radiology training for junior doctors ▪ New PACS system to improve accessibility for clinicians
Medication	▪ Learning shared in pharmaceutical editorial ▪ Discussion at local medication safety officers group and presented at a global webex conference

Harm free care

55 clinical areas have undertaken a test your care audit with nine out of 24 adult inpatient areas achieving over 95% compliance. The test your care data is incorporated into new ward-level dashboards and an integrated performance report enables staff to be aware of the performance in their area and across the Trust. This year has seen a rollout of ACE (accredited clinical environment); a framework which encompasses test your care data, matron quality checks, patient feedback and an environmental 15 step approach audit.

Learning from deaths

New guidance came into operation around learning from deaths in December 2017. To meet the guidance, the Trust adopted the Royal College of Physicians structured judgment review methodology to review care linked to the death of patients. During the reporting period, 1,525 patients died and 12

structured judgment reviews were carried out. Themes from the review were discussed by senior clinicians, including the medical director and chief nurse and at a wide range of forums, including sub-committees and a mortality review group.

Addressing patient concerns

In 2017/18, the PALS team dealt with 2,848 reported concerns with the two most prevalent concerns being around waiting for appointments and cancelled appointments. The Trust also saw an increase in contacts from patients who were concerned about their admission for treatment being delayed or cancelled. This increase related to a national directive to defer all non-urgent inpatient elective care and day case procedures in order for trusts to respond to emergency pressures. Planned care is currently being recommenced which should improve the need to delay and cancel admissions and procedures.

In some cases patients prefer to complain formally to the Trust and in 2017/18, 830 formal complaints were received. The Trust's complaints handing procedure and remedy aims to follow the Parliamentary and Health Services Ombudsman's Principles for Remedy which provide guidance on the way public bodies respond to complaints and concerns raised by patients and members of the public. Those principles are getting it right; acting fairly and proportionately; putting things right; being customer focused; being open and accountable and seeking continuous improvement. Further information is available at www.ombudsman.org.uk/about-us/our-principles/principles-remedy.

This reporting year, new ways of recording how complaints are closed was introduced and there was a marked improvement in the quality of responses which led to a significant decrease in reopened complaints compared to the previous year. The complaints team focused on proactively contacting patients to talk about their experiences and providing information on what was being done to improve patient flow, transport services, discharges and admissions.

In addition to many hundreds of letters, card, notes and small gifts received directly by wards and departments, during the period of this report, the chief executive received 187 formal compliment letters from satisfied patients and visitors.

National surveys

The Trust received an overall rating of 7.5/10 in the national inpatient survey. Patients identified that discharge was an important area for them, therefore there has been focused activity on reviewing and improving discharge processes. This work also links with priority three of the Trust's patient experience and carer strategy which focuses on improving the patient journey.

The national maternity survey was conducted on women who gave birth in February 2017 and the Trust's result mirrored the national picture, which showed marked improvements in women's experiences of maternity services across safety, personalisation and choice.

The Trust received an overall rating of 8.5/10 in the national cancer patient experience survey. A significant amount of work has taken place to improve the cancer service since an external review took place in January 2015. Some of the changes include a redesign of patient pathways, an increase in the specialist cancer nursing team and improved data quality.

The patients' panel

The patients' panel have maintained their position as a 'critical friend' to the Trust during 2017/18 and ensured the patient and carer voice is heard and listened to at every opportunity. There has been an increased level of activity and engagement from panel members in response to a number of new

projects and initiatives including participation in the ACE (accreditation care environment) scheme and supporting outpatient department listening events.

Learning from patient feedback

The Trust uses a variety of forums to collect and use patient feedback to improve its services. PALS and formal complaints act as a vital channel for patient feedback, as does the results of national and local surveys and the national friends and family test (FFT).

Over 80 clinical areas across the Trust are now using FFT and in 2017/18 more than 11,000 responses were received from patients with almost 90% of them recommending the Trust. The survey results are displayed across wards and departments with a selection of comments from patients and actions of improvement by staff. A further way that the Trust gains valued feedback from patients is by monitoring the comments published on the NHS Choices website.

A number of new measures have been introduced as a direct result of learning from patient feedback. Some of these are listed below:

- Parents of children and babies are benefitting from improved facilities, such parents' lockers.
- Improved communication of test results to parents of children and babies.
- Staggered admission times to the day surgery unit to reduce patients waiting times.
- An expanded carer support team in children's services.
- Staff wearing head torches and night lights to reduce noise and light at night.
- PALS and complaints leaflets have been translated into the top three foreign languages
- The adoption of a 'nurse in charge' badge.
- Outpatient letters can now be generated into braille, easy read and large font format.

Progress towards achieving equality

In 2017/18, the Trust published its second national NHS workforce race equality standard (WRES) report detailing its performance against each of the nine indicators. The WRES report is available on the Trust's website. A workforce equality forum continues to steer the Trust's equality and diversity agenda and address barriers experienced by people from protected characteristics. Extending engagement with under-represented groups has also helped the Trust to identify root causes and potential solutions to address the less positive staff and patient experience for disabled people. The Trust also continues to analyse the effect of any policy, service, or function, on staff and patients from the nine protected characteristics. A multicultural network is run by staff to provide support to BME staff with particular protected characteristics and, in October 2017, the Trust celebrated black history month.

Getting it right first time

Getting it right first time (GIRFT) is a national programme designed to improve medical care within the NHS by reducing unwarranted variations. Seven surgical specialties received a visit in 2017/18 and a subsequent action plan incorporating national and local recommendations. An implementation manager has been assigned to the Trust to assist in the delivery of agreed improvements, tracking progress and prioritising support where needed across all specialties.

Emergency preparedness and resilience

In October 2017 the Trust was assessed by NHS England against the NHS core standards for emergency preparedness and was found to be fully compliant. The Trust also participated in a multi-agency exercise which tested responses to a terrorist firearms attack and underwent a live hospital evacuation exercise to test evacuation skills in a smoke-filled environment.

The environment and support services

Recognising the length of time a major estate redevelopment would take, the Trust continues to invest in keeping its hospitals as safe and clean as possible. In this financial year, over £6m of capital funding has been invested to address significant backlog maintenance issues and undertake development projects. Some areas of the emergency department at Watford were refurbished and the footprint was expanded following a successful application for funding as part of the national funding to make improvements ahead of winter 2017/18. A significant number of smaller scale projects were also undertaken over the reporting period and the Trust became a smoke-free zone in order to provide a safe and healthy environment for patients, staff, visitors and volunteers.

The annual PLACE inspection was undertaken in 2017/18 to provide an independent measure of the quality of the environment. The table below shows the outcome of the inspection.

Category	National average	Hemel Hempstead	St Albans	Watford
Cleanliness	98.38%	99.22%	98.55%	98.38%
Food	89.68%	89.86%	83.89%	81.90%
Food Organisation	88.80%	84.62%	84.62%	85.91%
Ward Food Service	90.196%	93.91%	83.39%	80.90%
Privacy, Dignity and Wellbeing	83.68%	73.91%	64.39%	66.71%
Condition, Appearance and Maintenance	94.02%	80.23%	87.99%	85.51%
Dementia	76.71%	51.07%	60.80%	53.81%
Disability	82.56%	64.04%	70.50%	69.17%

Support services

The Trust entered into a contract with Mitie Cleaning and Environmental Services Limited on 01 April 2018 to provide a range of services including cleaning, catering, portering, pest control, linen and helpdesk services. Mitie will be investing in new technology and patients will benefit from the latest in meal delivery with the introduction of a new heating and chilling unit.

IT and data security

Work has continued in 2017/18 to develop a digital vision to describe the Trust's plans to deliver future IT services. The vision was launched in spring 2018 and includes digital dictation, electronic ordering of pathology tests and the digitalisation of medical records. Over 85% of desktop computer equipment was replaced in 2017/18 and a new state-of-the-art picture archive and communication system was established which has made the reviewing of x-rays and scans quicker and more efficient for clinical teams.

In response to a global cyber-attack in May 2017, the Trust declared a critical incident when a decision was made to switch off all emails coming into and going out of the Trust to prevent infection. To reduce the risk of a subsequent attack, the latest anti-virus software has been installed and the Trust has been identified by NHS Digital as a priority organisation for an onsite, cybersecurity assessment. The Trust has also been invited to submit a bid against a national cybersecurity fund.

To support the replacement of paper systems and increase the availability of real time information, a new suite of operational and digital applications has been developed, including a two-hourly status

report on the emergency department, a real time bed state and an electronic bed request. Fax machines have also being discontinued to improve information security.

Achieving the aim and objectives

The table below demonstrates progress in 2017/18 against achieving aim one and the underpinning objectives.

Aim one	Objective	Evidence
To deliver the best quality care for our patients	To sustain 'expected' or 'better than expected performance on key mortality indicators (SHMI & HSMR)	▪ Sustained either below expected or expected mortality rates
	To meet all national standards	▪ Five out of the ten national standards achieved. For further information see page 18
	To improve patient experience	▪ Raft of initiatives implemented as part of the priorities linked to the patient experience and carer strategy. (See pages 6 -17)
	To further strengthen and embed quality improvement processes through the development of a quality strategy and delivery of quality priorities set out in the 2017/18 quality account	▪ Board approval of a quality commitment developed in consultation with staff, patients and other key stakeholders. ▪ For evidence of delivery of the 2017/18 priorities see the quality account on the Trust's website.
	To agree and implement plans to improve our estate and IM&T*(to bid for additional capital funding to support urgent improvements to our estate)*	▪ Strategic outline case for acute redevelopment was submitted to NHSI in September 2017. ▪ £11.1m on new, refurbished and replacement capital assets. ▪ Digital vision approved and investment cases being developed to deliver its objectives ▪ Investment in new equipment and mobile technology ▪ Investment was secured to enhance cyber-security protection

AIM TWO	TO BE A GREAT PLACE TO WORK AND LEARN

Workforce and development

One of the key priorities for 2017/18 was to progress with delivering the 2016-2019 workforce and development strategy. This aims to make the Trust a great place to work by focusing upon four key priorities; laying firm foundations, finding the right people, supporting people and developing people.

Recruitment and retention

Recruitment continued to be a challenge in 2017/18, particularly for nurses and a number of other specialist clinical roles. To address these challenges the Trust worked with other trusts to develop a cross-organisational strategy, including running local recruitment campaigns to target overseas nurses living locally and those looking for flexible working; continuing with overseas recruitment of nurses; developing more flexible working options and broadening offers of career development and support. In addition, the Trust joined with partners to run a London-wide advertising campaign to

attract nurses into the Hertfordshire health system and participated in an NHSI initiative to improve retention rates.

In 2017/18, the Trust won a national award for the implementation of a shared staff bank collaboration with East and North Herts NHS Trust and HCT in partnership with NHS Professionals to maximise the capacity of bank staff across the partnership and to drive value.

Staff health and wellbeing

The Trust continues to run an extensive staff health and wellbeing programme, including workshops, classes, and health MOTs. In March 2017, a new portal was launched to further promote the programme to staff. The occupational health service also provides a fast track physiotherapy assessment scheme for staff with the aim of keeping staff fit and healthy and at work, as well as assisting and supporting them to return to work following injury or illness.

Afternoon tea parties hosted by members of the Board and executive team were held across the three hospitals in June 2017 to thank staff for their hard work and dedication.

Training and development

During the reporting period, the Trust continued to offer a range of leadership development programmes. These were run in conjunction with the University of Hertfordshire and offered staff the opportunity to achieve credits towards postgraduate study up to Masters level.

To make training more accessible and easier for staff to undertake, a new learning management system was installed and staff are now able to access the vast majority of core training from this system.

The Trust continues to be part of a nursing associate project to become one of the 24 approved test sites for a new nursing associate training and qualification programme. Plans are in place to implement other new roles including the advanced nursing practitioner and support operating department practitioner roles.

In order to lay the foundations for a new career advisory service, a coaching and mentoring network was initiated in 2017/18.

Flu vaccination campaign

This year's flu vaccination campaign was led by a senior multi-disciplinary steering group and a cohort of dedicated flu champions was enrolled to administer vaccinations. In November 2017, the Trust took part in the national #Jabathon campaign run by NHS Employers. The flu vaccination programme achieved a 60% compliance rate.

Volunteers

Volunteers play an invaluable role in the Trust of supporting staff to offer enhanced services to patients. During volunteers' week in June 2017 a number of the Trust's 400 volunteers were invited to breakfast with the chairman and all volunteers were invited to a thank you lunch where a number of long serving volunteers received awards for their commitment and dedication.

Staff survey

The results of the national staff survey showed that, although the Trust's performance had not improved from the previous year, overall performance was better than comparator Trusts. A clear

action plan is in place to act upon feedback from the survey; this is underpinned by five key corporate actions; let's talk, developing you, being kind, we value you and your working environment.

Further information

Full details of performance against workforce indicators can be found in the integrated performance reports on the Trust's website.

Achieving the aim and objectives

The table below demonstrates progress in 2017/18 against achieving aim two and the underpinning objectives.

Aim two	Objective	Evidence
To be a great place to work and learn	To improve staff satisfaction as measured by the national staff survey and local temperature check	▪ 72 out of 89 measures were better or the same as comparator trusts ▪ The Trust remains in the top third of trusts with highest staff satisfaction ratings
	To reduce staff turnover rates, vacancies and use of agency staff	▪ Agency costs reduced by a £8.0m to £18.5m from 2016/17 and has now decreased by a total of 50.1% over the last two years. ▪ Vacancy rate dropped to 10.7% from 13% at the start 2017/18 ▪ Labour turnover is 16.3%
	To ensure all staff have annual appraisals and personal development plans	▪ The appraisal compliance rate has ranged throughout the year with a high of 92% and the current rate at 78%
	To strengthen clinical and managerial leadership	▪ Senior clinicians are a core part of executive committee and Board. ▪ Five divisional directors and four associate medical directors attended a development programme which is being rolled out to clinical leads and clinical directors ▪ Well attended leadership programme in place.

Aim Four	To develop a strategy for the future

Future strategy

Work has continued during 2017/18 to develop services and the estate in line with the Trust's long term strategy. This strategy sets out priorities for delivering more care locally, strengthening core services and delivering excellent extended care where the Trust has appropriate skills and opportunities. Following engagement with the local community, the expectation for the future site

configuration is that emergency and specialised care will be provided at Watford hospital, with planned care being delivered at St Albans and Hemel Hempstead hospitals.

Following approval of a strategic outline case (SOC) for the future development of acute services by the Board in February 2017, HVCCG reviewed the SOC in June 2017 and supported the Trust's preferred option of a redevelopment of the Watford and St Albans sites, in favour of buying and building on a new site. Having received formal confirmation from commissioner and support from the Sustainability and Transformation Partnership (STP), the SOC has been submitted to NHSI for review.

During 2018/19, work will commence on the second stage of planning that culminates in an outline business case (OBC) to set out future plans for acute care in much greater detail. Work will also continue in partnership with HVCCG and wider stakeholders to develop a SOC for services in Dacorum and Hemel Hempstead. To support this, senior leaders from the Trust attended a clinical engagement event in October 2017, led by HVCCG, and attendees debated what services might look like for a future Hemel Hempstead hub. Colleagues from primary care and HCT, plus key players from the New Hospital Campaign joined in group discussions around young people's services, frailty, urgent care and long term conditions.

A SOC recommending the development of a new multi-storey car park at Watford hospital was approved by NHSI in February 2018. The next phase is for the Trust to invest in the development of an OBC and a full business case, with the aim of presenting this to NHSI prior to construction starting in spring 2019.

In addition to confirming longer-term plans, interim changes will be required in order to support high quality care and to maintain an environment that is fit for purpose. The immediate priorities include plans to develop long-term care pathways at Hemel Hempstead hospital, to establish further one-stop care pathways at St Albans for patients potentially requiring surgery and to ensure that there is sufficient capacity to meet future demand at Watford hospital.

Hertfordshire and West Essex sustainability and transformation partnership

The Trust continues to work across a wider geography as part of the Hertfordshire and west Essex STP which covers a population of 1.5 million. The Trust plans to transform its estate in line with plans across the wider STP, with both interim and longer-term plans supported by STP partner organisations.

A review of the STP governance processes was undertaken in 2017/18 to ensure they were fit for purpose to support implementation of the plan at pace, whilst recognising the statutory responsibilities and accountabilities of constituent organisations. There was a clear focus throughout the year on developing implementation plans and strengthening project management structures to support delivery. Activity and financial modelling was also reviewed to ensure all assumptions were robust and interdependencies were understood and appropriately mapped. A new work stream was initiated in 2017/18 to review future governance models for the STP and the potential for the STP to transition to an accountable care system.

