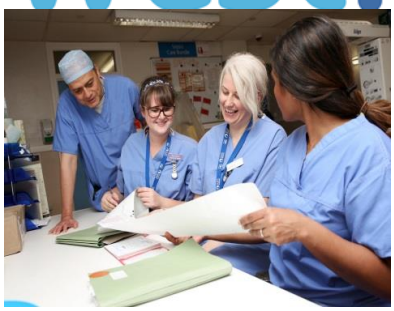
OUR VISION: *the very best care for every patient, every day*

NHS
West Hertfordshire Hospitals
NHS Trust

ANNUAL REPORT 2019/20

team westHerts



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PERFORMANCE REPORT

Overview from Phil Townsend, Chairman and Christine Allen, Chief Executive

Welcome to our 2019/2020 annual report which looks back at another period of significant and sustained improvement.

At the time of writing (May 2020), COVID-19 continues to dominate the news and our work. However, we should remind ourselves of brighter times and especially our many awards as well as the joy of collaborating with choirmaster Gareth Malone and the BBC for the uplifting Christmas broadcast featuring a choir comprised of our staff and patients.

It has been a year of highs and lows – the deepest being the loss of valued colleagues to COVID-19.

In previous reports we have given an overview of a whole 12 months, but the onset of COVID-19 brought a dramatic end to the financial year.

Whilst we are immensely proud of our response to this pandemic (see page 11 for more details), this is measured by disappointment at not seeing our hard work against activity and financial targets reflected in year-end results.

Before we shifted our focus to caring for COVID-19 patients, we were celebrating the fact that we received the accolade of being the most improved trust in England for A&E waiting times, according to the House of Commons February Briefing Paper on NHS Key Statistics.

We responded well to increased demand in our emergency department (ED) despite a 12% increase in attendance, we admitted 15% fewer patients compared to the same period in the previous year. We are one of only four acute trusts in England whose ED performance improved.

We also made great progress on eliminating our longest waits. Having made great progress on 52-week waits in 2018/19 (down from a peak of 123 in Oct 2018 to four in March 2019), we greatly reduced 40-week waits. On 1 April 2019 there were 321 patients waiting for 40 weeks, this had reduced to 171 by 29 February 2020, before the COVID-19 outbreak. We have consistently met the target for cancer two week wait referrals since September 2019.

The NHS set the trust a target to end the year, ensuring that the deficit of revenue costs over income did not exceed £22.7m. This target is referred to as the Trust's 'Control Total'. We met the Control Total with the contribution from excellent work in achieving a savings target of £15.1million.

During this year the Care Quality Commission (CQC) inspected urgent and emergency care, medical care (including older people), and surgery at Watford hospital. The minor injuries unit at St Albans hospital and the urgent treatment centre at Hemel Hempstead hospital were also inspected. And there was a review of our leadership, under the CQC's 'well led' regime. More details on the outcome of this inspection can be found on page 13.

Our plans for making significant improvements to our estate advanced when we identified our preferred way forward for redeveloping our hospitals. Our chosen option, which was endorsed by our main commissioners Herts Valleys Clinical Commissioning Group (HVCCG), is to transform the site at Watford hospital with several new buildings and a reconfigured site layout. This option also includes investment at our hospitals in Hemel Hempstead and St Albans. These plans were given a huge boost when the Prime Minister visited in September and pledged £400m for our redevelopment plans.

At the time of writing we are developing our outline business case (OBC) which will provide greater detail on our plans. The OBC follows government guidelines and as such should include a long list to ensure that we have taken full account of any new opportunities on potential alternative sites and any changes to the provision of local health services. We will also review the latest population forecasts in order to make sure that our plans match the needs of the communities we serve.

Before the outbreak of COVID-19, our integrated care partnership (ICP) work was well underway with good engagement. Although the crisis has forced us to delay some aspects, we are seeing great changes which are both driven by necessity and consistent with our ICP integrated care agenda.

At a local level, ICPs are being developed; three are geographical – west Hertfordshire, east & north Hertfordshire, and west Essex, and one is specialist, the Hertfordshire-wide integrated care partnership for people with complex mental health needs. In an ICP model we will share responsibility with partners for preventing ill health, enabling earlier diagnosis and treatment and ensuring care is joined up. The way we are funded is changing to reflect this, with a move towards 'fixed' or 'population' budgets. Our clinicians will play a key role in this and their leadership and contribution to decision-making and service improvement continues to enrich the care that we provide. We look forward to the benefits that this work will bring our patients.

Collaboration is at the core of our 2020 – 25 strategy, which was created with input from our partners. Despite the huge impact of COVID-19, we remain committed to our four key strategic aims; best care, best value, great team and great place. (More about our strategy can be found on page 5).

In closing, we would like to thank the much-enlarged 'TeamWestHerts'. We normally use this term to describe our staff but during this year, our team has grown to include hundreds of additional volunteers, local businesses and generous individuals. The Harry Potter bus, Spire Bushey and Sanctuary (our wellbeing centre for staff at Watford Football Club) are the most visible but there have been countless other acts of kindness that have buoyed us up during some dark days.

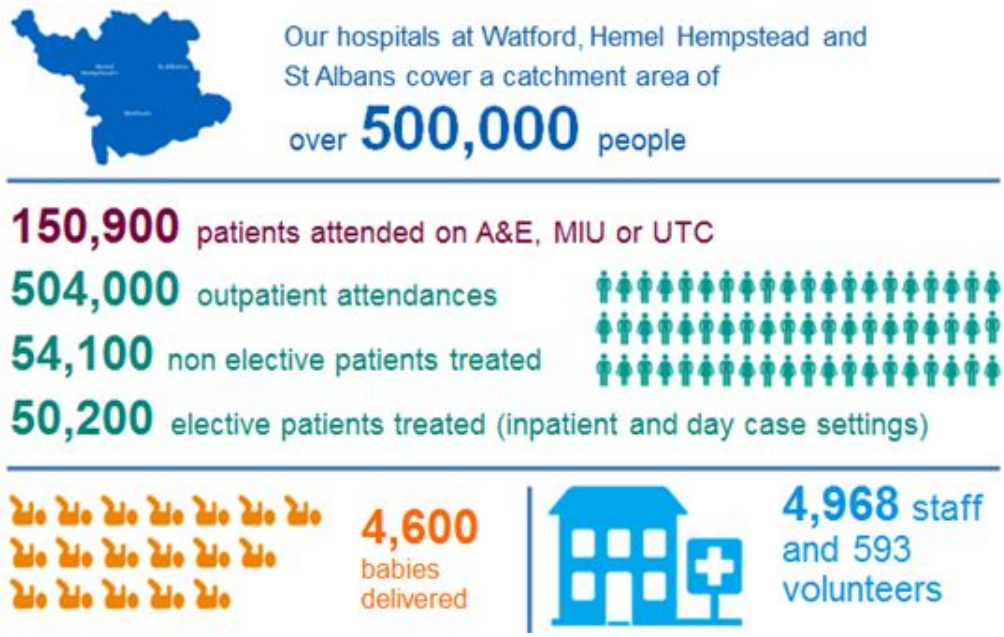
We don't, as a rule, single out a particular staff group for special thanks but 2019/20 has been incredibly demanding for our staff on the 'frontline'. We all owe them a debt of gratitude for their compassion and for their courage.

Phil Townsend
Chairman

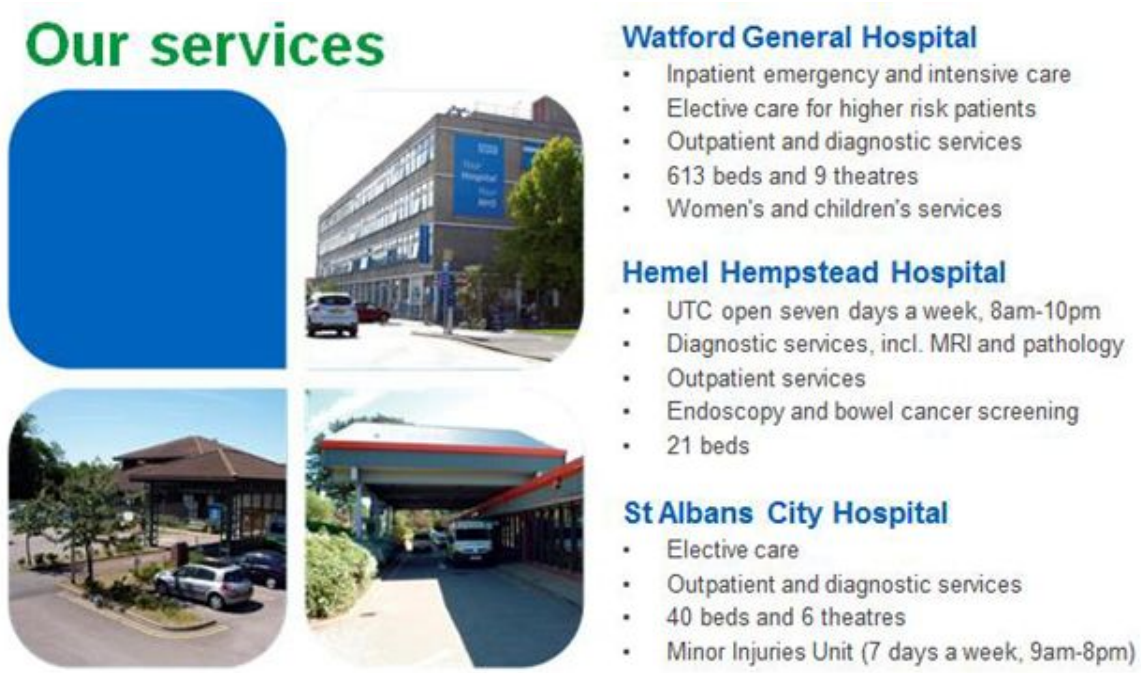
Christine Allen

Our purpose, strategy and objectives and risks

This section of the report provides a summary of what the Trust set out to do in 2019/20 and the progress it made in achieving this.



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 England/NHS Improvement (NHSI/E), Herts Valleys Clinical Commissioning Group (HVCCG), Department of Health and Social Care (DHSC), 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.



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 those aims. 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 committees.

In 2019/20, the four key aims to support the delivery of the Trust's vision are:

- To deliver the best quality care for patients
- A great place to work and learn
- To improve our finances
- A strategy for the future

The aims are underpinned by a set of twelve objectives and the table below demonstrates the progress made towards achieving the objectives over the past year. Delivery of the objectives have however been hampered by the COVID-19 pandemic at the latter end of the reporting year.

Performance against Trust objectives 2019/20	
Objective	**Evidence**
AIM ONE: TO DELIVER THE BEST QUALITY CARE FOR OUR PATIENTS	
To deliver excellent clinical outcomes for our patients	▪ Sustained expected or better than expected summary hospital-level mortality indicator (SHMI) and hospital standardised mortality ratios (HSMR) since April 2018. ▪ Achieved top quartile performance for harm free care.
To implement best practice, integrated care pathways and reduce unwarranted clinical variation in care and outcomes.	▪ Good progress made on implementing a care pathway group model with active work on eight pathways underway. ▪ Worked closely with HVCCG and partners to implement a range of new integrated care pathways with a number of other pathways in the planning stages. ▪ Some progress has been made in optimising St Albans City Hospital for planned care, including the centralisation of pre-operative assessment clinics. ▪ The urgent treatment centre at Hemel Hempstead Hospital has been 'upgraded' in line with the national specification. ▪ A new paediatric assessment unit at Watford Hospital has been established following a pilot earlier in the year.
To implement and embed our 'quality commitment' and 'west Herts way' quality improvement (QI) methodology	▪ Good progress has been made following the appointment of a QI lead nurse and two improvement leads. ▪ A baseline assessment has been undertaken, a strategy developed and the first cohorts of staff are completing newly commissioned QI training. ▪ 21 out of 27 adult inpatient wards have been accredited at silver or gold level. A programme is in place for all wards to be accredited by June 2020.
To improve our emergency care pathway and discharge processes	▪ Undertaken a major re-organisation and remapping of the emergency process and triage, as well as the SMART programme, supporting a reduction in

	conversion to admission and length of stay. ▪ Delivered an improvement in performance against the four hour standard in 2019 but below the national standard of 95%. ▪ Against the backdrop of increasing demand, achieved the biggest improvement in four hour waits in England in the three month period to January 2020. This pushed the Trust's ranking into the top half of all Trusts, having been in the bottom quarter in the previous year. ▪ Responded well to a 12% increase in emergency demand, admitting 15% less patients compared to the same period the previous year.
AIM TWO: A GREAT PLACE TO WORK AND LEARN	
To further develop the Trust's participation in research and development (R&D)	▪ A three year R&D strategy developed and approved. ▪ Some progress made but most research activity remains concentrated in a small number of specialties. ▪ Exceeded the NIHR CRN North Thames recruitment target with 1,338 participants recruited in 2018/19. ▪ Commercial income for R&D continues to rise. ▪ Three research grant applications submitted, with one awarded.
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	▪ Received a number of national awards. ▪ Overall, national staff survey results showed a generally positive picture; 29 questions were in the top 20% range; 50 in the intermediate range; and 11 were in the bottom 20% range.
To reduce vacancy rates & reduce our reliance on agency workers.	▪ The number of vacancies reflects positive progress, but is not in line with the ambition set. ▪ Achieved zero% band five vacancies for adult inpatient wards in August 2019. ▪ A further overseas recruitment campaign has been approved to target shortage areas and ensure a continued pipeline of general band five nurses. ▪ Reached the lowest turnover rate for three years, but remains higher than the ambition set. ▪ Good progress made to the development of new roles.
To become an excellent organisation for employee development.	▪ A development plan in place to support an application for Teaching Trust status by July 2020. ▪ The target of drawing down 80% of the apprenticeship level has not been achieved, however plans in place to increase availability and uptake of apprenticeships. ▪ Met and sustained core and essential training target of 90%. ▪ Two new leadership and management programmes launched. ▪ A significant number of staff trained on the accredited leadership coaching programme and in the use of coaching skills. ▪ Overall, national staff survey results showed a generally positive picture; 29 questions were in the top 20% range; 50 in the intermediate range; and 11 were in the bottom 20% range.
AIM THREE: TO IMPROVE OUR FINANCES	

