



ANNUAL REPORT

2018/19



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PERFORMANCE REPORT

Overview and analysis

Welcome to our 2018/19 annual report which looks back at another 12 months of significant and sustained improvement.

During this year the Care Quality Commission (CQC) inspected urgent and emergency care, medical care, surgery and maternity at Watford General Hospital. The Minor Injuries Unit (MIU) at St Albans City Hospital and the Urgent Treatment Centre (UTC) at Hemel Hempstead Hospital were also inspected. And there was a review of our leadership, under the CQC's 'well led' regime.

The increase in the number of 'good' ratings continues, as does the decline in 'inadequate' ratings. In fact, looking back to 2015, we have more than doubled 'good' ratings from 20 to 45.

We were pleased to read that inspectors noted that staff cared for patients with "compassion, kindness and respect". Bereavement care and support, multidisciplinary working in the dementia and stroke units and the ISeeU initiative (the use of technology to keep new mothers connected to their new-borns in the neonatal intensive care unit) were all praised.

The biggest uplift was in the emergency department (ED) at Watford General Hospital which has moved from 'inadequate' to 'requires improvement'. And its assessment against the 'well led' domain has risen significantly by two ratings to 'good'. The inspectors noted a "strong, supportive and visible leadership" reflecting the determined efforts of staff to make changes.

Surgery at Watford progressed from 'requires improvement' to 'good'. And surgery and outpatient services at St Albans are rated 'good'. Surgical staffs were commended for "creating an environment in which excellence in clinical care would flourish".

We were, however, disappointed with a rating of 'inadequate' for the MIU at St Albans City Hospital which resulted in an overall 'inadequate' rating for St Albans City Hospital overall. We acted on issues raised by inspectors at the time of their visit and we remain confident that this is a safe and reliable service.

The UTC at Hemel Hempstead Hospital was rated 'requires improvement' but inspectors observed "excellent multidisciplinary working" and the compassion of staff.

These were, overall, positive changes. However we recognise that there is more to do and our teams are working hard to continue to improve our services for patients.

Our work towards planning significant improvements to our estate is gathering pace. At the time of writing, we are finalising an update to our strategic outline case (SOC) which will accompany a bid for funding to be considered as part of the 2019 comprehensive spending review.

The SOC will be reviewed by the Board in July 2019 and will identify the 'preferred way forward' for redeveloping our hospitals. It will set out how the investment could significantly improve our hospitals with a mixture of new build facilities and improvements to existing buildings. Herts Valleys Clinical Commissioning Group (HVCCG) and the Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP) will then be asked to confirm their support for our SOC before we formally submit it to NHS regulators at the end of July, ahead of the comprehensive spending review expected in the autumn.

This work has been, and continues to be, our absolute priority— we are determined to secure funding so we can move forward and deliver much needed improvements to our estates.

From a performance point of view, we had a challenging winter due to another rise in demand (which has continued throughout spring). A small expansion to our emergency department, including a change to the layout, enhanced the experience for our patients. A well-developed 'winter plan' and additional beds helped us maintain a good flow of patients through our hospitals and resulted in a winter that felt much calmer. However, we recognise that there are further changes needed to raise our performance against the four hour standard.

We did, however, perform well against our other access targets and the numbers of complaints fell for a second year. The full suite of performance data can be seen in our board papers which are published each month on our website.

While finances remain challenging, we ended the year having delivered against our savings target and our planned deficit (full details on page 59). We spent £3.5m or 19% less (compared to 2017/18) on agency staffing, well under the £18.4m target set by regulators. This positive development is due to concerted efforts to recruit staff permanently and improve the use of our in-house temporary staff. Our proximity to London – where NHS wages are higher – creates a competitive recruitment environment.

The number of vacancies for consultant posts remains very low (and is often in single figures) which shows that the Trust is an attractive place to work and learn.

Leadership is key to a good organisation and we are fortunate that our senior leadership team has contributed many years' of service to the Trust. We have worked hard to strengthen our clinical leadership because we know that a clinically led organisation is the best way to deliver a safe, effective and caring one.

Our clinicians have taken the lead in service redesign which improves care for patients and paves the way for future service delivery. One example is the work that has been carried out by our diabetes team who worked in partnership with Hertfordshire Partnership University NHS Foundation Trust to develop a community led service. The teams updated clinical guidelines, combined community outreach services and brought together healthcare workers looking after high risk groups. Patients can now access care more easily and manage their diabetes and mental health conditions more effectively. The teams were regional winners of the NHS70 Parliamentary Awards in 2018.

Despite the fact that our colleagues often work in challenging circumstances, we were delighted that the results of our staff survey demonstrated significantly higher levels of motivation. Of the 90 questions asked, more than half of the responses fell within the top 20% of Trusts in the country.

Recognition and respect featured positively, with 73% of staff feeling encouraged by their line managers at work (compared to 67% nationally) and three quarters say they get the respect they deserve from their colleagues (compared to 71% nationally). The results also show that 81% of staff (compared to 76% nationally) felt that their work is valued by their organisation and 93% of staff feels that they are trusted to do their job.

In closing, we would like to thank Helen Brown, who stepped into the chief executive role for much of 2018/19 and also Professor Steve Barnett who oversaw a period of sustained improvement in his role as chair.

We wish to pay tribute to all our staff and volunteers who work with such energy and commitment to deliver our vision; the very best care for every patient, every day.



Phil Townsend
Interim Chairman



Christine Allen
Chief Executive

Our purpose, strategy and objectives and risks

This section of the report provides a summary of what the Trust set out to do in 2018/19 and the progress it made in achieving this.

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.

The Trust is governed by a Board and is required to meet national standards as defined within the NHS Operating Framework. Performance is monitored by NHS Improvement (NHSI), Herts Valleys Clinical Commissioning Group (HVCCG), Department of Health and Social Care (DHSC), NHS England (NHSE) and the Care Quality Commission (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 website www.westhertshospitals.nhs.uk.

There is a corporate governance structure in place which meets the requirements of the Code of Governance. Further details on this can be found in the Corporate Governance section of this report.

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

The vision is underpinned by values:



The Trust has set itself four aims and a set of objectives to ensure an appropriate focus is placed on what it wants to achieve in line with its strategic ambitions. Progress against the aims and objectives is overseen through the Board Assurance Framework (BAF) which is considered at Board meetings, with sections reviewed regularly by the relevant Board committee.

The Trust's aims are:

- Aim 1: To deliver the best quality care for our patients
- Aim 2: To be a great place to work and learn
- Aim 3: To improve our finance sustainability
- Aim 4: To develop a strategy for the future

The aims are underpinned by a set of twelve objectives, which set out plans over the forthcoming two years. The table below demonstrates the progress made at the end of the first year.

AIM ONE: TO DELIVER THE BEST QUALITY CARE FOR OUR PATIENTS

Objective		Evidence
1	To deliver excellent clinical outcomes for our patients	<ul style="list-style-type: none">▪ Maintained satisfactory performance on the mortality metrics of hospital standardised mortality ratio (HSMR) and summary hospital-level mortality indicators (SHMI) with an 'as expected performance' throughout the year▪ Making good progress with the implementation of a learning from deaths programme▪ Constantly reaching the national target of 95% for venous thromboembolism (VTE) assessment

		<ul style="list-style-type: none"> Falls with harm at 0.5%, which is in line with the national figure. There has been a sustained improvement with the reduction in falls with harm, with 12 consecutive months being under or equal to the national figure All falls with harm have seen comparable figures to last year of 20 per month on average Compliance for new pressure ulcers with harm have been consistently in line with the national figure In line with the national figure of 97.8%, with the majority regularly reaching 98% for new harm free care indicators
2	To implement best practice, integrated care pathways and reduce unwarranted clinical variation in care and outcomes	<ul style="list-style-type: none"> Established the first wave of operational clinical practice groups with the Royal Free London NHS Foundation Trust (RFL) and commenced work to redesign seven clinical pathways Worked with Herts Valleys Clinical Commissioning Group (HVCCG) to introduce service transformation in a number of pathways Reduced 52 week waits by 97% over the course of the year, finishing 2018/19 with only four (all of whom were patient choice delays) In line with national guidance, the patient tracking list was smaller at the end of the year than in March 2018, demonstrating a 1% reduction overall Although performance against the RTT (referral to treatment) 92% open pathway standard showed little change throughout the year, the position was maintained while working on reducing very long waits and managing the size of the waiting list
3	To implement and embed our 'quality commitment' and 'west Herts way' quality improvement (QI) methodology	<ul style="list-style-type: none"> Agreed a new structure for a quality hub and recruited a QI lead with further team recruitment planned Of the 16 wards, four achieved a gold standard in the ward accreditation programme, nine achieved silver standard and one achieved bronze standard. (Two wards were not assessed as they had recently had a change in leadership)
4	To improve our emergency care pathway and discharge processes	<ul style="list-style-type: none"> SAFER/Red2Green was implemented to improve discharges Improved utilisation of the patient lounge to support discharge More timely takeaway medication process (under one hour) Quicker and more effective ambulance handovers Improved streaming of patients A business case for the redevelopment of the emergency department was approved Implemented aftercare service to improve patient experience New majors cubicles and significant reduction in 'corridor care'
5	To further develop participation in research and development	<ul style="list-style-type: none"> Recruited the highest ever number of participants to research studies Involved in conducting 111 clinical research studies Recruited participants to 43 studies 100% of research participants who completed a national satisfaction survey reported that they had found it a good experience

AIM TWO: A GREAT PLACE TO WORK AND LEARN

6	To have happy, healthy, well supported staff who feel able to deliver great care and 'make a difference' in an inclusive environment and to be a clinically led organisation	<ul style="list-style-type: none"> 'Big 5 campaign' in response to the staff survey Developed a flexible pool for nursing workforce Developed divisional workforce plans Continued to promote workforce wellbeing with positive feedback in annual staff survey Trust ranked 21 out of over 100 acute Trusts in annual staff survey Introduced 'respect me' campaign
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		<ul style="list-style-type: none"> Executives allocated an equality and diversity objectives
7	To reduce vacancy rates and reduce our reliance on agency workers	<ul style="list-style-type: none"> Reduced turnover rate from 16.3% to 14.7% Reduced band five nursing vacancies from 17.2% to around 9% Appointed an 'on boarding and retention' lead Recruited 90 band five overseas Nurses Implemented a number of development programmes, e.g. band six development programme for nurses and a senior leader programme Continued to work through bank network with local Trusts and Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP) to ensure, where possible, consistent agency rates
8	To become an excellent organisation for employee development	<ul style="list-style-type: none"> Work began towards achieving Teaching/University Hospital Status Implementation of Acorn (a system for monitoring and tracking training) was completed Appraisal compliance was 86.1% at 31 March 2019 79% of staff agreed that appraisal helped them to their job better Mandatory training compliance was 92% at 31 March 2019 Basic life support training compliance was 84% at 31 March 2019 51 people started apprenticeships in 2019/20, making a total of 82 candidates undertaking apprenticeships 13 new nursing associates started an apprenticeship
AIM THREE: TO IMPROVE OUR FINANCES		
9	To deliver best value care	<ul style="list-style-type: none"> Delivered a £3.2m improvement on the Trust's full year target from £52.9m to £49.6m Agency costs of £14.9m was a reduction of £3.5m against the regulatory targets and continued the drive to reduce them over the past three years, being 19% lower than last year and 60% lower than three years ago Efficiency savings of £16.1m were achieved. This is better than the planned savings of £15.9m and is the highest ever achieved by the Trust
AIM FOUR: A STRATEGY FOR THE FUTURE		
10	To improve our IT and move towards full digitalisation	<ul style="list-style-type: none"> Approved a contract with a new ICT supplier to support the transformation of the ICT estate Appointed a general data protection officer Two of the ten data security protection requirements have been fully implemented and seven have been partially implemented
11	To work with local stakeholders and partner organisations to identify where, by working together, we can improve care for our patients	<ul style="list-style-type: none"> Actively engaged with Herts and west Essex Sustainability and Transformation Partnership (HWE STP) on the development of integrated care system, as well as taking active lead roles in a number of work streams, including planned care, frailty, workforce and estates and capital Worked with Herts Valley Clinical Commissioning Group (HVCCG) and local GPs to redesign care pathways Formalised the Trust's partnership with the Royal Free London NHS Foundation Trust (RFL) Worked with Imperial College Healthcare NHS Trust (ICH) on proposals to develop a joint upper gastrointestinal cancer service Worked with HVCCG and local stakeholders on the redevelopment of services in west Hertfordshire
12	To improve the quality of our estate and implement our service driven estates strategy	<ul style="list-style-type: none"> Fully utilised the capital allowance of £12.6m on projects to maintain and improve the estate and equipment, including a programme of work to improve fire safety On track to refresh a strategic outline case for the redevelopment of the Trust's estate

	<ul style="list-style-type: none"> ▪ Secured £11m funding to redevelop the emergency department ▪ Progressing with a full business case to improve theatres at Watford (<i>funding not yet confirmed</i>) ▪ Developed an outline business case to improve the neonatal unit (<i>funding not yet confirmed</i>) ▪ An outline business case for a new multi-storey car park at Watford was approved. Working to complete the full business case by September 2019, with completion of the car park due to be in 2021 ▪ Secured £1m funding to develop additional majors cubicles in the emergency department and delivered an expansion by December 2018. Improvements also made to ambulance care service facilities and day surgery at Watford
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Further details on the Trust's performance against its aims and objectives can be found in this report and in the Quality Account at www.westhertshospitals.nhs.uk.

Risks

The Board was fully informed of the issues and risks that could affect the Trust in delivering its objectives. The key risks to achieving its objectives are outlined in the Corporate Governance section of the report.

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 £49.6m in 2018/19, and expectation of future financial support. The Trust has submitted a financial plan for 2019-20 to the NHS Improvement (NHSI) which delivers a £22.7m deficit for 2019-20 including non-recurrent funding support of £27.7m. This includes a savings target planned for 4% which equates to £15.0m for 2019/20.

The Trust is seeking cash support of £22.7m to fund the planned income and expenditure deficit and have submitted a request for £4.8m of additional funds to support the capital expenditure plan. NHSI has not, at the date of our report, confirmed that they will provide this support. Of the outstanding loans supporting the Trust deficit, revenue loans of £32.0m expire on the 18th December 2019 and other loans worth £29.4m expire on the 20th January 2020. These loans will either need to be extended further, or re-financed with the agreement of the Department of Health and Social Care. Uncommitted Single Currency Interim Revenue Support Facilities will be available when required with effect from 01 April 2019.

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 2018/19 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.

Performance summary

The final position for the year against the national performance indicators is set out below:

Indicator	National Standard	2017/18	2018/19
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%)	Under achieved (80.9%)
Incidence of C.difficile should be identified and numbers minimised	Trust target was to have fewer than 22 cases of C. difficile through the year.	Achieved (28 cases reported, however 7 of the cases were identified as having no lapses in care)	Achieved (15 cases reported). Five cases have been successfully appealed and deemed as no lapses in care.
Indicator	National Standard	2017/18	2018/19
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	Under achieved (one case)	Under achieved (three cases). There is no formal target set. All three cases have been reviewed and no learning attributed to the Trust.
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)	Achieved (93.3% suspected cancer referrals) Under achieved (90.5% 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%)	Achieved (96.8%)
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)	Under achieved (82.3% referred by GP) (86.2% 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, palliative and other, and 98% for anti-cancer drugs.	Achieved (99% for surgery and 100% for palliative, other and anti-cancer drugs)	Achieved (100% for palliative care (100% for other) Under achieved (94.6% for surgery) (97.6% for anti-cancer drugs)
Maximum wait time of 18 weeks referral to treatment – patients not yet treated	>92%	Under achieved (88%)	Under achieved (83.9%)

Care Quality Commission's inspection

The Trust underwent an inspection under the CQC's new assessment methodology in October and November 2018. This resulted in the Trust maintaining an overall rating of 'requires improvement'. The individual ratings for each domain were 'good' for caring and 'requires improvement' for safe, effective, responsive and well led.

Unannounced visits were made to all three hospitals, looking at four core pathways in six services; urgent and emergency care, medicine, surgery, maternity, urgent treatment centre and minor injuries unit.

A well led inspection provided positive feedback on the leadership within the Trust, however it resulted in an overall rating of 'requires improvement' due to the financial deficit which the organisation carries. Inspectors also noted significant improvement in the leadership of the emergency department and commended the positive culture and cross departmental working.

The CQC highlighted areas of outstanding practice, including multi-disciplinary working in the dementia and stroke units; caring and responsive bereavement care to parents experiencing the death of a child and an initiative in maternity which keeps mothers and newborns connected via technology. As expected, areas for improvement were highlighted and the Trust is actively implementing these as part of its quality compliance programme. One of these is the minor injuries unit at St Albans hospital.

The Trust took immediate action at the time of the inspection to address the concerns raised, including the implementation of a 15 minute triage and review and update of risk assessments.

Full details of the inspection results can be found in the Quality Account which is published on the Trust's website (www.westhertshospitals.nhs.uk). 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 DHSC's guidance. Progress made against achieving identified priorities for 2017/18 has been monitored throughout the year and the 2018/19 Quality Account will be published in June 2019. For further details please see the Corporate Governance Report section.

Serious incidents

The Trust reported 43 serious incidents and declared two never events in 2018/19. 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 recurrence.

Work to improve the quality of serious incident reporting and investigation processes continued, including taking early decisions on whether an incident should be discussed by the serious incidents panel and whether it meets national serious incident criteria.

During 2018/19, the Trust introduced a revised process for the investigation of incidents which included staff involved in the incident attending a multi-disciplinary roundtable consultation to discuss the incident, identify the root cause and agree the required actions from the incident. This has led to increased compliance with the timely submission of reports to the commissioners.

The table below shows a selection of actions taken as a result of learning from serious incidents and never events during 2018/19.