The Chairs of the STP met regularly over the year and the Boards of all organisations approved a Memorandum of Understanding in November 2017. Trust clinicians were recruited to join a clinical oversight group to strengthen clinical engagement in the STP and good progress was made in delivering cash releasing efficiencies through the medicines optimisation and procurement STP work streams.

The Trust has been working closely with the STP on the implementation of the national apprenticeship levy. Further work is ongoing with system partners to align locum rates in East of

England, support the development of a proposal to bring together HR office functions across the STP and, subject to ministerial approval, (as part of the Hertfordshire consortium) the Trust has been chosen as a pilot site to improve bank flexible working.

Partnership working

The Trust continues to actively engage in discussions with HVCCG and local provider partners around building new collaborative provider arrangements to support the delivery of integrated care and pathway redesign as set out in Your Care, Your Future.

Active work was undertaken in the reporting year on the redesign of a range of planned and unplanned care pathways, in partnership with other providers with a particular focus on gynaecology; diabetes, MSK, dermatology ENT and ophthalmology. Clinicians have also been involved in scoping other areas of potential redesign and changes to commissioning arrangements. The Trust is working collaboratively with HCT and other partners to identify opportunities to implement new admission prevention and discharge to assess pathways to relieve pressure on emergency care services.

HVCCG has asked the Trust to take the overall coordinating lead across the provider partnership for the delivery of an integrated stroke pathway and detailed discussions are ongoing regarding mobilising the lead provider model.

The Trust worked with Hertfordshire Community Gynaecology Service (HCGS) on the development of a new community gynaecology service and the stroke team continued to work closely with community teams which resulted in the service achieving an 'A-rating' against key national patient care standards.

East and North Hertfordshire NHS Trust was awarded the contract as network lead for a specialised vascular hub, with the Trust and the Princess Alexandra Hospital NHS Trust as integrated members of the network. A programme board has been established and the Trust continues to work with partners to develop an operating model and implementation plan for the vascular hub.

The Board approved a Health Scrutiny Committee's (HSC) concordat in 2017/18 to create explicit consensus between HSC and the NHS in Hertfordshire on the principles that should underpin good consultation, to enable HSC to prioritise its scrutiny activity, to maintain the role of critical friend and, finally, to assist patients and the public to understand the principles on which consultation is carried out

Work has also progressed with local partners to redevelop the land around Watford hospital as part of the Watford Riverwell (formerly Watford Health Campus). Following the opening of a new access road to the hospital in 2016/17, the project has begun work on the first residential developments which will comprise of 95 new homes that will offer well-designed, modern apartments in landscaped grounds.

During the reporting year, the Trust continued to strengthen plans for working in partnership with the Royal Free London Foundation NHS Trust (RFL). A joint programme Board between the Trust and RFL agreed terms of reference and a work programme which focuses on identifying opportunities to improve care for patients and improve clinical and financial sustainability of both organisations. The RFL's medical director attended a clinical engagement event at the Trust in July 2017 and Trust clinicians are actively engaged in a number of the clinical pathway groups that were established by RFL. The RFL is making good progress in defining future options for provision of clinical and non-clinical support services and, in March 2018, the Boards of both organisations met to share this work and agreed in principle that the Trust would become a formal clinical partner to the RFL group during 2018/19, subject to a further dialogue with staff on the implications and expected benefits.

Achieving the aim and objectives

The table below demonstrates progress in 2017/18 against achieving aim four and the underpinning objectives.

Aim four	Objective	Evidence
To develop a strategy for the future	To identify and implement priorities to support delivery of our strategy and further develop service line strategies	▪ Work continues with HVCCG to redesign care pathways and deliver integrated. ▪ Ongoing work with specialties to develop service line strategies to support the longer term transformation and redevelopment of the hospitals
	To work with regulators to secure approval of our strategic outline case for the redevelopment of our hospitals and progress the development of the outline business case	▪ SOC formally submitted ▪ Work ongoing with HVCCG to develop a SOC for the redevelopment of Hemel Hempstead Hospital.
	To work with STP partners and local stakeholders to deliver system wide transformation priorities; to agree a partnership strategy to support the long term clinical and financial sustainability of our services, including consideration of the benefits of closer collaboration with the Royal Free Hospital	▪ Full engagement in the STP programme including leadership roles in workstreams. ▪ Work continues with the Royal Free and a proposal to join the group as a clinical partner being developed for consideration by the Board in July 2018.

Going concern

Due to an historic adjusted cumulative deficit of £124.9m to 31 March 2018 and a 2018/19 plan showing significant planned deficits as stated in the financial commentary above, the directors have considered all factors, and although there are material uncertainties that may cast significant doubt in the trust continuing as a going concern, it is reasonable to expect that the trust will have adequate resources to continue for the foreseeable future in operational existence and pay its liabilities, loan repayments and taxes.

As directed by Department of Health and Social Care Group Accounting Manual for Accounts1 the Trust's financial statements are prepared on going concern basis on the grounds that its local population will exist for the foreseeable future, and has not included adjustments which may apply if it was unable to continue as going concern.

Performance analysis

Performance management systems

The Trust is required to meet national standards as defined within the NHS Operating Framework. Performance is monitored by NHSI, HVCCG, DHSC, NHSE and the CQC. Additional measures are selected to form part of the Trust's integrated performance report which is discussed at each Board meeting and which is available via the Trust's website www.whht.nhs.uk.

[1] https://www.gov.uk/government/publications/department-of-health-group-accounting-manual-2017-to-2018

Managing service pressures

Over the course of the year, the Trust has established a wide range of projects to improve performance. In October 2017, a 'progress week' was launched which aimed to better understand and enable earlier discharge from wards. The initiative particularly focused on wards processes, team working, medicines to take home and the patients' lounge.

At the end of 2017, the Trust responded to recommendations made by the National Emergency Pressures Panel (NEPP) to support staff and reduce pressures and clinical risks faced by urgent and emergency care patients. The NEPP recommendations were universal across the country and included deferring all non-urgent inpatient elective care and day case procedures to free up capacity for the sickest patients, re-prioritising clinical time and prioritisation of the flu vaccination to all front line staff.

As a result, the Trust made a number of difficult decisions to reduce elective care service provision to enable senior clinical staff to prioritise the care of acutely unwell emergency patients. Unfortunately, this had a knock-on impact on other patients, including the cancellation of all non-urgent planned surgery at Watford hospital. The Trust also reviewed all planned, routine outpatient activity across the three hospitals and postponed some appointments. In addition to the negative effect on patients who were waiting for procedures, these actions impacted on the Trust's income position and referral to treatment (RTT) performance.

The Trust reached a critical situation in early March 2018 with significant numbers of additional beds open in clinical assessment areas in order to manage the increasing demand for urgent care services. This meant that patients were being moved around to accommodate new admissions from the emergency department and resulted in the use of additional temporary staff and nurses being moved around to maintain safe staffing levels.

To address this and alleviate the pressure, the Trust activated a total 're-set' approach to the admission and discharging of patients. This approach included arranging for every adult inpatient at Watford hospital to have a clinical review by a multi-disciplinary team; ensuring that patients are ready for discharge as soon as they are assessed as medically fit; and considering whether a patient could wait in the patients' lounge rather than on a ward when they are ready to leave hospital. To support this work, all non-urgent meetings were cancelled for a week to allow frontline staff to be working on wards.

This approach, combined with the use of additional consultants in the emergency department and 'hot clinics' (where patients receive early assessment by a senior clinician) resulted in a reduction in admissions and an increase in the number of patients discharged.

National standards

Indicator	National Standard	2017/18
95% of patients should be treated, admitted or discharged in 4 hours in accident and emergency	National target for over 95% patients to be within 4 hours	Under achieved (80.0%)
Incidence of C.difficile should be identified and numbers minimised	Trust target was to have fewer than 23 cases of C. difficile through the year.	Achieved (28 cases reported, however 7 of the cases were identified as having no lapses in care)

Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	Under achieved (one case)
All cancers – patients should have a maximum wait of 14 days for all urgent referrals of suspected cancer and referrals for breast symptoms	National target to see 93% of those referred within 14 days.	Achieved (94.9% suspected cancer referrals) Under achieved (92.3% breast symptomatic patients)
All cancers patients should have a maximum wait of 31 days for diagnosis to first treatment	National target was to have 96% of patients seen within 31 days	Achieved (98.7%)
All cancers patients should have a maximum wait of 62 days between urgent GP referral or screening service to first treatment	National target was to see: 85% referred by GP; and 90% of those referred by the screening service	Achieved (87.7% referred by GP) Under achieved (89.2% referred by screening service)
All cancers patients should have a maximum wait of 31 days for second or subsequent treatment	National target was to have 94% patients seen within 31 days for surgery and 98% for anti-cancer drugs.	Achieved (99% for surgery and 100% for anti-cancer drugs)
Maximum wait time of 18 weeks referral to treatment – patients not yet treated	>92%	Under achieved (88%)

A comprehensive summary of the Trust's performance against national and local indicators can be found in the integrated performance report and quality account on the Trust's website.

Sustainability

The Trust recognises that its day to day activities impact on the environment in a number of ways and is committed to embedding sustainable practices across its hospitals. To support this, the Trust is delivering a sustainable development management plan and sustainability has been embedded in all tendering processes. The strategy aims to reduce carbon emissions by 28% by 2020 using 2013 as the baseline year and a combined heat and power unit (CHP) at Watford hospital continues to save on energy costs and carbon reduction. The CHP runs 17 hours a day and in 2017/18 the unit generated 2,292,022 kWh of electricity and 3,574,229 kWh of heat.

Resource (Baseline)	2013/14	2014/15	2015/16	2016/17	2017/18	% Change on Baseline
Gas Usage (kWh)	40,620,606	41,920,825	44,997,895	43,529,517	44,231,142	+5.10%
Electricity Usage (kWh)	17,010,202	16,452,870	17,546,952	17,241,183	17,966,718	+2.46%
Oil (kWh)	268,752	160,611	189,419	441,584	1,179,768	+15.32%

CO_2 (tonne)	16,701	16,231	15,811	16,876	15,667	-6.79%
Total Energy Spend	£3,118,866	£3,218,042	£3,034,019	£2,827,000	£3,216,422	N/A
Figures as reported in ERIC and equate to approximately 22% of the Trust's total carbon footprint. The remainder is procurement (64%) and travel (14%).						

A baseline oil consumption has been recalculated which highlighted an increase in oil consumption in comparison to the baseline in 2013/14. This was due to the instigation of a compliance testing schedule of existing standby generators and the requirement to run the main boiler house at Watford on oil while the gas pressure boosters were being refurbished. An increase in gas consumption was attributable to the running of the CHP unit at Watford however this was offset by a consequential reduction in imported electricity. Overall the amount of waste produced by the Trust is in line with an increase in clinical activity.

Year	Total Waste (tonnes)	Waste Recycling (tonnes)
2013/14	1509	334
2014/15	1695	306
2015/16	1856	351
2016/17	2097	514

Freedom of Information

In 2017/18, the Trust received 641 freedom of information requests, of which 79% were responded to with the national 20 day timeframe.

Signed..... Date 24.5.18

Katie Fisher
Chief Executive

2. THE ACCOUNTABILITY REPORT

Corporate Governance Report

Directors' report

The names of the chair and chief executive and the names of individuals who were directors of the Trust at any point in the financial year and up to the date that the annual report and accounts were approved, are contained in the directors' remuneration on page 38, which also sets out full details of remuneration for Board members during 2017/18.

The composition of the Board (including advisory and non-executive members) having authority or responsibility for directing or controlling the major activities of the Trust during the year, are shown on page 31.

The names of the directors forming the audit committee and other committees are in the Board and committee attendance table on page 31.

Details of company directorships and other significant interests held by members of the management Board which may conflict with their management responsibilities are shown on pages 32 and 33.

There have been no personal data incidents reported to the Information Commissioner's Officer during this period.

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 they have taken all the steps that ought to be taken to make themselves aware of any such information and to establish that the auditors are aware of it.

Statement of the chief executive's responsibilities as the accountable officer of the Trust

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

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

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

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

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

Governance Statement

Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the 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 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 system of internal control has been in place in the Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As chief executive, I have overall responsibility for risk management in the Trust, which is discharged clearly amongst the executive and non-voting directors of the Board. The executive director with responsibility for risk management in 2017/18 was the deputy chief executive.

The Board comprises of 11 directors: the chair, five non-executive directors and five executive directors including myself. In an inspection report by the CQC in August/September 2017, the Trust's leadership was described as 'stronger, supportive and visible'. The chair and three non-executive directors were re-appointed for two further years in 2017/18; there were no other changes to Board membership. The Trust has plans in place in May/June 2018/19 to undertake a leadership review under NHSI's well-led framework. The Board and all committees have agreed terms of reference and work plans.

The members of the Board possess a wide range of skills and bring experience gained from NHS organisations, other public bodies and the private sector. All directors have been assessed as meeting the fundamental standards of the fit and proper persons test and Board and committee members are asked to declare any conflicts of interests they hold. A robust process for evaluating the performance of the chair and non-executive directors is in place and all executive directors, including the chief executive, has an annual appraisal to assess their performance and monitor delivery of objectives.

The principles of risk management are included as part of the corporate induction programme and cover both clinical and non-clinical risk. The programme provides an explanation of the Trust's approach to managing risk and how individual staff can assist in minimising risk. This includes comprehensive induction for all junior doctors with regard to key policies, standards and practice prior to commencement in clinical areas. Guidance and training are also provided to staff through

mandatory training programmes, specific risk management training, policies and procedures, information on the Trust's intranet and feedback from audits, inspections and incidents. Included within all of this is the sharing of good practice and learning from incidents.

Mandatory training reflects essential training needs, and includes risk management processes such as fire, health and safety, manual handling, resuscitation, infection control, safeguarding, blood transfusion and information governance. The majority of these processes is included within an e-learning programme available to staff. Root cause analysis training is provided to staff who have direct responsibility for risk management within their area of work. An inspection report by the CQC in the period of this report recognised that staff mandatory training level was above target at 90%.

The risk and control framework

The Trust has one system for the management of risk, which can be distilled at three levels across the organisation: 1) divisional and corporate risk registers, 2) the highest scoring risks on divisional risk registers are reviewed and escalated where necessary to the corporate risk register and 3) strategic risks which directly impact on the delivery of the organisations principal objectives are reviewed through the Board assurance framework.

Directors ensure that key risks have been identified and monitored within their directorates and the necessary action taken to address them. Directors are also directly involved in producing and reviewing the Board assurance framework and attend committees to report on risk within their areas of responsibility.

Divisional risk registers containing clinical and non-clinical risks are regularly reviewed by divisions and new operational risks identified and assessed. Divisions also carry out detailed reviews, action planning and assurance checks and there is a process of escalation in place where there are difficulties in implementing mitigations. Risks are identified through third party inspections, recommendations, comments, guidelines from external stakeholders and interlaced though incident forms, complaints, risk assessments, audit (both clinical and internal), benchmarking, claims and national survey results. Risks are placed on divisional risk registers, which are monitored on a quarterly basis by a risk review group. Risks are reviewed and scoring agreed and where extreme risks are confirmed, these are reviewed for potential inclusion on the corporate risk register.

Divisional management groups ensure that operational staff identify and mitigate risk and committees provide internal assurance to the Board that the mitigations are effective and the risks are adequately controlled. An internal audit programme, clinical audits, external reviews of the organisation, such as clinical pathology accreditation review, NHS Resolution assessment, Health and Safety Executive and CQC inspections, are the sources used to provide assurance that these processes are effective and risk monitoring is fully embedded.

The board assurance framework sets out the principal risks to the achievement of the Trust's organisational objectives and the mitigation required. The deputy chief executive is the lead executive for the assurance framework and the day to day maintenance is the responsibility of the trust secretary. Each principal risk is graded from green to red and committees review risks relevant to their terms of reference. The assurance framework is reviewed by the Board in full three times a year.

The assurance framework is a 'live' document and in the period of this report the rating of the nine principal risks moved to reflect the current level of risk. Mitigating action plans are in place and are summarised in a separate spreadsheet to support effective monitoring and reporting to committees and the Board. The management of actions are regularly monitored by the relevant lead committee and the Board. The assurance framework had been refreshed for 2018/19 and accompanying mitigating action plans are in place to ensure that risks will continue to be effectively managed.

The Trust has quality governance arrangements in place and the chief nurse is the executive lead for quality. In 2017/18, the Board approved a quality commitment which was developed in consultation with staff, patients and other key stakeholders and aims to drive a culture of continuous quality improvement across the Trust.