To deliver best value care	▪ Delivered the financial plan of a deficit of £22.7m. ▪ Demonstrated year on year improvement in financial position and performance against key value for money metrics. ▪ Delivered £15.1m efficiency savings across all divisions. ▪ Agency spend continues to fall, £13.8m in 2019/20 (£15m the previous year), a decrease of almost two-thirds in four years. ▪ A minimum income contract agreed with HVCCG.
AIM FOUR: A STRATEGY FOR THE FUTURE	
To improve our IT and move towards full digitisation	▪ Completed the transition to a new IT provider. ▪ A full business case to improve the local area network approved and implementation plan developed and being delivered. ▪ Approval received to move to Windows 10. ▪ Outline business case for electronic health records management approved. Following improvements to the local area network, a reassessment is planned on the implementation of a pilot of internal order communications for the pathology service. ▪ Following an upgrade onto Windows 10 software, a project to deliver remote access to radiology results will be completed. ▪ A data security and protection toolkit has been developed to move towards general data protection regulations (GDPR) compliance.
Proactively communicate and engage with local communities and stakeholders in the development and delivery of services, continuing to build confidence and trust of the local community.	▪ Good progress has been made in building the Trust's reputation in the community and building relationships with partners. ▪ Improved staff morale through a staff awards event, a televised Christmas choir and the use of social media and videos. ▪ External stakeholder agenda focused on the estate redevelopment programme underpinned by an extensive engagement programme. ▪ Updated communications and stakeholder strategy being developed. ▪ Full engagement in sustainability and transformation partnership activities. ▪ Lead role in the development of a West Hertfordshire Integrated Care Partnership and appointed dedicated programme director.
To improve the quality of our estate and implement our service driven estates strategy	▪ Strategic outline case (SOC) for an acute redevelopment refreshed and wave four bid resubmitted. £400m funding confirmed. ▪ A preliminary/interim development control plan (DCP) developed for Watford hospital. ▪ DCPs for Hemel Hempstead and St Albans hospitals delayed pending the main acute redevelopment SOC process, but will be progressed in 2020/21. ▪ Successfully applied for ITFF funding. ▪ Awarded funding to replace old MRI and CT scanners and completed installation on new CT scanner in the emergency department at Watford hospital. ▪ New outpatient orthopaedics centre opened at St Albans. ▪ Successfully applied for Salix funding to support

	investment in energy efficiency schemes in 2020/21. ▪ Business cases for key redevelopments have progressed, with further work planned in 2020/21. ▪ Business case for the development of a multi-storey car park at Watford hospital delayed due to commercial complexities and national approval processes. Work is on-going to move this forward in 2020/21.

Strategic plans and working in partnership

The Trust's strategic objectives underpin everything that it does and enables it to achieve its vision and to provide the right care for patients. The five year strategy has been refreshed this year which sets out how the Trust plans to continue its successful improvement journey and deliver national and local priorities for the NHS. The strategy was developed with input from a wide range of staff, stakeholders and patients and its delivery will require collaboration and partnership working to create a local health and care system that is fit for the future.

The Board has continued to spend time on its strategic thinking and is fully engaged in the work of the Herts and West Essex Sustainability and Transformation Partnership, including the work required to form a west Hertfordshire Integrated Care Partnership (ICP), which is reflected in the Trust's five year strategy.

Risks

The Board considers the Trust's significant risks at each of its meetings. In year these have included the financial position, mortality indices, failure to achieve the referral to treatment and the A&E four hour access standards. There are currently no extreme risks on the Board Assurance Framework. The Annual Governance Statement provides further detail.

Going concern

The Board has been regularly updated on the financial plans through the Finance and Performance Committee. The Audit Committee also reviewed the Trust's position in relation to going concern at its meeting held in April 2020, where it considered continuation of service and financial sustainability in reaching its recommendation to the Board to adopt the going concern basis in preparing the financial statements.

In preparing the financial statements the directors have considered the Trust's overall financial position, with outturn adjusted deficit of £22.5m in 2019/20, and expectation of future financial support. The Trust's Annual Plan process for 2020/21 is on hold due to the Coronavirus (covid-19) outbreak in the UK and worldwide as Trust responds to the emergency needs to its patients. Currently the Trust has agreements with its commissioners, a block contract (fixed funding for providing healthcare to its patients). These block contracts have been agreed to 31 July 2020. All COVID-19 related expenditure for capital and revenue to be funded separately by NHS England. Additional funding will be available for the Trust to achieve break-even to 31 July if there is a monthly income and expenditure deficit during this period. The Annual Plan preparation and agreement with NHS Improvement will resume in due course. The Trust control total signalled by NHSI is to break-even in 2020/21. Both Provider Sustainability and Finance Recovery Funding (PSF and FRF) will be included in the contracts agreed with commissioners to provide healthcare.

NHSI have written to all NHS entities on the 27 May 2020 confirming that though contracting arrangements are not in place for rest of 2020/21 and beyond, the Government has issued mandate to NHS England for the continued provisions of services in England in 2020/21. Clinical Commissioning Groups allocations and sufficient funding has been set for the remainder of 2020/21. Providers can therefore continue to expect NHS funding to flow for similar to that previously, provided services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitely in place, it is clear that NHS services

will continue to be funded, and government funding is in place for this.

Directors are not seeking any cash support for revenue but the Trust is likely to submit a request for £4.8m in 2020/21 to support the capital expenditure plan. NHSI has not, at the date of our report, confirmed that they will provide this support. On 2 April 2020, DHSC and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £237,761,000 are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the trust.

All these factors have improved the finances of the Trust and its 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 2019/20 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.

For further information please see 1.2.1. Of the annual accounts.

Performance summary

Like many trusts across the country, there has been little let-up in demand for emergency care throughout the year and the Trust has continued to see increased levels of demand. Patient safety has remained the Trust's key priority and every effort has been made to enable improved patient flow within the hospitals. In addition, to the increased demand, the management of the COVID-19 pandemic had a significant negative impact on operational performance across all indicator standards at the end of 2019/20. Further information on the impact of COVID-19 can be found on page 11.

In quarter four, the House of Commons published a briefing paper on key NHS statistics for February 2020, which showed that the Trust was one of only four trusts in England that saw an improvement in Emergency Department (ED) four hour performance year on year (6%). This improved performance reflected the hard work that had been done throughout the year to achieve quality improvements in acute pathways. It also reflected the benefits of a £3.2m investment which was approved by the Board in June 2019 to increase the staffing levels in emergency medicine, as well as an improved leadership structure across the Trust.

In addition, as part of the Trust's strategy to improve patient flow, a pilot known as SMART was established in October 2019. The main aims of the pilot were to bring forward a speciality review of patients admitted as an emergency, maximise the use of non-admitted pathways such as ambulatory care and hot clinics and for the medicine division to work as a more integrated team with emergency medicine. The benefits of this pilot have been realised and therefore work is underway to make permanent changes to the emergency care pathways and the staffing levels.

Performance is assessed through the corporate governance structure as set out on page 32. A performance management framework sets out how performance is managed and is also reviewed and approved annually. The Board's Finance and Performance Committee considers the finance and performance reports in detail; the Quality Committee considers all quality-related issues and the People, Education and Research Committee does the same for workforce related reports. All are presented to the Board each month and are available on the Trust's website.

COVID-19 pandemic

Since the outbreak of the COVID-19 pandemic in February 2020, the Trust has worked collaboratively with partners to manage the in line with Public Health England and NHS England guidance to ensure the safety of staff and patients. Procedures have been adapted constantly in line with best practice and national guidance, a command and control structure has been enacted and interim governance arrangements have been put in place, including establishing an ethical advisory panel.

Delivery of every aspect of clinical and non-clinical services has needed to be reassessed and fundamentally reorganised due to the pandemic. This has included case isolation, the establishment of assessment pods on each of the hospital sites and the cancellation of all non-urgent procedures. There has also been a key focus on the management of workforce scenarios, such as high levels of sickness absence and school closures and the Trust has been liaising with other organisations within the Herts and West Essex Sustainability and Transformation Partnership to ensure a consistent workforce approach.

Additional governance arrangements have been put in place in support of internalising national and local guidance and assessment of ongoing changing risks. Further information on these arrangements can be access in the annual governance statement on page 36.

Performance

The table below sets out the position the Trust reached against the national performance indicators at the end of February 2020 before the impact of the COVID-19 pandemic and also the final position at the end of the financial year.

Indicator	National Standard	2018/19	2019/20 (at Feb 2020)	2019/20 (Full year)
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 (80.9%)	81.4%	Under achieved - 81.1% (However achieved the biggest improvement in four hour waits in England in the three month period to January 2020).
Incidence of C.difficile should be identified and numbers minimised	Trust target was to have fewer than 32 cases of C. difficile through the year.	Achieved (15 cases reported). Five cases have been successfully appealed and deemed as no lapses in care.	Under achieved – 44	Definitions have changed at the beginning of the year. Under achieved – 49
Hospital acquired MRSA bacteraemias should be identified and steps taken to reduce them	Trust target was to have zero cases	Under achieved (three cases). There is no formal target set. All three cases have been reviewed and no learning attributed to the Trust.	Achieved – 0	Achieved – 0

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 (93.3% suspected cancer referrals) Under achieved (90.5% breast symptomatic patients)	Achieved (93.9% suspected cancer referrals) Achieved (95.7% breast symptomatic patients)	94.2% (2ww) 95.9% (breast symptomatic)
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 (96.8%)	97.3%	97.3%
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	Under achieved (82.3% referred by GP) (86.2% referred by screening service)	81.9 (62 day first) 83.2 (screening)	82% (62 day first) 84.7% (screening)
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 (100% for palliative care (100% for other) Under achieved (94.6% for surgery) (97.6% for anti-cancer drugs)	96.3% (surgery) 99.7% (drugs) 100% (radiotherapy)	96.6% (surgery) 99.7% (drugs) 100% (radiotherapy)
Maximum wait time of 18 weeks referral to treatment – patients not yet treated	>92%	Under achieved (83.9%)	Under achieved (85.5%)	Under achieved -85.4%

For staffing performance, please refer to page 48. For financial performance please see page 66.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and
Identifying potential support needs. The framework looks at five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance

4. Strategic change
5. Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from one to four where '4' reflects providers receiving the most support and '1' reflects providers with maximum autonomy. The Trust has been placed within segment 3, which means that mandated and targeted support needs have been identified in quality of care, finance and use of resources and operational performance. Segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Data quality and governance

There are a number of checks in place to validate data quality for referral to treatment (RTT), diagnostic and cancer wait times for reporting, including routine and deep dives into each patient pathway. All patient pathways for RTT, diagnostic and cancer waiting times 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.

Care Quality Commission

In February and March 2020, the Care Quality Commission (CQC) inspected a number of specific core services across the three hospitals; urgent and emergency care, medical care, surgery and maternity at Watford hospital, the minor injuries unit at St Albans hospital and the urgent treatment centre at Hemel Hempstead hospital.

At the time of publication, the CQC had not published its final report; however initial feedback was generally positive with inspectors commenting on how welcoming staff had been and a real sense of pride and commitment to patient care. They also recognised improvements in emergency and urgent care, in particular the improved leadership and integration between Hemel Hempstead and St Albans City hospitals and Watford. Inspectors also highlighted that the Trust had moved to a more strategic outlook and approach, leading to a change of focus and were impressed by the Trust's 2020-2025 strategy and how well it aligns with digital and estate redevelopment plans. When available, the final reports will be published on the Trust's website: westhertshospitals.nhs.uk.

Quality Account

While primary legislation continues to require providers of NHS services to prepare a quality account for each financial year, due to the COVID-19 pandemic, a revised deadline of 15 December 2020 has been published for the 2019/20 Quality Account and this will be completed in line with national guidance and a formal review process established which will involve the submission of the draft Quality. Further information on the quality account can be found in section 7 of this report.

Serious incidents

The Trust reported twenty six serious incidents in 2019/20, which were fully discussed by an executive led panel and, all externally reported incidents, were investigated in collaboration with the divisions. The main themes of the reported serious incidents were delayed diagnosis, treatment delays and falls. The table below identifies the actions taken in 2019/20.