Serious incidents and never events	Actions taken
Maternity/obstetric and neonatal incidents	<ul style="list-style-type: none"> ▪ All women who are induced for reduced fetal movements will have a scan for doppler, growth and liquor volume ▪ A new tool has been introduced for clinicians and midwives to highlight any issues during the handover of women's care ▪ Training sessions implemented for process and surveillance of Fetal growth ▪ Midwives and clinicians to use appropriate terminology so that women understand the questions regarding female genital mutilation ▪ Staff to ensure that women have an up-to-date venous thromboembolism (VTE) risk assessment on admission
Surgical invasive procedures	<ul style="list-style-type: none"> ▪ Surgeons to be reminded to check the integrity of their gloves ▪ Acute admissions to have a completed treatment escalation plan which is discussed with the patient and, if appropriate, their immediate family ▪ The tracking of non-cancer patients who are at risk of deteriorating clinically ▪ A process for recording the use of scopes in intensive treatment unit to be implemented
Hospital acquired pressure ulcers	<ul style="list-style-type: none"> ▪ Introduction of a staff education programme on the use of appropriate equipment in the prevention of pressure ulcers ▪ Targeted education on preventing tissue damage to heels ▪ Implementation of a process to escalate patients with pressure damage ▪ Targeted campaign to improve the documentation of pressure damage
Sub-optimal care of the deteriorating patient	<ul style="list-style-type: none"> ▪ Observations to be undertaken as identified by the clinical response to national early warning system (NEWS) triggers ▪ Staff to receive further training on the importance of NEWS as an early warning system
Medication	<ul style="list-style-type: none"> ▪ Patients to receive written and verbal information on the prevention of deep vein thrombosis and pulmonary embolism on discharge from hospital ▪ Nursing staff to sign to confirm thromboembolism-deterrent stockings (TED) are in place daily.

Harm free care

The Trust's key priority is to ensure that patients are cared for safely, without harm. Harm free care is a national programme to help NHS teams in their aim to eliminate harms such as pressure ulcers, harm from a fall, urine infection (in patients with a catheter), new VTE and harm from medication errors. Test your care audits are carried out in many clinical areas such as inpatient wards, theatres, outpatients, endoscopy, day surgery, maternity and paediatrics areas. This information is incorporated into the ward scorecard which enables clinical areas to be aware of performance. This data is then reflected in the integrated performance reports.

In 2018/19 audits were conducted in 14 inpatient ward areas under a ward accreditation framework which encompassed test your care data, matron quality checks, patient feedback and an environmental 15 step approach. Four wards achieved a gold award, Nine Silver and One bronze.

To ensure consistent oversight, a senior multi-professional team within a quality improvement forum has been formed to provide scrutiny and support to divisions in delivering harm free care to all patients.

Learning from deaths

During 2018/19 two medical examiners were appointed to provide independent oversight of the Trust's learning from death's policy. Their role includes undertaking structured judgement reviews, screening deaths and providing scrutiny to death certification.

There were 1,512 patient deaths in the Trust's hospitals in 2018/19, including 27 stillbirths and seven neonatal deaths. 102 deaths were screened and selected for a structured judgement review and 27 deaths were reviewed by trained consultant reviewers.

Of these, 12 cases were selected for second tier review and one death was found more likely than not to have been due to problems in the care provided. Themes from structured judgement reviews are assessed every six months and learning is shared with divisions and with specialties.

A recent survey of junior doctors indicated that of those having completed a medical certification of cause of death with the medical examiners, 91% found their support to be clinically helpful, practically helpful or educationally valuable.

In 2019/20, the aim is to enhance the dissemination of learning from deaths, increase the number of trained consultant structured judgement reviewers, improve the linkage with the national learning disabilities mortality review (LeDeR) programme and increase the capacity of the medical examiners.

National surveys

The 2018/19 national inpatient survey showed evidence of improvements in care and treatment. The number of patients reporting that they had a very good experience overall improved with a score of 7.9/10 compared to 7.5/10 the previous year. Consistent with a focus on improving discharge processes, the survey showed significant improvement in three elements of the 'leaving hospital' section.

The 2018/19 national maternity survey showed an average positive score ranking with key improvements. The survey showed that people were treated with respect and dignity; that they had confidence and Trust in staff and they were involved in decisions about their care.

The Trust received an overall rating of 8.6/10 in the national cancer patient experience survey. There was an improvement from the previous year in 26 scores with the most significant improvement in easy to understand written information and discussing taking part in cancer research.

Getting it right first time

Getting it right first time (GIRFT) is a national programme designed to improve medical care by reducing unwarranted variation. The GIRFT programme consists of a six-stage implementation pathway, which includes a clinical deep dive visit by expert clinicians and key recommendations to support Trusts in making effective improvements to the way in which services are delivered.

In 2018/19 there were ten GIRFT visits which focused on a wide range of surgical specialties. The resulting recommendations and actions were all assigned a clinical owner and were progressed and implemented by the relevant clinical teams through an action planning process.

Regular updates are reported through the quality committees to provide oversight on the improvement opportunities and assurance that actions are being implemented to become business as usual.

Performance analysis

Managing service pressures

Throughout the year, the Trust has established a number of specific initiatives to improve performance. The extreme winter pressures of 2017/18 resulted in 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 its elective care provision to enable senior clinical staff to prioritise the care of acutely unwell emergency patients.

This practice and its effect on elective procedures continued into the early part of this financial year and resulted in a deleterious effect on the income position and referral to treatment (RTT) performance. In particular, the number of patients waiting over 52 weeks for treatment reached a peak of 124 in July 2018. Although elective surgery resumed at Watford, emergency pressures continued due to the high level of attendance at the emergency department (ED), increasing by 6.6% compared to the previous year.

At the end of the financial year, four patients had waited over 52 week for treatment, each had elected to defer treatment until 2019/20 despite offers of an earlier date. This represented a dramatic reduction from the high numbers of patients waiting and the success of a number of specific strategies to reduce waiting times.

A number of initiatives have been established over the year to reduce waiting times for elective procedures, improve hospital inpatient flow and meet ED waiting times. These have included enhancing the model of care at St Albans to support the transfer of appropriate patients from Watford in order to free up beds, provisioning targeted weekend operating lists at Watford and outsourcing appropriate patients to the independent sector.

Ensuring accurate clinical data recording

There are a number of checks to validate data quality for RTT, diagnostic and cancer wait times (CWT) for reporting, including routine and deep dives into each patient pathway. All patient pathways for RTT, diagnostic and CWT standards are managed under the Trust's access policy, which describes the processes to be followed to ensure transparent, fair and equitable management of waiting lists. It includes guidelines and procedures to ensure that waiting lists are managed effectively, a high quality of service is maintained and optimum use is made of resources at all locations across the Trust.

A series of specific online RTT training modules are available to relevant staffing groups to strengthen the understanding of RTT rules further and provide greater assurance on the accuracy of elective waiting time reporting.

Quality commitment

The quality commitment sets out the 'West Herts Way' on how the Trust intends to build and embed a culture of quality improvement across the organisation to enable it to drive the provision of excellent services to patients that are safe, compassionate and innovative. To help achieve a supportive organisational environment that will drive this commitment, the Trust is developing a central quality improvement (QI) hub to provide expertise, guidance and embedded support to facilitate service improvement across the organisation. The hub will use a consistent QI methodology, developed by the Institute of Healthcare Improvement (IHI). As the Trust partnership with the Royal Free London NHS Foundation Trust group continues to develop, the Trust will explore opportunities for collaborating on quality improvement to ensure it makes the best possible use of available capacity and expertise.

Improving services

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

- The launch of a clinical partnership with RFL to initially focus on seven priority clinical pathways to deliver best care and reduce clinical variation
- The development of three specific pathways for frailty as part of joint working with the HWE STP
- The establishment of a nurse-led telephone assessment service to streamline urgent colorectal appointments
- The participation in a sponsored technology scheme aimed at significantly improving the diagnosis of patients with suspected coronary heart disease.
- The launch of a pilot scheme for GPs to directly refer patients with suspected cancer for diagnostic testing
- Investment in a new mammography machine at St Albans City Hospital
- Took part in a scheme to support the delivery of safer maternity care
- The establishment of a joint acute diabetes specialist multidisciplinary foot service with Hertfordshire Community Trust (HCT)
- The introduction of Volunteer Initiative to help support end of life care patients, their families and carers.

Addressing patient concerns

In 2018/19, the Patients Advice and Liaison Service (PALS) dealt with 3,265 reported concerns with the two most common areas relating to care and treatment and outpatient delays and cancellations.

The Trust implemented a tracker to allow divisions to oversee concerns raised on a weekly basis. The learning from concerns is recorded onto the Trust's risk system (Datix) and is triangulated with complaints and the friends and family test (F&FT) results to highlight themes to drive improvements.

In some cases patients prefer to make a formal complaint and in 2018/19, 431 were received. The complaints handling 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 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.

The Trust has continued to see a decrease in the number of reactivated complaints. The complaints team has received additional training in investigating complaints and letter writing and they now offer support to divisions with their investigations and drafting responses. This has resulted in reduced response times for complaints, whilst ensuring that complainants' concerns have been fully investigated and any learning shared with the relevant staff. Since the summer of 2018/19, over 70% of responses have been sent within the agreed timescale, compared to 57% in 2017/18.

In addition to many hundreds of letters, cards, notes and small gifts received directly by wards and departments, during the period of this report, the chief executive received 235 formal compliment letters from satisfied patients and visitors.

The patients' panel

The patients' panel has maintained its support of the Trust in 2018/19 with a focus on communication in all its forms; one of the four priorities in the patient experience and carer strategy. They have achieved this through involvement in the patient experience group and operational meetings; seeking feedback from patients, supporting ward accreditation audits and engagement with stakeholders as part of planning events for the Trust's redevelopment of services.

Learning from patient feedback

A variety of forums and methods are used to collect patient feedback to improve services. PALS and formal complaints act as a vital channel for patient feedback, as do the results of national and local surveys and the national friends and family test (F&FT).

The number of wards, departments and specialist areas offering patients the opportunity to give feedback on their experiences of care has risen in 2018/19, resulting in over 60,000 feedback forms being completed by patients. On average 94% of patients gave a positive recommendation.

The feedback from patients has been used to make improvements, including:

- A weekly tracker to monitor progress of concerns raised with PALS to ensure timely resolution for patients and carers
- The paediatric service undertaking a survey of parents who have benefited from the carer support team
- A patient pathway has been developed for 16-18 year olds to aid transition into the adult system
- The adoption of the national 'get up, dressed and active' campaign through activity and increased socialisation
- A valentine's day campaign in the maternity service with tea and cake served by midwives to mothers and fathers to ask them 'how was it for you?'
- A card left at a patient's bedside when a member of the chaplaincy team has visited.

Progress towards achieving equality

The Trust is committed to promoting an environment that values diversity, eliminates health inequalities and promotes equal access to appropriate and quality services. To support this commitment, the Trust employs a dedicated equality and diversity manager and in 2018/19 a disability champion joined the team to further support patients and staff.

All staff are responsible for ensuring that patients and their carers are treated equally and fairly and not discriminated against on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation, sex or any other unjustifiable reason.

Control measures are in place to ensure that all obligations under equality, diversity and human rights legislation are complied with. This is evidenced by an annual review which monitors a variety of indicators. This is also evidenced by demonstrating that all procedural documents incorporate an equality assessment prior to ratification by the relevant committee.

Following Board approval, the Trust publishes information annually to show its compliance against the Public Sector Equality Duty. It complies with the law and aims to continue to develop better practice to ensure that discrimination, harassment, victimisation and any other conduct prohibited by or under the Equality Act 2010 are eliminated, to advance equality of opportunity between people who share different equality groups and to foster good relations between different protected characteristic groups and those who are not within these groups.

In 2018/19, 34.4% of staff came from a black minority ethnic (BME) background; this has increased year on year over the last three years. In particular, almost 50% of the consultant body is from a BME group. A multicultural network is run by staff to provide support to BME staff with particular protected characteristics and, in October 2018, the Trust ran a series of events to celebrate black history month.

The Trust also publicly reports on its gender pay as required under the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

The Workforce Race Equality Standard (WRES) became a mandatory requirement of the NHS contract in 2015 to ensure effective collection, analysis and use of workforce data to address the under-representation of black and minority ethnic (BME) staff across the NHS. The Board approved the WRES data which was published in September 2018.

Equality and diversity was an area highlighted as requiring a further focus in the results of the national staff survey and an action plan has been developed to track improvements in 2019/20.

Emergency preparedness and resilience

Over the last year, the Trust participated in several multi-agency table top exercises which included response to a chemical, biological, radiological, nuclear and explosives (CBRNE) incident and a national power failure incident. Additionally, the Trust underwent a live CBRNE exercise to test decontamination skills following the arrival of self-presenters to the emergency service. In October 2018 the Trust was assessed by NHSE against the NHS core standards for emergency preparedness and was found to be fully compliant.

The environment and support services

Facilities management

Following a competitive tender process in April 2018, the Trust entered into a contract with Mitie Cleaning and Environmental Services Limited to provide a range of services including cleaning, catering, portering, pest control, linen and helpdesk services. Mitie is investing in new technology, including new digital software to support better communication and robotic cleaning, as well as offering the latest in meal delivery with the introduction of a new heating and chilling unit which allows easy preparation of personalised menu choices for patients.

As part of the new contract, Mitie refurbished the restaurant at Watford which now includes a dedicated staff only area, a separate coffee shop, new look servery and an improved outside eating area. The number of seats in the restaurant has also increased from 140 to 230.

In September 2018, there was an audit by the Environmental Health Office to review compliance with food hygiene and safety procedures, with structural requirements and management control procedures. Although initial results were concerning in relation to the kitchen area, an action plan was developed to rectify hygiene procedures and management control and a re-audit in March 2019 achieved a food hygiene rating score of four out of five.

Patient-led assessments of the care environment

The 2018/19 patient-led assessments of the care environment (PLACE) inspection continued to recognise the year on year improvements being made in many areas. The challenge to deliver these improvements increases annually due to restrictions created by an aging environment and updated legislation and guidelines. The results are as shown below:

Category	Hemel 2016	Hemel 2017	Hemel 2018	St Albans 2016	St Albans 2017	St Albans 2018	Watford 2016	Watford 2017	Watford 2018
Cleanliness	93.91%	99.22%	99.28%	99.23%	98.55%	100	98.17%	98.38%	98.65
Food	81.96%	89.86%	N/A	80.07%	83.89%	91.39	80.55%	81.90%	86
Food organisation	82.60%	84.62%	N/A	83.43%	84.62%	94.01	81.94%	85.91%	93.05
Ward food service	81.52%	93.91%	N/A	77.06%	83.39%	88.96	80.35%	80.90%	84.73

Category	Hemel 2016	Hemel 2017	Hemel 2018	St Albans 2016	St Albans 2017	St Albans 2018	Watford 2016	Watford 2017	Watford 2018
Privacy, dignity and wellbeing	56.12%	73.91%	85.26	60.62%	64.39%	90.75	70.44%	66.71%	90.59
Condition, appearance and maintenance	87.64%	80.23%	71.72	88.28%	87.99%	69.49	89.09%	85.51%	83.24
Dementia	63.33%	51.07%	45.63	62.20%	60.80%	55.29	52.72%	53.81%	53.98
Disability	72.29%	64.04%	54.05	63.07%	70.50%	63.12	59.92%	69.17%	65.69

The lower scores in the condition, appearance and maintenance category are due to restrictions within the current estate which cannot be addressed without significant capital investment.

Improving the estate

The Trust continues to work actively on the premises assurance model (PAM) to deliver a nationally consistent approach to evaluating and appropriately documenting estates and facilities performance and compliance.

In late 2018 it was announced that PAM scoring and assessment criteria was to become more stringent and specific and that this methodology would become a recognised national standard and be linked to the national annual estates return information collection (ERIC). The Trust continues to progress work to ensure it is compliant with PAM requirements and to utilise the PAM methodology to provide assurance and support the management of estates risks across our services and hospital sites. To ensure the success of this methodology, robust deep dives into each department are being undertaken, with clear remedial action plans developed to address any gaps in assurance.

An external six facet survey was completed in 2018/19 which identified the investment required to address areas of the estate, including physical condition, statutory compliance and functional suitability. The six facet survey highlights the very significant challenges presented by the Trust's estate and the urgent need for investment to ensure a long term sustainable solution. Over the past 12 months the Trust has continued to prioritise work to develop a strategic outline case for the redevelopment of its estate and secure regulator support; the first step in the process of securing the funding required.

In addition to the business as usual deliverables required to support the Trust in its day to day activities, over the past 12 months there have been been a number of improvement projects. These aim to support both clinical and non-clinical functions, providing a safer and more secure environment for patients, visitors and staff. The highlights are as follows:

- A series of linked projects to increase capacity within our emergency department and provide enhanced ambulatory and assessment facilities for patients with emergency care needs
- Improvements to day surgery facilities at Watford General Hospital
- Fire prevention work with approximately 300 replacement fire doors and all emergency lighting at Watford which did not meet national standards being replaced
- Fixed wire testing across all hospital sites with remedial works identified and completed
- Continued work to develop theatres at Watford
- Replacement of all endoscopy washer disinfectors at Watford and Hemel Hempstead
- Improved security to the emergency department and Bluebell and Winyard wards at Watford
- Car park resurfacing work in Verulam car park at Hemel Hempstead

Medical device management

In 2018/19 a review of the Trust's medical device management service was completed and an external specialist was appointed to deliver an improvement programme to mitigate the risks identified. This approach achieved a consistently high pre-planned maintenance compliance rating of over 86% against a national average of 63%.

IT and data security

A real focus in 2018/19 has been on improving the stability and quality of IT services. In the summer of 2018 the Board made a decision not to extend the previous IT contract. Following a procurement process, a three year contract was awarded to Atos to deliver IT services from September 2019.