Assurance on compliance with CQC registration requirements is obtained through the role of the safety and compliance committee, the performance framework and the Trust's schedule of unannounced visits to services. Regular reports to NHSI provides additional assurance with regard to the Trust's compliance with the provider license.

Incident reporting is actively encouraged within the Trust and during the period of this report, the Trust regrettably had four never events and 40 serious incidents. (see page 8 for further details) These were the subject of a thorough internal review to identify root causes and learning and were reported as required to HVCCG, NHSI and NHSE.

To prevent and reduce future risk, a full investigation was undertaken and the findings and learning reported to the Board and shared widely through corporate and divisional governance systems. A serious incident review group meets regularly at which divisions present evidence of completion of actions and learning taken from the investigation.

A CQC inspection report acknowledged lessons from incidents were mostly being learnt Trust-wide and that the medicine service shared details of incidents and used these to identify any learning, sharing information through local team meetings, peer support meetings and formal mortality review meetings. Furthermore the CQC inspection report recognised that the surgical department demonstrated a culture that supported the reporting and learning from incidents.

The Trust has a caldicott guardian, a senior information risk officer and a clinical information risk officer. The Trust's information governance management framework provides assurance that personal and sensitive data is managed legally, securely, efficiently and effectively. The chief information officer chairs the informatics group, the principal body which oversees the management of information risks. The group reports into the finance and investment committee and oversees submission of the Trust's information governance toolkit.

During the period of this report, the Board approved a plan to implement new general data protection regulations and received an update on actions being taken to reduce cyber security risks that had been identified by NHS Digital during a cybersecurity assessment.

The highest scoring key risks to the Trust achieving its strategic objectives are listed below, together with a summary of the mitigation taken during the year.

Current major risk	Mitigation
The current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care	▪ All environmental risks reviewed monthly ▪ Backlog maintenance programme ensures highest identified risks are addressed first ▪ Interim estates strategy in place to prioritise investment ▪ Authorised engineers engaged for all high risk areas
An underdeveloped IM&T infrastructure compromises the ability to deliver safe, responsive and efficient patient care	▪ Five year contract to provide full managed ICT service ▪ Contract management in place to hold supplier to account

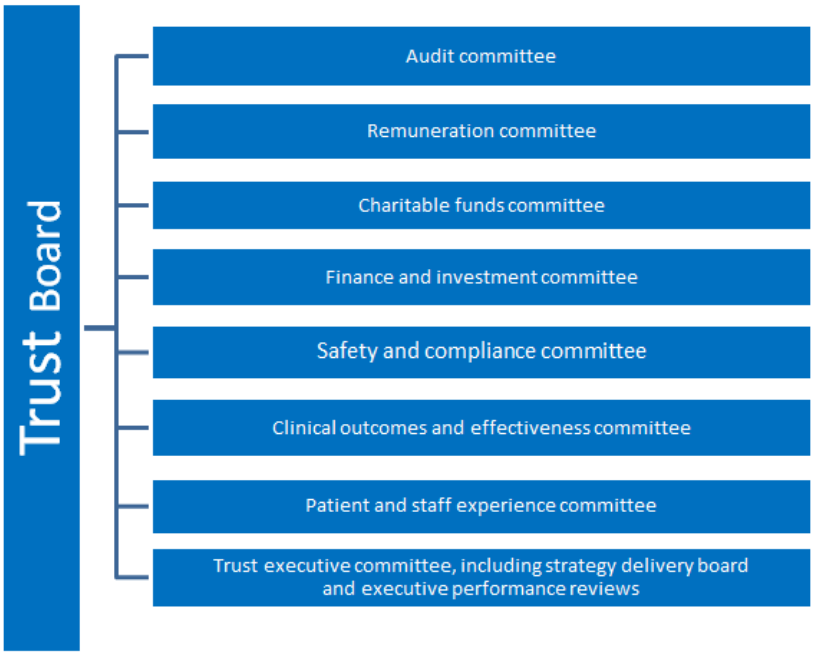
An inability to deliver and maintain performance standards	▪ Bed management and escalation policies and surge plan in place ▪ Monitoring by system wide local delivery Board ▪ Partnership wide system resilience plan in place ▪ Emergency care transformation plan established ▪ Access policy in place ▪ Daily, weekly and monthly RTT pathway validation
Failure to achieve financial targets, maintain financial control and realise and sustain benefits from cost improvement and efficiency programmes	▪ Monitoring by the finance and investment committee, trust executive committee and a review board ▪ Support in place to deliver efficiency programme ▪ Budget setting and management and business planning process in place ▪ Established contract negotiation and monitoring processes ▪ Approved standing financial instructions ▪ Monthly performance divisional review meetings ▪ NHSI funding application process in place
Failure to deliver a sustained long term clinical, financial and estates strategy	▪ Senior team actively engaged in STP governance and delivery processes ▪ Director of integrated care in place to support delivery of strategy and system wide pathway transformation ▪ Dialogue with NHSI to progress business cases ▪ Agreement in principle to explore closer working with RFL via the group model ▪ Long term financial model developed
System pressures adversely impact on the delivery of the Trust's aims and objectives	▪ Provider collaborative established, principles for collaboration agreed, shared work programme in place. ▪ A&E local delivery board established ▪ System support by the national emergency care improvement programme/emergency care improvement plan in place ▪ Pilot site for East of England Ambulance handover ▪ System wide discharge improvement plan developed

The overall financial risk rating in 2017/18 was 3 (1 indicates the least risk and 4 the highest risk). The Trust's improvement programme achieved savings of £10.3m, equivalent to 3.2% of income. All efficiency schemes were quality impact assessed and approved by the chief nurse and medical director prior to implementation.

The Board approved the NHS self-certification of Condition FT4 of the provider licence which confirms that the Trust has effective Board and committee structures, reporting lines and performance and risk management systems in place.

As an NHS Trust, compliance with the UK Corporate Governance Code is not required, however, it has reported on its corporate governance arrangements by drawing upon the best practice available, including those aspects of the UK Corporate Governance Code its considers to be relevant to the Trust.

To further strengthen the governance framework, a refreshed Board and committee structure was introduced in April 2017/18 (see below).



The new corporate governance structure has been embedded over the year and the Board undertook a comprehensive effectiveness review at the end of 2017 which concluded that, with some minor refinements, the framework was effective in supporting the responsibilities of the Board. See page 31 for Board and committee attendance record.

The system of internal control is underpinned by compliance with standing financial instructions, standing orders and scheme of delegation, as set by the Board. These outline the accountability and scope of responsibility of the Board and executive directors. The Board has been fully involved in agreeing the strategic priorities of the Trust with the most important priorities being those set out in the Trust's annual plan and overall strategy. Alongside regular reports on quality, finance and operational performance and, where required, the action being taken to reduce identified high-level risks, the Board received strategy updates and considered and approved outline business cases and contracts for capital investments with a value of over £1m.

The audit committee is chaired by a non-executive director and provides an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its function. The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the Board. It reviews the management of the Board assurance framework to assure itself that risks are being accurately identified and managed and appropriate assurance is obtained.

Internal audit services are outsourced to RSM UK which provides an objective and independent opinion on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives. Individual audit reports include a management response and action plan. Internal audit routinely follows up actions with the executive to establish the level of compliance and the results are reported to the audit committee.

An annual work plan of local counter fraud activity was approved and monitored by the audit committee. The proactive plan focused on key areas for NHS Protect standards for providers and was supplemented with additional resource for investigative activities.

The audit committee has reviewed reports during the period of this report on clinical audit and has monitored the integrity of the Trust's financial statements, in particular, the annual report, accounts

and governance statement, as well as reviewing the strength of the whistle-blowing arrangements and the effectiveness of the other committees.

With the exception of the trust executive committee which I chair, all committees are chaired by a non-executive director and the membership includes other non-executive directors, all of which have relevant experience and qualifications.

The chair of the clinical outcomes and effectiveness committee is the senior independent director. The committee is responsible for providing assurance on the delivery of harm free, high quality, safe and effective services and clinical outcomes and, in particular, the monitoring of the management of risk and the implementation of risk management arrangements. Full details of this work are contained in the Trust's risk management strategy.

The safety and compliance committee provides the Board with assurance that adequate controls are in place to meet the requirements of the CQC fundamentals of care standards and to monitor that the Trust's responsibilities for the health and safety of its staff, patients and visitors are effectively fulfilled.

The patient and staff experience committee is responsible for providing assurance to the Board that effective systems and processes are in place to support the workforce to deliver high quality, safe patient experience and that risks are being managed appropriately.
The three quality committees work alongside the audit, remuneration and finance and investment committees to manage risk, which collectively contribute to the Board's overall process for ensuring that an effective risk management system is maintained.

The Trust is fully compliant with the registration requirements of the Care Quality Commission and the effectiveness of governance processes was externally validated through a CQC hospital inspection in August/September 2017. Despite the inspection highlighting many examples of great care and outstanding practice and significantly improved ratings, the Trust's overall rating remains as 'requires improvement'. Due to the overall improved ratings, the Trust was moved out of special measures.

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.

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

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

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

In order to determine that it has the right staffing levels on its wards to provide effective, economic and efficient care, the Trust undertakes regular establishment reviews. The outcome of these reviews are monitored by the safety and compliance committee and the Board. The Trust also uses the data from NHSI's model hospital tool to support its efficiency programme.

Information Governance

The Trust reported no information governance SIRI level 2 cases in 2017/18. Incidents classified at lower severity level 1 have been aggregated and are reported in the table below.

Category	Breach type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	35
C	Lost in transit	0
D	Lost or stolen hardware	0
E	Local or stolen paperwork	2
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	0
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	4
K	Other	13

The Trust carried out an assessment of its compliance with NHS Digital's information governance toolkit for 2017/18 achieving level 2 compliance for 43 out of 45 requirements providing an overall compliance score of 70%.

Annual quality account

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

The Trust aims to take a balanced approach to developing the quality account through setting priorities that will deliver improved patient safety, clinical effectiveness and patient experience. These priorities are identified through reviewing the Trust's goals as defined by its quality commitment; national and local commissioning priorities; existing quality concerns and plans to address them; as well as key risks to quality and how these will be managed. As part of priority setting, the Trust identifies those targets and indicators that most usefully demonstrate whether or not it is on track to deliver those priorities.

The data used to demonstrate progress with the quality account priorities is provided by those who own the data, from an internal and external reporting perspective, using repeatable methodology to track the data over the course of the year. The quality account then goes through a number of internal sign off processes, including by the trust executive committee, assurance committees and the audit committee. Externally, the account is reviewed by the HVCCG, HealthWatch Hertfordshire, Herts County Council's overview and scrutiny committee and by external auditors.

The quality and accuracy of performance information, including elective waiting time data, is continually assessed. Each division operates a weekly access meeting where patient tracking lists are scrutinised in detail and divisions validate patient pathways prior to performance information being produced. Performance assurance is underpinned by a referral to treatment programme Board, which is chaired by the chief operating officer. Any issues highlighted within the data are reported by the service team through to the information team for investigation and are acted upon appropriately.

Review of the 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 and the executive managers and clinical leads within the NHS Trust that 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 results of my review of effectiveness of the system of internal control by the Board, the audit committee, safety and compliance committee and clinical outcomes and effectiveness committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The effectiveness of the system of internal control is maintained by ensuring clear duties and accountability is allocated to each part of governance framework and to individuals within the framework. I am assured that the Trust has in place a robust escalation framework which ensures timely and effective escalation from divisions and committees.

The Trust's corporate risk register and Board assurance framework have been in place and monitored by the Board throughout the year which provides me with evidence that the effectiveness of controls that manage risks to the organisation achieving its principal objectives are being managed appropriately.

I am also assured that the Board effectively reviews risks to the delivery of the Trust's performance objectives through its monitoring of performance in the key areas of finance, activity, national targets, patient safety, quality and workforce. This enables me, the executive team and the Board to focus and address key issues as they arise.

The audit committee independently monitors the effectiveness of internal controls and risk management arrangements by approving annual audit plans, receiving regular individual and progress reports and ensuring that recommendations arising from audits are actioned by the executive management.

I received further assurance from the outcome of an internal review of the Board and committee structure which concluded that the corporate governance structure was considered to be efficient and effective.

The Trust has a clinical audit strategy in place which clearly sets out clinical audit objectives and priorities in relation to resource allocation and corporate, divisional and individual responsibilities. Clinical audit is monitored by the clinical outcomes and effectiveness committee and the audit committee provides added assurance on the controls in place.

The Trust received no improvement notices in this financial year.

Internal audit issued eight reasonable assurance opinions 2017/18. It also issued an advisory review to support the Trust's action plan relating to the new GDPR. In addition, internal audit has issued the following six partial assurance opinions and two no assurance opinions:

Area reviewed	Actions being taken
Additional sessions and consultant leave plan	▪ Regular audits to be undertaken on a sample basis of all extra sessions ▪ Divisions to monitor and report all sessions worked over and above the contracted amount ▪ Establishing quarterly reporting on extra sessions to senior management team
Estates management (St Albans project)	▪ A random review of a sample of completed projects is undertaken on a quarterly basis ▪ Improvements being made to contingency management processes ▪ Considering having construction category management specialist staff within the procurement shared service function ▪ Ensuring tender specifications are consistent with NHS terms and conditions ▪ Establishing a threshold limit for the value and percentage of projected total project costs ▪ Considering investing in developing formal contract management practice for capital projects
Maternity activity data	▪ Establishing standard operating procedures for the collation, calculation and validation of maternity activity data ▪ Ensuring that data to support the maternity dashboard is available in a central location ▪ Data from CMiS to be used for the reporting within the Maternity Dashboard. ▪ Including integrity checks on cells in the maternity dashboard spreadsheet to highlight incorrect calculations ▪ Ensuring that data that does not meet the set criteria is highlighted and investigated
HTM safer standards at work	▪ Documentation of authorising engineers and competent persons and tailored job descriptions to be developed ▪ Monitoring of inspection and maintenance schedules ▪ Implementing a monitoring process for actions from inspections ▪ Report to be developed for divisional governance forum with respect to the safer standards at work function ▪ Engineering drawings to be in place for all areas
Medical devices (procurement, access, storage and security)	▪ Detailed improvement project plan being developed with key millstones and signed off ▪ Medical devices policy being updated ▪ Training needs assessment underway ▪ Team displacement review to optimise performance ▪ Capacity planning to cover routine maintenance, repairs and unplanned urgent work requirements ▪ Equipment related processes review
Contingency management on estates capital projects (Advisory)	▪ Standard operating procedure being developed for the calculation, application and use of project contingencies. In the interim all orders raised are excluding contingencies and separate orders are raised after approval ▪ A series of measures to improve guidance and policy around contingency

For the 12 months ending 31 March 2018, the head of internal audit opinion concluded that, in general, the organisation has an adequate and effective framework for risk management and governance. However, there are weaknesses in the framework of internal control such that it could be, or could become, inadequate and ineffective.

Whilst it recognises the improvements made within clinical areas reviewed during the year which is also borne out by the Trust coming of special measures during the year, this opinion is driven by the partial assurance (amber/red) opinions listed above which continue to indicate a need for greater and improved compliance with internal controls in particular in relation to the areas of estates, the procurement and management of medical devices and expensive clinical instruments/consumables, and temporary staffing – additional sessions. There is also a need to ensure that management actions are implemented on time and divisional accountability is embedded to minimise any exposure to risk. It should also be noted that management have directed us into these areas which demonstrates a mature use of the internal audit resource.

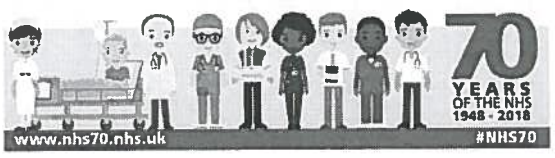
The audit committee supported by other committees and the Board will continue to monitor the areas highlighted in the head of internal audit opinion closely and agree additional actions as required.

Conclusion

With the exception of the issues that I have outlined in this statement, I am satisfied that no significant internal control issues have been identified.