Serious incidents	Actions taken
Delayed diagnosis	▪ Continued reiteration of paediatric teaching and training provided in governance forums ▪ Review of ward round documentation resulting in inclusion of the bloods

	flow chart within the standard admission medical notes in order to identify trends
Treatment delay	▪ All clinical staff reminded that a patient's weight must be recorded on the drug chart to enable weight dependent drug prescribing ▪ All patient transfers from the acute admissions unit at Watford are now recorded on e-handover
Serious incidents	Actions taken
Falls	▪ Post falls management has been reinforced to ensure that appropriate clinical priority is given to the request and that the required neurological observations are carried out
Sub optimal care of the deteriorating patient	▪ Staff nurses have completed or re-attended sepsis training to facilitate immediate recognition of any deterioration or changes

Three serious incidents were declared as never events. All never events are subjected to intense investigation and scrutiny and action plans are drawn up with the multi-disciplinary teams to ensure that national guidance is embedded and that where required changes in practice are implemented to prevent recurrence. The table below demonstrates the learning which resulted from the investigations into the three never events.

Category	Incident details	Actions taken
Misplaced naso-gastric (NG) tube	Incorrect interpretation of chest x-ray to identify position of NG tube	▪ Discussed at a radiology learning and discrepancy ▪ Introduction of a standard template for reporting the position of NG tube ▪ All x-rays requiring confirmation of NG tube position are reviewed by a consultant radiologist prior to commencing of feeding
Wrong site surgery	Fascia iliaca block was performed on the incorrect side. Foraminal epidural administered to the incorrect side.	• "Stop before you block" practice standardised • "Stop before you block" posters displayed in anaesthetic rooms in theatres. • Teaching sessions undertaken to increase awareness of "Stop before you block"

Harm free care

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 urine catheter), new venous thromboembolism (VTE) and harm from medication errors. Each month "test your care" audits are carried out in many clinical areas and this information is incorporated into the ward scorecard, which enables clinical areas to be aware of performance and develop initiatives for improvement. The Trust is part of a national collaborative to improve the assessment and planning of care within pressure ulcers and falls which enables peer support and sharing of ideas both regionally and nationally.

Learning from deaths

During 2019/20, the Trust's medical examiner service expanded in order to provide a five day service which supported a substantial increase in patients being referred to the service. Medical examiners scrutinise all hospital deaths, refer for structured judgement reviews, and promote accuracy and quality of medical death certification.

There were 1,494 patient deaths reported in 2019/20, including 19 stillbirths and 10 neonatal deaths, with 7% of adult deaths being assessed by trained consultant reviewers.
The national perinatal mortality tool was used in all neonatal deaths. Of the adult cases, 62 were

selected for second tier review and six deaths were found more likely than not to have been due to problems in the care provided.

Themes from structured judgement reviews are collated and learning shared with divisions and specialties. The feedback and dissemination of information from structured judgement review has been strengthened this year by collaboration with divisions to feedback their learning and any implementation of change of practice.

National award winners

The Trust is very proud of all the work that staff do to support patients and this year it has continued to see national recognition. Some examples of this are shown below.

Left: The Trust won the 'Best UK Employer of the Year' Nursing Times workforce award
Below: Chief Nurse, Tracey Carter received a Chief Nursing Officer Award

Below: Staff received well deserved National Cavell Star Awards which recognised those who have shone bright and showed exceptional care

Left: Dr Narayanan won Clinical Practitioner of the Year, Healthcare Quality Improvement Partnership

Right: The medical education team received the UCL 'Excellence in Medical Education award

Key achievements

The Trust has introduced a significant number of initiatives and developments to enable the

achievement of operational and efficiency measures in the future.

Visit from the prime minister and secured funding for estate redevelopment

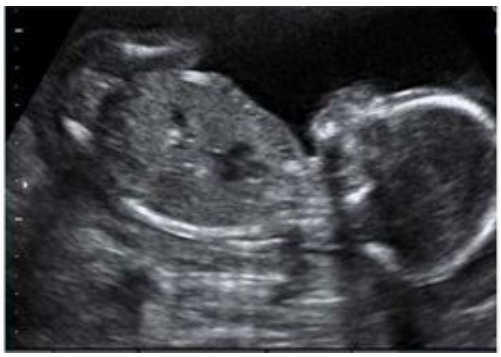
The Trust welcomed a visit from prime minister to confirm that the Trust would receive £400m from the government's capital funding to help redevelop its buildings and facilities. This was in response to the submission of a strategic outline case (SOC), following a lengthy period of engagement with local people.

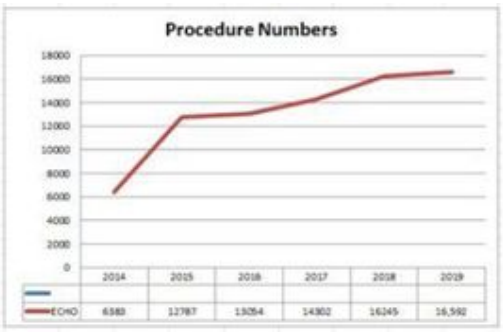
Caring until the very end of life

The Macmillan Palliative Care Team, Spiritual and Pastoral Care and Voluntary Services work with a small group of volunteers to make a very real difference to patients in their final days of life. This year, fund-raising activities have led the team to be able to make small changes to enhance the patient's environment, such as listening to music, homely table lamps enabling softer lighting and comfort packs being available.

Improving the early pregnancy pathway

As part of the Trust's work with the Royal Free London hospitals clinical practice group, the early pregnancy pathway has examined how the care for women with pain or bleeding in early pregnancy could be streamlined and the pathway has been improved, including offering a one-stop service where the vast majority of patients are seen within 24 hours of referral refer from a GP, A&E or a midwife.





Efficient echocardiology service

A dedicated seven-day inpatient facility has been introduced at Watford hospital to target cardiology patients and the acutely unwell, enabling echocardiograms to take place within a 12-24-hour period. This has improved patient outcomes, reduced diagnoses times and improved patient management and time to discharge.

Critical care without borders

A multi-disciplinary improvement drive in the Critical Care Unit at Watford has resulted in

better outcomes for patients, staff, and colleagues across London's hospitals. Over the last 12 months, staff in the department have collaborated to tackle the challenges through robust training programmes, inter-hospital pathway transfer reviews, outreach and awareness campaigns.

New technology in respiratory medicine

A new diagnostic service introduced at Watford hospital means that patients have shorter procedures, a smaller number of biopsies and fewer complications. The minimally invasive procedure is used to check for lung cancer, other cancers suspected of spreading to the lymph nodes, lymphoma and also non-cancerous conditions such as sarcoidosis or tuberculosis.

Maternity and neonatal improvements

A multi-disciplinary intervention and improvement programme in the maternity and neonatal units are reducing mother infant separation and dramatically reducing numbers of babies with neonatal hypoglycaemia, necrotizing enterocolitis and cerebral palsy.

In the spotlight

The Trust was in the spotlight on Christmas Eve when a documentary featuring a choir of around 60 staff which had been created by choirmaster Gareth Malone was broadcast on TV. As well as showing the development of the choir, the programme included interviews with staff and patients and culminated in a wonderful concert in the restaurant at Watford hospital.

National inpatient survey

The national inpatient survey was distributed to patients admitted in July 2019. With 508 surveys returned completed, the Trust had a response rate of 42.9% against a national average of 45%. When compared to the previous year's survey, the Trust scored the same in 49 questions and significantly lower in 12 questions.

The results demonstrate an improvement in the number of elements of the 'leaving hospital' section that reflects a focus on discharge planning however, further work to improve patients' experience of discharge is required. The scoring of cleanliness and food choices is another areas which required further focus and this will be monitored through the patient experience group and service level contract meetings with the Trust's facilities management service.

Getting it right first time

In the reporting year, a getting it right first time **(**GIRFT) steering group was established to oversee the delivery of the GIRFT programme. Regular updates continue to be reported through the Quality Committee to provide oversight on the improvement opportunities and assurance that actions are being implemented to become business as usual. Since the programme was launched in 2014, the Trust has received nineteen deep dive visits across a range of specialties with the majority of visits taking place over the last year with eight deep dives, two revisits and a regional event. There are currently fourteen specialty implementation plans in place and review in ways of working and changes in practice have resulted in improvements across a range of specialities.

Quality improvement

To help achieve a supportive organisational environment that will drive the Trust's quality commitment, a central quality improvement (QI) hub has been established to provide expertise, guidance and embedded support to facilitate service improvement across the organisation. The hub uses a consistent QI methodology developed by the Institute of Healthcare Improvement (IHI). The Trust partnership with the Royal Free London NHS Foundation Trust group has continued in 2019/20 and a lead for QI has been appointed and is leading on the education and supporting QI projects across the Trust.

Addressing patient concerns

In 2019/20, performance in responding to complaints in a timely manner was consistently above 80%. Complaints management is carried out in line with the NHS Complaints procedure. Complaints are acknowledged within three working days and initial contact is made wherever possible in order to discuss the detail and context of the issue and enable a response timescale to be agreed.

During the early days of the COVID-19 pandemic, there was a decline in the number of complaints made to the Trust. A small number of COVID-19 related complaints largely related to the timely availability of death certificates and were acknowledged and immediate actions taken, and complainants were notified that a formal response would be made at a later date with the full investigation findings.

The complaints team works in collaboration with the divisional teams to ensure that detailed responses are provided which address all of the issues raised. All complaints are reviewed and signed-off by the chief executive.

As a Trust, key performance indicators are used to monitor complaints management performance and the number of complaints, themes and trends are discussed in detail within governance meetings to ensure that learning takes place and actions are implemented.

The Board often receives a patient story at the start of a Board meeting, occasionally with the patient attending personally, to provide an overview of their experience of the service they received. Reflecting on individual patient experiences provides assurance to the Board that the processes in place are effective and ensures that the Board has considered some of the detail that supports the formal reporting through the Quality Committee and the annual complaints report.

In 2019/2020, the patients advice and liaison service (PALS) dealt with 2,847 reported concerns with the three most common themes, being outpatient appointments, including delays and cancellations, care and treatment and communication.

A new weekly tracker has been embedded which allows divisions to monitor issues and address concerns in a timely manner and learning from the concerns raised is captured electronically.

In addition to many hundreds of letters, card, notes and small gifts received directly by wards and departments, during the period of this report, the chief executive received 244 formal compliment letters from satisfied patients and visitors.

Duty of candour

The Trust is committed to open and effective communication with patients, their families and/or carers throughout the time spend under the care of the Trust. When something goes wrong with the clinical care provided and a patient has or could have suffered harm as a result of this, the Trust ensures full compliance with its statutory duty to be open and honest as outlined in its duty of candour policy.

This remained a priority during the COVID-19 pandemic and a review of the risk management activities was undertaken to establish the best way to communicate with patients, relatives and carers during the time of pressure. It was agreed with commissioners that the Trust would continue to investigate all incidents assessed as causing harm and those that fulfilled the serious incident framework. However, the investigations would be in some instances (based on an assessment) scaled down in the interim, with a focus on action planning. With these changes in place, the Trust remained compliant with the duty of candour regulation.

The patients' panel

The patients' panel has maintained its support of the Trust in 2019/20 with a continued 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, and engagement with stakeholders as part of the Trust's redevelopment of services.

The patients' panel will continue to play a key role following the development of a co-production board as part of a new model of patient involvement. This board aims to create opportunities for partnership working, and to jointly develop a patient involvement model that helps realise the ambitions within the Trust's patient experience strategy.

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. The number of wards, departments and specialist areas that offer patients an opportunity to give feedback on their experiences of care has risen year on year with last year's 60,000 being surpassed to 83,612; with 94% of patients giving a positive recommendation.

The Trust is also involved in multi-organisational patient engagement events to capture views of service users using the 'Whose Shoes' model and an aftercare patient call back programme has been initiated that makes on average 1000 calls per month. Monthly patient experience metrics and person-centred care dignity and respect data are collected each part of monthly quality checks.

Progress towards achieving equality

In year, the Board approved a refreshed People Strategy with diversity and inclusion running through it and joining up all elements of the strategy. An inclusion and diversity policy is also being developed which will include a screening element for equality impact assessments to complete when implementing new policies, programmes and procedures and progress has been made to provide interpreting support, tailored care for people with learning disabilities and dementia, as well as offering

spiritual, pastoral and religious assistance relevant to a person's faith.
Also, significant progress has been in reducing the gender pay gap, achieving a level two disability confident accreditation, growing diversity and inclusion core staff team and creating diversity and inclusion objectives for the executive team.

The Rainbow NHS Badge project is now well established across all areas of the hospitals. This demonstrates that the Trust is open and an inclusive place for those that identify as LGBT+.

Detailed information on equality and diversity can be found in the Trust's workforce race report, disability equality standard report, gender pay gap report and annual equality reports on the website: www.westhertshospitals.nhs.uk.

Emergency preparedness and resilience

One of the key challenges for the Trust in 2019/20 was, and still is, to respond to the outbreak of the Coronavirus (COVID19) pandemic. Further information on this can be found on page 37.