Following on from cyber security improvements made over the past year, new monitoring and governance processes have been implemented in relation to anti-virus and malware protection and in ensuring IT security updating regimes.

A project to implement the national cyber essentials scheme is underway which concentrates on five key security principles; secure your infrastructure, secure your devices, control who has access, protect from viruses and malware and keep your systems up to date.

In the first instance, a gap analysis is being carried out to scope the work required to achieve this certification; work to date includes assessing new clinical systems, upgrading existing software/devices and working with outsourcers to ensure they are aligned to the key principles.

Looking after staff

Support the health and wellbeing of staff

The health and wellbeing programme continues to offer workshops, health checks and awareness events to staff. This year there has been a greater focus on mental wellbeing support, with the addition of an online stress management programme, support from external partners such as the Samaritans and delivery of information directly to the workplace. Additionally, individuals and teams have been encouraged to improve their physical wellbeing with partnerships being formed with local gyms to enable discounts for staff. In addition, workplace activity challenges were implemented and had good take up.

The Trust's physiotherapy assessment scheme offers staff quick access to expert advice and expedites referrals for physiotherapy treatment if required. In addition, a fast-track hospital appointment request scheme for people suffering from a work impacting health condition has helped to support early diagnosis and treatment for many staff members.

Recognising achievement

The Trust marked the 70th birthday of the NHS with staff tea parties across the three hospitals. Over 1,500 staff attended and special trays were taken to staff that were not able to leave their wards and departments. Wards were decked out in bunting and balloons and NHS history displays were placed at each hospital. Babies born at Watford on 05 July 2018 were presented with a special NHS birthday babygro.

The diabetes and mental health team, who were regional winners of the 'Celebrating Excellence in Mental Health' NHS70 Parliamentary Award, were invited to an event at the Houses of Parliament and three members of staff attended a service of celebration and thanksgiving in Westminster Abbey.

This long service recognition ceremony was also scheduled to coordinate with the NHS70 anniversary with an afternoon tea party hosted by members of the Board and executive team to thank staff for their hard work and dedication. Its staff awards were also held during July 2018, to tie in with NHS70.

In addition to internal awards, the Trust won and was shortlisted in a number of national award schemes; some of which are listed below:

- The stroke team won the Healthcare People Management Association (HPMA) award for employee engagement
- The employee relations team were shortlisted for an HPMA award
- Dr Hala Kandil and Tejal Vaghela received a highly commended at the International Antibiotic Guardian awards 2018 on prescribing and stewardship
- The maternity and special care baby team were shortlisted for a Health Service Journal award for an 'I see U baby' innovation
- The children's carer support team for being shortlisted in the Helpforce Champions National awards for health volunteers 2018

Education, Learning and Development

During the reporting period, the Trust continued to offer a range of leadership development programmes in conjunction with the University of Hertfordshire. The Trust's learning management system was radically improved from a user perspective and departmental processes were upgraded, bringing the accuracy of mandatory training reporting up to industry standards and Trust-wide mandatory training compliance to 91% in March 2019.

The Trust's nursing associate apprenticeship project has delivered excellent results, with the first nursing associate apprenticeships now underway. A new careers advisory service was launched in June 2018 and this service will be expanded in 2019/20 into a wider coaching service to support the leadership programmes.

The current successful leadership programme will be refreshed in 2019/20 to offer new opportunities to staff at first line, senior and clinical leadership levels and, as a foretaste to these, an international coach federation accredited coaching programme was launched in the summer of 2018.

Volunteers

Volunteers play an invaluable role; undertaking a wide range of jobs, including talking to patients, helping at mealtimes, providing a friendly welcome, giving directions and supporting staff with administration duties. To promote volunteering further, a number of new volunteer roles and bi-monthly training sessions have been established in 2018/19. All volunteers were invited to attend an afternoon tea party in June 2018 to provide an opportunity for the Trust to thank them for their hard work and dedication.

Staff survey

A significant improvement was seen in the results of the 2018/19 national staff survey, both against comparator Trusts and against the 2017/18 results. 56 questions were rated as significantly better than the average for acute Trusts which had been surveyed by Quality Health and significant improvement was made in 21 questions.

In 2018/19 a campaign was established to focus on areas which had been highlighted in the staff survey as needing additional attention. This was known as the 'Big 5' and focused around a different theme each month. This successful campaign will continue in 2019/20 to address staff feedback by focusing on five key themes; communication, equality, safe working environment, recognition and looking after staff.

Freedom to speak up

The Trust's freedom to speak up (FTSU) guardian is a non-executive director and the Trust continues to closely follow the recommendations from Robert Francis' FTSU report.

In the last 12 months, 13 FTSU cases were reported with broad themes relating to managerial behaviour, bullying and harassment and staffing levels. All cases have been investigated in accordance with the FTSU policy which was developed to encompass the recommendations from the Francis Review and based on national policy. The policy and process is widely publicised throughout the Trust and regularly communicated to staff.

In addition to specific actions taken to address issues highlighted by individual cases, key themes arising from FTSU are linked to the staff survey action plan, which is underpinned by five key corporate actions; let's talk, developing you, being kind, we value you and your working environment.

Research and development

The Trust continues to be committed to contributing to clinical research to support the development of new ideas, products and clinical services for the benefit of patients. There are systems in place to ensure that the principles and requirements of research governance are applied consistently through a full set of policies and standard operating procedures which have been ratified by the Trust.

During 2018/19 the highest ever number of participants was recruited to research studies; with 1338 participants to research approved by the Health Research Authority. The Trust recruited participants to 43 studies and was involved in conducting 111 clinical research studies. The National Institute for Health Research supported 99 of these through its research networks.

The research involved a number of different types of studies; patients on medications or treatments or involving patients completing a questionnaire or a review of data held on systems. The projects involved participating in large non-commercial and commercial studies and some were sponsored by pharmaceutical companies.

All divisions were actively involved to ensure that research was available alongside standard clinical care and one hundred percent of research participants who completed a national satisfaction survey in 2019/20 reported that they had found the process to be a good experience and would be happy to participate in another research study.

Future strategy

In order to realise the Trust's vision of 'the very best care for every patient, every day', a number of key strategic priorities are continuing to be implemented to manage delivery today, improve ways of working for tomorrow and transform the organisation for the future. A total of 22 initiatives were identified as priorities to take forward in 2018/19; these varied in scale and nature and included internal projects which focused on improving the quality and/or efficiency of care provided in the short to medium term, as well as a range of external or partnership programmes where the Trust is working with a range of local partners to drive improvements to care.

Key achievements in this year include:

- The relocation of orthopaedic outpatients and pre-operative assessment services from Watford to St Albans to create an orthopaedic 'hub' and free up capacity for emergency care at Watford
- An enhanced care pilot to enable patients with more complex needs to have their surgery at St Albans, reducing waiting times patients at Watford and optimising the capacity at St Albans
- The creation of additional majors cubicles within the emergency department (ED) at Watford to provide additional capacity to meet increased attendances and eliminate corridor waits. (There was only one corridor wait reported between January and March 2019.)
- A successful wave four capital bid for improvements to the ED at Watford
- The development of an outline business case (OBC) for the modernisation of pathology services in partnership with HWE STP. The case has been approved by regulators and work has commenced on a full business case.

- The approval of an outline business case for a new multi-storey car park at Watford. Work on a full business case is underway for completion in September 2019.
- The development of a full business case for theatres redevelopment at Watford is in progress for completion in September 2019.

A key piece of work in 2018/19 has been the continued close dialogue with commissioners, regulators and stakeholders on the refresh of a strategic outline case for the redevelopment of hospital estate in west Hertfordshire.

A number of stakeholder panel events have been held as part of an options evaluation process. The panel comprised of senior clinicians, colleagues from partner organisations, representatives from the voluntary sector, Healthwatch, the local authority and members of the public to represent the Trust's four localities; Dacorum, Hertsmere, St Albans and Watford & Three Rivers.

The next step is for the preferred option(s) to undergo a detailed financial and technical appraisal before a recommendation on the preferred way forward is presented to the Boards of both NHS organisations during early summer 2019/20. The Boards' agreed proposal will be reviewed by the DHSC and regulators with a view to the funding requirement being requested via the comprehensive spending review in autumn 2019.

In 2019/20, a programme of work will be undertaken to refresh and streamline the Trust's strategy and the transformation work plan will be updated.

Working in partnership

In 2018/19, a number of the Trust's clinical teams have worked with HVCCG and local GPs to redesign care pathways. These have included:

- A new respiratory advice and guidance and outpatient pathway redesign
- Frailty pathway redesign
- A tele-dermatology pilot
- New pathways for ear, nose and throat and ophthalmology (working with new community providers for these services)
- A gastroenterology telephone advice service
- A pilot of a new children's outpatient pathway with GPs in Watford

In 2018, the Trust formalised its partnership with the RFL confirming the Trust as a 'clinical partner' within the RFL hospital group. As part of this programme, the Trust is participating in a clinical practice group (CPG) programme and has commenced work on redesigning seven key clinical pathways in line with the RFL methodology. A CPG programme manager and additional analytics support have been recruited to support this work and the Trust is continuing to explore wider opportunities for collaboration with the RFL through the group model, including digital transformation by learning from the RFLs experience as a global digital exemplar, as well as estates redevelopment, workforce and finance shared 'back office' solutions.

Work is continuing with Imperial College Healthcare NHS Trust on proposals to develop a joint specialist upper gastrointestinal cancer at the Hammersmith Hospital. Subject to Board and commissioner approval, the current target date for the new service to go into operation is July 2019.

The Trust has agreed its 2019/20 contract with HVCCG and, in addition to the activity and finance elements; the contract includes a range of quality and service transformation priorities which include:

- The extension and/or expansion of pilot services in the 2018/19 plan, including community paediatric clinics and referral management for respiratory
- The re-specification of services and associated quality and performance indicators, including critical care and frailty unit

- Demand management through expansion and revision of first to follow up ratios across a range of specialities
- The roll out of STP work streams including frailty pathways (identification, proactive management and emergency care)
- Unplanned care developments, including GP streaming, urgent treatment centre developments and ambulatory care
- The pathway developments for cardiology, dermatology, patients with a mental health condition presenting as an emergency and stroke services
- The development and implementation of protocols for inpatients with Parkinson's disease

Sustainability and transformation partnership

The Trust continues to actively engage with Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP). As well as discussions on the development of integrated care system, executive directors are taking active lead roles in a number of HWE STP work streams, including planned care, frailty, workforce and estates and capital.

In 2018/19 HWE STP developed a new health and care strategy and medium term financial plan. Together these two documents provide a 'blueprint' for the future development of health and care services across Hertfordshire and west Essex.

HWE STP has agreed a programme brief for the development of an integrated care system. The broad principles have been agreed, together with a series of steps to develop detailed transition plans and to progress the appointment of a single clinical commissioning group accountable officer and STP lead.

HWE STP submitted an operating plan in April 2019 which provides an STP-wide 'aggregated view' of individual organisations' operating plans, provides assurance to regulators that activity and finance plans are aligned and that plans are in place to deliver key national commitments, including access standards.

The HWE STP's health and care strategy and the medium term financial plan set out the longer term transformational work programme for the STP. In addition to the clinical/service transformation work streams, there is a continued focus on system wide enablers such as workforce, digital, estates and contracting and commissioning models to support organisations across the STP to work together to deliver the vision set out in the NHS Long Term Plan.

Further work to clarify and streamline STP-wide work plans and minimise duplication at different levels in the system is underway.

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.

Energy optimisation and sustainability remain a key focus for the Trust and in 2019/20 a highly experienced sustainability manager was appointed to further progress the implementation of energy saving initiatives and help to further reduce the Trust's carbon footprint.

The Trust's sustainability strategy aims to reduce carbon emissions by 28% by 2020 using 2013 as the baseline year, which will require a reduction across procurement, transport, waste management and energy utilisation. This is a challenging target and has been exacerbated by a number of factors:

- Aged infrastructure reliant on aged steam systems
- Increased requirement for cooling of pharmaceuticals all areas
- Delayed deployment of sharp smart which will divert over 40 tonnes of plastic sharps bins from incineration per annum

Ongoing reviews are identifying further opportunities including:

- An LED lighting scheme which aims to generate £120k energy savings per annum, improve lighting and remove ligature risks. The scheme is self-funding over two years;
- Funding is being sought for a heat recovery scheme which will deliver a saving of £431k per annum, whilst reducing the associated backlog maintenance costs for the site
- A full review of variable speed drives to generate optimum efficiency
- A review of all backlog issues to identify sustainable solutions and opportunities

Overall, the Trust's sustainability performance is positive, as set out below:

- Utilising the combined heat and power unit (CHP) at Watford hospital to save on energy costs and carbon reduction. The CHP runs up to 17 hours a day and in 2018/19 the unit generated 4,656,397 kWh of electricity and 6,244,086 kWh of heat
- The Trust is moving from electric power consumption to generation which, whilst increasing gas usage, significantly lowers CO2 emissions
- Oil consumption varies dependent on activities as the generators are run for differing periods of time.

In 2018/19 the management of the carbon footprint has demonstrated good progress in several areas due to contract renewals in soft facilities management, including:

- Micro-fibre cleaning technology has been introduced which has reduced chemical and water usage by an estimated 85%
- Recycling has increased substantially with currently zero to landfill and 80% overall recycling being achieved
- The introduction of an obnoxious waste stream has reduced clinical waste volumes
- Incinerated waste is sent to energy from waste centre to lower the environmental impact

The Trust remains compliant with the carbon reduction commitment targets and legislation which applies to large energy users in the public and private sectors across the UK. Organisations that meet the qualification criteria are required to participate and must buy allowances for every tonne of carbon they emit. Utility spend remains stable despite adverse market trends, as demonstrated in the table below.

Resource (baseline)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	% Change on baseline
Gas Usage (kWh)	40,620,606	41,920,825	44,997,895	43,529,517	44,231,142	49,136,739	-20.96%
Electricity Usage (kWh)	17,010,202	16,452,870	17,546,952	17,241,183	17,966,718	13,534,679	79.57%
Oil (kWh)	268,752	160,611	189,419	441,584	1,179,768	170,814	36.44%
CO ₂ (tonne)	16,701	16,231	15,811	16,876	15,667	14,456	-13.44%
Total Energy Spend	£3,118,866	£3,218,042	£3,034,019	£2,827,000	£3,216,422	£3,168,739	1.016%

Figures as reported in estates return information collection (ERIC). Due to an erroneous meter read in March 2018, the 2018-19 has been based upon historic consumption at Hemel Hempstead Hospital.

As accountable officer, I confirm that this is an accurate reflection of the Trust's performance in 2018/19.

Christine Allen

Christine Allen
Chief Executive

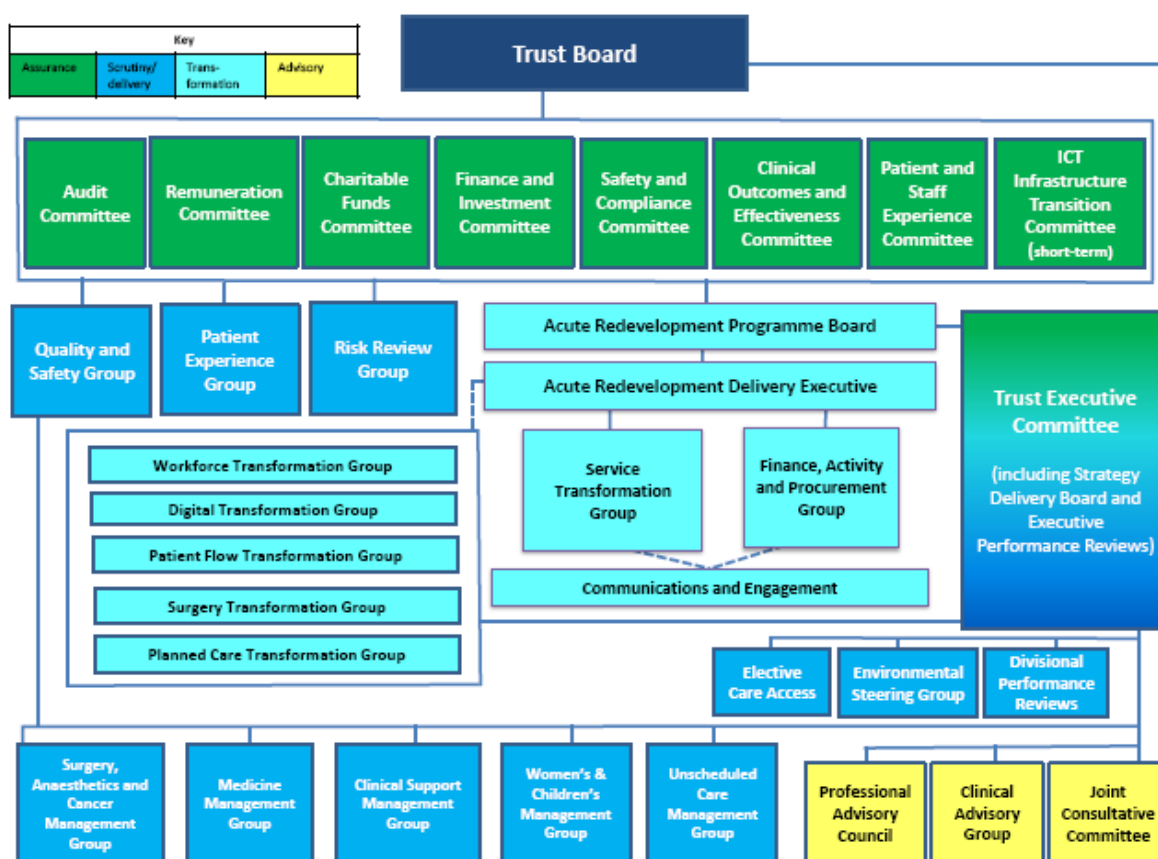
Date 24 May 2019

ACCOUNTABILITY REPORT

Corporate Governance Report

Directors' report

The corporate governance structure in 2018/19 is set out below:



Composition of the Board

The names of the chair and chief executive and the names of individuals who were directors of the Trust during the financial year are contained in the directors' remuneration section of the report, which also sets out full details of the remuneration of Board members during 2018/19.