Signed..... Date 24.5.18

Katie Fisher
Chief Executive



Board and committee membership and meeting attendance

Name of member	Board	Audit Committee	Safety & Compliance Committee	Finance and Investment Committee	Patient and Staff Experience Committee	Remuneration Committee	Charitable Funds Committee	Clinical Outcomes and Effectiveness Committee
Chairman	11/11			9/12		3/3		
Chief Executive	10/11		5/6					
Ginny Edwards Non Executive Director	10/11				6/6	3/3	4/4	3/6
John Brougham Non Executive Director	11/11	4/4		12/12		3/3		Reserve 3/6
Jonathan Rennison Non Executive Director	11/11		4/6		Reserve 2/6	3/3	3/4	6/6
Phil Townsend Non Executive Director (vice chair)	9/11	Reserve 2/4	5/6	10/12		3/3		
Paul Cartwright Non Executive Director	8/11	3/4	Reserve 3/6		5/6	1/3	Reserve 1/4	
Medical Director	9/11		6/6	10/12	3/6			5/6
Chief Nurse	10/11		4/6		6/6		3/4	6/6
Chief Financial Officer	11/11	4/4		10/12			4/4	
Chief Operating Officer	8/11		5/6	9/12	5/6			

Declarations of interest of Board members and executive team (as at 31 March 2018)

Name	Role	Description of Interest
Tammy Angel	Divisional Director of Unscheduled Care	None
Kevin Howell	Director of Environment (formally Estates and Facilities)	None
Freddie Banks	Associate Medical Director for Clinical Strategy	Private Practice
Andrew Barlow	Women's and Children's services Divisional Director	Barlow Medical Services Ltd
Professor Steve Barnett	Chairman	Chair and Client Partner of SSG Health Ltd
		Non-Executive Chairman of Finegreen Associates
		Trustee and Director of the Institute of Employment Studies
		Visiting Professor University of West London Business School.
		Honorary Visiting Professor Cranfield University School of Management
		Wife is CEO of Rotherham NHS Foundation Trust
Howard Borkett Jones	Associate Medical Director for Education	None
John Brougham	Non-Executive Director	Non-Executive Director and Chair of the Audit Committee of Technetix Ltd
Helen Brown	Deputy Chief Executive	None
Tracey Carter	Chief Nurse and Director of Infection Prevention and Control	None
Paul Cartwright	Non-Executive Director	Trustee and Chair of Finance and Audit Committee for the Church Lands, St Albans
		Treasurer of St Peter's Church, St Albans
		Charitable Funds for West Hertfordshire Hospitals NHS Trust
Paul da Gama	Director of Human Resources	None
Anthony Divers	Clinical Support Services, Divisional Director	Private Practice - BMI Chiltern - Spire
Lisa Emery	Chief Information Officer	None
Ginny Edwards	Non-Executive Director	Trustee Peace Hospice Care Global Action Plan; providing support to their programme called Operation TLC Director of Edwards Consulting Ltd
		Husband is CEO of Nuffield Trust

		Husband is Director of Edwards Consulting Ltd
		Husband is a non-remunerated member of the Strategy Committee of Guy's and St Thomas's Charitable Trust
		Charitable Funds for West Hertfordshire Hospitals NHS Trust
Katie Fisher	Chief Executive	None
Fran Gertler	Director of Integrated Care	None
Sean Gilchrist	Associate Director of ICT	None
Louise Halfpenny	Director of Communications	None
Patrick Hennessy	Director of Environment	None
Jean Hickman	Trust Secretary	None
Rachel Hoey	Director of Emergency Medicine	None
Jeremy Livingstone	Surgery, Anaesthetics and Cancer Divisional Director	Private Practice - Jeremy Livingstone Ltd
Arla Ogilvie	Divisional Director, Medicine	Private Practice
Emanuel Quist-Therson	Associate Medical Director for Appraisal and Revalidation	None
Jonathan Rennison	Non-Executive Director	Trustee of Rising Tides Ltd
		Change Management and strategy support with Kings College London
		Director of Yellow Chair Ltd
		Edgecumbe Consulting - Consultancy
		Association of NHS Charities
		The Teapot Trust - Coaching
		BNET - Consultancy
Don Richards	Chief Financial Officer	None
Jane Shentall	Director of Performance	Husband is Head of Business Intelligence & Performance at NEL
Phil Townsend	Non-Executive Director	None
Sally Tucker	Chief Operating Officer	None
Dr Mike Van der Watt	Medical Director	Private practice - Owner Heart Consultants Ltd
Dr Anna Wood	Deputy Medical Director and Associate Medical Director of Clinical Standards & Audit	Private practice, spire Bushey

Modern Slavery Act

In line with the requirements of the Modern Slavery Act 2015, the Board approved a statement which provided an overview of the steps taken by the Trust during the financial year to ensure that slavery and human trafficking had not taken place in any of its supply chains, and in any part of its own business. The statement, which is published on the Trust's website, confirms that the Trust has zero tolerance of slavery and human trafficking its policies, procedures, governance and legal arrangements are robust, ensuring that proper checks and due diligence are applied in employment procedures to ensure compliance with this legislation. The Trust also conforms to the NHS

employment check standards within its workforce recruitment and selection practices, including through managed service provider contract arrangements.

Remuneration and staff report

Director and very senior manager remuneration

The Trust has an active remuneration committee with a membership of non-executive directors who are responsible for approving remuneration decisions linked to all directors and a limited number of other senior managers. The committee adheres to all NHSI requirements and decisions are taken using a mixture of benchmarking data with other NHS trusts taken from a range of sources, NHSI guidance and consideration of prevailing market conditions. As well as approving remuneration decisions for all new appointments into very senior manager (VSM) roles, the remuneration committee also undertakes an annual review of remuneration for its existing VSM population.

Expenditure on consultancy

Total expenditure on consultancy services in 2017/18 was £1.1m (£1.7m in 2016/17) of which £319K relates to service improvement in response to CQC and £143K relates to supporting transformation work by the Trust's programme management office.

Director's salary relative to workforce (audited)

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the organisation's workforce. The mid point of the banded remuneration of the highest paid director in the financial year 2017/18 was £276k (2016/17 £283k). This was 8.3 times the median remuneration of the workforce, which was £33.2k (2016/17 £34.9k).

In 2017/18 no employee received remuneration in excess of the highest paid director. Remuneration ranged for full time employees from pay banding £10-15k to pay banding £275 – £280k.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance pay. It does not include employer pension contributions nor the additional cash equivalent transfer value of pensions.

Off payroll engagements

There were no off payroll engagement in 2017/18.

Staff profile

Banding	Female	Male	Total
Band 1 - 7	3321	628	3949
Band 8A and above	209	79	288
Medical	270	353	623
Non-Exec Directors	1	5	6
Totals	3801	1065	4866

Staff banded by ethnicity

Ethnicity	Band 1-7	Band 8A and Above	Medical	Non-Exec Directors	Total
White - British	1913	192	123	5	2233
White - Irish	103	9	3	1	116
White - Any other White background	411	10	65		486
Mixed - White & Black Caribbean	17				17
Mixed - White & Black African	14		2		16
Mixed - White & Asian	11	2	6		19
Mixed - Any other mixed background	24	2	8		34
Asian or Asian British - Indian	360	31	127		518
Asian or Asian British - Pakistani	82	2	39		123
Asian or Asian British - Bangladeshi	14	2	10		26
Asian or Asian British - Any other Asian background	322	5	49		376
Black or Black British - Caribbean	67	8	1		76
Black or Black British - African	229	9	25		263
Black or Black British - Any other Black background	38	1	2		41
Chinese	37		12		49
Any Other Ethnic Group	85	2	23		110
Undefined	121	7	121		249
Not Stated	101	6	7		114
Totals	3949	288	623	6	4866

Staff numbers and composition

	2017-18						2016-17	
	Total		Permanently employed		Other		Other	
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
Medical and dental	636	72,043	576	58,456	60	13,587	581	66,362
Ambulance staff	0	0	0	0	0	0	0	0
Administration and estates	1,161	41,586	1,045	37,239	116	4,347	1,090	35,495
Healthcare assistants and other support staff	941	24,871	787	20,200	154	4,671	968	17,886
Nursing, midwifery and health visiting staff	1,567	71,509	1,289	56,090	278	15,419	1,592	70,204
Nursing, midwifery and health visiting learners	0	0	0	0	0	-	10	4,385
Scientific, therapeutic and technical staff	495	25,027	435	21,006	60	4,021	510	24,229
Social Care Staff	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	42	5,554
TOTAL	**4,800**	**235,036**	**4,132**	**192,991**	**668**	**42,045**	**4,793**	**224,115**

Staff sickness absence

An average of 9.17 working days were lost per staff member in 2017/18 in comparison to 7.21 in 2016/17.

Staff policies applied during the financial year

The Trust has a recruitment and selection policy in place, which is committed to supporting employees whilst also delivering the highest standards of care and service to patients and service users. The Trust aims to be the employer of choice locally and draws on a wide and diverse range of people with a variety of skills and talents to deliver and manage its services; concentrating positively on the real requirements of jobs and the individual abilities of people who seek employment.

The national NHS jobs website is used to advertise all posts and applicants are asked about disabilities as part of the process. Any candidate who has declared a disability and invoked the 2 tick scheme within their applications is guaranteed an interview provided they meet the minimum criteria for the post. A functional requirement form is also completed as part of pre-employment checks and where a disability is identified, a discussion is held with the line manager as to what adjustments need to be made in conjunction with the occupational health department. Where staff become disabled during employment, the Trust has a managing attendance policy in place to inform the need for reasonable adjustments and support as required. Close links take place with the occupational health department in order to ensure that all is done to support staff with disabilities at work.

Directors' pension entitlement

	Real increase in pension (bands of £2,500)	Real increase in pension lump sum at (bands of £2,500)	Total accrued pension at 31 March 2018 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real increase/(decrease) in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
K Fisher (note 1)	**7.5-10**	**0-2.5**	**55-60**	**75-80**	638,928	525,945	108	0
D Richards	**2.5-5**	**(2.5)-0**	**40-45**	**85-90**	931,787	853,181	70	0
T. Carter	**2.5-5**	**0-2.5**	**35-40**	**95-100**	596,824	527,866	69	0
H. Brown	**2.5-5**	**0-2.5**	**35-40**	**95-100**	642,800	570,031	73	0
M. Van Der Watt	**0-2.5**	**0-2.5**	**50-55**	**160-165**	1,118,757	1,071,366	47	0

Note 1: Pension details for K Fisher and D Richards are under query with the Pension Agency.
Non-executive directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for these directors.

A cash equivalent transfer value (CETV) is the actuarially assessed 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 or chooses to transfer the benefits accrued in their former pension 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 the 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 benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute of Faculty of Actuaries. Real increase /decrease in CETV - This reflects the change in-year of CETV after adjusting the start of the year CETV for the change in consumer price indice.

Directors' remuneration

			2017/18				2016/17			
NAME	TITLE	In year start/ leave dates	SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000	SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000
Prof Steve Barnett	Chairman		40-45	11600	0	50-55	40-45	13400	0	40-45
K. Fisher	Chief Executive	Start Jul 2016	185-190	300	0	185-190	135-140	0	0	135-140
J. Kelly	Interim Chief Executive	Start Jan 15 - left Jul 2016	-	0	0	0	45-50	0	0	45-50
L. Hill (note 1)	Deputy Chief Executive	Left Jul 2016	-	0	0	0	105-110	0	0	105-110
P. Townsend	Non-Executive Director (vice Chair)		5-10	400	0	5-10	5-10	100	0	5-10
V. Edwards	Non-Executive Director Freedom to speak up Guardian		5-10	0	0	5-10	5-10	0	0	5-10
J. Brougham	Non-Executive Director		5-10	900	0	5-10	5-10	0	0	5-10
J. Rennison	Non-Executive Director (Senior Independent Director)		5-10	0	0	5-10	5-10	0	0	5-10
P. Cartwright	Non-Executive Director		5-10	0	0	5-10	5-10	0	0	5-10
D. Richards	Chief Financial Officer		165-170	0	0	165-170	165-170	100	0	165-170
T. Carter	Chief Nurse & Director of Infection Prevention and Control		115-120	0	0	115-120	115-120	0	0	115-120
H. Brown	Deputy Chief Executive and Director of Strategy		120-125	300	0	120-125	115-120	200	0	115-120
M. Van Der Watt (note 2)	Medical Director/ Director of Patient Safety		275-280	0	0	275-280	280-285	100	0	280-285

Note 1: Salary includes exit package as disclosed in the remuneration and staff section of the annual report
Note 2: 79% of salary as medical director/director of patient safety and 21% for clinical work.

The salaries above may include salary sacrifice schemes.

Exit packages agreed in 2017-18 (audited)

Exit Packages in 2017-18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made
	2017-18						
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**
<£10,000	1	8,336	24	47,419	**25**	**55,755**	0
£10,000 - £25,000	0	0	4	42,051	**4**	**42,051**	0
£25,001 - 50,000	0	0	0	0	**0**	**0**	0
£50,001 - £100,000	0	0	0	0	**0**	**0**	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0
>£200,000	0	0	0	0	**0**	**0**	0
Total	**1**	**8,336**	**28**	**89,470**	**29**	**97,806**	**0**

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made
	2016-17						
	Number	**£s**	**Number**	**£s**	**Number**	**£s**	**Number**
<£10,000	0	0	12	42,334	**12**	**42,334**	0
£10,000 - £25,000	1	21,519	1	23,000	**2**	**44,519**	0
£25,001 - 50,000	0	0	1	37,500	**1**	**37,500**	0
£50,001 - £100,000	0	0	0	0	**0**	**0**	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0
>£200,000	0	0	0	0	**0**	**0**	0
Total	**1**	**21,519**	**14**	**102,834**	**15**	**124,353**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS agenda for change terms and conditions. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme detailed in note 9.1 of the financial statements and are not included in this note.

	2017-18		2016-17	
	Payments agreed Number	Total value of agreements £000s	Payments agreed Number	Total value of agreements £000s
Contractual payments in lieu of notice	28	90	14	103
Total	**28**	**90**	**14**	**103**

This note reports the number and value of exit packages agreed in the year. There was no Trust's voluntary resignation scheme.

Above does not include any non-contractual severance payment made following judicial mediation or relating to non-contractual payments in lieu of notice.

There was no non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that report.

Parliamentary Accountability and Audit Report

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Adverse conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, because of the significance of the matters described in the basis for adverse conclusion section of our report, we are not satisfied that in all significant respects West Hertfordshire Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following significant matters which relates solely to sustainable resource deployment.

The Trust has been unable to set a sustainable budget as a result of the current configuration of its services across West Hertfordshire.

The Trust's outturn position for 2017-18 was a £42.6 million adjusted retained deficit which is an increase of £27.2 million compared to the Trust's control total of no more than £15 million, agreed with NHSI. This movement was due to:

- delivery of £10.3 million of savings compared to the revised £13.7 million savings target agreed with NHSI. Originally this savings target was £21.9 million which the Trust identified as unachievable. Nationally directed restrictions to elective care capacity contributed significantly to this shortfall;
- loss of £9.3 million Sustainability and Transformation funding; and
- increased clinical staff costs of £7.4 million more than planned, due to the need to maintain emergency care quality in light of increased emergency care activity and dependency.

In addition, the Trust's medium term financial plan shows a further forecast deficit of £52.9 million in 2018/19. £10 million of this forecast in linked to a contingency for contract penalties that were not chargeable in the 2017/18 year. The forecast excludes Provider Sustainability Funding.

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

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied 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 review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

To help auditors consider this overall criterion the guidance issued by the Comptroller and Auditor General includes three sub-criteria (informed decision making, sustainable resource deployment and working with partners and other third parties) which are intended to guide auditors in reaching their overall judgements.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of West Hertfordshire Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Ciaran McLaughlin
Director

for and on behalf of Grant Thornton UK LLP

30 Finsbury Square | London EC2A 1AG

29 May 2018

I certify that the above are a true and accurate reflection of the remuneration and other associated staff reports.

Signed ..... Date 24.5.18

Katie Fisher
Chief Executive

AIM 3	TO IMPROVE OUR FINANCES

THE FINANCIAL STATEMENTS

Financial headlines

The Trust has relied on non-recurrent funds for a number of years to support the challenge of providing safe services within the confines of the tariff payment structure.

For a number of years now the Trust has operated in deficit. The size of the deficit increased following a series of risk assessments undertaken by the Board and publication of the Francis report[2]. Unfunded investment was made in quality, increased staffing and infrastructure costs in order to comply with Francis' recommendations. In 2015/16, the Trust incurred costs relating to the creation of additional clinical capacity to accommodate increasing numbers of patients delayed in their transfer of care, as well as corrective actions following the CQC inspection in 2015.

For the 2017/18 financial year, NHSI has set net revenue targets control totals for all NHS trusts. The revenue targets include the ability for trusts to earn additional funding from centrally held 'Sustainability and Transformation (STF) Funds' dependent on achieving certain financial and clinical targets. The target set for the Trust was to end the 2017/18 year with a revenue deficit no greater than £15.0m. This target assumed full receipt of £10.7m of STF.