Prior to the pandemic, the Trust was in a secure position in relation to general regulatory scrutiny and meeting statutory obligation in emergency planning and resilience. In 2019/20 it was assessed as being substantially compliant with NHS England's annual assessment for emergency preparedness and an action plan was developed to address the one element that was incompliant in data security. In year, an staff e-learning emergency preparedness package was also developed and joint emergency services interoperability principles were launched for on-call managers and directors as required by the Home Office.

Ensuring the Trust was prepared for exit from the European Unit (EU) was a key focus of the Trust's emergency preparedness planning throughout the year. The Trust made preparations through 2019/20 for the potential impact of the UK's exit from the European Union, including planning for the case of a 'no deal' EU Exit, including following recommendations in the Department of Health and Social Care's EU Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers. The Trust's organisational risk register has recognised the potential impact of EU Exit and this has been monitored through the year by the Board and the Quality Committee.

During the year, the Trust was recognised for its engagement in the planning and participation of a successful NATO 2019 summit by providing a medical centre to support the principles, delegates and staff supporting the event.

Patient care environment

Patient-led assessment of the care environment (PLACE) puts patients' views at the centre of the process with assessments carried out throughout the Trust's premises against: privacy and dignity, dementia friendly, cleanliness, general building condition and food. The results of these assessments identify how well hospitals are performing nationally against the areas assessed. The PLACE programme underwent a national review, which started in 2018 and concluded in the summer 2019, and the question set has been significantly refined and revised, and guidance documents have been updated. As the changes have been extensive, it is important to note that the results of the 2019 assessments will not be comparable to previous year's collections. The table below show the scores achieved in 2019/20 at each hospital.

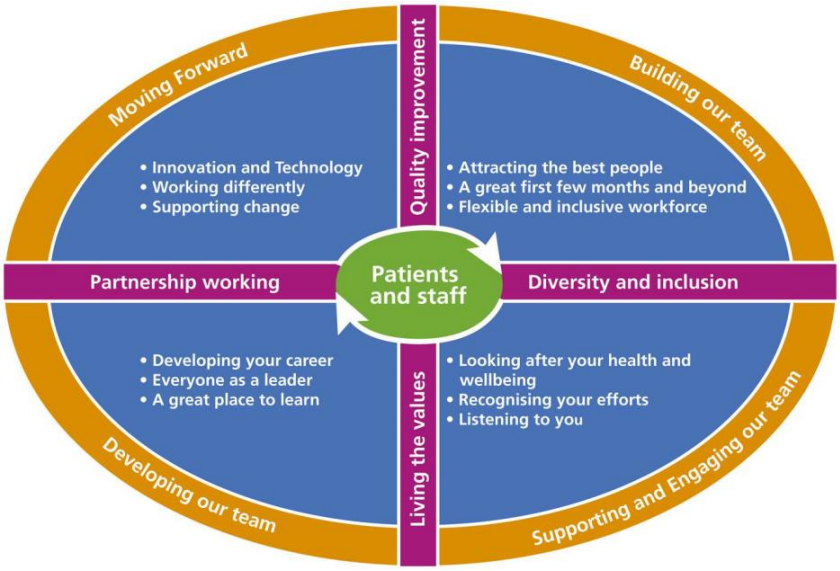
Category	Overall score	Hemel Hempstead	St Albans	Watford
Cleanliness	98.99%	99.69%	99.04%	98.93%
Food	87.31%	89.25%	88.98%	87.07%
Food organisation	88.98%	88.98%	88.98%	88.98%
Ward food service	86.77%	89.58%	89.02%	86.43%
Privacy, dignity and wellbeing	73.96%	73.74%	72.11%	74.09%
Condition, appearance and maintenance	91.03%	93.69%	95.58%	90.57%
Dementia	68.04%	69.39%	65.84%	65.82%
Disability	66.83%	68.42%	65.79%	66.78%

People strategy

The Trust has launched a refreshed people strategy for 2020-2025, which builds on the 2016-2019 workforce and development strategy and places much greater emphasis on partnership working, quality improvement, diversity and inclusion, and living our values.

The strategy has been cross referenced against the Hertfordshire and west Essex workforce strategy, the NHS Long Term Plan and the Interim People Plan, among other key policy drivers including the Topol Review (HEE, 2019).

The graphic wheel below shows the overall strategy and how the four different phases fit together with the four threads that run through and join up the people strategy.



A great place to work steering group has been established to deliver the strategy, which reports into the people, education and research committee.

Staff survey

All staff were encouraged to take part in the national staff survey which ran from September to December 2019 and achieved a response rate of 42% against an average of 46% for the sector. The survey is divided into five key areas; your job, your manager, health and wellbeing, personal development and your organisation. This year, the Trust also included additional survey questions on health and wellbeing, values, communications and improvements within the Trust.

Overall, the results of the survey showed a generally positive picture with two of the theme scores significantly better than the sector score and two being significantly worse (equality/diversity and violent incidents).

The remainder of theme scores were around average with 29 were in the top 20% range; 50 in the intermediate range; and 11 were in the bottom 20% range. The overall staff engagement score remained the same as 2018 at 7.02%.

Feedback from the staff survey will continue to feed into a programme of work supporting the People Strategy 2020-2025. Divisions are responsible for reviewing and considering actions for their respective areas, which will be built into a refresh of the successful 'Big 5' campaign which will focus on one of five key improvement areas each month. Disappointingly the two friends and family engagement questions were both lower than the sector score, however this was inconsistent with other results and the drivers for this will be closely examined in 2020/21 and built into the 'Big 5' campaign

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. An updated R&D Strategy has recently been agreed by the Trust. 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.

Recruitment to studies at WHHT is 824 participants in 2019/20 to research approved by the Health Research Authority. The Trust recruited participants to 41 studies and was involved in conducting 88 clinical research studies. The National Institute for Health Research supported 85 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.

Education, learning and development

During the reported period the Trust has created and commenced delivery of two new leadership development programmes. The first is evolve, a nine month programme for new leaders and managers which started in September 2019 with the intention of running three times a year. The programme focuses on the core skills of leadership and management with a particular focus on people practising them for the first time. The second is transform, a 12 month programme for new, current and aspiring clinical and divisional directors. This programme commenced in October 2019 with the intention of running twice in every two month period. This programme focuses on leaders setting a strategic direction for their areas and carrying it through, whilst not assuming any prior formal leadership or management training. A third programme, rise will replace the now concluded senior leadership programmes, for all staff in between the evolve and transform levels early in 2020/21.

The Trust has continued to offer International Coach Federation accredited coaching programmes throughout the year however they are now integrated into both the 'evolve' and programmes, and will be integrated into the rise programmes.

Medical education continued its excellent progress and the Undergraduate UCL Team was awarded an Excellence in Medical Education Award for their activities supporting the Trust's UCL undergraduate programmes in 2019. In addition the simulation centre grew to the point of financial self-sufficiency during the year.

Library and knowledge services has commenced a clinical outreach role within both A&E and paediatric service and now provides journal clubs in many Trust areas. Healthcare literacy support has also begun to be delivered to patients.

The Trust's nursing associate apprenticeship project was inspected by Ofsted in the autumn of 2019 (as part of the University of Hertfordshire's inspection) and was considered excellent. These and many other apprenticeships continue to be offered and taken up. An apprenticeship funding model is under consideration (amongst other options) for the upcoming senior leadership programme.

Mandatory training did not fall below 90% (all compliance against all targets across all subjects) at any point during the 2019/20 year, with compliance reaching 93% at the end of the year. Consistency between subjects and divisions has improved with no one division or subject posting compliance below 85% by year end 2019/20.

Supporting the health and wellbeing of staff

Ensuring that staff are supported to allow them to continue to provide the best possible care is vitally important and it has been particularly important at the end of the reporting year to be mindful of the impact that the COVID-19 pandemic has had on staff, both physically and mentally.

The Trust's staff wellbeing programme focuses primarily on mental wellbeing support; offering workshops on stress, resilience and mindfulness, and access to online programmes. There are regular events across sites supported by external partners such as the Samaritans and Hertfordshire Mind Network, run as wellbeing cafes to broaden awareness of the support available. Uptake on mental health first aid training has increased with champions encouraging better understanding of mental health within the workplace.

Twice-yearly health checks that are also welcomed by staff and a physiotherapy assessment scheme offers staff quick access to expert advice and exercises and refers back to the GP if necessary. Back care awareness is delivered via annual events and direct to the workplace where possible.

During the COVID-19 pandemic, the Trust collaborated with the Watford Football Club who opened its doors to create a temporary space for staff to relax away from the wards and departments; this was known as the Sanctuary. The Sanctuary included a suite with social distancing seating with free refreshments, offered breakfasts and lunches, quiet rooms for staff that needed personal space, private rooms for counselling and pastoral care, accommodation for on-call staff, a memorial room for staff to pay their respects to patients and members of staff who had died during the pandemic and facilities for staff to shower before they went home.

In addition to the excellent facilities provided by the Football club, the Trust was overwhelmed with many kind offers of goods, services and time from the local community. The Trust would like to take this opportunity to thank Watford Football Club and all the individuals and businesses for supporting the Trust during the pandemic, which was greatly appreciated by all staff across the hospital sites.

Volunteers

The Trust recognises that volunteers bring richness to how patients experience their stay in hospital, reducing anxiety and helping many to get well faster and return home sooner. The Trust has a dedicated pool of nearly 600 volunteers who provide support to staff, patients and their families across the three hospitals. In the past 12 months, the number of volunteers has nearly doubled which meets the ambition set out in the NHS Long Term plan.

In year, the volunteer service has focused on increasing the diversity of the volunteers, and there are

now 45 different defined volunteering roles across the organisation, with many roles designed specifically for different groups from local communities. Two thirds of volunteers are under 25 years old, compared to one fifth of volunteers a year ago.

The Trust has also focused on developing and sustaining recruitment and proactively developing roles in line with the volunteer strategy and on specialised volunteering initiatives, including supporting the Rose end of life care project, offered peer support to over 80 young people as part of an initiative by the Pears Foundation and supported parents and carers on the children's inpatient ward, for which the team were regional winners of the 'Volunteer of the Year Team" in the NHS Parliamentary Awards 2019.

Recognising staff

The Trust is one of the largest employers in the west Hertfordshire area and it is extremely proud of its 5,000 staff which are essential to the way that the Trust operates and the services that it is able to provide to patients.

All Trust policies are in line with the legal requirements and national guidance and are adhered to by employer and employees. These are reviewed and adapted in line with any new recommendations.

In the last year staff recognition has been a priority, recognising the amazing things that staff do every day with a range of activities to show them how much they are valued. A new #StarsOfHerts campaign was run three times to shine a light on particular staff and teams who have gone the extra mile both in and outside of work. Additionally, as part of a 'Big 5' staff survey programme, the Trust had a wide range of wellbeing events from mental health first aid to health checks and monthly massage sessions and staff who went the extra mile were presented with coffee and cake vouchers. In addition to the popular annual tea parties, long service awards and monthly staff awards, the Trust celebrated achieving zero band five vacancies in adult inpatient wards with branded cupcakes delivered to the wards by the executive team.

Star of Herts Awards

The highlight of the year was the first ever Star of Herts Awards event held to recognise staff that had gone above and beyond their role. Staff attended a glittering awards ceremony, held at Shendish Manor, Hemel Hempstead to support friends and colleagues who had been nominated by both patients and staff for the awards.

All the awards were presented by Trust chairman, Phil Townsend and chief executive Christine Allen.

Many congratulations to everyone who was nominated short-listed with special congratulations to the winners shown above and listed over the page.

Stars of Herts Awards 2019

The winners in each category were:

- **Professional Connections award for Excellence for Care**
  Ben Eliad, core medical trainee
- **Atos award for Excellence for Commitment**
  Angela Wellman, head of nursing, Medicine
- **NHS Professionals award for Excellence for Quality**
  Karen Bowler, deputy head of nursing, Medicine
- **Chief Nurse award for Improving patient experience**
  Cardiac cath lab
- **Watford FC award for Outstanding collaborative working**
  Workforce, HR, senior nurses
- **Allocate award for Outstanding contribution to efficiency**
  Vicky Flanagan, Lisa Gray (finance and environment)
- **Chief Medical Officer award for Hidden star of #TeamWestHerts**
  Katie Tomkins, head of mortuary
- **McGee award for Outstanding innovation**
  Michele Cui, charge nurse, frailty/enhanced care
- **Selenity award for Star of fundraising**
  Jackie Fitzsimons, healthcare assistant, Katherine ward
- **Chief Executive award for Rising star**
  Katie Vovrosh, senior sister, Croxley ward
- **Chairman's award for Outstanding contribution to volunteering**
  Colin Stodel, volunteer trainer
- **People's choice award**
  Dermatology Secretarial Team

Freedom to speak up

The Trust's freedom to speak up (FTSU) guardian is a non-executive director, however in line with new NHS England/Improvement guidance published in July 2019, an independent FTSU guardian has been appointed and will take up post in 2020. Once in place, the current FTSU guardian will continue as the non-executive director with a responsibility for FTSU and be able to provide support when required.

Over the last 12 months the Trust has introduced speak up champions who support the FTSU guardian as an alternative channel for employees to raise concerns. Currently 20 champions are in place with a number of others going through a training process. Speaking up is widely promoted throughout the Trust through posters, leaflets, in training and through a wide range of internal communications channels.