Changes to Board membership

During the year, the following changes were made to the membership of the Board:

- Katie Fisher, chief executive, left in June 2018 and Helen Brown, deputy chief executive acted as chief executive until 28 February 2019. Christine Allen took on the position of chief executive on 01 March 2019
- Steve Barnett left the role of chair at the end of February 2018 and vice-chair, Phil Townsend took on the position of acting chair on 01 March 2019
- Ginny Edwards took up the position of vice chair from 01 March 2019
- Paul Cartwright was re-appointed as a non-executive director in May 2018
- Sally Tucker, chief operating officer was a voting member of the Board between June 2018 and February 2018
- Natalie Edwards was appointed as an associate (non-voting) non-executive director on 01 March 2019

Audit Committee

The names of the directors forming the audit committee can be found in the table on page 27. This table also sets out the Board and committee attendance in 2018/19.

Board member interests

For a number of years, Board members interests have been included as part of the Board meeting in public, which is available on the Trust's website. However, in line with the 'Managing Conflicts of Interest in the NHS' guidance published in 2017/18, the Trust has also published an up-to-date register for decision-making staff within the past twelve months on its website. This can be accessed at www.westhertshospitals.nhs.uk.

On appointment, new Board members complete a declaration with any changes during the year declared to the corporate governance department immediately and formally included at the next meeting. This process is externally audited and forms part of the annual review of the CQC's fit and proper person (F&PP) requirement for director, with the chair reviewing the evidence for all Board members. Further details are available on request from the corporate governance department (governance@whht.nhs.uk).

Personal data incidents

There have been 59 personal data information security related incidents reported to the Information Commissioner's Officer during the period of this report. Further details on personal data incidents can be found in the corporate governance section of the report.

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, 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.



Christine Allen
Chief Executive
Date 24 May 2019

Board and committee membership and meeting attendance 2018/19

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	10/11			10/12		3/3		
Chief Executive	11/11		4/6	11/12				
Ginny Edwards Non Executive Director	11/11			Reserve 2/12	6/6	3/3	3/4	6/6
John Brougham Non Executive Director	11/11	4/4		12/12		3/3		Reserve 0/6
Jonathan Rennison Non Executive Director	8/11		5/6		Reserve 2/6	1/3	4/4	6/6
Phil Townsend Non Executive Director (moved to chairman March 2019)	9/11	Reserve 2/4	6/6	9/12		3/3		
Paul Cartwright Non Executive Director	11/11	4/4	Reserve 1/6		5/6	3/3	Reserve 3/4	
Medical Director	10/11		6/6	9/12				5/6
Chief Nurse	11/11		3/6		1/6		3/4	6/6
Chief Financial Officer	11/11	4/4		11/12			2/4	
Chief Operating Officer	11/11		5/6	12/12	4/6			5/6

Governance statement

1. 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.

2. 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 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 Leadership

As accountable officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Trust and for meeting all statutory requirements and adhering to guidance issued by NHSI in respect of governance and risk management.

The Board has overall responsibility for setting the strategic direction of the Trust and managing the risks in delivering the strategy. All committees with risk management responsibilities have reporting lines to the Board. The Trust's corporate governance structure is shown on page 24.

The Trust's risk management strategy was reviewed and approved by the Board in October 2018. The strategy describes the roles and responsibilities of all employees within the Trust and sets out the requirement for an active lead from managers at all levels to ensure risk management is a fundamental part of the total approach to quality, safety, corporate and clinical governance, performance management and assurance. There is a clearly defined structure for the management and ownership of risk which through the risk register enables significant risks to be escalated to the Board via the Board Assurance Framework (BAF) and Corporate Risk Register (CRR).

Through the internal audit plan, the audit committee has continued to seek assurance on the effectiveness and compliance with the risk management strategy.

A lead executive director has been identified for each strategic risk defined within the BAF; each risk is in relation to the Trust's strategic objectives. These high level strategic risks within the BAF, supported by the CRR which contains high level operational risks are subject to ongoing review by the Board and its committees on a quarterly basis.

In 2019/20, this will increase to monthly reporting to provide added assurance to the Board that high level risks are being managed effectively.

The medical director has overall responsibility for the implementation and compliance with the risk management framework within the Trust in order that the executive directors are supported in providing strategic leadership for:

- Financial risks and the effective coordination of financial controls throughout the Trust
- Clinical quality and safety risks
- Workforce and staffing risks
- Medical risks
- Information risks
- Estates and capital risks
- Governance risks and
- Divisional risks.

All divisional triumvirate members have responsibility for the risk management activity in their division, including:

- Providing leadership for risk management activities in their division
- Promoting and supporting the implementation of the Risk Management Strategy
- Monitoring the risk mitigation activities within their division to ensure that risks and remedial action plans are being appropriately managed, reviewed and updated in accordance with the risk management strategy
- Monitoring and, where appropriate, challenging the scoring of risks to ensure consistency with the risk matrix
- Ensuring divisional risk management activity is discussed and reviewed at relevant divisional meetings
- Ensuring that staff are made aware of risks within their work environment and of their personal responsibilities for risk management
- Presenting risk management reports to Trust committees, where required
- Management of the identified risks within their division/department, including the escalation of risks, where appropriate
- Promoting and embed an 'open' and 'just' culture
- Monitoring that all relevant risk assessments are undertaken, reviewed and documented appropriately

Senior managers routinely attend monthly risk review meetings to advise on specialty matters and provide assurance on operational risk management and divisional risk registers. The divisional risk registers are reviewed at divisional governance meetings at least on a quarterly basis to ensure actions have been taken to mitigate the risks. The divisional triumvirate is responsible for ensuring that any agreed local risks are added to the appropriate risk register and submitted to the risk review group for consideration.

3.2 Training

Training is provided to staff members who have direct responsibility for risk management within their area of work, as defined by the Trust's Risk Management Strategy. Through the local workplace induction checklist, new employees are trained and notified of local risk arrangements including health and safety, incident reporting/escalation, and risk assessments. In addition, the Trust's mandatory training programme reflects essential training needs and includes risk management processes such as health and safety, clinical risk management, fire safety, conflict resolution, resuscitation, moving and handling, safeguarding adults and children, infection prevention and equality and diversity.

Facilitated by the training and development team, the Trust has a training needs analysis in place, which documents the mandatory training requirements for all staff within the financial year.

4. The risk and control framework

4.1 Key elements of the Risk Management Strategy

The Trust's risk management strategy covers all aspects of risk and is subject to annual review to ensure it remains appropriate and current. The strategy assigns responsibility for the ownership, identification and management of risks to all individuals at all levels in order to ensure that risks are managed appropriately at a local level together with a framework which allows risks to be escalated through the organisation. The process populates the BAF and CRR, committee risk registers, divisional risk registers and specialty/departmental risk registers to form a systematic record of risks including the control measures designed to mitigate and minimise identified risks.

In 2018/19, the Board started work to consider its risk appetite with an externally facilitated workshop as part of its Board development programme. This work will continue to develop in 2019/20.

Risks can be identified from a variety of different sources through the operation of the Trust's business; these can be proactive processes (planning processes, general observations and internal/external audits) or reactive processes (incidents, complaints, claims, inspections, assessments, accreditations, reviews) and regulatory assessments. All identified risks are assessed and are entered into the risk register system, DATIX. The risk management strategy is available to all staff via the intranet.

The Trust requires that all risks on the risk registers have an active, robust and time specific mitigation plan. The Board believes that the Trust must do all that is reasonable in the management of all risks and once it is satisfied that controls and assurances are in place and effective, the Board is prepared that a residual risk may be tolerated or accepted. The Board understands that some strategic risks carry a high level of inherent risk and provided that the condition of reasonableness has been met, the Trust is prepared to tolerate strategic risks at a high level. This approach forms a fundamental part of the Trust's thinking on risk and corporate decision making. To aid decision-making, the Trust utilises the National Patient Safety Agency's risk matrix, which the Board uses as a basis of identifying acceptable and unacceptable risk.

An advisory audit into risk management and the BAF in 2018/19 concluded that there have been improvements in the risk management framework. However, work was required to ensure that risks at divisional level were being identified, recorded and escalated appropriately. The audit report recommended that the BAF is developed further to include the tracking of risks overtime and this has been included in the latest version.

4.2 Key elements of the quality governance arrangements

Strategy

Patient safety, clinical effectiveness and patient experience, alongside improving efficiency, drive the Board's strategic framework, which identifies key elements in the quality of care it delivers to patients and provides the basis for annual objective setting. The potential risks to patient safety, clinical effectiveness or patient experience are identified and escalated to the Board in accordance with the process outlined in the section above.

Capabilities and culture

The Board works hard to ensure that it has the necessary leadership, skills and knowledge to deliver on all aspects of the quality agenda. Board development activities are in place to support leadership and strategic decision making and all Board members receive an annual appraisal.

In 2018/19, the Board commissioned an externally facilitated leadership review which focused on NHSI's well-led framework's eight key lines of enquiry and used a wide range of forums, including a document review, one to one meetings with key staff, focus groups and interviews with external stakeholders. This assessment demonstrated a clear focus on and commitment to, the delivery of high quality services and evidenced good corporate management processes with established reporting lines. The CQC rated well-led for the Trust overall as 'requires improvement'.

A self-assessment of the Board's effectiveness was also undertaken in 2018/19 and no key areas of concern were highlighted. In addition, NHSI undertook a series of Board and committee observations during the year as part of the Trust's quality improvement plan.

Feedback and recommendations from the range of assessments, reviews and observations will be developed in 2019/20 into an improvement plan with timescales and owners, which will be monitored regularly through the assurance committees and Board.

The Board keeps under review its clinical leadership model which puts senior medical and nursing colleagues at the heart of decision-making and management of each division within the Trust. During 2018/19, the Trust continued to strive to place patients at the heart of everything, as well as being honest, open and striving to provide the best care possible.

Processes and structure

Accountability for patient safety, clinical effectiveness and patient experience and improved efficiency are set out in the Quality Commitment which was approved by the Board in March 2018.

The Board holds ultimate accountability for ensuring the Trust's services are safe, effective and reflective of the needs of patients; to that end it is the responsibility of the Board to foster a culture of quality and patient safety within the organisation by driving and overseeing the implementation of this strategy plan.

The Board regularly monitors the progress of the Quality Commitment and delivery plan through its assurance committees and scrutinises the information contained in the integrated performance report and quality, workforce and finance performance reports which are produced regularly for the Board and committees.

Divisional directors, heads of nursing, lead allied health professionals and divisional managers have responsibility for facilitating the implementation of the Quality Commitment and to adopt the principles of quality to guide them in their day to day roles. Furthermore, it is the responsibility of the divisional team to contribute to the delivery of quality targets. This is managed through the development and delivery of divisional business plans which include specific requirements relating to quality, patient safety and risk.

The Board commences every meeting with a patient story or service improvement story, reflecting on the experiences (positive or negative) of patients using the Trust's services. The assurance committees receive quality and integrated performance reports to provide assurance on quality outcomes, including compliance with the CQC registration requirements and CQC essential quality and safety standards.

The Board actively seeks feedback from patients, staff, visitors, commissioners and other stakeholders in the pursuit of excellence as part of the continuous improvement cycle. All Board members participate in walkabouts to engage with frontline teams and evaluate the safety, clinical effectiveness and experience of care for patients.

Information reported to the Board regarding performance against nationally mandated targets is collated from the dataset submitted to the DHSC. Likewise, data to support compliance with locally commissioned services and targets is reported to the Board from the dataset provided to commissioners.

4.3 The organisation's key risks

The key organisational risks for the year were identified from the corporate strategic objectives for 2018/19, forming part of the BAF and included the following:

In year risks 2018/19	Mitigation
These are taken from the Board Assurance Framework, Corporate Risk Register, five year strategic plan, two year operational plan, integrated performance report and Quality Account	
The current estate and infrastructure compromises the ability to consistently deliver safe, caring, responsive and efficient patient care	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ New contract in place to provide full managed ICT service ▪ Contract management in place to hold supplier to account
An inability to deliver and maintain performance standards	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ Close monitoring by the Board and committee structure ▪ 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 ▪ NHS Improvement funding application process in place
Failure to deliver a sustained long term clinical, financial and estates strategy	<ul style="list-style-type: none"> ▪ Senior team actively engaged in STP governance and delivery processes ▪ Director of integrated care supporting delivery of strategy and system wide pathway transformation ▪ Dialogue with NHSI to progress business cases ▪ Close 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	<ul style="list-style-type: none"> ▪ 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 ▪ System wide discharge improvement plan developed

Each risk remains under constant review and are assessed by reviewing progress with measureable targets, auditing compliance with national and local standards and regulations. Mitigating actions and outcomes are monitored as a minimum on a bi-monthly basis by the reporting committees and the escalation and de-escalation of risks is dependent upon progress to achieve outcomes.

4.4 Responsibilities of directors and committees

The Board comprises of 11 directors: the chair, five non-executive directors and five executive directors including myself. Changes to the Board membership in 2018/19 are set out on page 24.

In order to discharge its duties effectively, the Board is required to have a number of statutory committees. The 2019/19 corporate governance structure is outlined on page 24.

All assurance committees are chaired by a non-executive director and the membership includes other non-executive directors, all of which have relevant experience and qualifications. Attendance at Board meetings and assurance committees is shown on page 27.

The audit committee 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 BAF to assure itself that risks are being accurately identified and managed and appropriate assurance is obtained.

4.5 Effectiveness of Governance Structures

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 it considers to be relevant to the Trust.

The Trust has reviewed its corporate objectives and vision and values which focus on quality. Underpinning these are objectives and work programmes and progress of these is reported to the Board and its assurance committees.

The quality governance team works with the divisional management team to strengthen and embed the following areas within the Trust:

- Risk management
- Incident reporting and investigation
- Clinical audit
- NICE guidance
- Patient reported outcome measures
- Complaints and litigation
- CQUIN
- Involving and engaging patients and the public

The quality compliance programme incorporates national requirements and locally identified measures. Quality goals have been selected to have the highest possible impact across the whole organisation. The majority of measures are specific, measurable and time-bound.

Each division has a divisional governance framework in place. Divisional performance meetings are held on a monthly basis and executive directors hold divisions to account for their performance. Areas of concern are escalated to the assurance committees.

To test the effectiveness of its governance structures and process, the Trust employs RSM as its internal auditors. Set out below is the 2018/19 work programme delivered by internal audit:

Review title	Assurance level
Learning from complaints	Reasonable
Fire safety	Reasonable
Medicines management including controlled drugs	Reasonable
Theatre utilisation including data quality	Partial
Rostering	Partial
Data security and protection toolkit including GDPR	Advisory
Divisional governance – surgery	Reasonable
Risk management and Board Assurance Framework	Reasonable
Key financial controls	Partial
Cost Improvement plans	Reasonable
Estates management	Partial

The assurance committees seek assurance from executive directors and divisions about risk and performance. Through the integrated performance report and finance, quality and workforce reports, non-executive directors are able to seek assurance and hold directors to account for quality, risk and performance.

The Board also receives assurances through external assessments, clinical audit, internal and external audit which report regularly to the assurance committees. Visits are undertaken by Board members which enable the Board to meet with staff and patients and triangulate assurances received in formal meetings.

Together with internal and external audit, the audit committee receives reports on the effectiveness of the governance systems and structures to ensure they remain fit for purpose.

During 2018/19 the Trust continued to meet its requirements to undertake a fit and proper person assessment of its directors. All directors required to undertake the assessment met the requirements.

4.6 How risk management is embedded in the activity of the Trust

The Trust has a risk management strategy in place which ensures that risks are considered and managed as part of the activity of the Trust. Each division has a risk register which is regularly reviewed and updated and operational risks are considered through the divisional governance framework. The risk registers are used to develop the quarterly CRR and BAF report to the Board and bi-monthly risk reports to assurance committees. In 2019/20 the frequency of Board risk reporting will move from quarterly to monthly.

Staff are encouraged to report incidents and near misses using the incident reporting system (DATIX). The Trust encourages reporting within an open and fair culture, where reporting is congratulated and individuals are not blamed or penalised if they speak out. The Trust has adopted and supports the Speak out Safely initiative.

Following the publication of NHS Employers' review into raising concerns in March 2015, the organisation continues to promote a culture of speaking up for patients to improve and maintain the patient and staff experience. The FTSU guardian is a non-executive director and the Trust continues to closely follow the recommendations from Robert Francis' Freedom to Speak Up report. Further details on this are on page 20.

An incident reporting system is in place and incidents are entered onto a database for analysis. All incidents that are submitted using the incident reporting system are evaluated, with root cause analysis undertaken for instances of harm that are deemed to be serious under the Trust's incident reporting (including serious incident) and management policy.

A weekly incident review meeting led by the medical director or chief nurse reviews the previous week's incidents and determines whether rapid reviews or other actions are required. All identified changes in practice identified through a root cause analysis are signed off by the serious incident review group.

Impact assessments are used by the Trust in respect to business cases, programme management activities and cost improvement programme proposals. Significant proposals must be signed off by the medical director and chief nurse and impact assessments are kept under review.

The Trust has a zero tolerance approach to fraud and counter fraud services are provided by RSM. This includes developing an antifraud culture across the workforce, fraud proofing policies and procedures, conducting fraud detection exercises, investigating allegations of suspected fraud and obtaining, where possible, appropriate sanctions and redress.