£3.8m of the available STF total could be earned for achieving clinical targets relating to A&E waiting times; and £8.9m was available for achieving quarterly planned financial performance. If financial performance targets were not achieved in a given quarter, no payment would be made at all, irrespective of A&E waiting time achievement. The Trust achieved its financial targets in Q1 and in accordance with the STF earning formula received a payment of £1.4m; The Trust did not achieve its A&E target in Q1, nor the financial targets in Q2-4, and therefore failed to receive further instalments of STF (worth £9.3m) for the remainder of the year. The Trust was however allocated a further £2.3m of STF for exceptional efforts and additional commitment undertaken to deliver financial control totals in very challenging operational circumstances.

Furthermore, in order to achieve the control total, the Trust would have had to have achieved savings worth £21.9m, equivalent to 6.5% of revenue. This level of savings would exceed the Trust's record savings of £14.7m (4.6%) in one year, achieved for 2016/17. The Trust's long term financial plan to return to viability models savings of 4% each year.

[2] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-Trust-public-inquiry

The Trust ended 2017/18 with a revenue deficit of £42.6m. Income in 2017/18 remained largely the same at £324.8m in comparison to £322.6m in 2016/17. However, this small net movement masked a number of significant offsetting items, including:

- STF funding foregone (see above) at £9.3m.
- Non-elective income up £10.3m at £103.3m despite a 0.2% overall decrease in activity.
- Elective income down £3.6m at £49.7m due to several factors, including the impact of the national decision to suspend elective operations in early 2018 and the non-availability of some theatres during the year.

Activity-related income was also put under pressure by persistent business continuity incidents, mostly due to capacity issues driven by seasonal demand for non-elective services. Maintaining level overall income shows that the Trust's efforts to limit the impact of these incidents has been highly effective.

The Trust derives most of its income from an activity-based contract with HVCCG, which is negotiated on an annual basis with updates during the year. The Trust has been exploring the possibility of entering into a block contract with HVCCG (i.e. a contract with a fixed monetary amount and is not dependent on the level of activity undertaken). For 2017/18 income it was not possible to reach agreement relating to a block contract, therefore the existing activity-based arrangements stand and will remain into 2018/19 (subject to further negotiation).

The Trust's operating costs (excluding impairments) rose from £348.6m in 2016/17 to £364.4m in 2017/18. After excluding the costs of clinical negligence premium payments, Trust costs rose by 4.3% (from £332.7m in 2016/17 to £347.0m in 2017/18). Staff costs increased by £10.9m which has been driven by pay awards and service developments in the year.

Agency costs have reduced by a highly significant £8.0m to £18.5m from 2016/17 and has now decreased by a total of 50.1% over the last two years. In order to meet its 2018/19 financial target, it is necessary to reduce agency expenditure by a more modest £4.5m, and the Trust plans to achieve this by continuing to make substantive appointments more attractive and encouraging staff to join the internal bank.

The rise in operating costs would have been greater if not for the delivery of the Trust's efficiency programme in 2017/18 at £10.3m (3.2% of revenue). While this did not match the record achievement of 2016/17, staff at all levels within the Trust helped to improve operational performance and underpin financial sustainability in future years through thorough planning and implementation of innovative schemes throughout the year. The strategy delivery office and programme management office have supported clinical leadership in ensuring that schemes are delivered in the right way as well as for the right amounts.

As the Trust recorded a revenue deficit in 2017/18, and did so in previous years, the Trust was unable to break even over a four year period, taking one year with another. Due to a planned deficit in 2018/19 the Trust is likely to breach the Statutory Breakeven duty in 2019/20 over the permitted five year period. The Trust is working with NHSI and the local economy to develop a plan to achieve the breakeven duty in future years.

In order to ensure that sufficient cash remained available for operating needs, the deficit was supported by revenue loans from the Independent Trust Financing Facility. Capital expenditure was supported by an additional capital loan application for £13.7m. The short space of time between loan approval and year end meant that when authorisation was received in March 2018, drawdown of certain portions of the loan was permitted across 2018/19 and 2019/20.

The Trust spent £11.1m on new, refurbished and replacement capital assets including medical equipment. The agreed plan was to spend £22.2m in the year with external funding of £15.5m in line with the agreed financial plan. The loan application to Department of Health and Social Care was made for £14.4m of which £13.7m was approved in March 2018. However due to lateness in the approval of the capital loan much of this was deferred and only £1.4m was planned to spend in the remaining financial year. Major projects included:

- External funding of £1.1m for the ED at Watford was received much earlier in the year and the reconfiguration of the department has been completed with costs of £1.2m.
- Fire safety capital programme, to be complaint with current Health & Safety standards, has commenced and £1.0m has been spent in the year.
- A spend of £0.5m has been made in the year on the theatre ventilation project at St Albans and Watford.
- A spend of £0.7m for the remaining building works to complete the bowel screening, MRI and CT scanner project. Both these services have been fully operational as from 2016/17.
- A total investment of £4.1m; estate's backlog maintenance programme.
- An ongoing programme to replace ageing medical equipment accounted for a further £1.0m, which includes a new digital mammography machine to improve the radiology service at St Albans.

In developing the 2018/19 financial plan, the Trust has ensured that it responds to NHSI's financial challenges whilst drawing on existing plans, knowledge and skills within divisional teams. An executive director and a responsible manager lead on developing different elements of the plan, ensuring consistency with longer term planning and strategic documents, such as the estate, quality, and workforce strategies. Work continues to ensure consistency with the STP area plan and incorporation into the Trust's financial strategy and long-term financial model.

The challenge now is for the Trust to maintain quality improvements at the same time as very significant improvements to its financial position. In order to achieve operational and financial goals in the future the Trust will continue to work in partnership with other health organisations in the STP footprint and with the RFL to pursue efficiencies and increased clinical standardisation.

The Trust requires significant investment in its estate to realise its proposed vision for new seamless models of care.

The starting position for the 2018/19 plan is the forecast deficit for 2017/18, adjusted for events unique to 2017/18. Financial forecasts are aligned with quality, workforce and activity plans and priorities.

The planning framework for 2018/19 retained conditional access to STF revenue. The Trust was notified of a new control total that, would require the Trust to develop a plan for a deficit of no greater than £21.6m in 2018/19 (excluding STF monies), incur no more than £18.4m of agency costs and comply with a number of quality measures, it could access the fund up to £15.0m, thus reducing the deficit plan to a new control total to £5.4m in 2018/19. The Trust remains committed to working with NHSI and other appropriate bodies to maximise the opportunities for achieving these challenging targets, however as the Trust enters the 2018/19 year, the Board has estimated that the Trust would need new efficiencies in excess of £35m to meet this target. An early assessment is that savings of this size in the 2018/19 year would compromise the Trust's ability to respond to patient demand and provide safe care.

This outlook reinforces the need for improvements in financial performance at all levels in 2018/19 and beyond.

Financial risk

The Trust's financial risk is assessed against a five-point rating developed by NHSI, each one scored from 1 to 4. The Trust's performance for the year against these financial indicators provides an overall score of 3, reflecting the current cash situation alongside the ongoing operating deficit (four of the measures), offset by a continued reduction in agency costs. The Board uses this each month, together with other information to manage its finances. An overall score of greater than 2 is unsatisfactory.

The outcome of strategic work on the provision of healthcare to west Hertfordshire will support the Trust's longer term financial plans to address the overall financial risk score. As cash flow is a key component of any future financial recovery, future plans and agreements with regulators will need to address the schedule of loan repayments to the Department of Health. A key milestone in this area is December 2018, where loans taken out in 2015/16 must be repaid.

Internal audit

RSM Risk Assurance Services LLP (RSM) was appointed to provide the Trust's Internal Audit service after a competitive tendering exercise, with effect from 01 April 2017. With Trust input, RSM develops an annual plan of work that is approved by the audit committee. Progress reports highlighting any significant weaknesses identified are reviewed at each committee meeting to ensure action is taken to manage risks and resolve weaknesses in the system of internal control. For further details please refer to the head of internal audit opinion in the governance statement on page 30.

External audit

The Trust has a statutory duty to appoint external auditors under the Audit Commission Act 1998. Grant Thornton UK LLP was appointed after a competitive tender exercise for two years, as from 01 April 2017, for the provision of external audit services.

In the event that the Trust appoints Grant Thornton for work other than that of external audit, the expense is shown separately in the annual accounts as "other auditor remuneration" (see note 8 of the accounts). Any award of such work is subject to appropriate competitive processes and assurance that there is no conflict of interest with the role of external auditor.

Related parties

The Trust has received declarations from all Board and trust executive committee members (see pages 32 and 33) relating to any potential conflicts of interest in conducting NHS business (e.g. external appointments, suppliers etc). Any member associated with the organisations thus disclosed will be shown in the register of interest held by the Corporate Governance Office.

Note 30 of the accounts sets out transactions with related parties, which are mainly other NHS bodies commissioning patient activity provided by the trust, or other government bodies with which the trust has financial transactions. There are three related transaction involving a board member and other two senior managers.

Better payment practice code

The Trust strives to pay its suppliers on time. Performance in achieving this is set out in note 11 of the accounts. Performance during 2017/18 was maintained, albeit after a marked deterioration during 2016/17 as cash management challenges continued. The Trust actively engages with suppliers where issues may arise in order to put in place arrangements which are appropriate to both parties' needs.

Fraud

The Trust's counter fraud policy is available on the Trust's intranet and internet to provide advice for staff in relation to reporting and dealing with suspected fraud. The Trust has a nominated local counter fraud specialist who assists the chief financial officer in raising awareness and dealing with fraud matters. The Trust has developed an action plan to improve its counter-fraud effectiveness after consulting with NHS Protect. The local counter fraud services contract is currently held by RSM.

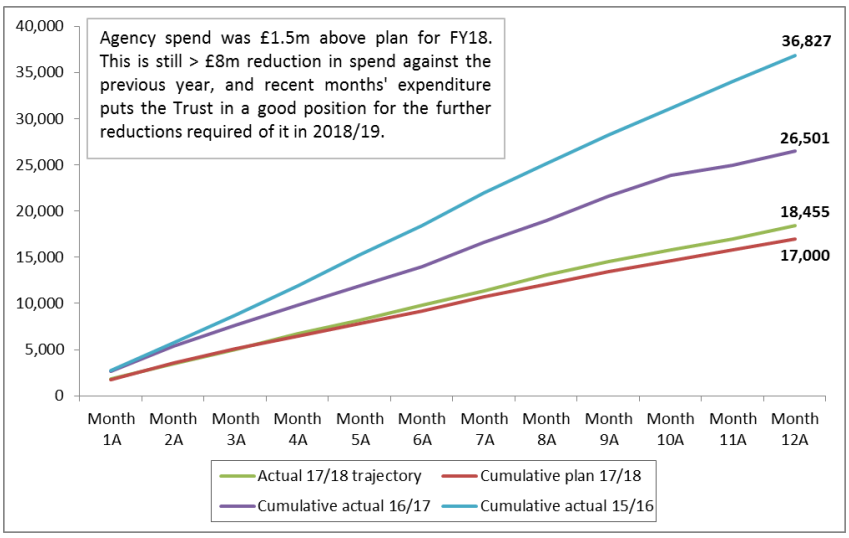
Income generation activities

The Trust does not conduct material income generation activities outside of its usual business, where the aim is to achieve profit. Any financial benefit derived from these activities is used in patient care.

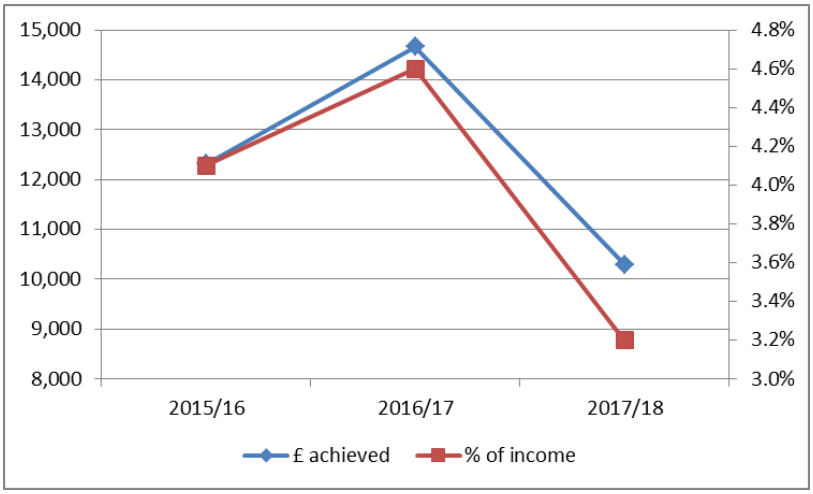
Pensions

Past and present employees are covered by the NHS pension schemes. Details of the benefits payable under these provisions can be found on the NHS pensions website at https://www.nhsbsa.nhs.uk/nhs-pensions. Further details can be found in note 10.7 of the accounts.

Agency expenditure for financial years 2015/16 – 2017/18



Efficiency savings for financial years 2015/16 – 2017/18 (£k & % of income)



Achieving the aim and objectives

The table below demonstrates progress in 2017/18 against achieving aim three and the underpinning objectives.

Aim three	Objective	Evidence
To improve our finances	To deliver our 2017/18 financial plan	▪ Ended the year with a revenue deficit of £42.6, in line with expectations. ▪ Achievement compared to an agreed revised plan of £35.0m, and accounting for one-off impacts of certain national operational decisions.
	To deliver our efficiency savings programme, including opportunities highlighted in the Carter review	▪ Achieved £10.3m (3.2% of revenue) compared to the target of £13.7m.

Statement of the chief executive's responsibilities as the accountable officer of the trust

The chief executive of NHS Improvement, 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, recognised gains and losses and cash flows for the year.

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

Signed ..... Date 24-5-18

Katie Fisher
Chief Executive

Statement of directors' responsibilities in respect of the accounts

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

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

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

By order of the Board

Signed ..... Date 24.5.18

Katie Fisher
Chief Executive

Signed ..... Date 24.5.18

Don Richards
Chief Financial Officer

West Hertfordshire Hospitals NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	291,818	286,358
Other operating income	4	32,954	36,285
Operating expenses	7, 9	(364,253)	(359,022)
Operating surplus/(deficit) from continuing operations		**(39,481)**	**(36,379)**
Finance income	12	24	23
Finance expenses	13	(1,823)	(1,834)
PDC dividends payable		-	(1,632)
Net finance costs		**(1,799)**	**(3,443)**
Other gains / (losses)	14	-	(33)
Surplus / (deficit) for the year from continuing operations		**(41,280)**	**(39,855)**
Surplus / (deficit) for the year		**(41,280)**	**(39,855)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(21,722)
Revaluations	16.1	7,468	-
Total comprehensive income / (expense) for the period		**(33,812)**	**(61,577)**

Financial performance for the year

Retained surplus/(deficit) for the year		**(41,280)**	(39,855)
Impairments (excluding IFRIC 12 impairments)	8	**(165)**	10,410
Adjustments in respect of donated gov't grant asset reserve elimination		**93**	14
Adjustment re absorption accounting		**0**	0
CQUIN Risk Reserve - 1617 CT non achievement adjustment		**(1,282)**	0
Adjusted retained surplus/(deficit)		**(42,634)**	**(29,431)**

The adjusted retained deficit of £42,634,000 is after excluding impairments,the net of donated income and depreciation and the Commissioning for Quality & Innovation (CQUIN) income. The Trust financial performance is measured on the adjusted Breakeven duty deficit of £41,352,000 as described in note 36.

The notes on pages 6 to 37 form part of this account.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	3,292	2,024
Property, plant and equipment	16	151,724	141,763
Trade and other receivables	17	1,602	1,594
Total non-current assets		**156,618**	**145,381**
Current assets			
Inventories	16	5,427	4,428
Trade and other receivables	17	20,461	21,336
Cash and cash equivalents	18	3,578	4,623
Total current assets		**29,466**	**30,387**
Current liabilities			
Trade and other payables	19	(43,940)	(44,048)
Borrowings	22	(33,760)	(4,523)
Provisions	24	(523)	(645)
Other liabilities	21	(1,529)	(1,411)
Total current liabilities		**(79,752)**	**(50,627)**
Total assets less current liabilities		**106,332**	**125,141**
Non-current liabilities			
Borrowings	22	(104,636)	(91,342)
Provisions	24	(4,495)	(4,381)
Total non-current liabilities		**(109,131)**	**(95,723)**
Total assets employed		**(2,799)**	**29,418**
Financed by			
Public dividend capital		224,671	223,076
Revaluation reserve		25,096	17,628
Income and expenditure reserve		(252,566)	(211,286)
Total taxpayers' equity		**(2,799)**	**29,418**

The notes on pages 6 to 37 form part of this account.