In the past 12 months, 42 FTSU cases were reported with broad themes relating to managerial behaviour, bullying and harassment, behaviour of staff and patient safety. It is recognised that many of the concerns raised through FTSU are linked to conflicts that should have been addressed sooner and therefore different approaches to resolution and supporting employees are being considered.

Future strategy

A key piece of work in 2019/20 has been the development of the Trust's five year strategy which sets out how the Trust plans to continue its successful improvement journey and deliver national and local priorities for the NHS.

The five year strategy emphasises the importance of partnership working. It recognises that the Trust is part of a wider health system which needs to focus on health not just illness, redesigning and 'joining up care' to improve patient experience and deliver best value care models for the system.

The strategy was developed with input from a wide range of staff, stakeholders and patients and its delivery will require collaboration and partnership working to create a local health and care system that is fit for the future.

The strategy is aligned to the Trust's vision to deliver the very best care for every patient, every day and to its four main aims of best care, best value, great team and great place as clearly shown in the Trust's 'sunny tree'.

The strategy is underpinned by a series of more detailed strategies and plans. An updated people strategy and a research and development strategy have been developed and approved by the Board. An updated communications and engagement strategy will also be considered by the Board for approval in 2020/21.

A number of shorter term supporting objectives and metrics were approved by the Board in April 2020 that set out specific areas of focus over the next one, two and three years to drive forward progress on the high level ambitions in the strategy.
A clinical strategy will also be updated in 2020 which will set out at service / specialty level specific improvements to deliver the aims set out in the five year strategy.

The key elements of the current clinical strategy are:

- Care closer to home / integration & pathway redesign.
- Strengthening core 'acute' service offer (QI, emergency care flow etc.).
- Developing more specialist service where the Trust has the capability to deliver excellent care (e.g. cardiology, respiratory, gastroenterology).
- Working with specialist centres where patients can benefit from their expertise and only providing specialist services where the Trust is confident it can deliver excellent care.

Acute redevelopment

This year has seen a significant move forward in achieving the Trust's aim to improve the hospital facilities for both patients and staff and to make the best use of 21st century digital technology.

Over a number of years the Trust has been developing a strategic outline case (SOC) which makes the case for a significant investment in the Trust's estate, enable new care models to meet the changing needs of the local population and deliver operational efficiencies to deliver best value care.

At a Board meeting in May 2019, the Board formally discussed and agreed a proposed shortlist of four options taking into account the affordability constraint set out by the Trust's regulators (£350m), and a recommended preferred way forward.

In June 2019, in a meeting held jointly with Herts Valleys CCG (HVCCG), the two Boards discussed the initial outputs from an options appraisal and agreed that, subject to the final work being completed and formal decision making, that option one was the emerging preferred way forward. Option one involved prioritising investment at Watford hospital as the main emergency and specialist hospital, with a sizeable element of new building proposed. This option also allowed both Hemel Hempstead and St Albans hospitals to attract capital investment to deliver considerable improvements.

In a further extraordinary Board meeting in July 2019, feedback from stakeholders, together with the risks and issues associated with each option were discussed and a formal decision made by the Board to approve option one of the SOC as the preferred way forward.

As part of the approval process, the SOC was considered and option one approved by HVCCG and Herts and West Essex Sustainability and Transformation Partnership (HWE STP), before being submitted to regulators alongside a 'wave four bid' for funding.

In September 2020, the Trust received the fantastic news that it was one of six trusts to share £2.7bn of Treasury funds to improve buildings and facilities. This is clearly excellent news for patients and staff.

This is however just the start of the approval process, and work has now begun towards the development of an outline business case, following which a full business case will be required, which will include the identification of a construction partner and firm costs for the project prior to construction work commencing in 2023.

Unfortunately, the general election and COVID-19 has disrupted the Trust's stakeholder engagement plans during the year, however a wide reaching stakeholder engagement event was held in January

2020 to discuss the development with local people and further engagement is planned during 2020/21 as part of a wide ranging communications and engagement strategy.

Strategic projects

In the meantime, 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 26 initiatives were identified as priorities to be delivered in-year which varied in scale and impact and included internal facing projects focused on improving the quality and/or efficiency of care, 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.

Examples of a number of the achievements in this year include:

- The development of a joint oesophagogastric (OG) cancer unit with Imperial Healthcare NHS Trust at the Hammersmith hospital.
- The development of a new orthopaedic outpatient hub at St Albans City hospital.
- The installation of a new CT scanner in the emergency department at Watford hospital.
- The implementation of a new 'medical take' model in the emergency department at Watford hospital, known as SMART.
- A business case was approved and building work begun to create a new and expanded 'medical assessment unit'.
- A successfully piloted new community dermatology service and continued development of a tele-dermatology service.
- Worked with partners to implement improvements to the frailty pathway, including the use of the 'Rockwood scale' evidence based tool to identify frail patients.

The Trust has also made good progress this year towards achieving its IT and digital work programme, including transitioning to a new IT support provider, installing some new servers for key applications, approving investment to upgrade telephony and the local area network (both of which are in progress) and securing funding to implement Windows 10. The investment in the core IT infrastructure will bring significant improvement to the delivery of services, improve patient care and the working lives of staff. A process to secure the major investment required to implement a full electronic patient record and confirm the Trust's ambition to be 'paperless' by 2025 is also underway.

Working in partnership / sustainability and transformation partnership

In line with all NHS organisations and local authorities, the Trust is working closely with local partners to develop new ways of working to meet the challenges facing health and care services and deliver the ambitions in the NHS long term plan.

The Hertfordshire and West Essex Sustainability and Transformation Partnership (HWE STP) will become a more formal Integrated Care System to support organisations to work together to achieve improved health outcomes, provide more joined up care for local residents and ensure that services are managed in the most cost effective way possible to meet the needs of the population.

At a local level, four integrated care partnerships (ICPs) are being developed; three are geographical; west Hertfordshire, east and north Hertfordshire, and west Essex and one is specialist; the Hertfordshire-wide integrated care partnership for people with complex mental health needs.

The Trust is playing a key leadership role in the West Hertfordshire Integrated Care Partnership, including the development of the vision, aims, principles and priorities. This work has been 'paused'

as the local health and care system works to respond to the COVID 19 pandemic; work will recommence as soon as possible to enable new governance and ways of working that support integrated care to be established from April 2021.

Sustainability

The Trust acknowledges that its activities impact on the environment in a variety of ways and is in the process of reviewing sustainable practices throughout its hospitals. Despite complex operating challenges, the Trust remains focussed on improving its green credentials and associated carbon footprint. A challenging operating environment during the year, particularly from a technical perspective, led to a slight increase in the amount of electricity imported from the national grid however gas consumption was reduced. Further, over 3.2 GWh of electricity was generated onsite at Watford hospital.

A large retrofitting project of LED lighting is underway at the Watford and Hemel Hempstead sites. The energy savings from this project will amount to over £100k each year and avoid 600 Tonnes of CO2 being emitted. This will be bolstered by the on-going LED replacement programmes delivered by the maintenance teams, thereby creating further savings.

A number of ambitious energy efficiency projects have been identified and are being moved-forward through utilisation of interest-free Salix finance, the Trust can address aged plant whilst reducing energy consumption. The loan repayments are made from the energy savings realised and therefore allows the Trust to remain cash-positive throughout the projects. These projects have potential savings in excess of £1m per year from the Trust's energy spend.
Sustainable travel is being promoted through reinstatement the intra-site transport service as well as the lift share scheme facilitated on the Trust intranet; these schemes helping to reduce cars on the road and improve air quality. Additionally, Watford hospital has a 'Beryl Bike' hub and this creates a healthy, sustainable option for staff and visitors to travel to and from the hospital.

Through close working with procurement teams, a methodology for the consideration of environmental impact into purchasing decision-making is being developed.

The Trust recognises that what is good for the environment is good for healthcare and as such, work has begun in the production of the Trust's new Green Plan; its purpose is to improve the health, wellbeing, quality of life, and quality of care experienced by all users of the Trust. This will form a major focus on sustainability throughout the Trust in the coming year.

The Trust is looking to take part in the Green Ward Competition initiative which is run by the Centre for Sustainable Healthcare, Oxford. The idea is that comparable wards are encouraged to make small changes in practice and undertake simple initiatives with the most-successful ward being crowned the winner. The newly adopted approach can then be rolled-out and repeated throughout the Trust. As well as energy, this project often realises savings in waste and the way in which medicines are dispensed. The Trust is looking to run the competition in Autumn-Winter 2020.

Energy Consumption

Resource (baseline)	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	% Change on baseline
Gas Usage (kWh)	40,620,606	41,920,825	44,997,895	43,529,517	44,231,142	49,136,739	48,882,077	20.34%
Electricity Usage (kWh)	17,010,202	16,452,870	17,546,952	17,241,183	17,966,718	13,534,679	14,644,355	-13.91%
Oil (kWh)	268,752	160,611	189,419	441,584	1,179,768	170,814	756,714	181.57%
CO_2 (tonne)	16,701	16,231	15,811	16,876	15,667	14,456	12,927	-22.60%
Total Energy Spend	£3,118,866	£3,218,042	£3,034,019	£2,827,000	£3,216,422	£3,168,739	£3,728,699	19.55%

As accountable officer, I confirm that this is an accurate reflection of the Trust's performance in 2019/20.

Christine Allen
Chief Executive

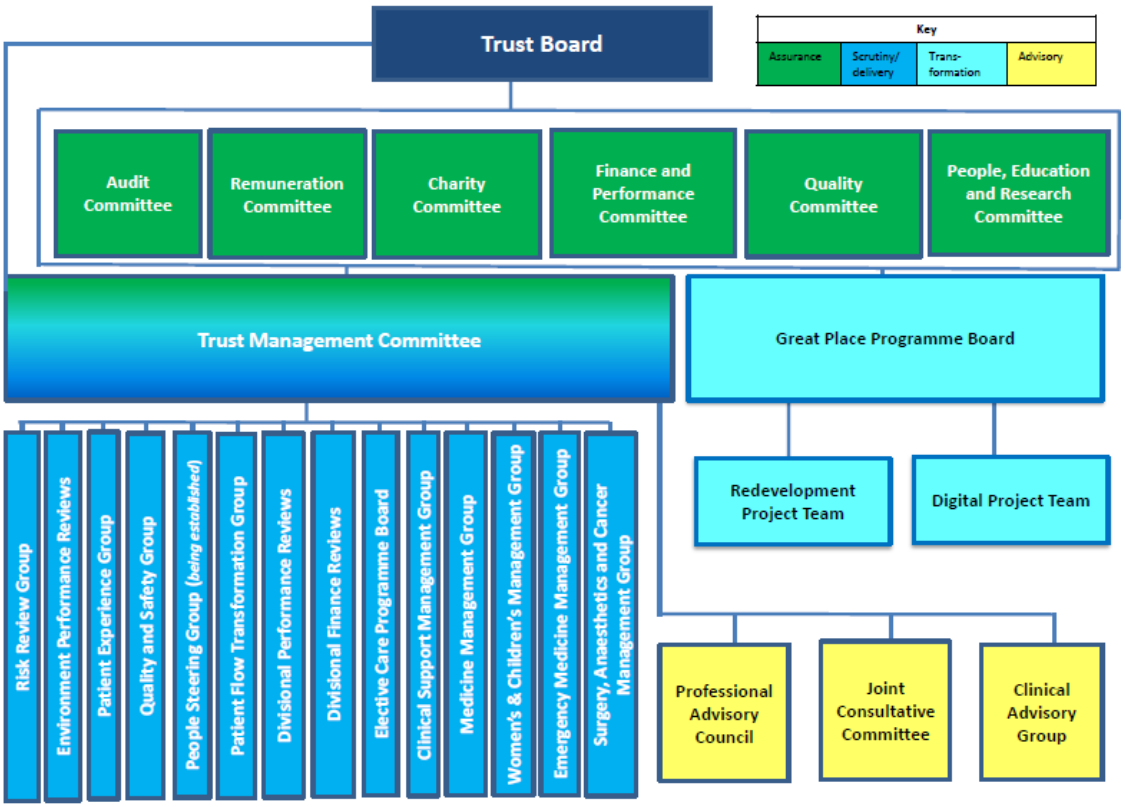
Date 17 June 2020

ACCOUNTABILITY REPORT

Corporate Governance Report

Directors' report

The corporate governance structure in 2019/20 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 2019/20.

Changes to Board membership

After having been interim chairman for a year and vice-chairman for the previous five, Phil Townsend moved into a substantive role of chairman of the Trust in February 2020. The Trust is fortunate to have a strong non-executive director team and this will continue as non-executive directors, Ginny Edwards, Paul Cartwright and Jonathan Rennison agreed in 2019/20 to extend their contracts with the Trust for two further years and John Brougham for one year.

Dr Arla Ogilvie, divisional director of medicine, left the Trust in May 2019 and Dr Andy Barlow, took over her place at Board meetings. In February 2020, Dr Anna Wood changed her role from deputy medical director to director of governance and will continue to attend Board meetings.

Following a review of directors' roles and responsibilities during the year, it was agreed that directors who are line managed by the chief executive should all hold the title of 'chief'. Therefore, the medical

director's title changed to chief medical officer and the director of workforce changed to chief people officer.