All policies, procedures, guidelines, schemes and strategies incorporate an equality impact assessment (EIA) before being submitted to the relevant committee for discussion and sign off. Completion of an EIA is also undertaken when a new service is being planned or there is a change to an existing service. Where an adverse impact is identified during the completion of the initial assessment, a full EIA is carried out. This involves engaging with people who represent protected characteristic groups and other groups if required to do so.

The Trust conducts engagement with patients, carers and local communities when there are plans to make significant changes to services. This may include formal public consultation, depending on the nature and scope of the proposed change.

4.7 Elements of the assurance framework

Through its governance structures, the Trust is able to assure itself on its performance. The Board receives submission of timely and accurate information in the integrated performance report and in quality, workforce and finance reports, the BAF and the CRR which are produced regularly for the Board and its assurance committees.

The Board also receives assurances through external assessments, inspections and visits, clinical audit and internal and external audit which report on a regular basis to the assurance committees, including the audit committee. The Board is therefore satisfied that there is a high degree of rigour and oversight of risk and performance.

The BAF is a live document and the elements are monitored and reviewed on a quarterly basis by the lead directors, assurance committees and the Board. It ensures that the Trust is addressing its risks systematically. The action plan arising from each risk also serves as a work plan through lead managers to ensure mitigation against risk and closure of any gaps in control or assurance.

The BAF was developed and embedded during 2018/19 and it:

- Identifies the objectives and targets that the Trust is striving to achieve
- Identifies the risks to the achievement of the objectives and targets
- Identifies the system of internal control in place to manage the risks
- Identifies and examines the review and assurance mechanisms which relate to the effectiveness of the system of internal control and
- Records the actions taken by the Board to address control and insurance gaps

An advisory audit into the BAF concluded that there had been improvements in 2018/19 and recommended some actions which have been incorporated to improve this further.

Risk prioritisation and action planning is informed by the Trust's corporate objectives. In preparation for the start of the new fiscal year, the Board identifies the key strategic risks to the organisation's objectives and ensures that mitigating measures are established and managed.

The Trust uses risk registers to both manage the key strategic risks, receive assurances that mitigating actions are effective and to enable the escalation of any new areas of risk representing through the year. The risks managed on the risk register are derived from a number of internal and external sources including national requirements, national guidance, complaints, claims, incident reports and internal audit findings and are all contextualised against the Trust's strategic objectives.

Strategic risks are owned at an executive level in the organisation; however the management of operational risks and their control measures and actions is undertaken at various levels. Lead executive directors and lead managers are identified for each risk that assumes responsibility for addressing any gaps in control or gaps in assurance by developing and managing the corresponding action plans.

The risk management and assurance processes are evaluated on an annual basis by the audit committee. The audit committee provides assurance that internal controls are enabling the Trust to achieve its objectives. Where there are gaps in assurance, these are highlighted to the Board who is responsible for overseeing the completion of action plans to address the gaps.

4.8 How public stakeholders are involved in managing risks which impact on them

The Trust involves both patients and public stakeholders in the governance agenda, strategic planning and risks facing the Trust. This has been achieved through engagement with patients, HVCCG, Hertfordshire County Council's (HCC) health scrutiny committee, local safeguarding boards and Hertfordshire HealthWatch. The Trust is also represented at the local health and wellbeing board.

A number of patients attend the Trust's assurance committees and other meetings. This is to ensure that the views of patients, carers and families are taken into consideration when the Trust is planning and developing services. Patient representatives contribute to meetings by bringing their personal experience and offering ideas and opinions and helping to facilitate the 'patient voice' being heard whenever decisions that affect patient care are made.

Stakeholder engagement in 2018/19 has been very much focused on the options for the future redevelopment of the Trust's estate. A series of public stakeholder engagement events were held as part of the options evaluation process relating to the future of acute services in west Hertfordshire. Social media was used to extend the invitation to as wide an audience as possible, ensuring that there was lay representation for all localities. The panel comprised of senior clinicians, colleagues from partner organisations, representatives from the voluntary sector, Healthwatch, the local authority and members of the public to represent the Trust's four localities; Dacorum, Hertsmere, St Albans and Watford & Three Rivers.

The Trust continues to maintain a close working relationship with the HCC's health scrutiny committee as the principle means of engagement with elected members. As this committee has a statutory role and is comprised of members from across the county, it is the most appropriate formal engagement route. There were two formal presentations to the HSC in 2018/19; in December and March covering a range of topics; hospital redevelopment; surgery wait times; CQC results and the Quality Account.

In addition, an informal briefing was arranged in January to allow members to explore the options for hospital redevelopment in more depth. As well as engagement with the HCC's health scrutiny committee there have been a number of briefings from the Trust with district and borough council members. The Trust also interacts with campaign groups via frequent correspondence on the topic of hospital redevelopment.

Prior to the publication of the CQC re-inspection in January 2019, the Trust's quality improvement plan was monitored through an oversight group which was chaired by NHS Improvement and included CQC and commissioning membership. Following publication of the latest CQC inspection report, which identified significant improvement in the quality of services, the oversight group was discontinued.

4.9 Measures in place to ensure safe staffing processes

Developing workforce safeguards supports the Trust to give patients safe, high quality, compassionate care that is financially sustainable. The Board recognises the need to be consistent in its approach to safe staffing levels across all clinical workforce groups.

An adult nursing establishment review is completed bi-annually and reported to the quality committee and Board using evidence based tools, such as the safe care tool that uses patient acuity and dependency. Quality impact assessments are made when any ward reconfiguration occurs and have been undertaken for new roles introduced into the workforce. A quality dashboard is discussed at divisional, executive and Board meetings with a monthly divisional and organisational performance review that monitors quality metrics, patient outcomes, staff and patient experience and financial sustainability. Throughout the day staffing is reviewed using safer care tool and senior staff undertake a risk assessment which is triangulated with professional judgement and documented. Formal escalation procedures are in place to be used in and out of hours.

There is a forward plan for establishment and skill mix reviews across nursing and midwifery services which are discussed and agreed at Board level. Further work is also being undertaken to scope other parts of the workforce such as therapies.

In addition the Trust is one of three founder members of a shared bank across Hertfordshire that allows staff to work across all three Trusts and is part of a Department of Health and Social Care's (DHSC) pilot scheme to understand how it can be extended to include in-house banks and give further choice and opportunities to workers across all sectors.

The right skills are monitored and supported through mandatory training, development and education. E-roster and Medi-rota are used to manage staffing resources effectively and to enable the right staff with the right skills to be deployed on a daily basis as part of a risk assessment process which is documented and reported daily.

To enable improved productivity, the Trust continually reviews its skill mix to ensure the appropriate use of staffing and has introduced nursing associates where appropriate, using the apprenticeship levy to fund the training of new and existing healthcare support workers into these roles.

The national Getting It Right First Time programme is supporting increased productivity and efficiency across all areas by identifying unwarranted variation in clinical practice and/or divergence from the best evidence.

The Trust is working in collaboration with HWE STP on a range of workforce priorities, including back office collaboration, leadership and management development opportunities for the region as a whole, and workforce planning at STP level. This includes pre-registration planning as the Trust looks to ensure an adequate supply of registered staff locally.

4.10 Disclosure of registration requirements

The Trust is required to register with the CQC and its current registration status is compliant with all conditions.

The Trust underwent a CQC inspection in the September to November 2018. Two enforcement notices were issued as a result of this inspection in relation to the urgent treatment centre at Hemel Hempstead and the minor injuries unit at St Albans.

The final report was published in January 2019 and, despite a significant improvement in the rating of individual services, the overall rating remained at 'requires improvement'.

In response to verbal feedback following the inspection, the Trust immediately put measures in place to promptly address any issues that had been highlighted. The quality compliance programme, which incorporates all the Trust-wide and divisional 'must do' and 'should do' actions which were identified as areas for improvement, was submitted to the CQC in April 2019. Oversight of the quality compliance programme is monitored through the Trust's quality committee and reported through to the Board.

The inspection reports and ratings are available on the CQC's website (www.cqc.org.uk).

4.11 Register of interests

The Trust has published an up-to-date register for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. Further information on this can be found in the director's report section.

4.12 Compliance with the NHS pension scheme regulations

As an employer with staff entitled to membership of the two NHS pension schemes, control measures are in place to ensure all employees 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 schemes rules and regulations and that member pension schemes records are accurately updated in accordance with the timescales detailed in the regulations.

4.13 Compliance with equality, diversity and human rights legislation

Over the past year, the Trust has been working hard to ensure the quality of its services take account of the many different communities it serves and the diversity of its skilled and talented workforce. More details on this work can be found in the performance analysis section of this report.

4.14 Compliance with climate adaptation requirements under the climate change act 2008

The Trust has undertaken risk assessments and has a sustainable development management plan which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

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

The Trust has an annual plan which is approved by the Board and submitted to NHSI. The plan is monitored by the assurance committees and the Board.

A monthly integrated performance report is produced which contains performance indicators and NHSI's metrics for quality, performance, workforce and finance information.

The Trust's resources are managed within the corporate governance framework and include standing financial instructions, standing orders and scheme of delegation. Financial governance arrangements are supported by internal and external audit that assess the economic, efficient and effective use of resources and provide assurance to the audit committee.

Divisional and corporate departments are responsible for the delivery of financial and other performance targets through a performance management framework which incorporates service reviews with the executive teams.

Where necessary, the Trust utilises external support to identify areas of improvement and develop and implement action plans to deliver the required efficiency. Through the contracts and commissioning team, business cases are developed to ensure that rigour is applied to significant changes in operation and service provision. This includes impact assessments and due diligence tests.

The Trust's efficiency programme achieved record savings of £16.1m, equivalent to 4.8% of income in 2018/19. All efficiency schemes were quality impact assessed and approved by the chief nurse and medical director prior to implementation.

In June 2018, the Board approved two regulatory NHS self-certifications; Condition G6(3), the provider has taken all precautions to comply with the licence, NHS Acts and NHS Constitution; and Condition FT4(8), the provider has complied with required governance arrangements.

1. Information governance

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.

Data quality and data security risks are the responsibility of the chief information officer and compliance is monitored within the joint information governance and security group. This group is chaired by the director of ICT and reports to the quality committee. Independent assurance is provided by the data security and protection toolkit review process and any risks identified are added to the risk register.

During the financial year 2018/19, there were 59 personal data information security relating incidents reported, all of which were severity rated from level zero to two. All were thoroughly investigated and reported upon. Incidents classified as a severity rating of level two are reported as a serious untoward incident and reported to the DHSC, NHS Digital, NHSI and the information commissioner. The table below provides a summary of the incidents that were reported in 2018/19. In comparison there were 111 personal data information related incident reported during 2017/18.

Summary of personal data related incidents 2018/19		
Breach type	Level 0 – 1	Level 2
Disclosure in error	39	0
Lost in transit	5	0
Unauthorised access/disclosure	1	0
Other	13	0
Non-secure disposal – paperwork	1	0
Total	59	0

(Level 0 - near miss, level 1 - not reportable and level 2, reportable)

From April 2018, the data security and protection (DSP) toolkit replaced the information governance toolkit as the standard for cyber and data security for healthcare organisations. Compliance with the DSP Toolkit requires organisations to demonstrate that they are meeting the requirements of the general data protection regulation (GDPR) and are implementing the ten data security standards recommended by the national data guardian review 2016.

All health and social care organisations processing personal identifiable information are expected to achieve 'standards met' on the DSP toolkit. With this being the first year of the DSP toolkit standard, NHS Trusts, local authorities and CCGs, are allowed to publish a DSP toolkit if they are approaching a level of 'Standards Met' in all but a few areas. Organisations are required to provide an improvement plan of how they will bridge the gap between their current position and meeting the DSP toolkit 'standards met'. At the end of 2018/19, of the ten DSP requirements, two have been fully implemented, seven have been partially implemented and one has not been implemented.

An implementation plan is currently in place to achieve full compliance with all ten assertions by September 2019.

7. Annual Quality Account

The Trust is required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Account for each financial year. The Trust has built on the work undertaken to develop the Quality Account and has drawn on the various guidance published in-year in relation to the Quality Account.

The Trust has delivered 44% of its 2018/19 quality priorities for improvement for clinical effectiveness, quality of patient experience and patient safety as set out in the 2018/19 Quality Account.

Work has been completed to develop new targets and priorities for the 2019/20 Quality Account and a formal review process has been established which involves the submission of the draft Quality Account to external stakeholders (commissioners, health scrutiny committee and Healthwatch). The Quality Account goes through a number of internal sign off processes, including assurance committees and the audit committee.

Steps have been put in place to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of the data. These steps cover the following areas as detailed below:

7.1 Governance and leadership

The quality improvement system is led directly by the Board which also exercises its governance responsibilities through monitoring and reviewing the Trust's quality performance. The quality committees report directly to the Board, lead the Trust's quality agenda and provide assurance on compliance with the Trust's quality indicators.

7.2 Policies

The Trust has in place a suite of policies which have quality at their heart, focusing on care that is safe, effective and reflective of the needs of patients and staff. The quality committees set out the framework in which quality improvement will be achieved within the Trust, with all key policies such as the incident policy and complaints policy.

7.3 Systems and processes

The Board ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness and efficiency, as well as the quality of the healthcare it delivers. The Board regularly reviews performance in these areas against regulatory requirements and approved plans and objectives.

7.4 Clinical audit

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 quality committee and the audit committee provides added assurance on the controls in place.

7.5 People and skills

The Trust actively encourages and supports staff to gain the skills and qualifications that will support their future employability and meet the needs of the organisation. There is a robust induction and mandatory training programme as well as a wide range of learning and development programmes.

8. Data use and reporting

External assurance is provided from national data submissions and national patient survey results, local inpatient survey results and information governance toolkit results. Local internal assurance is also provided through the analysis of data following local internally led audits in relation to nursing care indicators, analysis of data following incidents in relation to medication errors and slips, trips and falls incidents for patients and other patient harm.

The quality and safety metrics are also reported monthly to the Board through the integrated performance report and other quality and safety reports.

For further details of how the Trust ensures accurate clinical data recording, please go to page 13.

9. Review of effectiveness

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

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

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I will detail below some examples of the work undertaken and the role of the Board, the audit committee, the assurance committees, clinical audit, internal audit and external audit in this process.

I was pleased that improvements made were formally recognised by the CQC in the latest inspection. We will continue to work with the CQC and NHSI to ensure that the quality and safety of services delivered to our patients continues to improve.

The effectiveness of the system of internal control is maintained by ensuring clear duties and accountability is allocated to each part of the 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 CRR and BAF 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.

The Board has taken assurance from assessments reported to the assurance Committees on how the Trust is meeting the requirements of the NHS single oversight framework and quality improvement framework. I can report that the Trust has a single oversight framework segmentation of three, which means that the Trust has been identified for mandated and targeted support in respect to the quality of care, finance, use of resources and operational performance.

The internal audit reports show that the Trust has been successful in embedding good controls at all levels. However the Trust remains vigilant and continues to strive for further improvements across all areas.

In 2018 the Board did not agree a control total with its regulators on the grounds that patient safety would be compromised. As a result, the Trust was placed into the capped expenditure process and penalties were imposed and access to certain NHS funding was denied.

There is a long-term plan to bring the organisation back into financial balance by addressing the structural deficit and implementing a sustainability programme. As part of its financial plan for the next five years, the Trust is working with HVCCG, NHSI and NHSE to secure the necessary resources to continue its operations and, in the longer-term, achieve financial sustainability.

I received further assurance from an external assessment which was undertaken against NHSI's well-led framework. This demonstrated a clear focus on, and commitment to, the delivery of high quality services and evidence of good corporate management processes with established reporting lines. This triangulates with the findings of the latest CQC report and internal audit reports. Progress continues to be monitored by the Audit Committee on further actions to embed effective governance systems at all levels within the organisation.

Performance indicators such as breaches of the emergency department four-hour standard and the RTT standard suggest that there is still some way to go and new processes and procedures continue to be introduced to further strengthen performance.

Additionally the Director of Internal Audit Opinion is that:

Level 2 opinion for governance and risk management

In general, the organisation has an adequate and effective framework for risk management and governance.

Level 3 opinion for system of internal controls

There are weaknesses in the framework of internal control such that could be inadequate and ineffective.

The number of 'no assurance' opinions reduced to zero in 2018/19 compared to two such opinions issued in 2017/18. We also note that the Trust has improved its risk management arrangements this year.

However, we continue to see compliance challenges in the areas of: estates and procurement, workforce rostering and the utilisation of theatres. The Trust is also challenged by its underlying financial position. It is important that internal controls are improved to effectively manage risks in these areas.

In the light of the internal and external audit work, I'm able to provide assurance that the system of internal control is well designed and effective and enables the Trust to isolate and respond to issues of concern. There are no significant control issues; however, there is recognition that systems require ongoing monitoring and evaluation.

The Trust continues to address areas of risk identified by regulators in addition to the strategic risk as set out in section four above.

Fundamental to the future of the Trust is the need to continue to find ways of improving how it works. This will be achieved by continuing to invest in the estate, improving patient pathways and working closely with partners. This will include promoting quality improvement by launching clinical pathway groups in partnership with the RFL and working with HVCCG and HWE STP on a service development improvement plan, as well as implementing the GIRFT programme of pathway and speciality reviews.

Through the Quality Account and the quality compliance programme, key quality priorities and plan to achieve them have been identified. In line with open and honest reporting, the Trust publishes staffing levels and key quality data including harm free care for every ward on ward noticeboards and the website.

The Trust is required by NHSI to report data on patient safety incidents to the national reporting and learning service. This is also published on the Trust's website to support an open and honest reporting culture around learning from incidents and also demonstrates openness and transparency to patients and other stakeholders.