Name Katie Fisher

Position Chief Executive Officer

Date 24.5.18

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**223,076**	**17,628**	**(211,286)**	**29,418**
Surplus/(deficit) for the year	-	-	(41,280)	**(41,280)**
Impairments	-	-	-	**-**
Revaluations	-	7,468	-	**7,468**
Public dividend capital received	1,595	-	-	**1,595**
Public dividend capital repaid	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**224,671**	**25,096**	**(252,566)**	**(2,799)**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**223,076**	**39,350**	**(171,431)**	**90,995**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**223,076**	**39,350**	**(171,431)**	**90,995**
Surplus/(deficit) for the year	-	-	(39,855)	**(39,855)**
Impairments	-	(21,722)	-	**(21,722)**
Taxpayers' equity at 31 March 2017	**223,076**	**17,628**	**(211,286)**	**29,418**

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.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(39,481)	(36,379)
Non-cash income and expense:			
Depreciation and amortisation	7	7,490	7,349
Net impairments	8	(165)	10,410
Income recognised in respect of capital donations	4	(17)	(127)
(Increase) / decrease in receivables and other assets		884	(1,014)
(Increase) / decrease in inventories		(999)	(257)
Increase / (decrease) in payables and other liabilties		(1,447)	2,030
Increase / (decrease) in provisions		(68)	(493)
Net cash generated from / (used in) operating activities		**(33,803)**	**(18,481)**
Cash flows from investing activities			
Interest received		25	25
Purchase of intangible assets		(1,312)	(2,400)
Purchase of property, plant, equipment and investment property		(8,514)	(14,890)
Receipt of cash donations to purchase capital assets		17	-
Net cash generated from / (used in) investing activities		**(9,784)**	**(17,265)**
Cash flows from financing activities			
Public dividend capital received		1,595	-
Movement on loans from the Department of Health and Social Care		42,531	39,830
Movement on other loans		-	2,000
Other interest paid		(1,566)	(1,648)
PDC dividend (paid) / refunded		(18)	(1,552)
Net cash generated from / (used in) financing activities		**42,542**	**38,630**
Increase / (decrease) in cash and cash equivalents		**(1,045)**	**2,884**
Cash and cash equivalents at 1 April - brought forward		**4,623**	**1,739**
Cash and cash equivalents at 1 April - restated		**4,623**	**1,739**
Cash and cash equivalents at 31 March	18.1	**3,578**	**4,623**

NOTES TO THE ACCOUNTS

1. Accounting Policies

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 2017-18 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.

1.1. Accounting convention

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

1.2. Acquisitions and discontinued operations

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

1.3. Critical accounting judgements and key sources of estimation uncertainty

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

1.3.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (note 1.3.2) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- IAS 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector such as the Trust, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements are prepared on a going concern basis unless there were plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

  In preparing the financial statements the directors have considered the Trust's overall financial position, with outturn adjusted deficit of £42.6m in 2017-18, and expectation of future financial support.The Trust has submitted a financial plan for 2018-19 to the NHS Improvement (NHSI) which delivers a £52.9m deficit for 2018-19 excluding any support from provider sustainability fund. This includes a savings target of 4.3% which equates to £15.9m for 2018-19. Over 67% of the savings have been identified to date. In order to achieve the control total of £7.9m deficit in 2018-19, unrealistic savings target of £38.4m would need to be planned.

  A requirement for £63.8m for revenue and capital cash support is also planned. A further £20.0m loan for improving working capital is planned in 2018-19. Directors are seeking additional cash support of £83.8m from NHSI for 2018-19. NHSI has not confirmed this support. Uncommitted Single Currency Interim Revenue Support Facility will be available when required with effect from 1 April 2018.

  As part of the Annual Plan the revenue loan repayment of £32.0m on the 18 December 2018 will need to be extended for a further three years, and restructuring of all loans will need to be considered as part of the Trust's overall strategy and its work with suitable partner organisations.

  Although these factors represent a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still 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 2017-18 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. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.
- The risks and rewards of ownership of assets leased by the Trust rest with the leasing company; rental payments are charged to the period to which they relate; see note 11.
- Some of the Trust's buildings are used by other organisations, either for NHS purposes or staff welfare. These are not investment properties and rental is credited to the period to which it relates. The associated buildings are included within the total value of Trust properties.
- The Watford Health Campus committed the Trust to share the costs relating to a major road development* providing alternative access to Watford General Hospital (WGH). The road development has to date benefitted from NHS grants of £7m. These grants were received from the Department of Health and Social Care to be paid to Watford Borough Council as contribution to the cost of construction of the access road.

  The monies paid to Watford Borough Council for the construction of this new access road to Watford General Hospital have been capitalised and impaired as the road will not be owned by the Trust; see note 15.2.
- The fair value of early retirement provisions has been reassessed using the latest information from Pensions Agency and the Government Actuary Department (GAD) tables detailing revised life expectancy. For further details see note 24.1.
- NHS debtor provision will not be provided unless agreed with the creditor NHS organisation as required by the Department of Health and Social Care Group Accounting Manual 2017-18 . Provision will form part of Agreement of Balance exercise; see note 17.2.
- Some IT assets purchased under agreement by IT sub-contractor, mainly end-users devices, which have been deployed for use in the Trust. Standard number 4 of the International Financial Reporting Interpretations Committee (IFRIC4) provides guidance on whether or not an asset purchased by third party and used by an organisation should be regarded as an asset of that organisation. The Trust has capitalised these devices under terms of IFRIC4 on the basis that the Trust:
  i) uses the end-user devices
  ii) owns risks and rewards associated with the devices
  iii) use these devices for the term of their economical useful lives
- Since 6 April 2017, employers with an annual pay bill exceeding £3 million are required to pay a levy of 0.5% of that pay bill, with payments to be made via the PAYE system along with payroll taxes. Funds paid under the levy are credited to a 'Digital Apprenticeship Services Account' (DAS) which can be used to pay for vocational training and assessment provided by government approved training/assessment organisations.
  Government will also contribute to the costs of apprenticeships through a 10% 'top up' of funds paid into an employer's DAS and 90% 'co investment' when there are insufficient funds to pay for approved training/assessment. As required in the Department of Health and Social Care Group accounting Manual 2017-18, the apprentice levy together with the top up from government is shown as expenditure in the year.

1.3.2 Key sources of estimation uncertainty

In preparing these accounts the Trust might make assumptions concerning the future affecting the amounts of assets, liabilities, revenue or expenses reported. Any such assumptions and the basis of estimate are explained in the related notes. These include:

- from 1 April 2013 income from commissioners for maternity care is received at commencement of the Care Pathway. An estimate of incompleted elements of the pathway has been deferred.
- the valuation of land and buildings using the modern equivalent asset discounted replacement cost method detailed in note 16.5. The basis of estimate for Watford site includes changes to internal area informed by new drawings and revised build dates.
- management have determined that it is appropriate for surplus assets to be held at nil value and not at fair value because they were held for their service potential and there are restrictions that would prevent the marketing of the assets for sale (ie. that they are specialist hospital buildings that are integral parts of the Trust's sites).
- The land at St Albans, Watford and Hemel Hempstead sites has been valued under the Modern Equivalent Asset (MEA) methodology in 2017-18. The approach to the MEA technique used for land valuation allows an alternative site to be used where the location requirements of the service being provided can be met from this location. Should the MEA have the potential to be relocated to a less expensive area due to changes in the nature of how existing facilities are used, the value of land in this alternate location should be adopted for valuation. This principle was applied to all three Trust sites in 2017-18, details of the impact of which can be found in note 16.5.
- Sustainability & Transformation Fund (STF) income, up to a maximum of £10.7m, was allocated to the Trust by NHS Improvement based on the achievement of certain financial and clinical targets. The financial targets were set with an expectation that the Trust would achieve its planned deficit (control total) in any given quarter. The clinical performance targets were set around the key areas of referral to treat (RTT), accident & emergency waiting times (A&E), and cancer treatment.
  STF outcomes were estimated in the financial statements throughout the year, including appeals on certain performance measures. Further details can be found in notes 4 and 5.

*From Wiggenhall Road to the hospital and through to Vicarage Road for emergency vehicles and buses only.

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

1.4. Charitable Funds

Following Treasury's agreement to apply IFRS 10 to NHS Charities from 1 April 2013, the Trust has assessed whether it is appropriate to group the Trust's accounts and those of West Hertfordshire Hospitals NHS Trust Charity. The Trust Board as corporate trustee of the charity has the power to exercise control so as to obtain economic benefits therefore consolidation is appropriate. However the transactions are immaterial in the context of the group and are therefore not consolidated. A summary of the Charity's activities is disclosed in note 31.

1.5. Revenue

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

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred and matched to the period in which it is undertaken.

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

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.6. Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

Retirement benefit costs

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

For early retirements, other than those due to ill health, approved by the Trust the additional pension is not funded by the NHS Pension Scheme. The full cost is a liability of the Trust and is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the period over which the Trust pays its liability.

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

1.7. Other expenses

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8. Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent had similar purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Capital expenditure on strategic schemes, i.e. those schemes which are of a longer-term nature such as building or large infrastructure projects, is initially charged to assets in the course of construction during the construction phase. Capital schemes are regularly assessed for progress, and once completed, costs are transferred from assets in the course of construction to the appropriate asset category and are recognised as coming into full use.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at current value. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2009, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. With effect from 1 April 2009, through its appointed valuers GVA Grimley Ltd the Trust has adopted the HM Treasury standard approach to depreciated replacement cost valuations based on modern equivalent assets. The effect of this estimation technique is detailed in note 16.3.

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

Until 31 March 2009, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historical cost. From 1 April 2009 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

Subsequent expenditure

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

1.9. Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5k.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant or equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

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

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

1.10. Depreciation, amortisation and impairments

Freehold land, properties under construction and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Further details of each class of asset is shown in note 16.5.

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

If there has been an impairment loss the asset is written down to its recoverable amount with the loss charged to the revaluation reserve to the extent there is a balance on the reserve for the asset and thereafter, to expenditure. Unless the impairment results from use of the asset where the impairment is charged fully to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there, and thereafter, to the revaluation reserve.

In compliance with the DH Group Accounting Manual, from 2011-12, impairments relating to property, plant and equipment are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). The analysis is used by the Department of Health in consolidating the accounts of NHS bodies. In summary, DELs set as part of NHS spending are not expected to be exceeded. AME is less predictable and, subject to Treasury approval, may be revised. The related Trust impairment is classified as AME and is detailed in note 16.3.

1.11. Donated assets

A donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are also as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.12. Non-current assets held for sale

Non-current assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met: the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales; the sale must be highly probable ie: management are committed to a plan to sell the asset, an active programme has begun to find a buyer and complete the sale, the asset is being actively marketed at a reasonable price, the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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. Assets are de-recognised when all material sale contract conditions have been met.

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

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

1.13. Useful economic lives of property, plant

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

	Min life Years	Max life Years
Buildings, excluding dwellings	1	99
Dwellings	1	99
Plant & machinery	1	15
Transport equipment	1	15
Information technology	1	8
Furniture & fittings	1	99

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.14. Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The Trust does not hold any finance leases, its leases are classified as operating leases, further details of which are contained in note 11.

The Trust as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term.

The Trust as lessor

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

1.15. Inventories

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

1.16. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of 24 hours or less. 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. The Trust does not hold cash equivalents.

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

1.17. Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using the appropriate HM Treasury's discount rate. Liabilities expected to be settled in 0 to 5 years are discounted at minus 2.70%, 5 to 10 years at minus 1.95% and beyond 10 years at minus 0.8%. Those relating to employee early retirement obligations are discounted at 0.1%.

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

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

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

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

1.18. Clinical negligence costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSR who in return settles all clinical negligence claims.
Although the NHSR is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed at note 24.2.

1.19. Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS 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 as and when they become due.

1.20. Contingencies

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

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

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

1.21. Financial assets

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

1.22. Financial liabilities

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

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

1.23. Value Added Tax (VAT)

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.

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

1.24. Foreign currencies

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

The Tust do not have any assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

1.25. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 18.2 to the accounts.

1.26. Public Dividend Capital (PDC) and PDC dividend

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.

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

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

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 thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.27. Losses and Special Payments

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

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

1.28. Research and Development

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

1.29. Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 14 Regulatory Deferral Accounts - Not yet endorsed by The European Financial Reporting Advisory Group hence early adoption is not permitted.
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021 but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2019.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

1.30 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

Note 2 Operating Segments

The Trust's activities are managed collectively as a single operating segment to provide the wide range of patient healthcare usually available from a district general hospital; predominately for the population of West Hertfordshire.

Revenue relating to NHS patient care accounts for 90% of the total, further analysis of which is shown in note 3.1. This is managed through contracts established with commissioners, mainly Clinical Commissioning Groups (CCGs) which are the main commissioners, each contract covering the complete range of activities provided. The Trust's assets are used collectively to deliver the range of activities encompassed within these contracts.

Note 3.1 Income from patient care activities (by nature)	**2017/18**	**2016/17**
	£000	**£000**
Acute services		
Elective income	49,688	53,306
Non elective income	103,953	93,002
First outpatient income	37,880	37,177
Follow up outpatient income	28,626	32,579
A & E income	15,812	14,742
High cost drugs income from commissioners (excluding pass-through costs)	11,514	11,001
Other NHS clinical income	42,733	42,880
All services		
Private patient income	683	408
Other clinical income	929	1,263
Total income from activities	**291,818**	**286,358**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2017/18**	**2016/17**
	£000	**£000**
NHS England	21,317	18,663
Clinical commissioning groups	268,242	265,798
Other NHS providers	646	225
Non-NHS: private patients	303	408
Non-NHS: overseas patients (chargeable to patient)	380	391
NHS injury scheme	929	834
Non NHS: other	1	39
Total income from activities	**291,818**	**286,358**
Of which:		
Related to continuing operations	291,818	286,358
Related to discontinued operations	-	-

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

	2017/18	2016/17
	£000	£000
Income recognised this year	380	391
Cash payments received in-year	158	221
Amounts added to provision for impairment of receivables	332	314
Amounts written off in-year	25	182

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Education and training	9,918	9,194
Receipt of capital grants and donations	17	127
Charitable and other contributions to expenditure	129	235
Non-patient care services to other bodies	16,704	14,695
Sustainability and transformation fund income	3,688	8,949
*Other income (including income generation activities)	2,498	3,085
Total other operating income	**32,954**	**36,285**
Of which:		
Related to continuing operations	32,954	36,285

* Refer to Note 6

Note 5 Details of Trust Revenue

Most of the Trust's income is derived through contracts with Clinical Commissioning Groups and other NHS organisations, and is almost entirely derived from the supply of services; Income from the sale of goods is immaterial. As shown in note 3 and 4, the Trust may receive additional funds outside the main contract.

The Trust received in 2017-18 £1.4m of Core Sustainability and Transformation Fund (STF) of the possible maximum of £10.7m available for the year , this was accrued in quarter 1 having met the targets as set by NHS Improvement. The Trust for the remaining year did not meet the financial targets as agreed with NHS Improvement. The Trust further accrued Incentive STF of £2.3m as agreed with NHS Improvement.

The Trust received £8.25m out of a maximum possible £12.0m of STF in 2016-17. Quarter 1 payments were based solely on financial performance (£3.0m), quarters 2 and 3 were based on a combination of financial and operational performance (£5.25m combined), and quarter 4 was again based solely on financial performance (£nil, as the deficit target was not met). Indicative STF bonus income of £699k was also accrued as agreed with NHS Improvement.

Income generation includes car parking revenue, rental of hospital space to other trusts, use of the Trust's roofs for aerials and other minor health related services.

Overseas Visitors' income is recognised when payment is made by the patient. As from 1 April 2015, changes in regulation has meant that the Trust recognises 50% of the income billed to Herts Valley Clinical Commissioning Group for all Overseas Visitors excluding patient from European Economic Area with reciprocal agreement. Herts Valley Clinical Commissioning Group will eventually be reimbursed with the advance of income if the Trust is successful in receiving full/part of the invoiced value from the patient.

Note 6 Income Generation Activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material.