Audit Committee

The names of the directors forming the audit committee can be found in the table on page 35. This table also sets out the Board and committee attendance in 2019/20.

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 (westherts.corporategovernance@nhs.net).

Personal data incidents

There have been two 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.
- confirming that as far as I am aware that there is no relevant audit information of which the auditors are unaware in the Annual Report, and that the judgements made are fair, balanced and understandable.

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

Christine Allen
Chief Executive

Date 17 June 2020

Board and committee membership and meeting attendance 2019/20

Name of member	Board	Audit	Remun-eration	Charity	Safety and Compliance *(disbanded June 2019)*	Clinical Outcomes and Effectiveness (disbanded June 2019)	Finance and Investment *(changed to Finance and Performance July 2019)*	Patient and Staff Experience (disbanded June 2019)	People Education and Research (established July 2019)	Quality (established July 2019)
Phil Townsend, Chairman	10/11		3/3	0/1	1/2		12/12			
Ginny Edwards, NED*	11/11		3/3	3/4	2/2	1/1		1/1		8/9
John Brougham, NED*	11/11	4/5	3/3				12/12			1/1
Jonathan Rennison, NED*	10/11		3/3	3/4	1/2	1/1				8/9
Paul Cartwright, NED*	11/11	5/5	3/3		1/2			1/1	4/4	
Natalie Edwards Associate NED*	11/11	1/1	3/3					1/1	3/4	
Chief Executive	11/11						8/12			7/9
Deputy Chief Executive	10/11	3/5		2/4	2/2				3/4	
Chief Information Officer	8/11									
Chief Nurse	11/11	3/5		3/4	2/2	1/1		1/1	4/4	8/9
Chief People Officer	10/11		3/3	3/4				1/1	4/4	
Chief Financial Officer	11/11	4/5		2/4			11/12			
Chief Operating Officer	9/11				2/2	1/1	11/12	1/1		8/9
Chief Medical Officer	11/11				2/2	0/1	10/12		3/5	7/9

* Non-Executive Director

Governance Statement 2019-20

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 2020 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 NHS Improvement in respect of governance and risk management.

The Board has overall responsibility for setting the strategic direction of the Trust and managing the risks to delivery of the strategy. All committees have risk management responsibilities and report directly to the Board. The Trust's corporate governance structure is shown in appendix 1.

The risk management 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 monthly review by the Board and its committees.

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 actions 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; and
- Monitoring that all relevant risk assessments are undertaken, reviewed and documented appropriately.

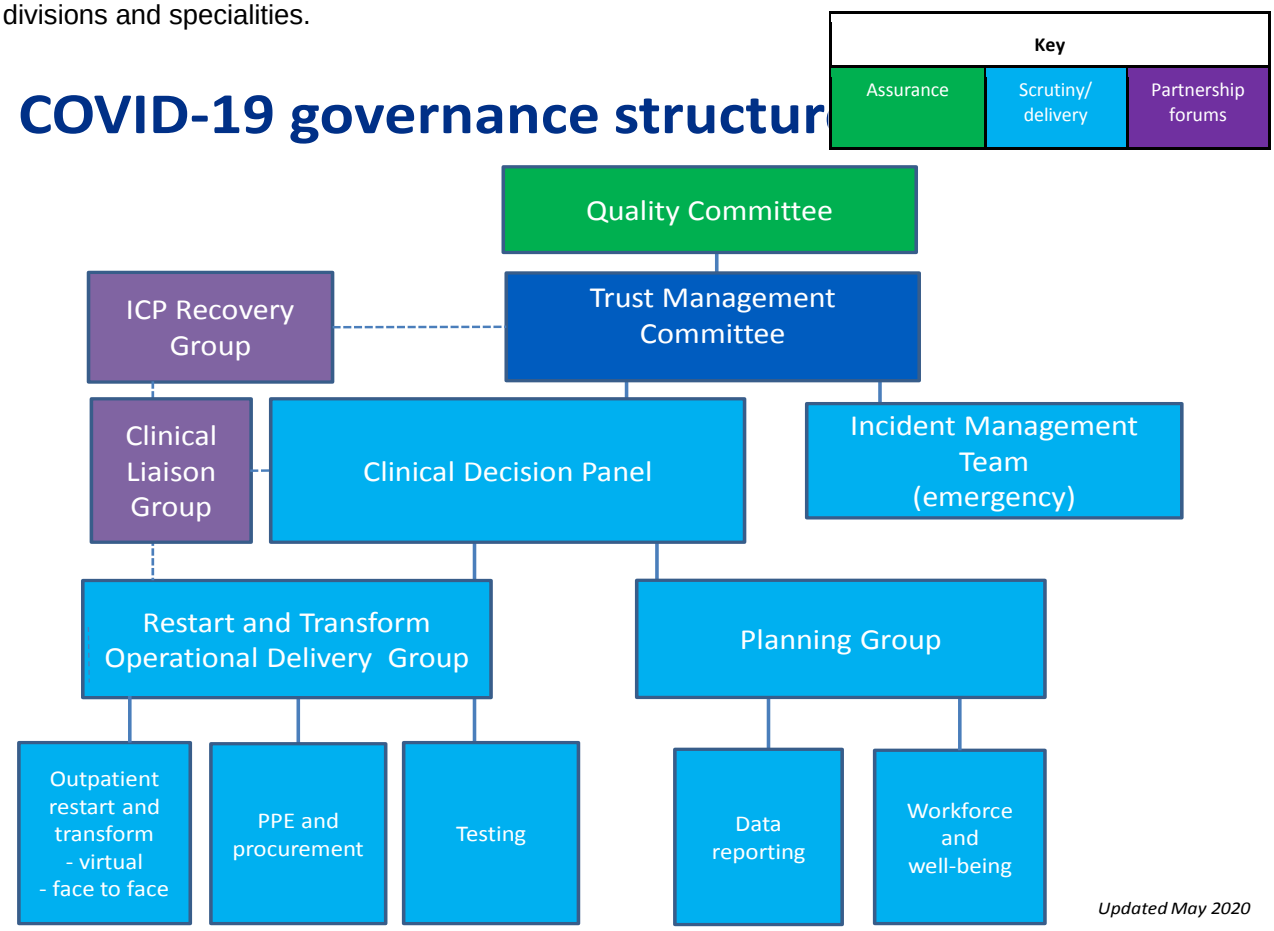
Senior managers routinely attend monthly risk review meetings to advise on specialty matters and provide assurance on operational risk management and divisional risk registers. The divisional risk registers are reviewed at divisional governance meetings at least on a quarterly basis to ensure actions 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.

Risk management of COVID-19

NHS England and other national regulatory bodies issued a range of targeted directives and essential guidance that focus on the delivery of patient safety and operational activity within healthcare in response to COVID-19 pandemic. In response the Trust introduced new ways of working that complement existing governance systems and processors. A clinical advisory panel was convened in March 2020 which aimed to provide rapid, senior clinical and executive overview and scrutiny to all national and local changes.

All identified risks were managed in line with Trust policies and procedures and remained within the existing organisational governance arrangements. Risks were reviewed via the divisional governance arrangements or directly raised with the lead executive director. The risk review group chaired by the chief medical officer reviews and accepts risks onto the corporate risk register as appropriate. Executive scrutiny and assurance was managed on a day by day basis in partnership with divisions and specialties, escalation as appropriate was also received into the incident management team and risk assessed as appropriate.

A range of risks recorded within the divisional and corporate risk registers, have all been separately coded to indicate they were as a direct result of, or have been influenced by COVID-19 pandemic. This approach supports the monitoring of risks across the whole organisation as well as aligning to the divisions and specialities.



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, including the principles of risk management and escalation, when a risk is deemed to be tolerable and the frequency of review for the controls that mitigate risks and the operation and review of the risk register module of the safeguarding system.

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 risk management 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 2019/20, the Board continued its work on the development of risk appetite, and following a Board development seminar, a risk appetite statement and threshold matrix was approved by the Board. These are both dynamic documents and are used by the Board and assurance committees to influence decision making at an individual risk level.

Risks are 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 Trust's risk register system, DATIX. The risk management strategy is available to all staff via the Trust's intranet.

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.

All risks on the risk registers have an active, robust and time specific mitigation plan. It is understood that some strategic risks associated with the business of the Trust 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, risk tolerance and corporate decision making. The National Patient Safety Agency's risk matrix is used to aid the Trust in making decisions on risk, and this is used by the Board as a basis of identifying acceptable and unacceptable risk.

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 in the Trust. 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.

An internal audit into divisional governance and risk management concluded that there was reasonable assurance.

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 ensures 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 the Board in its leadership and strategic decision making and all Board members receive an annual appraisal. 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 culture of the Trust continued 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 Trust's 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 this strategy and plan. Furthermore, it is the responsibility of the divisional teams to contribute to the delivery of the Trust's 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.

All managers and staff have a responsibility for supporting the Trust in its implementation of this strategy and plan and to adopt the principles of quality to guide them in their day to day roles.

The Board commences every meeting with a patient story or service improvement story, reflecting on positive and negative experiences 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 Department of Health and Social Care. Likewise, data to support compliance with locally commissioned services and targets is reported to the Board from the dataset provided to commissioners.

- **Data security**

Data quality and data security risks are the responsibility of the chief information officer and compliance is monitored by the joint information governance and security group, chaired by the chief information officer. Independent assurance is provided by the data security and protection (DSP) toolkit review process and any risks identified are added to the risk register.

- **Major risks**

The estate
Whilst the Trust aims to provide the best care, the age of its buildings makes it harder to always deliver the best experience for patients and staff. The government has announced that we will receive some investment to support the Trust's estate redevelopment strategic outline case and it will continue to be in discussions with regulators to confirm the anticipated next steps.

In the meantime, significant funding has been allocated in year to address the general fabric of buildings, prioritising health and safety and infection control. A program of works has been underway since mid-2019 to address defects such as flooring, decorations (including dementia-friendly ward improvements), sanitary ware, toilet upgrades. Works are also continuing to address high priority backlog maintenance, including replacement of key heating and pressure systems, lifts upgrades, plus high priority items as identified in a six-facet survey.

Major investment has also been made across the estate in terms of fire protection of our buildings. The Trust is currently in year three of an estimated five year program, whereby we have invested heavily in fire doors, fire suppression systems, emergency lighting, compartmentation and the fire alarm network.

Finances
Benchmarking data indicates that costs are comparable to similar sized hospital trusts. However, our poor estate and IT and three site configuration make it more difficult for the Trust to be as efficient as hospitals with more modern infrastructure. It is recognised that there is much more that can be done to make services more efficient and an in-depth assessment has been carried out to understand what drives the deficit. A combination of operational, structural (poor estates and digital infrastructure) and strategic (system wide) issues were identified. These findings are being used to devise the longer term solutions required to get us to a financially balanced position.

In 2019 the Trust agreed a new 'guaranteed income contract' contract with Herts Valleys Clinical Commissioning Group (HVCCG), which fixes the income for the year. This is intended to help both organisations plan with more certainty and focus on reducing the total cost of delivering care across all local organisations. This is an important step towards the new ways of working that the proposed west Hertfordshire Integrated Care Partnership will bring.

IT infrastructure
The Trust recognises the importance of improving its IT infrastructure and this will be a key feature of future redevelopment plans. A significant programme of work is already underway, year one focused on improving the core infrastructure, year two will focus on operating software and clinical applications (which will include upgrading our PAS system) with year three representing the initialisation of an electronic patient record implementation.

Other key risks to the Trust achieving its strategic objectives can be found in the BAF via the Board papers published on the Trust website. All risks remain 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 by the reporting committees and the escalation and de-escalation of risks is dependent upon progress to achieve outcomes.

4.3 Compliance with licence conditions

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

In April 2019, on behalf of the Board, the Quality Committee approved two regulatory NHS self-certification; 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. Actions identified to mitigate these risks are outlined below:

- **Effectiveness of governance structures**

The corporate governance team works with 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; and
- 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 overall Trust. The majority of measures are specific, measureable 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 2019/20 work programme delivered by internal audit:

Review title	Assurance level
Waiting list management	Partial assurance
Medical devices maintenance	Partial assurance
Accounts received	Reasonable assurance
Divisional governance and risk management	Reasonable assurance
Consultant job planning	Partial assurance
Care Quality Commission's action plan	Partial assurance
Locum booking process	Advisory
Data security and protection toolkit	Advisory
Procurement	Advisory
ATOS contract management	Partial assurance

- **Responsibilities of directors and committees**

The Board provides leadership and sets the tone for the organisation. As a unitary board, the Non Executive Directors share responsibility with the Executive Directors for ensuring that resources are in place to meet the objectives set.
The Board comprises of 11 directors: the chair, five non-executive directors and five executive directors including myself.

In order to discharge its duties effectively, the Board is required to have a number of statutory committees. 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 35.

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.

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.

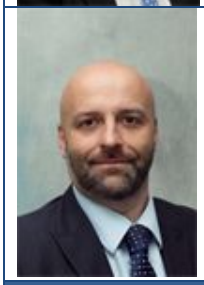
Together with internal and external audit, the Audit Committee receives reports on the effectiveness of the governance systems and structures to ensure they remain fit for purpose.

During 2019/20 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.