10. Conclusion

My review of the effectiveness of the systems of internal control has taken account of the work of the executive team within the organisation, which has responsibility for the development and maintenance of the internal control framework within their discreet portfolios. In line with the guidance on the definition of the significant internal control issues, I have not identified any significant control issues.



Christine Allen
Chief Executive
Date 24 May 2019

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.

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



Christine Allen
Chief Executive
Date 24 May 2019



Don Richards
Chief Financial Officer
Date 24 May 2019

Modern Slavery Act 2015 – Transparency in supply chains

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 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.

The statement can be accessed at www.westhertshospitals.nhs.uk.

Remuneration and staff report

Expenditure on consultancy

Total expenditure on consultancy services in 2018/19 was £1.1m (£1.1m in 2017/18). This spend is in relation to various strategic outline business cases that are currently being written. These include the SOC for the acute redevelopment and the theatres refurbishment. In addition to this, there has been support to assist with capital and revenue planning and spend against various IT projects, supporting the network infrastructure.

Director 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 2018-19 was £287k (2017/18 £276k). This was 8.5 (2017/18 - 8.3) times the median remuneration of the workforce, which was £34.0k (2017/18 £33.2k).

In 2018/19 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 £285-290k.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind as well as severance pay. It does not include employer pension contributions or the additional cash equivalent transfer value of pensions.

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.

The Trust has a management policy in place to inform the need for reasonable adjustments and support staff who become disabled during employment. Close links are in place with the occupational health department in order to ensure that all is done to support staff with disabilities at work.

Off payroll engagements

Table 1: Off-payroll engagements for longer than six months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months

	Number
Number of existing engagements as of 31 March 2019	2
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	1

There were no new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months.

Table 2: Off-payroll board members/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019,

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and on-payroll engagements	14

Staff banded by ethnicity

Category	Band 1 - 7	Band 8a above	medical	Non-Executive Director	Grand Total
White – British	1872	188	142	4	2206
White – Irish	98	9	3	1	111
White - Any other White background	376	11	58		445
Mixed - White & Black Caribbean	20	1	1		22
Mixed - White & Black African	12		1		13
Mixed - White & Asian	13	1	6		20
Mixed - Any other mixed background	26	2	6		34
Asian or Asian British - Indian	433	33	142		608
Asian or Asian British - Pakistani	79	1	42		122
Asian or Asian British – Bangladeshi	15	1	10		26
Asian or Asian British - Any other Asian background	372	6	48		426
Black or Black British - Caribbean	71	9	2		82
Black or Black British - African	224	9	31		264
Black or Black British - Any other Black background	37	1	3		41
Chinese	35	1	14		50
Any Other Ethnic Group	83	2	27		112
Undefined	208	11	86		305
Not Stated	96	7	8		111
Grand Total	4070	293	630	5	4998

**Staff Numbers and composition - 2018/19
(audited)**

	2018-19						2017-18	
	Total		Permanently employed		Other		Other	
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
Medical and dental	678	74,865	608	60,802	70	14,063	60	13,587
Ambulance staff	0	0	0	0	0	0	0	0
Administration and estates	1,176	43,359	1,058	38,106	118	5,253	116	4,347
Healthcare assistants and other support staff	978	27,096	806	21,902	172	5,194	154	4,671
Nursing, midwifery and health visiting staff	1,613	74,991	1,356	60,739	257	14,252	278	15,419
Nursing, midwifery and health visiting learners	0	0	0	0	0	-	0	0
Scientific, therapeutic and technical staff	506	25,748	458	22,477	48	3,271	60	4,021
Healthcare science staff	0	0	0	0	0		0	0
Social Care Staff	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
TOTAL	4,951	246,059	4,286	204,026	665	42,033	668	42,045

Staff Sickness Absence Data (audited)

	2018-19	2017-18
	Number	Number
Total Days Lost	31,089	30,721
Total Staff Years	4,340	4,207
Average working Days Lost	7.16	7.30

DIRECTORS' REMUNERATION 2018-2019
(audited)

NAME	TITLE	In year start/ leave dates	2018/19				2017/18			
			SALAR Y bands of £5,000	Expense payment s (taxable) total to nearest £100	Performanc e pay and bonuses bands of £5,000	TOTA L bands of £5,000	SALAR Y bands of £5,000	Expense payment s (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000
Prof S. Barnett	Chairman	Left Feb 2019	35-40	3,200	0	40-45	40-45	11,600	0	50-55
K. Fisher	Chief Executive	Left Jun 2018	40-45	0	0	40-45	185-190	300	0	185- 190
C. Allen	Chief Executive	Start Mar 2019	15-20	0	0	15-20	0	0	0	0
P. Townsend	Non-Executive Director (vice Chair)	Left Feb 2019	5-10	100	0	5-10	5-10	400	0	5-10
P. Townsend	Interim Chair	Start Mar 2019	0-5	0	0	0-5	0	0	0	0
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	100	0	5-10	5-10	900	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	200	0	165- 170	165-170	0	0	165- 170
T. Carter	Chief Nurse & Director of Infection Prevention and Control		120-125	0	0	120- 125	115-120	0	0	115- 120

H. Brown (note 1)	Deputy Chief Executive and Director of Strategy	Apr 2018 - Jun 2018	30-35	0	0	30-35	120-125	300	0	120-125
H. Brown	Acting Chief Executive	Jun 2018 - Feb 2019	100-105	200	0	100-105	0	0	0	0
M. van der Watt (note 2)	Medical Director/ Director of Patient Safety		285-290	0	0	285-290	275-280	0	0	275-280
S. Tucker	Chief Operating Officer	Jun 2018 - Feb 2019	85-90	100	0	85-90	0	0	0	0

NOTES

Note 1: H. Brown from 1st March 2019 is a non-voting director, as Deputy Chief Executive, and no disclosure required.

Note 2: 79% of salary as Medical Director/Director of Patient Safety and 21% for clinical work.

Note 3: Salary includes exit package as disclosed in the remuneration and staff section of the annual report.

The salaries above may include salary sacrifice schemes.

Signed by: Christine Allen

Christine Allen

Chief Executive

Date: 24/05/2019

Exit packages agreed in 2018-19 (audited)

2018-19							
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made Number
<£10,000	1	8,955	19	52,421	20	61,376	0
£10,000 - £25,000	0	0	0	0	0	0	0
£25,001 - 50,000	2	81,043	0	0	2	81,043	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	3	89,998	19	52,421	22	142,419	0

2017-18							
Exit package cost band (including any special payment element)	Number of compulsory redundancies Number	Cost of compulsory redundancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made 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

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.

Exit Packages - Other departure analysis

	2018-19		2017-18	
	Payments agreed Number	Total value of agreements £000s	Payments agreed Number	Total value of agreements £000s
Contractual payments in lieu of notice	19	53	28	90
Total	19	53	28	90

- This note reports the number and value of exit packages agreed in the year
- There was no Trust 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.

DIRECTORS' PENSION ENTITLEMENT 2018-2019 (audited)

	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 2019 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real increase/(decrease) in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
K. Fisher (note 1)	0-2.5	0	60-65	75-80	808,809	638,928	29	0
D. Richards	10-12.5	25-27.5	50-55	110-115	1,090,347	931,787	110	0
T. Carter	0-2.5	0	40-45	95-100	722,790	596,824	91	0
H. Brown (note 1)	7.5-10	15-17.5	45-50	115-120	897,492	642,800	197	0
M. Van Der Watt	2.5-5	10-12.5	55-60	175-180	1,336,678	1,118,757	143	0
S. Tucker (note 1)	0-2.5	0	55-60	150-155	1,204,250	1,034,431	82	0

Note 1: Real increase in pension, lump sum and CETV is pro-rated for the duration in post as a voting director.

- Non-Executive members do not receive pensionable remuneration, therefore there are also 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.

- * Staff Numbers and Composition
- * Sickness Absence Data
- * Director's salary relative to workforce
- * Exit packages
- * Director's Remuneration
- * Director's Pension Entitlement

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

Signed by:



Christine Allen, Chief Executive

Date: 24 May 2019

Independent auditor's report to the Directors of West Hertfordshire Hospitals NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of West Hertfordshire Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Material uncertainty related to going concern

We draw attention to note 1.3.1 in the financial statements, which indicates the Trust incurred an adjusted deficit of £49.6 million in 2018/19. The Trust has submitted a financial plan for 2019/20 to NHS Improvement (NHSI) which delivers a £22.7 million deficit. This plan assumes receipt of non-recurrent funding of £27.7million (made up of provider sustainability funding of £8.3 million, financial recovery funding of £14.8 million and marginal rate emergency tariff funding of £4.6m), which is dependent on the Trust delivering its planned deficit. Directors are seeking £40.7 million for revenue, capital and loan support including cash support of £29.5 million from NHSI for 2019/20. NHSI has not, at the date of our report, confirmed that they will provide this support.

The Trust is due to make revenue loan repayments of £32.0m on 18 December 2019 and other loans of £29.4m expire on 20 January 2020. These loans will either need to be extended further, or the restructuring of all loans will need to be considered as part of the Trust's overall strategy. At the date of our report, no agreement has been reached with the Department of Health and Social Care in respect of these loans.

These events or conditions, along with the other matters as set out in note 1.3.1, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

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

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- We make a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 30 May 2017 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to West Hertfordshire Hospitals NHS Trust's planned breach of its break-even duty for the three year period ended 31 March 2019.

Responsibilities of the directors and those charged with governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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

The Audit Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

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

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's 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 2019.

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 relate 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 incurred an adjusted financial performance deficit of £49.6 million in 2018/19. This was less than the Trust's planned budget deficit of £52.9 million, primarily because contract penalties of £10 million were waived by Herts Valleys Clinical Commissioning Group.
- The Trust plans to incur a deficit of £22.7 million in 2019/20. This plan assumes receipt of non-recurrent funding of £27.7million (made up of provider sustainability funding of £8.3 million, financial recovery funding of £14.8 million and marginal rate emergency tariff funding of £4.6m), which is dependent on the Trust achieving its agreed financial plan on a quarterly basis.
- The Trust is heavily reliant on borrowing from the Department of Health and Social Care (DHSC). The Trust forecasts that it will require £40.7 million for revenue, capital and loan support including cash support of £29.5 million in 2019/20. NHSI has not, at the date of our report, confirmed that they will provide this support.
- The Trust is due to make revenue loan repayments of £32.0m on the 18 December 2019 and other loans of £29.41m expire on 20 January 2020. These loans will either need to be extended further, or the restructuring of all loans will need to be considered as part of the Trust's overall strategy. At the date of our report, no agreement has been reached with the Department of Health and Social Care in respect of these loans.

These matters 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(1)(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 2019, and to report by exception where we are not satisfied.

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.

Use of our report

This report is made solely to the Directors of the Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Trust's Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Ciaran McLaughlin, Director
For and on behalf of Grant Thornton UK LLP
30 Finsbury Square
London EC2A 1AG

23 May 2019

THE FINANCIAL STATEMENTS

Financial headlines

Earning sufficient income to the cover costs of treating the ever increasing demand for acute patient care is a significant challenge for all NHS acute Trusts. For a number of years the Trust has operated in deficit meaning that the Trust has had to borrow to meet day to day cash flow demands and to invest in replacing equipment and repairing ageing buildings.

While the size of the deficit increased following a series of risk assessments undertaken by the Board following publication of the Francis report¹ the Trust has managed to keep deficits relatively stable despite improvements in quality (including corrective actions recommended after CQC inspections), increased staffing and infrastructure costs and the creation of additional clinical capacity to accommodate increasing numbers of patients delayed in their transfer of care.

In 2017/18 the Trust reported adjusted retained deficit of £41.4m² (£45.1m after the exclusion of Sustainability and Transformation Funding). For the 2018/19 financial year, the Trust agreed Annual Plan with NHS Improvement was a planned deficit of £52.9m. This excluded any support from centrally held 'Provider Sustainability Fund' (PSF) as the Trust could not agree to the control total set by NHS Improvement deficit of £7.9m. PSF was only available to organisations which agreed to operate within the financial deficit set by NHS Improvement. The plan for 2018/19 included costs for anticipated financial penalties linked to clinical targets, if not achieved by the Trust.

The planned deficit partially relied on achieving savings worth £15.9m equivalent to 4.8% of turnover or 4.3% of costs. In order to achieve the control total of a £7.9m deficit, the Trust would have had to save £38.4m in the year, which the Board considered to be unrealistic. The Trust's longer term financial plan to return to viability models savings of 4% of turnover each year.

The Trust ended the 2018/19 year with a revenue deficit of £49.6m against the planned £52.9m deficit. The favourable performance was driven largely by financial sanctions linked to clinical performance not being levied. This benefit mitigated against significant increased pay costs compared to the previous year.

Income for the Trust saw an increase in 2018/19 of 2.6%. The income generated was £333.3m in comparison to £324.8m in 2017/18. The main increases by point of delivery were:

- A £2.2m increase in income received for attendances to our Accident and Emergency, minor injuries and Urgent Treatment centres. Attendances increased by 7% over the previous year.
- £107.4m of our income was linked to patients admitted for emergency (non-elective) care. This was £4.1m higher than 2017/18 levels despite a 0.2% overall decrease in activity. This was due to more complex and dependent patients being admitted.
- Elective and outpatient income increased by £4.8m to £121m driven by the need to keep pace with the increased referrals for elective care. Despite the increase, elective activity fell short of planned expectations.

In general, 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.

¹ <https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-Trust-public-inquiry>

² This is the deficit reported against the breakeven duty of the Trust and included £3.7m from provider sustainability fund.

The Trust derives most of its income from an activity-based contract with Herts Valleys Clinical Commissioning Group (HVCCG). Income is paid to the Trust mainly in line with activity numbers paid for at rates determined by a national tariff payment system. For 2019/20 similar reimbursement arrangements have been agreed with the CCG.

The Trust's income also included £3.4m paid directly by the Department for Health and Social Care (DHSC) to fund the late agreement of 'Agenda for Change' related pay rises in 2018/19.

The Trust's operating costs (excluding impairments) rose from £364.4m in 2017/18 to £380.2m in 2018/19. After excluding the costs of clinical negligence premium payments, Trust costs rose by 4.8% (from £346.8m in 2017/18 to £363.5 m in 2018/19). Staff costs increased by £11.6m, including pay awards of £3.0m and the costs of growth in service volume in the year.

The Trust continued to reduce its reliance on agency staff to reduce costs and improve quality. 2018/19 agency costs reduced by a further £3.5m to £14.9m, from 2017/18, and have now decreased by 59.0% since 2015/16. In order to support meeting our 2019/20 income and expenditure target, we expect to reduce reliance on agency staff even more 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 2018/19 at £16.1m (4.8% of revenue). This was an improvement from 2017/18 achieving £10.3m (3.2% of revenue) and also surpassed 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 2018/19, and did so in previous years, the Trust was unable to break even over a five year period, taking one year with another. The Trust is in breach of the Statutory Breakeven Duty over the permitted five year period.

As highlighted above, the deficit was supported by revenue loans from the Department of Health and Social Care of £54.7m³. These loans support payments for day to day running costs. Investment in new assets (capital expenditure) was supported by a capital loan of £4.2m⁴ and additional public dividend capital of £1.4m for winter pressure and cancer transformation capital projects.

The Trust spent £12.6m on new, refurbished and replacement capital assets including medical equipment.

The main areas of spending were:

- Over £2m on fire safety improvements throughout the Trust to ensure compliance with current Health & Safety standards
- £0.7m on general refurbishment of clinical areas throughout the Trust.
- £0.3m to develop plans to significantly improve theatres at Watford General Hospital.
- £1.4m to develop options, business plans and consultations for the complete redevelopment of the Trust's sites.
- Over £1m relocations between Watford at St Albans and improvements to support capacity for emergency services before winter.
- Over £3m spent to replace ageing medical equipment.

³ The revenue loans were in form of Uncommitted Single Currency Interim Revenue Support on monthly basis. This included £5.0m of working capital to improve on liquidity of the Trust and improve upon prompt payment to suppliers.

⁴ A capital loan of £13.7m was approved in 2017/18 of which £4.2m was drawn down in 2018/19 as agreed with NHSI. Remaining loan of £8.1m will be drawn down in 2019/20.

- £2.1m on the estates backlog maintenance programme.
- Over £2.0m of IT investment including investment in the network infrastructure, end user devices, other hardware and software to improve clinical productivity, safety and experience.

The Trust can record that it has operated within the original plan for net revenue and capital expenditure set at the start of the financial year, although this achievement was supported by not being subject to the scale of financial penalties anticipated when the plan was set.

The Trust will remain challenged coming out of 2018/19 by an underlying situation where recurrent costs are approximately £49m greater than anticipated recurrent income levels. However the financial regime for 2019/20 coupled with plans for further efficiencies has allowed the Trust to set a plan to reduce its deficit for 2019/20 to £22.7m, more than halving the deficit recorded for 2018/19.

This is a significant challenge for the Trust and will be an important step toward services being provided within the Hertfordshire and west Essex area in a consistently financially sustainable way.

The plan requires another significant investment in the estate (at least £25m for 2019/20) and will be supported by further borrowing to meet the revenue deficit and capital expenditure plans.

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 and Social Care. A key milestone in this area is December 2019⁵ and January 2020⁶, where loans taken out in 2015/16 and 2016/17 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 2016. 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 42. The contract with RSM has been extended to deliver the internal audit programme and counter fraud services for the year 2019/20.

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

⁵ DHSC has extended the repayment of £32m from December 2018 to December 2019.

⁶ Further deficit loans of £29.1m will need to be repaid in January 2020.

expense is shown separately in the annual accounts as “other auditor remuneration” (see note 7.2 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 page 25) 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 33 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 two related transactions involving a board member and a divisional director.