Summary Table - aggregate of all schemes

	2017/18	2016/17
	£000	£000
Income	2,157	1,975
Full cost	(1,410)	(1,306)
Surplus / (deficit)	**747**	**669**

Note 7 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies - see i) below	4,109	3,233
Purchase of healthcare from non-NHS and non-DHSC bodies - see ii) below	5,038	3,661
Staff and executive directors costs	235,036	224,115
Remuneration of non-executive directors	77	77
Supplies and services - clinical (excluding drugs costs)	28,562	29,039
Supplies and services - general	12,360	11,771
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,513	21,742
Consultancy costs - see iii) below	1,122	1,685
Establishment	4,068	3,924
Premises	16,438	17,254
Transport (including patient travel)	547	629
Depreciation on property, plant and equipment	7,446	7,298
Amortisation on intangible assets	44	51
Net impairments - see iv) below	(165)	10,410
Increase/(decrease) in provision for impairment of receivables - see v) below	640	74
Change in provisions discount rate(s)	422	-
Audit fees payable to the external auditor		
audit services- statutory audit	49	75
other auditor remuneration (external auditor only) - see vi) below	7	10
Internal audit costs	141	128
Clinical negligence - see vii) below	17,623	15,864
Legal fees	101	113
Insurance	202	210
Education and training	1,676	544
Rentals under operating leases	536	457
Hospitality	-	7
Other - see viii) below	5,661	6,651
Total	**364,253**	**359,022**
Of which:		
Related to continuing operations	364,253	359,022
Related to discontinued operations	-	-

i) Total services from NHS bodies does not include expenditure which falls into a category below

ii) Purchase of healthcare from non-NHS bodies relates to the outsourcing of activity both to meet waiting time targets and manage bed capacity.

iii) Consultancy services includes costs of support on clinical and estates strategy. In 2016/17 this also included programme management support to efficiency savings programme

iv) The Trust's revaluation of its land and buildings in 2017-18 has generated reversal of impairments. See notes 16.5 and 1.3.2 for further details. In 2016-17 this includes payment to Watford Borough Council for the new access road to Watford General Hospitals charged to expenses as per notes 15.2 and 1.3.1.

v) Increase in Non NHS bad debt provision mainly due to dispute with facilities management contract.

vi) The other auditor remuneration (external auditor only) relates to Quality Accounts Review.

vii) Contribution paid as agreed with NHS Resolution - see notes 1.17 and 1.18

viii) Other expenditure includes the following services:

- £2,145,000 for portering
- £997,000 for linen
- £331,000 for contract management
- £541,000 for security
- £522,000 for waste disposal

Note 7.1 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
Other non-audit services	7	10
Total	**7**	**10**

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £0m).

Note 8 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(165)	8,410
Other (new access road)	-	2,000
Total net impairments charged to operating surplus / deficit	**(165)**	**10,410**
Impairments charged to the revaluation reserve	-	21,722
Total net impairments	**(165)**	**32,132**

2017-18 impairments relates to buildings at the Trust. No impairment on intangible assets in 2017-18 is incurred. The analysis by site of the impairment on property, plant and equipment is shown in note 16.5. £2m in 2016-17 impairment in Other relates to intangible assets relates to final payment to Watford Borough Council for the construction of new access road at Watford General Hospital which has been capitalised and impaired. See notes 1.3.1 and 15.2.

Note 9 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	156,016	147,203
Social security costs	16,966	14,902
Apprenticeship levy	862	-
Employer's contributions to NHS pensions	19,140	18,135
Pension cost - other	7	5
Termination benefits	-	124
Temporary staff (including agency)	42,045	43,746
Total gross staff costs	**235,036**	**224,115**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**235,036**	**224,115**
Of which		
Costs capitalised as part of assets	-	-

Note 9.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £124k (£196k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9.2 Staff Numbers

The average number of staff employed at the Trust during 2017-18 was 4,800 of which 4,132 were permanently employed. This compares to 4,793 total average number of staff employed in 2016-17. Further details on staff numbers are reported in remuneration and staff section of the annual report.

Note 9.3 Staff Sickness Absence

An average of 7.3 working days were lost per staff member in 2017/18 in comparison to 7.2 in 2016/17. Further details on staff sickness are reported in the remuneration and staff section of the annual report.

Note 9.4 Exit Packages agreed in 2017-18

The total number of exit packages agreed in 2017-18 was 29 compared to 15 for 2016-17. Further details on exit packages are reported in remuneration and staff section of the annual report.

Note 9.5 Exit packages - Other Departures analysis agreed in 2017-18

The total number of other departures in exit packages agreed in 2017-18 was 28 compared to 14 for 2016-17. Further details on other departures in exit packages are reported in remuneration and staff section of the annual report.

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the Scheme Actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 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 last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the Scheme Actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The 95 and 2008 schemes are "final salary" schemes. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. The 2015 Scheme pays a pension based on the average of a members pensionable earnings throughout their whole career - calculated as 1/54th of each years pensionable earnings revalued each year in line with the CPI plus 1.5%

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Ill-health retirement

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Early retirement

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Additional Pension Purchase

Members can purchase additional pension in the NHS Scheme in units of £250.

Note 11 Operating leases

Note 11.1 West Hertfordshire Hospitals NHS Trust as a lessor

The Trust has no operating lease agreements as a lessor

Note 11.2 West Hertfordshire Hospitals NHS Trust as a lessee

Operating Leases
Leases relate mainly to the hire of medical equipment: contracts are entered into using standard NHS conditions that include:

- Retained asset ownership by the Lessor;
- Fixed rental payments over the agreed lease period;
- Residual value being the property of the Lessor;
- The equipment used by the Trust is for its intended purpose;
- Options for the Trust to extend the lease period or return
- The equipment when returned is complete and in reasonable condition.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	536	457
Total	**536**	**457**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	516	489
- later than one year and not later than five years;	1,070	1,160
- later than five years.	8	76
Total	**1,594**	**1,725**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	24	23
Total	**24**	**23**

Note 13.1 Finance expenditure

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,731	1,688
Interest on late payment of commercial debt	32	87
Total interest expense	**1,763**	**1,775**
Unwinding of discount on provisions	60	59
Total finance costs	**1,823**	**1,834**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	32	87
Total	32	87

Note 14 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gain/(Losses) on disposal of assets other than by sale (PPE)	-	(33)
Total gains / (losses) on disposal of assets	-	(33)
Total other gains / (losses)	**-**	**(33)**

Note 15.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**7,051**	**1,421**	**400**	**8,872**
Additions	1,148	-	-	164	**1,312**
Gross cost at 31 March 2018	**1,148**	**7,051**	**1,421**	**564**	**10,184**
Amortisation at 1 April 2017 - brought forward	**-**	**6,848**	**-**	**-**	**6,848**
Provided during the year	-	44	-	-	**44**
Amortisation at 31 March 2018	**-**	**6,892**	**-**	**-**	**6,892**
Net book value at 31 March 2018	**1,148**	**159**	**1,421**	**564**	**3,292**
Net book value at 1 April 2017	**-**	**203**	**1,421**	**400**	**2,024**

Note 15.2 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Development expenditure	Intangible assets under construction	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**-**	**6,913**	**6,421**	**-**	**13,334**
Adjustment*			**(5,000)**		**(5,000)**
Valuation / gross cost at 1 April 2016 - restated	**-**	**6,913**	**1,421**	**-**	**8,334**
Additions	-	-	-	2,400	**2,400**
Impairments	-	-	-	(2,000)	**(2,000)**
Reclassifications	-	138	-	-	**138**
Valuation / gross cost at 31 March 2017	**-**	**7,051**	**1,421**	**400**	**8,872**
Amortisation at 1 April 2016 - as previously stated	**-**	**6,797**	**5,000**	**-**	**11,797**
Adjustment*			**(5,000)**		**(5,000)**
Amortisation at 1 April 2016 - restated	**-**	**6,797**	**-**	**-**	**6,797**
Provided during the year	**-**	**51**	**-**	**-**	**51**
Amortisation at 31 March 2017	**-**	**6,848**	**-**	**-**	**6,848**
Net book value at 31 March 2017	**-**	**203**	**1,421**	**400**	**2,024**
Net book value at 1 April 2016	**-**	**116**	**1,421**	**-**	**1,537**

***** The opening balances for development expenditure - internally generated are reclassified for 2016-17 in order not to carry forward the impact of £5.0m of money paid to Watford Borough Council for the costs relating to a major road development providing alternative access to Watford General Hospital. See accounting treatment explained in note 1.3.1.

The maximum remaining asset life of computer software in use is 5 years.

There are no material intangible assets fully amortised in use.

There were no changes in asset lives, residual values, or impairment loss recognised during the period for assets in use.

Intangible assets are held at depreciated cost as a proxy for fair value; there are no associated revaluation reserves.

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**35,132**	**78,710**	**197**	**21,114**	**41,843**	**176**	**12,735**	**2,446**	**192,353**
Additions	-	-	-	8,037	365	-	1,372	-	**9,774**
Impairments	-	(7,449)	-	-	-	-	-	-	**(7,449)**
Reversals of impairments	1,172	2,389	-	-	-	-	-	-	**3,561**
Revaluations	5,864	1,479	(15)	-	-	-	-	140	**7,468**
Reclassifications	-	8,328	-	(11,253)	2,009	-	916	-	**-**
Valuation/gross cost at 31 March 2018	**42,168**	**83,457**	**182**	**17,898**	**44,217**	**176**	**15,023**	**2,586**	**205,707**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**6,192**	**28**	**-**	**31,520**	**176**	**12,335**	**339**	**50,590**
Provided during the year	**-**	**4,617**	**30**	**-**	**2,247**	**-**	**422**	**130**	**7,446**
Impairments	-	(3,909)	(28)	-	-	-	-	(116)	**(4,053)**
Accumulated depreciation at 31 March 2018	**-**	**6,900**	**30**	**-**	**33,767**	**176**	**12,757**	**353**	**53,983**
Net book value at 31 March 2018	**42,168**	**76,557**	**152**	**17,898**	**10,450**	**-**	**2,266**	**2,233**	**151,724**
Net book value at 1 April 2017	**35,132**	**72,518**	**169**	**21,114**	**10,323**	**-**	**400**	**2,107**	**141,763**

Note 16.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**58,734**	**80,500**	**323**	**20,635**	**39,778**	**176**	**12,709**	**2,491**	**215,346**
Valuation / gross cost at 1 April 2016 - restated	**58,734**	**80,500**	**323**	**20,635**	**39,778**	**176**	**12,709**	**2,491**	**215,346**
Additions	-	-	-	11,523	67	-	-	-	**11,590**
Impairments	(23,602)	(10,144)	(131)	-	-	-	-	(363)	**(34,240)**
Reclassifications	-	8,354	5	(11,044)	2,203	-	26	318	**(138)**
Disposals / derecognition	-	-	-	-	(205)	-	-	-	**(205)**
Valuation/gross cost at 31 March 2017	**35,132**	**78,710**	**197**	**21,114**	**41,843**	**176**	**12,735**	**2,446**	**192,353**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**5,866**	**66**	**-**	**29,130**	**176**	**11,967**	**367**	**47,572**
Accumulated depreciation at 1 April 2016 - restated	**-**	**5,866**	**66**	**-**	**29,130**	**176**	**11,967**	**367**	**47,572**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**4,224**	**28**	**-**	**2,562**	**-**	**368**	**116**	**7,298**
Impairments	-	(3,898)	(66)	-	-	-	-	(144)	**(4,108)**
Disposals/ derecognition	-	-	-	-	(172)	-	-	-	**(172)**
Accumulated depreciation at 31 March 2017	**-**	**6,192**	**28**	**-**	**31,520**	**176**	**12,335**	**339**	**50,590**
Net book value at 31 March 2017	**35,132**	**72,518**	**169**	**21,114**	**10,323**	**-**	**400**	**2,107**	**141,763**
Net book value at 1 April 2016	**58,734**	**74,634**	**257**	**20,635**	**10,648**	**-**	**742**	**2,124**	**167,774**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	42,168	76,557	152	17,666	10,450	2,266	2,233	**151,492**
Owned - donated	-	-	-	232	-	-	-	**232**
NBV total at 31 March 2018	**42,168**	**76,557**	**152**	**17,898**	**10,450**	**2,266**	**2,233**	**151,724**

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	35,132	72,418	169	20,899	9,955	400	2,107	**141,080**
Owned - donated	-	100	-	215	368	-	-	**683**
NBV total at 31 March 2017	**35,132**	**72,518**	**169**	**21,114**	**10,323**	**400**	**2,107**	**141,763**

Note: The opening balances for buildings and dwellings are reclassified for 2016-17 in order to reflect the correct values as recorded in primary source, the fixed asset register. This reclassification has no impact on the net valuation of these assets and does not require prior year adjustment.

Note 16.5 Property, plant and equipment (cont).

Annual valuation of Land, Buildings and Dwellings is a forecast as at 31 March. The valuation is undertaken by an independent valuer; RICS Registered Valuers of GVA Grimley Ltd. Because of the specialised nature of hospital buildings, i.e. they would not normally be sold on the open market, the valuations are based on the depreciated replacement cost method (DRC) using the modern equivalent asset (MEA) technique. This valuation technique estimates the cost of a MEA; for buildings, this is then adjusted to reflect the age, condition and functionality of the buildings to which the valuation relates and can result in an impairment or reversal, details of which are shown below. The approach adopted by the Trust is for a full revaluation to be undertaken every five years with a desktop review in the interim years. Valuation reflects the capital investment to September each year, after which it is included at cost. VAT is added to the valuations to the extent that it would be payable were the Trust to construct the MEA. In 2017-18 a desktop valuation has been carried out by GVA Grimley Ltd.

The approach to MEA technique used for land valuation is based on 'alternative site basis'. Should the MEA have the potential to be re-located to a less expensive area due to changes in the nature of how the existing facility is used, the value of the land in this alternate location should be adopted for valuation.
All three sites land have been valued on 'alternative site basis' in 2017-18 which has given a rise to an increase in valuation by £7m.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2017-18			
	£000s	£000s	£000s	£000s
Operating expenses - note 7				
Land - MEA (alternative site valuation)	0	0	(1,172)	(1,172)
Buildings, dwellings and fittings - MEA	2,144	(489)	(648)	1,007
Total	2,144	(489)	(1,820)	(165)
Statement of change in taxpayers equity				
Land - MEA (alternative site valuation)	(3,579)	(1,820)	(466)	(5,865)
Buildings, dwellings and fittings - MEA	(360)	(910)	(333)	(1,603)
	(3,939)	(2,730)	(799)	(7,468)
Total impairment/(reversal) 2017-18	(1,795)	(3,219)	(2,619)	(7,633)

	2016-17			
	£000s	£000s	£000s	£000s
Operating expenses - note 7				
Land - MEA	0	0	1,172	1,172
Buildings, dwellings and fittings - MEA	5,583	338	1,317	7,238
Total	5,583	338	2,489	8,410
Statement of change in taxpayers equity				
Land - MEA	1,861	(75)	20,644	22,430
Buildings, dwellings and fittings - MEA	325	(1,487)	454	(708)
	2,186	(1,562)	21,098	21,722
Total impairment/(reversal) 2016-17	7,769	(1,224)	23,587	30,132

The impairment charged to operating expenses is classified as annually managed expenditure for the purposes of NHS consolidated accounts - see note 1.10.

Assets under construction are transferred to the relevant class of assets when complete and depreciated in accordance with that class.

For plant and machinery, transport, information technology, the carrying value as at 1 April 2009 is written off over their remaining lives as per Note 1 to the accounts - Accounting Policies. Net assets in these classes are carried at depreciated historic cost as this is not considered to be materially different from fair value (see note 1.8). Property Plant and Equipment includes £42.5m of fully depreciated assets.

Details of asset life across the Trust's three hospital sites are tabled below:

	As at 31 March 2018		As at 31 March 2017	
Asset Class	Maximum remaining asset life Years	Minimum remaining asset life Years	Maximum remaining asset life Years	Minimum remaining asset life Years
Buildings	**37**	**2**	47	2
Dwellings	**5**	**5**	7	7
Plant and machinery	**9**	**1**	9	1
Transport	**1**	**1**	0	1
Information Technology	**4**	**1**	5	1
Furniture and Fittings	**37**	**2**	47	2

The full valuation exercise included revision to the remaining asset lifes of some buildings and their fittings, consequently the maximum remaing lives between 31 March 18 and 31 March 17 do not necessarily reduce by one year. Cherry Tree House is the only dwelling in both 2017-18 and 2016-17.

For all classes of assets, residual value is estimated at nil.

The Trust provides accomodation facilities to a number of other NHS organisations and a creche provider, where these organisations occupy accommodation within the Trust's buildings. The net carrying amount of these facilities and related depreciation are included in the Trust's figures.