- **Reporting lines and accountability**

Non-Executive Directors	
	**Phil Townsend, Chair** Joined the Trust as a non-executive director in 2011, he was vice chair for five years and non-executive director for nearly eight years, before becoming the substantive chairman in February 2020. Phil comes from a commercial background, having spent over 30 years in the complex telecommunications industry, focused on IT and business transformation. Responsibilities: Chair of Board
	**Ginny Edwards, Vice-Chair** Joined the Trust in 2014 and is a registered nurse who has been working within the NHS and the healthcare industry since 1975. She's held a number of director-level positions in organisations and at national level. Responsibilities: Lead for Freedom to Speak UP. Chair of Quality Committee.
	**John Brougham, Non-Executive Director** Joined the Trust in 2014 and has 40 years' experience of working in large and small businesses, mainly in the technology and telecoms sectors, including 22 years at BT (British Telecom) where he was a divisional finance director. He has served as a non-executive director on the boards of both private and public limited companies, and has also been audit committee chair. Responsibilities: Chair of Finance and Performance Committee.

	**Paul Cartwright, Non-Executive Director** Joined the Trust in 2014 after working for Accenture (management consultants) for more than 20 years, where he specialised in finance, risk management and regulation. He is a Member of Council of King's College London. Responsibilities: Chair of Audit Committee and Remuneration Committee.
	**Jonathan Rennison, Non-Executive Director** Joined the Trust in 2014 with over 20 years' experience of working in the education, voluntary and public sectors. He currently runs an organisation which provides coaching for private businesses, as well as public sector and voluntary organisations and his expertise lies in helping leadership teams to manage change and development. Responsibilities: Senior Independent Director. Chair of Charity Committee.
	**Natalie Edwards, Associate Non-Executive Director** Appointed associate non-executive director in 2019. She has 20 years' extensive HR experience working in both strategic and operational roles. She has a strong track record of delivering business focused people strategies and transformation change projects. Responsibilities: Chair of People, Education and Research Committee.
Executive Directors	
	**Christine Allen, Chief Executive Officer** Appointed chief executive in March 2019. Christine has worked for the NHS for over 30 years, including chief executive and other board level roles. She has also led service transformation and held senior positions in business development and IT in her NHS career. Responsibilities: Accountable officer. Chair of Trust Management Committee.
	**Helen Brown, Deputy Chief Executive Officer** Joined the Trust in 2014 and has an in depth understanding of the NHS developed over a 20-year career in North and East London. She has worked in both provider and commissioning organisations, with a focus on community and integrated care service development and major service change. Responsibilities: Lead executive for Charity Committee, deputising for the chief executive, strategy, acute redevelopment, sustainability and transformation partnership, estates and facilities, communications and engagement, integrated care, redevelopment of hospitals.
	**Tracey Carter, Chief Nurse** Joined the Trust in 2014 with over 30 years' experience as a nurse and has held several senior positions. In May 2019, Tracey received a prestigious Chief Nursing Officer award. Responsibilities: Lead executive for Quality Committee, maternity safety champion governance, nursing, midwifery and allied health professional (NMAHP), quality improvement, NMAHP education, infection prevention and control, safeguarding, end of life care, duty of candour, CQC.

	**Mike van der Watt, Chief Medical Officer** Joined the Trust in 2011 as a consultant cardiologist before becoming divisional director of medicine a year later. He was appointed as chief medical officer (formerly known as medical director) in April 2013. Responsibilities: Caldicott Guardian, medical establishment, medical education, medical revalidation, risk management, serious incidents, discharge services, mortality, medicines management, clinical strategy, patient safety.
	**Don Richards, Chief Financial Officer** Joined the Trust in 2014, having previously been an NHS director of finance with over 20 years' experience in director roles for a number of NHS organisations, mostly in the acute sector. Responsibilities: Financial performance and management, operating and financial plan, procurement, efficiency delivery, income, contracts and commerce, service line reporting and patient level costing, financial accounts, treasury accounting and cashiers, accounts receivable and payable, private patient services, overseas visitors.
	**Sally Tucker, Chief Operating Officer** Appointed in November 2016, with over 35 years extensive experience in NHS operational management, initially joining as a management trainee. Her previous roles include deputy mental health services manager and deputy director of strategy and corporate services. Responsibilities: Emergency services, business continuity, elective care, bed management, A&E performance, space utilisation, divisional performance, senior managers and directors on call service, service delivery, RTT/ED/cancer performance.
	**Paul da Gama, Chief People Officer** Joined the Trust in 2014 as director for human resources. Paul career has included teaching, banking and the Royal Mail, before joining the NHS in 2012. Responsibilities: Medical education, recruitment, occupational health, employee relations , education, learning and development, temporary staffing, medical resourcing, health and wellbeing, organisational development, apprenticeship, workforce redesign STP lead for workforce planning, leadership and temporary staffing, East of England locum consortium lead
	**Paul Bannister, Chief Information Officer** Appointed in 2019, Paul is a qualified accountant with 15 years' NHS experience and extensive experience in commissioning, financial and acute contract management. Responsibilities: Senior information responsible officer ICT, digital transformation, business intelligence and reporting, performance assurance, outpatient administration, including medical records, information governance and data protection.

Clinical representatives

 **Dr Andy Barlow** **Divisional Director, Medicine**	 **Dr Anna Wood** **Director of Governance**	 **Dr Jeremy Livingstone** **Divisional Director, Surgery, Anaesthetics and Cancer**

- **Submission of timely and accurate information**

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 Trust is therefore satisfied that there is a high degree of rigour and Board oversight of risk and performance.

- **Board oversight of performance**

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

A monthly integrated performance report is produced which contains performance indicators and NHS Improvement'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 team in four key areas, and compliance with the Trust's financial accountability framework.

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 cost improvement programme achieved savings of £15.1m, equivalent to 3.8% of income. Efficiency schemes are quality impact assessed and approved by the chief nurse and medical director prior to implementation.

4.4 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 for the Board and monthly risk reports for assurance committees.

The Trust openly encourages staff to report incidents and near misses using the Trust's 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 supported the Speak out Safely initiative.

Following the publication of NHS Employers' *Review into Raising Concerns* in March 2015, the organisation continues to promote the culture of speaking up for patients to improve and maintain the patient and staff experience.

The Trust's Freedom to Speak up Guardian is a non-executive director and the Trust continues to closely follow the recommendations from Robert Francis' *Freedom to Speak Up* report.

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 program 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. The counter fraud service is provided by RSM. This helps to embed and tackle fraud and potential fraud in several ways.

- developing an antifraud culture across the Trusts workforce.
- fraud proofing of all Trust policies and procedures.
- conducting fraud detection exercises into areas of large risk.
- investigating any allegations of suspected fraud.
- obtaining, where possible, appropriate sanctions and re-dress.

All policies, procedures, guidelines, schemes, strategies have a completed equality impact assessment (EIA) before being submitted to the relevant committee for discussion and sign off. Likewise completion of an EIA is expected when there is a new service to be implemented, a change to a service or cessation of the service along with the relevant consultation and engagement with service users. Where an adverse impact is identified during the completion of the initial assessment, a full EIA is carried out. This involves consulting and engaging with people who represent protected characteristic groups and other groups if required to do so.

4.5 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, Herts Valleys Clinical Commissioning Group, Hertfordshire County Council's Health Scrutiny Committee (HSC), local safeguarding Boards and Hertfordshire HealthWatch. The Trust is also represented at the local Health and Wellbeing Board.

A number of patients attend Trust's meetings 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 throughout the Trust whenever decisions that affect patient care are made.

Stakeholder engagement in 2019/20 has been very much focused on the options for the future redevelopment of the trust's hospital 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 and Three Rivers.

As we start to develop the next phase of the hospital redevelopment (outline business case), public engagement events will take place in May 2020. In light of new guidance from the government around social distancing, and to protect residents of west Hertfordshire from Covid-19 the Trust is planning to conduct engagement via digital platforms such as webinars, online video conferencing and social media.

The Trust continues to maintain a close working relationship with the County Council's HSC 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 2019/20; 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 2020 to allow members to explore the options for hospital redevelopment in more depth. In addition to engagement with the HSC 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.

4.6 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 and the Trust is one of three founder members of a shared bank across Hertfordshire that allows staff to work across all three trusts.

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.

4.7 Disclosure of registration requirements

The Trust is fully compliant with the registration requirements of the CQC and oversight of the Trust's quality compliance programme is regularly monitored through the Quality Committee and reported through to the Board. The Trust was the subject of inspection in the February and March 2020 and informal feedback received from the CQC did not highlight any significant issues and immediate measures were put in place to promptly address any areas identified for improvement as part of the inspection. The final inspection reports and ratings will be published in due course and will be available on the CQC's website (www.cqc.org.uk).

4.8 Register of interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS'* guidance.

4.9 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.

4.10 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 takes 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.

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

The Trust has undertaken risk assessments and has a sustainable development management plan in place 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 the set target of savings of £15.1m, (3.8% of revenue). All efficiency schemes were quality impact assessed and approved by the chief nurse and medical director prior to implementation.

In May 2020, the Quality Committee on behalf of 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.

6. Well-led framework

In 2018/19, the Trust received a number of external observations and assessments undertaken under the scope of NHS Improvement's well-led framework. In addition, between March and May 2019, the Board and the committees conducted a self-assessment of effectiveness against their terms of reference. Overall, feedback from the observations and assessments was positive and reported that members of the Trust's senior leadership team generally had the appropriate range of skills knowledge and experience and there was an appropriate level of operational and financial experience and expertise across both non-executive directors and executives.

The key themes/recommendations from the reviews were analysed and collated into an overarching plan to address areas of further improvement, which was approved by the Board in June 2019. An important element of the plan was a refresh of the committee structure which was established in July 2019 and is outlined on page 32.

The refreshed committee structure was kept under continual review in 2019/20 and overall, to date, unofficial feedback has been positive and will be tested formally in early 2020/21 through an annual corporate governance self-assessment programme and a survey of the Board and committee members.

7. Information governance

Information governance incidents are graded using the NHS Digital breach assessment grid which is in line with new requirements under the General Data Protection Regulations 2016 and Data Protection Act 2018.
Incidents are graded using a 5 x 5 breach assessment grid according to the significance of the breach and the likelihood of serious consequences occurring on the individual or groups of individuals affected, with 1 being the least serious and 25 the most serious. Incidents graded a 6 or above are reportable to the Information Commissioner's Office (ICO) via the Data Security and Protection Toolkit Incident Reporting Tool.

During the financial year 2019/20, the following two serious incidents were reported to the ICO.

Month of incident	Nature of incident	Number affected	How patients were informed	Lessons learned
10/19	A clinic letter containing sensitive personal information was incorrectly addressed and posted to a neighbouring block of flats in the same road as the patient's home address that lived opposite.	1	The GP gave the patient a copy of the clinic letter during their patient appointment. Both addresses were in the same road with only a single letter being different for each postcode.	An amendment to the patient's postcode which was initially held correctly was made in error. Corrections to patient demographics must be confirmed by the

				patient before being made.
04/19	Patient referred for six week pregnancy scan. A mobile number belonging to the patient's mother was entered as a contact number for the patient when they were last seen in hospital as a child. Contact details had not been updated since and details relating to the pregnancy scan were inadvertently disclosed to the patients' mother in error when trying to contact the patient.	1	By the patient's mother.	Inadvertent disclosure of clinical information of a sensitive nature caused anxiety and distress to the patient. Extra care must be taken to ensure contact information is correct and up-to date before contacting patients.

No regulatory action was taken by the ICO and both incidents were closed after a full investigation was undertaken, and measures put into place to ensure similar incidents from reoccurring.

8. 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 Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS trusts on the form and content of annual quality reports which incorporate the above legal requirements in the NHS Trust Annual Reporting Manual. Due to the COVID-19 pandemic, a revised deadline of 15 December 2020 has been published for the 2019/20 Quality Account and this will be completed in line with national guidance and a formal review process established which will involve the submission of the draft Quality Account to external stakeholders (Commissioners, Overview and Scrutiny Committee and Healthwatch). The Quality Account will do 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:

- **Governance and leadership**

The quality improvement system is lead directly by the Board which also exercises its governance responsibilities through monitoring and reviewing the Trust's quality performance. The Quality Committee reports directly to the Board and leads the Trust's quality agenda and provides assurance on compliance with the Trust's quality indicators.

- **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 Committee sets 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.

- **Systems and processes**

The Board ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy, as well as the quality of the healthcare it delivers.

The Board regularly reviews the performance of the Trust in these areas against regulatory requirements and approved plans and objectives.

- **Data use and reporting**

The Trust is provided with external assurance 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.

- **Data quality of elective waiting time data**

There are a number of ways in which the Trust carries out checks to validate data quality for referral to treatment (RTT), diagnostic, and cancer waiting times (CWT) for elective waiting time reporting. All patient pathways for RTT, diagnostic and CWT standards are guided by 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 with the Trust.

The access policy allocates clear lines of responsibilities within the organisation for ensuring that services have the frameworks, policies and processes to support delivery of operational standards in relation to RTT, diagnostics and CWT, including robust checking to ensure adherence to the policy a wide range of specific checks are undertaken by the Trust to validate data quality.

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

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 within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system in place.

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

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

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

I am assured that 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.