Better payment practice code

The Trust strives to pay its suppliers on time. Performance in achieving this is set out in note 36 of the accounts. Performance during 2018/19 was much improved in comparison to 2017/18. The improvement was possible due to the deficit loans received in year of £54.7m which supported the Trust in paying suppliers promptly and improving compliance with the Better Payment Practice Code (BPPC). The Trust actively engages with suppliers where issues may arise in order to put in place arrangements which are appropriate to both parties' needs. Much improvement to BPPC compliance was seen as from August 2018 where the average performance has increased to 82.4% to March 2019.

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.

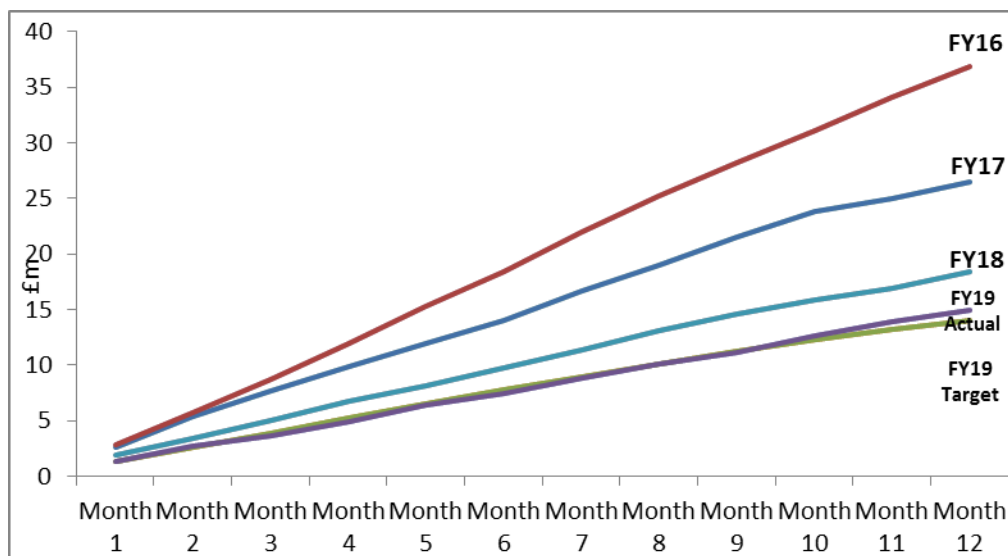
Income generation activities

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.

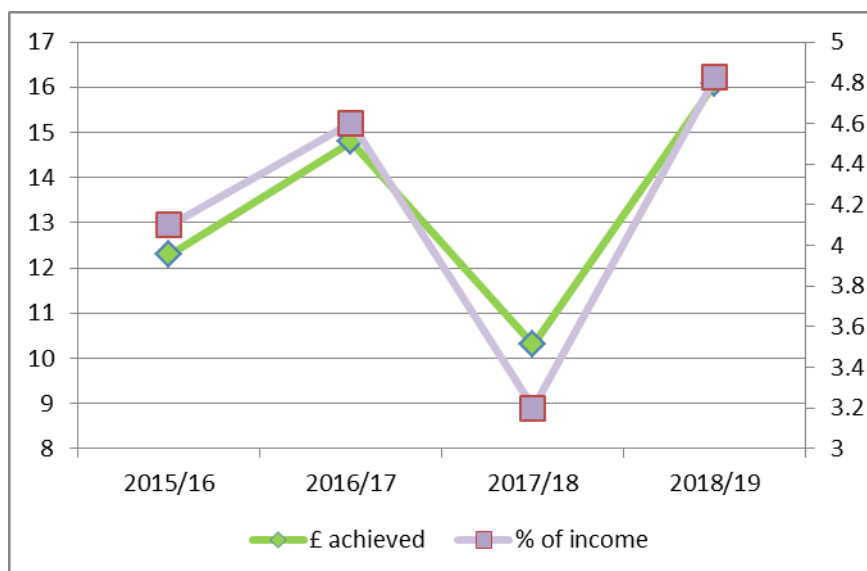
Pensions

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 pension's website at <https://www.nhsbsa.nhs.uk/nhs-pensions>. Further details can be found in note 10 of the accounts.

Agency expenditure for financial years 2015/16 – 2018/19



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



West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

Statement of Comprehensive Income

		2018/19	2017/18
	Note	£000	£000
Operating income from patient care activities	3	307,748	291,818
Other operating income	4	25,619	32,954
Operating expenses	7, 9	(381,024)	(364,253)
Operating Deficit from continuing operations		(47,657)	(39,481)
Finance income	12	69	24
Finance expenses	13	(2,850)	(1,823)
Net finance costs		(2,781)	(1,799)
Deficit for the year from continuing operations		(50,438)	(41,280)
Deficit for the year		(50,438)	(41,280)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17	27,436	7,468
Total comprehensive Expense for the period		(23,002)	(33,812)
Adjusted financial performance (control total basis):			
Deficit for the period		(50,438)	(41,280)
Remove net impairments not scoring to the Departmental expenditure limit		799	(165)
Remove I&E impact of capital grants and donations		(2)	93
CQUIN risk reserve adjustment (2017/18 only)		-	(1,282)
Adjusted financial performance Deficit		(49,641)	(42,634)

The adjusted retained deficit of £49,641,000 is after excluding impairments, the net of donated income and depreciation and the extra Commissioning for Quality & Innovation (CQUIN) income in 2017/18. The Trust financial performance is measured on the adjusted Breakeven duty deficit of £49,641,000 as described in note 39.

West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

Statement of Financial Position

		31 March 2019	31 March 2018
	Note	£000	£000
Non-current assets			
Intangible assets	15	3,314	3,292
Property, plant and equipment	16	182,562	151,724
Receivables	19	1,793	1,602
Total non-current assets		187,669	156,618
Current assets			
Inventories	18	4,451	5,427
Receivables	19	19,132	20,461
Cash and cash equivalents	20	2,858	3,578
Total current assets		26,441	29,466
Current liabilities			
Trade and other payables	21	(36,057)	(43,940)
Borrowings	24	(76,741)	(33,760)
Provisions	25	(617)	(523)
Other liabilities	23	(1,626)	(1,529)
Total current liabilities		(115,041)	(79,752)
Total assets less current liabilities		99,069	106,332
Non-current liabilities			
Borrowings	24	(119,552)	(104,636)
Provisions	25	(3,966)	(4,495)
Total non-current liabilities		(123,518)	(109,131)
Total assets employed		(24,449)	(2,799)
Financed by			
Public dividend capital		226,023	224,671
Revaluation reserve		52,532	25,096
Income and expenditure reserve		(303,004)	(252,566)
Total taxpayers' equity		(24,449)	(2,799)

West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	224,671	25,096	(252,566)	(2,799)
Deficit for the year	-	-	(50,438)	(50,438)
Revaluations	-	27,436	-	27,436
Public dividend capital received	1,352	-	-	1,352
Taxpayers' equity at 31 March 2019	226,023	52,532	(303,004)	(24,449)

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

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

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.

West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(47,657)	(39,481)
Non-cash income and expense:			
Depreciation and amortisation	7.1	8,406	7,490
Net impairments	8	799	(165)
Income recognised in respect of capital donations	4	(77)	(17)
Decrease in receivables and other assets		987	884
Decrease in inventories		976	(999)
Decrease in payables and other liabilities		(8,230)	(1,447)
Decrease in provisions		(447)	(68)
Net cash generated from / (used in) operating activities		(45,243)	(33,803)
Cash flows from investing activities			
Interest received		63	25
Purchase of intangible assets		(416)	(1,312)
Purchase of property, plant, equipment and investment property		(11,312)	(8,514)
Receipt of cash donations to purchase capital assets		77	17
Net cash generated from / (used in) investing activities		(11,588)	(9,784)
Cash flows from financing activities			
Public dividend capital received		1,352	1,595
Movement on loans from the Department of Health and Social Care		57,040	42,531
Interest on loans		(2,438)	(1,566)
PDC dividend (paid) / refunded		157	(18)
Net cash generated from / (used in) financing activities		56,111	42,542
Increase / (decrease) in cash and cash equivalents		(720)	(1,045)
Cash and cash equivalents at 1 April - brought forward		3,578	4,623
Cash and cash equivalents at 1 April - restated		3,578	4,623
Cash and cash equivalents at 31 March	20.1	2,858	3,578

West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

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 2018-19 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 £49.6m in 2018-19, and expectation of future financial support. The Trust has submitted a financial plan for 2019-20 to the NHS Improvement (NHSI) which delivers a £22.7m deficit for 2019-20 including non-recurrent funding support of £27.7m*. This includes a savings target planned for 4% which equates to £15.0m for 2019-20.

Directors are seeking cash support of £22.7m to fund the planned income and expenditure deficit and have submitted a request for £4.8m of additional funds to support the capital expenditure plan. NHSI has not, at the date of our report, confirmed that they will provide this support. Of the outstanding loans supporting the Trust deficit, revenue loans of £32.0m expire on the 18th December 2019 and other loans worth £29.4m expire on the 20th January 2020. These loans will either need to be extended further, or re-financed with the agreement of the Department of Health and Social Care. Uncommitted Single Currency Interim Revenue Support Facilities will be available when required with effect from 1 April 2019.

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 2018-19 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.

* Non-recurrent funding in 2019/20 includes:
Marginal Rate Emergency Tariff - £4.6m
Provider Sustainability Fund - £8.3m
Financial Recovery Fund - £14.8m

West Hertfordshire Hospitals NHS Trust – Annual Accounts 2018-19

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

1.3.1 Critical judgements in applying accounting policies (continued)

- 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.
There were certain conditions attached to these grants which have been fulfilled and a final liability of £2m which crystallises in 2016-17 has to be paid upon meeting investment criteria or annual instalments of £0.1m commencing from 18 June 2025 if investment criteria are not met.
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.
- 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 29.1
- 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 2018-19. Provision will form part of Agreement of Balance exercise; see note 23.2
- 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 2018-19, 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 incompleting 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 17. 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 2018-19. 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 2018-19, details of the impact of which can be found in note 17.
- No Provider Sustainability Fund (PSF) was allocated to the Trust by DHSC as it did not sign up to the control total deficit in 2018/19 of £7.9m. PSF was available to Trusts that signed up in the Annual Plan to the control total deficit. In 2017/18 the Trust received Sustainability and Transformation Funding as detailed in note 6.1.

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

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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 41.

1.5. Revenue

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Generally revenue from contracts will be payable within 30 days upon satisfaction of performance obligation. All non NHS contract balances over 90 days old are 100% provided for as bad debt. NHS contract balances as per the GAM are not provided for bad debts.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

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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 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.

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

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.

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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 Avison Young (formerly known as 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 17.

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.

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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 17.

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 17.

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 25.2.

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 and subsequently measured at amortised cost.

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 and subsequently measured at amortised cost.

1.22.1 Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

1.22.2 Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

NHS financial assets are not impaired with expected losses as per the GAM only non NHS contract receivables are impaired as explained in note 1.5

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

1.22.3 Derecognition

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

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

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 Trust 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 20.2 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 2018-19. These standards are still subject to HM Treasury FReM interpretation, and the government implementation date for IFRS 16 is still subject to HM Treasury consideration.

- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 April 2020, 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 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 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

Note 3.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Elective income	52,719	49,688
Non elective income	107,422	103,953
First outpatient income	36,634	37,880
Follow up outpatient income	31,692	28,626
A & E income	17,645	15,812
High cost drugs income from commissioners (excluding pass-through costs)	11,542	11,514
Other NHS clinical income	43,161	42,733
Private patient income	763	683
Agenda for Change pay award central funding	3,408	-
Other clinical income	2,762	929
Total income from activities	307,748	291,818

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	22,258	21,317
Clinical commissioning groups	278,196	268,242
Department of Health and Social Care	3,408	-
Other NHS providers	361	646
NHS other	197	-
Non-NHS: private patients	763	303
Non-NHS: overseas patients (chargeable to patient)	544	380
Injury cost recovery scheme	1,098	929
Non NHS: other	923	1
Total income from activities	307,748	291,818
Of which:		
Related to continuing operations	307,748	291,818

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

	2018/19	2017/18
	£000	£000
Income recognised this year	544	380
Cash payments received in-year	153	158
Amounts added to provision for impairment of receivables	383	332
Amounts written off in-year	80	25

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Education and training (excluding notional apprenticeship levy income)	10,014	9,124
Non-patient care services to other bodies	12,887	16,704
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	3,688
Other contract income	2,487	2,498
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	128	794
Receipt of capital grants and donations	77	17
Charitable and other contributions to expenditure	26	129
Total other operating income	25,619	32,954
Of which:		
Related to continuing operations	25,619	32,954

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

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.

	2018/19	2017/18
	£000	£000
Income	2,128	2,157
Full cost	(1,811)	(1,410)
Surplus	317	747

Note 6.1 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 no funding from Provider Sustainability Fund (PSF) in 2018/19 as it had not agreed to the control total deficit of £7.9m. To fund the Agenda for Change pay rises a funding of £3.4m was received in 2018/19.

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.

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 7.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies - see i) below	5,377	4,109
Purchase of healthcare from non-NHS and non-DHSC bodies - see ii) below	4,314	5,038
Purchase of social care	94	-
Staff and executive directors costs	246,608	235,036
Remuneration of non-executive directors	77	77
Supplies and services - clinical (excluding drugs costs)	31,168	28,562
Supplies and services - general	13,939	12,360
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,896	22,513
Consultancy costs - see iii) below	1,110	1,122
Establishment	3,854	4,068
Premises	17,505	16,438
Transport (including patient travel)	522	547
Depreciation on property, plant and equipment	8,012	7,446
Amortisation on intangible assets	394	44
Net impairments - see iv) below	799	(165)
Movement in credit loss allowance: contract receivables / contract assets - see below v)	265	-
Movement in credit loss allowance: all other receivables and investments	-	640
Change in provisions discount rate(s)	(35)	422
Audit fees payable to the external auditor		
audit services- statutory audit	49	49
other auditor remuneration (external auditor only) - see vi) below	7	7
Internal audit costs	142	141
Clinical negligence - see vii) below	16,687	17,623
Legal fees	123	101
Insurance	190	202
Education and training	1,172	1,676

Rentals under operating leases	532	536
Redundancy - see viii) below	296	8
Hospitality	26	-
Losses, ex gratia & special payments	46	28
Other - see ix) below	4,855	5,625
Total	381,024	364,253

Of which:

Related to continuing operations	381,024	364,253
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 both 2017/18 and 2018/19.
- iv) The Trust's revaluation of its land and buildings in 2018-19 has generated impairments. See notes 17 and 1.3.2 for further details. In 2017-18 there was a reversal of impairment.
- v) Increase in Non NHS bad debt provision now shown in this line under IFRS 15.
- 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) Redundancies in 2018/19 is disclosed separately and it includes cost of redundancies made in year due to outsourcing of payroll services to Northumbria Healthcare NHS Foundation Trust. Further analysis of exit packages is in the Annual Report on page xx.

ix)	Other expenditure includes the following services:
•	£492,000 for security
•	£392,000 for external accommodation
•	£326,000 for contract management
•	£412,000 subscriptions
•	£584,000 for waste disposal
Other expenditure in 2017/18 have been re-categorised to be shown in different measurement categories in 2018/19.	

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
8. Other non-audit services	7	7
Total	7	7

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).

Note 8 Impairment of assets

2018/19 £000	2017/18 £000
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Net impairments charged to operating surplus / deficit resulting from:

Changes in market price	799	(165)
Total net impairments charged to operating surplus / deficit	799	(165)
Impairments charged to the revaluation reserve	-	-
Total net impairments	799	(165)

2018-19 impairments relates to buildings at the Trust. No impairment on intangible assets in 2018-19 is incurred. The analysis by site of the impairment on property, plant and equipment is shown in note 17.

Note 9 Employee benefits

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	165,354	156,016
Social security costs	18,206	16,966
Apprenticeship levy	845	862
Employer's contributions to NHS pensions	20,447	19,140
Pension cost - other	19	7
Temporary staff (including agency)	42,033	42,045
Total gross staff costs	246,904	235,036
Recoveries in respect of seconded staff	-	-
Total staff costs	246,904	235,036

Note 9.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £224k (£124k in 2017/18).

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 2018-19 was 4,951 of which 4,286 were permanently employed. This compares to 4,800 total average number of staff employed in 2017-18. 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 7.16 working days were lost per staff member in 2018/19 in comparison to 7.3 in 2017/18. Further details on staff sickness are reported in the remuneration and staff section of the annual report.

Note 9.4 Exit Packages agreed in 2018-19

The total number of exit packages agreed in 2018-19 was 22 compared to 29 for 2017-18. 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 2018-19

The total number of other departures in exit packages agreed in 2018-19 was 19 compared to 28 for 2017-18. 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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

This note discloses income generated in operating lease agreements where West Hertfordshire Hospitals NHS Trust is the lessor.

The Trust has no operating lease agreements as a lessor.

Note 11.2 West Hertfordshire Hospitals NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where West Hertfordshire Hospitals NHS Trust is the lessee.

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, early on payment of amounts are determined by the Lessor and
- The equipment when returned is complete and in reasonable condition.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	532	536

Total	532	536
	2018/19	2017/18
	£000	£000
Future minimum lease payments due:		
- not later than one year;	456	516
- later than one year and not later than five years;	731	1,070
- later than five years.	1	8
Total	1,188	1,594

Note 12 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	69	24
Total finance income	69	24

Note 13.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,905	1,731
Interest on late payment of commercial debt	(67)	32
Total interest expense	2,838	1,763
Unwinding of discount on provisions	12	60
Total finance costs	2,850	1,823

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

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	(67)	32

The Trust successfully negotiated in 2018/19 refund of interest charged on late payment of invoices in previous years.