Note 16.5 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	1,273	1,024
Consumables	4,053	3,300
Energy	101	104
Total inventories	**5,427**	**4,428**

Inventories recognised in expenses for the year were £37,614k (2016/17: £30,693k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 17.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	14,982	14,358
Capital receivables (including accrued capital related income)	-	-
Accrued income	3,976	4,748
Provision for impaired receivables	(2,340)	(1,742)
Prepayments (non-PFI)	1,391	1,921
Interest receivable	-	1
PDC dividend receivable	157	139
VAT receivable	1,686	1,372
Other receivables	609	539
Total current trade and other receivables	**20,461**	**21,336**
Non-current		
Other receivables	1,602	1,594
Total non-current trade and other receivables	**1,602**	**1,594**
Of which receivables from NHS and DHSC group bodies:		
Current	14,928	16,159
Non-current	-	-

Note 17.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**1,742**	**1,855**
At 1 April - restated	**1,742**	**1,855**
Increase in provision	640	74
Amounts utilised	(42)	(187)
At 31 March	**2,340**	**1,742**

The provision for the impairment of receivables relates to Non NHS, over 90 days old.

Note 17.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	3,305	-	2,244	-
Over 180 days	-	-	-	-
Total	**3,305**	**-**	**2,244**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	6,806	-	4,125	-
90- 180 days	6,457	-	7,543	-
Over 180 days	-	-	-	-
Total	**13,263**	**-**	**11,668**	**-**

Trade and other receivables are carried at the original invoice amount. As the majority of trade is with Clinical Commissioning Groups (CCGs), as commissioners funded by government to buy NHS patient care services, no credit scoring of these is considered necessary. Other trade receivables mainly relate to private patients who are generally covered by insurance. No formal credit scoring is undertaken. Injury cost recovery relates to patients with personal injury claims, as this is administered centrally for the NHS, no credit scoring is undertaken.

Note 18.1 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.

	2017/18	2016/17
	£000	£000
At 1 April	**4,623**	**1,739**
At 1 April (restated)	**4,623**	**1,739**
Net change in year	(1,045)	2,884
At 31 March	**3,578**	**4,623**
Broken down into:		
Cash at commercial banks and in hand	32	31
Cash with the Government Banking Service	3,546	4,592
Total cash and cash equivalents as in SoFP	**3,578**	**4,623**
Total cash and cash equivalents as in SoCF	**3,578**	**4,623**

Note 18.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Monies on deposit	3	3
Total third party assets	**3**	**3**

Note 19.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	18,422	17,669
Capital payables	3,641	2,381
Accruals	16,666	19,483
Receipts in advance (including payments on account)	-	-
Social security costs	2,455	2,256
VAT payables	-	-
Other taxes payable	2,204	2,000
PDC dividend payable	-	-
Accrued interest on loans	457	259
Other payables	95	-
Total current trade and other payables	**43,940**	**44,048**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	7,169	5,480
Non-current	-	-

Note 19.2 Early retirements in NHS payables above

There is no early retirement in the year payable by the Trust.

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
Outstanding pension contributions	2,768	4,386	2,575	N/A

Note 20 Other financial liabilities

The Trust has no other payables or financial liabilities.

Note 21 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,529	1,411
Total other current liabilities	**1,529**	**1,411**
Non-current		
Total other non-current liabilities	**-**	**-**

Deferred income includes maternity pathway care income received in advance with effect from 2013-14 as per the accounting policy note 1.3.2.

Note 22 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Loans from the Department of Health and Social Care	33,760	4,523
Total current borrowings	**33,760**	**4,523**
Non-current		
Loans from the Department of Health and Social Care	102,636	89,342
Other loans	2,000	2,000
Total non-current borrowings	**104,636**	**91,342**

The borrowings relate to Department of Health and Social Care and Social Care loans:

£27m loan; £13.5m accessed in July 2008 and a further £13.5m in September 2008. The loan was taken to finance the Acute Assessment Unit at Watford General Hospital and other site improvements. It is repayable by twice yearly equal instalments, over ten years, ending March 2018. Interest is at a rate of 5.4% payable twice-yearly on a reducing balance. This loan is fully paid by 31 March 2018.

£11.1m capital loan agreed by Department of Health and Social Care; loan drawdown of £1.6m in 2016-17 (£2.4m in 2014-15 and £7.1m in 2015-16) is included above. The term of the loan is for 12 years commencing repayment from September 2016. Interest is at rate of 1.51% payable twice yearly. Balance outstanding as at 31 March 2018 is £9.1m.

£32.0m loan accessed in January 2016. The loan was taken to finance the deficit and loan repayments in 2015-16. It is repayable fully on 18 December 2018. Interest is at a rate of 1.5% payable twice-yearly.

£7m loan accessed on 14 March 2016 from the Revolving Working Capital loan (RWC) to support liquidity. The Trust had approved loan facility of £26.8m, to be accessed when required, by the Department of Health and Social Care. The loan facility is available until 18 January 2020. Interest is at rate of 3.5% payable twice yearly. This loan has been fully paid on the 3rd February 2017.

£26.8m loan accessed in February 2017. The loan was taken to finance the deficit in 2016-17 and was used to fully pay the Interim Revolving Working Capital Facility loan of £26.8m in February 2017. It is repayable fully on 18 January 2020. Interest is at a rate of 1.5% payable twice-yearly.

£7.5m capital loan accessed in March 2017 to support the capital programme in 2016-17. It is repayable on twice yearly equal instalments over ten years ending in March 2027. Interest is payable at 0.63%. Balance outstanding as at 31 March 2018 is £6.8m.

The Trust also accessed from October 2016 to February 2018 a total of £60.4m, as separate monthly loans, as Uncommitted Single Currency Revenue Support Facility to support the deficit and working capital of the Trust. All loans are at 1.5% interest rate and fully repayable in 3 years' time.

The Trust received authorisation of £13.7m to support the capital programme for a 3-year period from 2017-18 to 2019-20. £1.4m was accessed in 2017-18. It is repayable on twice yearly equal instalments over ten years ending March 2027. Interest is payable at 1.25%. Balance outstanding as at 31 March 2018 is £1.4m.

Other borrowings:
£2m of other loans relate to the loan from Watford Borough Council as contribution to the cost of construction of the access road*. This loan is repayable subject to investment by Trust, on Watford Health Campus**, of between £30m and £40m a payment of £1.0m crystallises and investment of over £40m the full amount is due. Any shortfall in whole or part is payable on instalments of £0.1m per annum from April 2028.

*From Wiggenhall Road to the hospital and through to Vicarage Road for emergency vehicles and buses only.
** The Watford Health Campus is the regeneration of the land surrounding the Watford General Hospital.

Note 23 Finance leases

Note 23.1 West Hertfordshire Hospitals NHS Trust as a lessor or as lessee

The Trust has no finance lease obligations as a lessor or as lessee

Note 24.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**4,661**	**1**	**364**	**5,026**
At start of period for new FTs	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	**-**
Change in the discount rate	422	-	-	**422**
Arising during the year	152	-	51	**203**
Utilised during the year	(500)	(1)	(75)	**(576)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	(53)	-	(64)	**(117)**
Unwinding of discount	60	-	-	**60**
Transfer to FT upon authorisation	-	-	-	**-**
At 31 March 2018	**4,742**	**-**	**276**	**5,018**
Expected timing of cash flows:				
- not later than one year;	512	-	11	**523**
- later than one year and not later than five years;	2,010	-	56	**2,066**
- later than five years.	2,220	-	209	**2,429**
Total	**4,742**	**-**	**276**	**5,018**

i) The fair value of the provision for future pension payments relating to early retirement is assessed using information provided by the Pensions Agency and Government Actuary Department (GAD) tables concerning life expectancy. The forecast cashflow is discounted in accordance HM Treasury prescribed discount rates (see note 1.16).

ii) Staff and public liability claims are managed by NHS Resolution and NHS Pensions Authority. The provision relates to the excess for which the Trust is liable.

Note 24.2 Clinical negligence liabilities

At 31 March 2018, £344,362k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Hertfordshire Hospitals NHS Trust (31 March 2017: £250,188k).

Note 25 Contingent assets and liabilities

The Trust has no contigent assets and liabilities.

Note 26 Contractual capital commitments

	2018
	£000
Property, plant and equipment	592
Intangible assets	93
Total	**685**

Note 27 Other financial commitments

The Trust has no other financial commitments

Note 28 Financial instruments

Note 28.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners (Clinical Commissioning Groups) 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 and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

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

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

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

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed and fixed 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 2018 are in receivables from customers, as disclosed in the trade and other receivables note 17.1.

Liquidity risk
The Trust's operating costs are incurred under contracts with clinical commissioning groups, which are financed from resources voted annually by Parliament and funds its capital expenditure within limits set by the Department of Health and Social Care. The Trust is not, therefore, exposed to significant liquidity risks. However, the Trust's deficit position since 2014/15 and insufficient surpluses to finance loan repayments means liquidity is weaker than the board of directors would wish. This has partially been addressed with an interim revenue loan of £45.6m (£26.8m in 2016-17) which partly funds the deficit and repayment of capital loans. The Trust has also used loan finance of £1.4m in 2017-18 (£9.1m in 2016-17) approved by the Department of Health and Social Care to fund capital projects. In the year 2017-18 the Trust had access to Uncommitted Single Currency Interim Revenue and Support Facility.

Note 28.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
*Trade and other receivables excluding non financial assets	17,933	-	-	-	**17,933**
Cash and cash equivalents at bank and in hand	3,578	-	-	-	**3,578**
Total at 31 March 2018	**21,511**	**-**	**-**	**-**	**21,511**

*In 2017-18 the Trade and other receivables excluding non financial assets includes accruals (in 2016-17 accruals were not included)

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	12,233	-	-	-	**12,233**
Cash and cash equivalents at bank and in hand	4,623	-	-	-	**4,623**
Total at 31 March 2017	**16,856**	**-**	**-**	**-**	**16,856**

Note 28.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	138,396	-	**138,396**
*Trade and other payables excluding non financial liabilities	39,123	-	**39,123**
Total at 31 March 2018	**177,519**	**-**	**177,519**

*In 2017-18 the Trade and other payables excluding non financial liabilities includes accruals (in 2016-17 accruals were not included).

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	95,865	-	**95,865**
Trade and other payables excluding non financial liabilities	13,773	-	**13,773**
Total at 31 March 2017	**109,638**	**-**	**109,638**

Note 28.4 Fair values of financial assets and liabilities
Book value (carrying value) is a reasonable approximation of fair value.

Note 28.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	72,884	18,296
In more than one year but not more than two years	43,272	33,760
In more than two years but not more than five years	41,119	41,119
In more than five years	20,244	16,463
Total	**177,519**	**109,638**

Note 29 Losses and special payments

	2017/18		2016/17	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	0
Bad debts and claims abandoned	64	29	65	187
Total losses	**64**	**29**	**66**	**187**
Special payments				
Ex-gratia payments	36	27	47	26
Total special payments	**36**	**27**	**47**	**26**
Total losses and special payments	**100**	**56**	**113**	**212**
Compensation payments received		-		-

No single item over £300,000

Note 30 Related parties

During the year none of the Department of Health and Social Care Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust. Trust Board members' remuneration is shown in the Annual Report in Directors' remuneration and pension entitlement.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities and the transactions which were over £0.5m are:

2017-18	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
Spire Healthcare Ltd - see i) and ii) below	1,308	0	146	0
BMI -see note ii) below	668	0	211	0
Kings College London NHSFT -see note iii)below	15	1	0	1
Department of Health and Social Care	6,094	46,781	136,583	0
Foundation Trusts				
Chelsea and Westminster NHS FT	55	2,666	11	66
Hertfordshire Partnership NHSFT	1,044	785	481	394
Trusts				
Central London Community Healthcare NHST	69	677	15	619
Barts Health NHS Trust	0	572	2	2
East & North Hertfordshire NHS Trust	1,207	1,351	689	544
Hertfordshire Community NHS Trust	1,870	2,373	1,184	792
Imperial College NHS Trust	522	652	222	222
St Helens & Knowsley NHST	1,012	9	125	2
Clinical Commissioning Groups (CCG)				
Barnet CCG	0	1,201	0	476
Bedfordshire CCG	0	1,201	0	59
Brent CCG	0	459	47	0
Chiltern CCG	0	898	0	132
East and North Hertfordshire CCG	78	2,906	61	154
Harrow CCG	0	3,306	17	56
Herts Valley CCG	11	251,598	1,246	3,159
Hillingdon CCG	0	4,879	55	0
Luton CCG	0	1,098	77	55
NHS England				
NHS England Core	0	7,148	641	2,363
Central Midlands Local Office	0	5,367	0	471
East of England Commissioning Hub	0	14,949	888	886
Special Health Authorities				
Health Education England	4	8,752	0	193
NHS Litigation Authority	17,623	0	0	0
NHS Blood & Transplant	1,528	24	19	1
2017-18	**31,117**	**359,652**	**142,363**	**10,646**
2016-17	54,487	343,972	99,041	12,776

In addition, the Trust has had a number of material transactions with public corporations government departments and local authorities:

2017-18	Payments to related party £000	Receipts from related party £000	Amounts owed to related party £000	Amounts due from related party £000
HM Revenue and Customs	52,961	9,504	4,659	1,685
NHS Pension Scheme	32,064	0	2,768	0
NHS Professionals	33,606	0	8,438	0
2017-18	**118,631**	**9,504**	**15,865**	**1,685**
2016-17	**82,225**	**13,625**	**8,831**	**1,372**

Note i) M Van Der Waat, the Medical Director/Director of Patient Safety, see his private patients at Spire Healthcare Ltd.

Note ii) Anthony Divers, the Clinical Support Services Divisional Director has private practices at BMI Chiltern and Spire Healthcare Ltd.

Note iii) Emanuel Quist-Therson the Associate Medical Director for Appraisal and Revalidation does change of management and strategy support with Kings College NHS Foundation Trust.

The Trust has also received revenue and capital payments from a number of charitable funds, the corporate trustee is the Trust's Board.

Note 31 Summary of West Hertfordshire Hospitals NHS Charity Activities

	2017-18 £000s	2016-17 £000s
Income	**337**	237
Expenditure	**(322)**	(467)
Net Incoming/Outgoing Resources Before Transfers	**15**	(230)
Gains/(losses) on Revaluation and Disposals of Investment Assets	**(11)**	124
Funds b/fwd	**1,028**	1,134
Funds c/fwd - Net Assets	**1,032**	1,028

The Trust does not consolidate charitable funds into the financial statements. Please refer to Note 1.4

Note 32 Events after the reporting date

There are no material events after the reporting date

Note 33 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	56,441	148,335	53,340	152,114
Total non-NHS trade invoices paid within target	11,638	28,305	23,835	61,987
target	20.62%	19.08%	44.69%	40.75%
NHS Payables				
Total NHS trade invoices paid in the year	2,491	7,942	2,405	7,862
Total NHS trade invoices paid within target	360	2,281	1,131	3,497
Percentage of NHS trade invoices paid within target	14.45%	28.72%	47.03%	44.48%

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.

Note 34 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	**45,171**	38,946
External financing requirement	**45,171**	38,946
External financing limit (EFL)	48,237	41,969
Under / (over) spend against EFL	3,066	3,023

Note 35 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	11,086	13,989
Less: Disposals	-	(33)
Less: Donated and granted capital additions	(17)	(126)
Charge against Capital Resource Limit	11,069	13,830
Capital Resource Limit	11,106	16,548
Under / (over) spend against CRL	37	2,718

Note 36 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	(42,634)
Remove impairments scoring to Departmental Expenditure Limit	-
Remove CQUIN risk reserve adjustment	1,282
Add back income for impact of 2016/17 post-accounts STF reallocation	-
scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	(41,352)

For adjusted financial surplus/(deficit) see the Statement of Comprehensive Income (SOCI)

Note 37 Breakeven duty rolling assessment

	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	5,699	7,530	3,657	1,904	(13,370)	(13,837)	(41,155)	(29,431)	(41,352)
Breakeven duty cumulative position	1,186	8,716	12,373	14,277	907	(12,930)	(54,085)	(83,516)	(124,868)
Operating income	254,308	260,398	266,716	278,230	291,119	313,291	299,769	322,643	324,772
Cumulative breakeven position as a percentage of operating income	0.47%	3.35%	4.64%	5.13%	0.31%	-4.13%	-18.04%	-25.88%	-38.45%

i) The adjusted deficit for break-even duty in the year is after adjustments shown in note 36.

ii) In line with note 1.11 the Trust no longer maintains a donated asset reserve. Donations are credited to income, the extent that this differs from depreciation of donated assets (expense) improves the reported position. As this is not an operational activity it is excluded from the break-even duty.

The Trust reported cumulative deficit in 2014-15 of £12,930,000 (-4.13% of operating income). The Trust is in the fourth year of consecutive break-even duty breach achieving a cumulative deficit of £124,868,000 (-38.45% of operating income) above the -0.5% permitted. The Trust is working with NHS Improvement and the local economy to develop a plan to achieve the breakeven duty in future years.