Note 14 Other gains / (losses)

There are no gains or losses on disposals in 2018/19 or 2017/18

Note 15.1 Intangible assets - 2018/19

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2018 - brought forward	1,148	7,051	1,421	564	10,184
Additions	-	-	-	416	416
Valuation / gross cost at 31 March 2019	1,148	7,051	1,421	980	10,600
Amortisation at 1 April 2018 - brought forward	-	6,892	-	-	6,892
Provided during the year	383	11	-	-	394
Amortisation at 31 March 2019	383	6,903	-	-	7,286
Net book value at 31 March 2019	765	148	1,421	980	3,314
Net book value at 1 April 2018	1,148	159	1,421	564	3,292

Note 15.2 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	-	7,051	1,421	400	8,872
Prior period adjustments	-	-	-	-	-
Valuation / gross cost at 1 April 2017 - restated	-	7,051	1,421	400	8,872
Additions	1,148	-	-	164	1,312
Valuation / gross cost at 31 March 2018	1,148	7,051	1,421	564	10,184
Amortisation at 1 April 2017 - as previously stated	-	6,848	-	-	6,848

Amortisation at 1 April 2017 - restated	-	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

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

There are £3.6m 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 - 2018/19

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	42,168	83,457	182	17,898	44,217	176	15,023	2,586	205,707
Additions	-	-	-	12,213	-	-	-	-	12,213
Impairments	-	(8,706)	-	-	-	-	-	-	(8,706)
Reversals of impairments	-	3,413	-	-	-	-	-	-	3,413
Revaluations*	20,639	7,791	(104)	-	-	-	-	(890)	27,436
Reclassifications	-	8,126	58	(11,970)	2,535	-	73	1,178	-
Disposals / derecognition	-	-	-	-	(1,739)	-	(147)	-	(1,886)
Valuation/gross cost at 31 March 2019	62,807	94,081	136	18,141	45,013	176	14,949	2,874	238,177

Accumulated depreciation at 1 April 2018

- brought forward	-	6,900	30	-	33,767	176	12,757	353	53,983
Provided during the year	-	5,070	27	-	2,215	-	553	147	8,012
Impairments	-	(4,334)	(30)	-	-	-	-	(130)	(4,494)
Disposals / derecognition	-	-	-	-	(1,739)	-	(147)	-	(1,886)
Accumulated depreciation at 31 March 2019	-	7,636	27	-	34,243	176	13,163	370	55,615

Net book value at 31 March 2019	62,807	86,445	109	18,141	10,770	-	1,786	2,504	182,562
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Net book value at 1 April 2018	42,168	76,557	152	17,898	10,450	-	2,266	2,233	151,724
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Note 16.2 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 - as previously stated	35,132	78,710	197	21,114	41,843	176	12,735	2,446	192,353
Valuation / gross cost at 1 April 2017 - restated	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 - as previously stated	-	6,192	28	-	31,520	176	12,335	339	50,590
Accumulated depreciation at 1 April 2017 - restated	-	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
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*** Note**
Revaluation of land is based on alternative site basis as from 2016/17. The increase in land valuation of £20.6m is due to current market prices. See further details on valuation in note 17.

Note 16.3 Property, plant and equipment financing - 2018/19

	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
Net book value at 31 March 2019									
Owned - purchased	62,807	86,445	109	17,832	10,770	-	1,786	2,504	182,253
Owned - donated	-	-	-	309	-	-	-	-	309
NBV total at 31 March 2019	62,807	86,445	109	18,141	10,770	-	1,786	2,504	182,562

Note 16.4 Property, plant and equipment financing - 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
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 17 Revaluations of property, plant and equipment

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 Avison Young (formerly known as 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 2018-19 a full valuation has been carried out by Avison Young (formerly known as 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 2018-19 which has given a rise to an increase in valuation by £20.6m.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2018-19			
	£000s	£000s	£000s	£000s
<u>Operating expenses - note 7</u>				
Land - MEA (alternative site valuation)	0	0	0	0
Buildings, dwellings and fittings - MEA	2,411	(804)	(808)	799
Total	2,411	(804)	(808)	799
<u>Statement of change in taxpayers equity</u>				
Land - MEA (alternative site valuation)	(10,123)	(5,535)	(4,981)	(20,639)

Buildings, dwellings and fittings - MEA	(694)	(5,957)	(146)	(6,797)
	(10,817)	(11,492)	(5,127)	(27,436)
Total impairment/(reversal) 2018-19	(8,406)	(12,296)	(5,935)	(26,637)

2017-18

	£000s	£000s	£000s	£000s
<u>Operating expenses - note 7</u>				
Land - MEA	0	0	(1,172)	(1,172)
Buildings, dwellings and fittings - MEA	2,144	(489)	(648)	1,007
Total	2,144	(489)	(1,820)	(165)
<u>Statement of change in taxpayers equity</u>				
Land - MEA	(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)

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 1.10 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 £39.9m of fully depreciated assets.

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

<u>Asset Class</u>	<u>As at 31 March 2019</u>		<u>As at 31 March 2018</u>	
	Maximum remaining asset life	Minimum remaining asset life	Maximum remaining asset life	Minimum remaining asset life
	Years	Years	Years	Years
Buildings	44	1	37	2
Dwellings	4	4	5	5
Plant and machinery	10	1	9	1
Transport	1	1	1	1
Information Technology	7	2	4	1
Furniture and Fittings	44	1	37	2

The full valuation exercise included revision to the remaining asset lives of some buildings and their fittings, consequently the maximum remaining lives between 31 March 19 and 31 March 18 do not necessarily reduce by one year. Cherry Tree House is the only dwelling in both 2018-19 and 2017-18.

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

The Trust provides accommodation 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 18 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,134	1,273
Consumables	3,210	4,053
Energy	107	101
Total inventories	4,451	5,427
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £30,024K (2017/2018 : £37,614K). Write down of inventories recognised as expenses for the year were £0 (2017/2018 : £0)

Note 19.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	17,779	-
Trade receivables*	-	14,982
Accrued income*	-	3,976
Allowance for impaired contract receivables / assets*	(2,475)	-
Allowance for other impaired receivables	-	(2,340)
Prepayments (non-PFI)	2,659	1,391
Interest receivable	6	-
PDC dividend receivable	-	157
VAT receivable	1,163	1,686
Other receivables	-	609
Total current trade and other receivables	19,132	20,461
Non-current		
Contract receivables*	1,793	-
Other Receivables	-	1,602
Total non-current trade and other receivables	1,793	1,602

Of which receivables from NHS and DHSC group bodies:

Current	13,719	14,928
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 19.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		2,340
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	2,340	(2,340)
New allowances arising	265	-
Utilisation of allowances (write offs)	(130)	-
Allowances as at 31 Mar 2019	2,475	-

Allowances for credit losses is for Non NHS, over 90 days and all classified under contract receivables and contract assets.

Note 19.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	1,742
Allowances as at 1 Apr 2017 - restated	1,742
Increase in provision	640
Amounts utilised	(42)
Allowances as at 31 Mar 2018	2,340

Note 19.4 Exposure to credit risk

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 20.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	3,578	4,623
At 1 April (restated)	3,578	4,623
Net change in year	(720)	(1,045)
At 31 March	2,858	3,578
Broken down into:		
Cash at commercial banks and in hand	48	32
Cash with the Government Banking Service	2,810	3,546
Total cash and cash equivalents as in SoFP	2,858	3,578

Total cash and cash equivalents as in SoCF

2,858

3,578

Note 20.2 Third party assets held by the trust

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

	31 March 2019 £000	31 March 2018 £000
Bank balances	-	-
Monies on deposit	-	3
Total third party assets	-	3

Note 21.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	11,747	18,422
Capital payables	4,542	3,641
Accruals	11,918	16,666
Social security costs	2,624	2,455
Other taxes payable	2,297	2,204
Accrued interest on loans*	-	457
Other payables	2,929	95
Total current trade and other payables	36,057	43,940
Non-current		
Total non-current trade and other payables	-	-
Of which payables from NHS and DHSC group bodies:		
Current	4,136	7,169
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 21.2 Early retirements in NHS payables above

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

Note 22 Other financial liabilities

The Trust has no other payables or financial liabilities.

Note 23 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,626	1,529
Total other current liabilities	1,626	1,529
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 24 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	76,741	33,760
Total current borrowings	76,741	33,760
Non-current		
Loans from the Department of Health and Social Care	117,552	102,636
Other loans	2,000	2,000
Total non-current borrowings	119,552	104,636

The borrowings relate to Department of Health 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 2019 is £8.1m.

£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 2019. Interest is at a rate of 1.5% payable twice-yearly. This will be renegotiated to extend the repayment date.

£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. This will be renegotiated to extend the repayment date.

£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 2019 is £6.0m.

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 from the date of inception. Many loans due within 12 months will be renegotiated to extend the repayment date.

The Trust accessed from April 2018 to May 2018 a total of £10.0m, 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 accessed from June 2018 to March 2019 a total of £44.7m, 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 3.5% 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 and further £4.1m in 2018-19. 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 2019 is £5.5m.

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 Wiggenshall 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 24.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2018	136,396	2,000	138,396
Cash movements:			
Financing cash flows - payments and receipts of principal	57,040	-	57,040
Financing cash flows - payments of interest	(2,438)	-	(2,438)
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	457	-	457
Application of effective interest rate	2,838	-	2,838
Carrying value at 31 March 2019	194,293	2,000	196,293

Comparative disclosure note is not required for this note under IAS 7 para 60.

Note 25 West Hertfordshire Hospitals NHS Trust as a lessor or as a lessee

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

Note 25.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits* £000	Other £000	Total £000
At 1 April 2018	4,720	228	70	5,018
Change in the discount rate	(35)	-	-	(35)
Arising during the year	80	-	94	174
Utilised during the year	(489)	(25)	(30)	(544)
Reversed unused	-	-	(42)	(42)
Unwinding of discount	11	1	-	12
At 31 March 2019	4,287	204	92	4,583
Expected timing of cash flows:				
- not later than one year;	501	24	92	617
- later than one year and not later than five years;	1,944	99	-	2,043
- later than five years.	1,842	81	-	1,923
Total	4,287	204	92	4,583

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

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 25.2 Clinical negligence liabilities

At 31 March 2019, £437,959k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Hertfordshire Hospitals NHS Trust (31 March 2018: £344,362k).

Note 26 Contingent assets and liabilities

The Trust has no contingent assets and liabilities.

Note 27 Contractual capital commitments

	31 March 2019 £000
Property, plant and equipment	642
Intangible assets	95
Total	737

Note 28 Other financial commitments

The Trust has no other financial commitments.

Note 29 Financial instruments**Note 29.1 Financial risk management**

Financial reporting standard IFRS 9 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note 19.1.

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 loans over the years to cover for the deficit and capital loan repayments. The Trust has also used loan finance of £4.1m in 2018-19 (£1.4m in 2017-18) approved by the Department of Health and Social Care to fund capital projects. In the year 2018-19 the Trust had access to Uncommitted Single Currency Interim Revenue and Support Facility.

Note 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	17,078	-	-	17,078
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	2,858	-	-	2,858
Total at 31 March 2019	19,936	-	-	19,936

	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available- for-sale £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39					
Trade and other receivables excluding non financial assets	17,933	-	-	-	17,933
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	3,578	-	-	-	3,578
Total at 31 March 2018	21,511	-	-	-	21,511

Note 29.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9

Loans from the Department of Health and Social Care	194,293	-	194,293
Other borrowings	2,000	-	2,000
Trade and other payables excluding non financial liabilities	31,109	-	31,109
Total at 31 March 2019	227,402	-	227,402

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	136,396	-	136,396
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	2,000	-	2,000
Trade and other payables excluding non financial liabilities	39,123	-	39,123
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	177,519	-	177,519

Note 29.4 Fair values of financial assets and liabilities

After initial recognition at cost, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Note 29.5 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	107,850	72,884
In more than one year but not more than two years	48,026	43,272
In more than two years but not more than five years	57,071	41,119
In more than five years	14,455	20,244
Total	227,402	177,519

Note 30 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	2	13	-	-
Bad debts and claims abandoned	50	130	64	29
Total losses	52	143	64	29
Special payments				
Ex-gratia payments	52	33	36	27
Total special payments	52	33	36	27
Total losses and special payments	104	176	100	56
Compensation payments received		-		-
No single item over £300,000				

Note 31 Gifts

No gifts were made in the year.

Note 32.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £457k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,602k.

Hertfordshire NHS Procurement is hosted by the Trust, it provides procurement services to 6 NHS organisations in the locality. Under IFRS 15 and the GAM the Trust will disclose net expenditure for the Trust under net accounting as from 1 April 2018. Previous year comparator will not be re-instated. The Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any comparators.

Note 32.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33 Related parties

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

The Department of Health 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 where over £0.5m are:

	Payments to related party	Receipts from related party	Amounts owed to related party	Amounts due from related party
2018-19	£000	£000	£000	£000
Spire Healthcare Ltd - see i) below	312	0	518	0
BMI Healthcare - see note ii) below	291	0	0	0
Gate One Limited - see iii) below	148	0	0	0
<u>Department of Health and Social Care</u>	4,267	63,560	194,293	0
<u>Foundation Trusts</u>				
Chelsea and Westminster NHS Foundation Trust	51	2,857	9	492
Hertfordshire Partnership NHSFT	858	1,237	205	193
<u>Trusts</u>				
Central London Community Healthcare NHST	73	1,005	17	444
Barts Health NHS Trust	0	857	0	45
East & North Hertfordshire NHS Trust	660	1,310	877	589
Hertfordshire Community NHS Trust	3,652	2,056	909	690
Imperial College NHS Trust	312	480	275	330
St Helens & Knowsley NHST	1,041	10	176	0
<u>Clinical Commissioning Groups (CCG)</u>				
Barnet CCG	0	1,162	6	673

Bedfordshire CCG	0	1,145	2	167
Brent CCG	0	480	4	86
Buckingham CCG	0	1,320	5	186
East and North Hertfordshire CCG	23	2,972	6	305
Harrow CCG	0	3,538	39	380
Herts Valley CCG	61	257,904	1,038	5,589
Hillingdon CCG	0	4,682	41	52
Luton CCG	0	1,020	1	22
<u>NHS England</u>				
NHS England Core	0	16,242	1	531
Central Midlands Local Office	1	5,975	184	0
East Local Office	0	334	0	5
NHS England - Central Specialised Commissioning Hub	0	196	0	0
<u>Special Health Authorities</u>				
Health Education England	5	9,437	1	279
NHS Litigation Authority	16,869	0	0	0
NHS Blood & Transplant	1,442	0	10	15
2018-19	30,066	379,779	198,617	11,073
2017-18	31,117	359,652	142,363	10,646

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

<u>authorities :</u>				
2018-19				
HM Revenue and Customs	57,308	12,331	4,921	1,163
NHS Pension Scheme	34,352	0	2,929	0
NHS Professionals	38,240	0	1,612	0
Department of Work and Pensions	0	875	1,612	0
Watford Borough Council	969	0	2,001	0
2018-19	130,869	13,206	13,075	1,163
2017-18	118,631	9,504	15,865	1,685

Note i) Michael Van Der Watt, the Medical Director / Director Of Patient Safety, sees his private patients at Spire Healthcare Ltd.

Note ii) Anthony Divers, Divisional Director, sees his private patients at Spire Healthcare Ltd and at BMI Healthcare.

Note iii) Nick Kennell, is a Director of Gate One Limited

Note 34 West Hertfordshire Hospitals NHS Trust Charity Activities

(Unaudited)	2018-19	2017-18
	£000s	£000s
Income	320	366
Expenditure	(430)	(342)
Net Incoming/Outgoing Resources Before Transfers	(110)	24
Gains/(losses) on Revaluation and Disposals of Investment Assets	18	(11)
Funds b/fwd	1,041	1,028
Funds c/fwd - Net Assets	949	1,041

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

Note 35 Events after the reporting date

There are no material events after the reporting date.

Note 36 Better Payment Practice code

	2018/19	2018/19	2017/18	2017/18
	Number	£000	Number	£000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	64,913	145,312	56,441	148,335
Total non-NHS trade invoices paid within target	<u>43,080</u>	<u>86,112</u>	<u>11,638</u>	<u>28,305</u>
Percentage of non-NHS trade invoices paid within target	<u>66.4%</u>	<u>59.3%</u>	<u>20.6%</u>	<u>19.1%</u>
NHS Payables				
Total NHS trade invoices paid in the year	2,466	11,887	2,491	7,942
Total NHS trade invoices paid within target	<u>1,060</u>	<u>3,906</u>	<u>360</u>	<u>2,281</u>
Percentage of NHS trade invoices paid within target	<u>43.0%</u>	<u>32.9%</u>	<u>14.5%</u>	<u>28.7%</u>

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 37 External financing

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

	2018/19	2017/18
	£000	£000
Cash flow financing	<u>59,112</u>	<u>45,171</u>
External financing requirement	<u>59,112</u>	<u>45,171</u>
External financing limit (EFL)	<u>59,370</u>	<u>48,237</u>
Under spend against EFL	<u>258</u>	<u>3,066</u>

Note 38 Capital Resource Limit

	2018/19	2017/18
	£000	£000
Gross capital expenditure	12,629	11,086
Less: Donated and granted capital additions	(77)	(17)
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	12,552	11,069
Capital Resource Limit	12,552	11,106
Under / (over) spend against CRL	-	37

Note 39 Breakeven duty financial performance

	2018/19
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(49,641)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	(49,641)

Note 40 Breakeven duty rolling assessment

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£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)	(49,641)
Breakeven duty cumulative position	1,186	8,716	12,373	14,277	907	(12,930)	(54,085)	(83,516)	(124,868)	(174,509)
Operating income	254,308	260,398	266,716	278,230	291,119	313,291	299,769	322,643	324,772	333,367
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%)	(52.35%)

i) The adjusted deficit for break-even duty in the year is after adjustments shown in note 46.

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 fifth year of consecutive break-even duty breach achieving a cumulative deficit of £174,509,000 (-52.35% 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.