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

The Trust has in place a 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, 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.

From informal feedback on an inspection by the CQC in February and March 2020, I was assured that there were no significant quality and patient safety issues in the Trust.

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 it could be inadequate and ineffective. This is based on non-compliance issues identified in our reviews of medical device maintenance, waiting list management, consultant job planning. We acknowledge that the system of internal controls at the Trust continues to be evaluated by management and that action plans have been agreed to address compliance issues. We note that the Trust and its officers are alert to their responsibilities and accountabilities in respect of internal control.

We also note that the Trust has a challenging underlying financial position; however we recognise that the Trust has met its control total for 2019/20 and has agreed its control total for 2020/21.

10. Conclusion

In line with the guidance on the definition of the significant internal control issues, I have not identified any significant control issues.

Signed  . Date 17 June 2020

Christine Allen
Chief Executive

Remuneration and staff report

Expenditure on consultancy (audited)

Total expenditure on consultancy services in 2019/20 was £1.9m (£1.1m in 2018/19). This spend is in relation to advisory services in connection with the Trust's expected estate redevelopment. These include the strategic outline case for the major redevelopment and the refurbishment of Watford General Hospital theatres. In addition to this, there has been support to assist with various IT projects in particular supporting network infrastructure.

Director salary relative to workforce (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in the Trust in the financial year 2019/20 was £293k (2018/19, £289K). This was 8.4 (2018/19 - 8.5) times the median remuneration of the workforce, which was £35.0k (2018/19 £33.9k).

In 2019/20 no employee received remuneration in excess of the highest paid director. Remuneration ranged for full time employees from pay banding £15-20k to pay banding £290-295k.

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

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 two 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.

Staff banded by ethnicity

Ethnicity	Bands 1 - 7	Bands 8+	Medical	Non-Executive Director	Grand Total
A White - British	1,848	186	133	4	2,171
B White - Irish	90	11	3	1	105
C White - Any other White background	374	13	68		455
D Mixed - White & Black Caribbean	19	1	2		22
E Mixed - White & Black African	13	1	4		18
F Mixed - White & Asian	16		8		24
G Mixed - Any other mixed background	29	2	8		39
H Asian or Asian British - Indian	515	32	150		697
J Asian or Asian British - Pakistani	95	2	50		147
K Asian or Asian British - Bangladeshi	15	1	12		28
L Asian or Asian British - Any other Asian background	405	11	64	1	481
M Black or Black British - Caribbean	67	10	3		80
N Black or Black British - African	249	10	35		294
P Black or Black British - Any other Black background	35	1	1		37
R Chinese	29	1	15		45
S Any Other Ethnic Group	91	3	29		123
Unknown	180	13	74		267
Z Not Stated	86	5	17		108
Grand Total	4,156	303	676	6	5,141

Staff numbers and composition

Staff Numbers and composition - 2019/20 (audited)

	2019/20						2018/19	
	Total		Permanently employed		Other		Total	
	Number	£'000	Number	£'000	Number	£'000	Number	£'000
Medical and dental	741	84,276	638	67,028	103	17,248	678	74,865
Administration and estates	1,176	47,840	1,052	41,725	124	6,115	1,176	43,359
Healthcare assistants and other support staff	1,010	29,791	837	24,393	173	5,398	978	27,096
Nursing, midwifery and health visiting staff	1,622	81,236	1,406	68,965	216	12,271	1,613	74,991
Nursing, midwifery and health visiting learners	0	0	0	0	0	-	0	0
Scientific, therapeutic and technical staff	511	27,871	462	24,625	49	3,246	506	25,748
Engaged on capital projects	8	655	7	532	1	123	0	0
TOTAL	**5,068**	**271,669**	**4,402**	**227,268**	**666**	**44,401**	**4,951**	**246,059**

This table excludes Apprentice Levy costs of £840k in 2019/20 (£845k in 2018/19) included in note 9 of the financial statements

Staff numbers by gender

Staff Group	Female	Male	Grand Total	Female %	Male %
Add Prof Scientific and Technic	119	40	159	74.8%	25.2%
Additional Clinical Services	784	218	1,002	78.2%	21.8%
Administrative and Clerical	995	210	1,205	82.6%	17.4%
Allied Health Professionals	211	47	258	81.8%	18.2%
Estates and Ancillary	33	49	82	40.2%	59.8%
Healthcare Scientists	113	38	151	74.8%	25.2%
Medical and Dental	306	370	676	45.3%	54.7%
Nursing and Midwifery Registered	1,454	148	1,602	90.8%	9.2%
Students	6		6	100.0%	0.0%
Grand Total	4,021	1,120	5,141	78.2%	21.8%

Staff sickness absence data (audited)

For further details on average staff sickness per day in 2019/20 please refer to
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
An average of 7.16 working days were lost per staff member in 2018/19.

Policy on remuneration of directors

Decisions on remuneration of directors are made by the Remuneration Committee which seeks to position the Trust in a way that is able to attract, retain and motivate very senior managers (VSM) and associated directors of sufficient calibre to maintain high quality, patient-centred healthcare and effective management of the Trust's resources. The Committee ensures that it strikes an appropriate balance between this approach and the duty to ensure effective stewardship of public resources. On an annual basis the Committee will consider the remuneration packages of all VSM and associated directors to ensure that remuneration remains appropriate and continues to ensure effective stewardship of public resources.

Directors' remuneration

DIRECTORS' REMUNERATION 2019-2020 (audited)			2019/20					2018/19			
NAME	TITLE	In year start/ leave dates	SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	All pension-related benefits bands of £2,500	TOTAL bands of £5,000	SALARY bands of £5,000	Expense payments (taxable) total to nearest £100	Performance pay and bonuses bands of £5,000	TOTAL bands of £5,000
Prof S. Barnett	Chairman	Left Feb 2019	0	0	0	0	0	35-40	3,200	0	40-45
K. Fisher	Chief Executive	Left Jun 2018	0	0	0	0	0	40-45	0	0	40-45
C. Allen	Chief Executive	Start Mar 2019	205-210	0	0	0	205-210	15-20	0	0	15-20
P. Townsend	Non-Executive Director (vice Chairman)	Left Feb 2019	0	0	0	0	0	5-10	100	0	5-10
P. Townsend (note 1)	Chairman	Start Mar 2019	40-45	300	0	0	40-45	0-5	0	0	0-5
V. Edwards	Non-Executive Director Freedom to speak up Guardian, and Vice Chair		5-10	0	0	0	5-10	5-10	0	0	5-10
J. Brougham	Non-Executive Director		5-10	0	0	0	5-10	5-10	100	0	5-10
J. Rennison	Non-Executive Director (Senior Independent Director)		5-10	0	0	0	5-10	5-10	0	0	5-10
P. Cartwright	Non-Executive Director		5-10	0	0	0	5-10	5-10	0	0	5-10
N. Edwards (note 2)	Associate Non-Executive Director	Start Apr 2019	0-5	0	0	0	0-5	0	0	0	0
D. Richards	Chief Financial Officer		165-170	0	0	0	165-170	165-170	200	0	165-170
T. Carter	Chief Nurse & Director of Infection Prevention and Control		125-130	0	0	57.5-60	185-190	120-125	0	0	120-125
H. Brown (note 2)	Deputy Chief Executive		140-145	200	0	42.5-45	185-190	30-35	0	0	30-35
H. Brown	Acting Chief Executive	Jun 2018 - Feb 2019	0	0	0	0	0	100-105	200	0	100-105
M. Van Der Watt (note 3)	Chief Medical Officer/Director of Patient Safety		290-295	0	0	50-52.5	340-345	285-290	0	0	285-290
S. Tucker (note 4)	Chief Operating Officer	Jun 2018 - Feb 2019	0	0	0	0	0	85-90	100	0	85-90

NOTES
Note 1: P. Townsend was appointed as Interim Chairman from March 2019 to February 2020. In March 2020 was substantively appointed as Chairman.
Note 2: H. Brown and N Edwards are non-voting directors.
Note 3: 79% of salary as Chief Medical Officer and 21% for clinical work.
Note 4: S. Tucker from 1st March 2019 is a non-voting director, no disclosure required.
Note 5 : Pension related benefits disclosure made in 2019/20 only. No disclosure was made in 2018/19.

The salaries above may include salary sacrifice schemes.

Off payroll engagements

Table 1: Off-payroll engagements for longer than 6 months

For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	2
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: Off Payroll Engagements

For all new off-payroll engagements between 1 April 2019 and 31 March 2020, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	1
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	1
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	3
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off Payroll board members (including non-executive directors)/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	11

Exit packages

Exit Packages in 2019/20 (audited)

2019/20

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made
	Number	£s	Number	£s	Number	£s	Number
<£10,000	1	5,000	26	72,411	**27**	**77,411**	0
£10,000 - £25,000	1	10,900	4	56,273	**5**	**67,173**	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	**2**	**15,900**	**30**	**128,684**	**32**	**144,584**	**0**

2018/19

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

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

	2019/20		2018/19	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000s	Number	£000s
Contractual payments in lieu of notice	30	129	19	53
Total	**30**	**129**	**19**	**53**

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

There was no Trust's voluntary resignation scheme.

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

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

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

Directors' pension entitlement

DIRECTORS' PENSION ENTITLEMENT 2019-2020 (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 2020 (bands of £5,000)	Lump sum related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real increase/(decrease) in Cash Equivalent Transfer Value (bands of £1,000)	Employer's contribution to stakeholder pension
T. Carter	**2.5-5**	**2.5-5**	**45-50**	**105-110**	810,208	722,790	52	0
H. Brown (note 1)	**2.5-5**	**0**	**50-55**	**120-125**	970,741	897,492	36	0
M. Van Der Watt	**2.5-5**	**10-12.5**	**60-65**	**190-195**	1,512,023	1,336,678	101	0

Note 1: H Brown opted out of the NHS Pension Scheme on the 01 January 2020

No disclosure is made for Directors who have opted out of the NHS Pension Scheme for the whole of 2019/20.

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: 17 June 2020

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 2020, 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 2019 to 2020.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2020 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 2019 to 2020; 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.

The impact of macro-economic uncertainties on our audit

Our audit of the financial statements requires us to obtain an understanding of all relevant uncertainties, including those arising as a consequence of the effects of macro-economic uncertainties such as Covid-19 and Brexit. All audits assess and challenge the reasonableness of estimates made by the Directors and the related disclosures and the appropriateness of the going concern basis of preparation of the financial statements. All of these depend on assessments of the future economic environment and the Trust's future operational arrangements.

Covid-19 and Brexit are amongst the most significant economic events currently faced by the UK, and at the date of this report their effects are subject to unprecedented levels of uncertainty, with the full range of possible outcomes and their impacts unknown. We applied a standardised firm-wide approach in response to these uncertainties when assessing the Trust's future operational arrangements. However, no audit should be expected to predict the unknowable factors or all possible future implications for an entity associated with these particular events.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Directors' use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the Directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2019 to 2020 that the Trust's financial statements shall be prepared on a going concern basis, we considered the risks associated with the Trust's operating activities, including effects arising from macro-economic uncertainties such as Covid-19 and Brexit. We analysed how those risks might affect the Trust's financial resources or ability to continue operations over the period of at least twelve months from the date when the financial statements are authorised for issue. In accordance with the above, we have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Emphasis of Matter – effects of Covid-19 on the valuation of land and buildings

We draw attention to Note 1.2.2 of the financial statements, which describes the effects of the Covid-19 pandemic on the valuation of land and buildings as at 31 March 2020. As, disclosed in Note 1.2.2 to the financial statements, the Trust's valuer has declared a "material valuation uncertainty" in the valuation report. This is on the basis of uncertainties in markets caused by Covid-19. The valuers have provided additional clarification that the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. It is used in order to be clear and transparent with all parties, that in the current extraordinary circumstances less certainty can be attached to the valuation than would otherwise be the case. The values in the report have been used by management to inform the measurement of property assets as at 31 March 2020 within these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. 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 2019/20, 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 in April 2015 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement 2019-20 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 Governance Statement 2019-20 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 2019 to 2020 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 2019/20 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 18 June 2020 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to West Hertfordshire Hospitals NHS Trust's breach of its break-even duty for the three year period ended 31 March 2020.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

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
Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in April 2020, except for the effects of the matters described in the basis for qualified conclusion section of our report we are 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 2020.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- during the course of 2019/20 the Trust incurred a deficit of £22.5 million, compared to a planned deficit of £22.7 million, which is inclusive of planned Provider Sustainability Fund, Marginal Rate Emergency Tariff and Financial Recovery Fund (FRF) income totalling £27.8 million. This increased the Trust's cumulative deficit to £197 million as at 31 March 2020;
- for 2020/21, the Trust has set an in-year break even target. Achievement of this target is dependent on the financial regime as set out in the "Statement from NHS England and NHS Improvement to support provider and commissioner forecasting". Prior to the emergence of the Covid-19 pandemic the Trust has set a plan to break-even partially dependent on an NHSEI notification of expected payments of £49.1m of Financial Recovery Fund income. There is a risk that the Trust will not deliver its financial plan or will not receive all of the anticipated top up funding and will not meet its break-even target as a result.

These matters identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures.

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.

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources
Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.
We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer
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 April 2020, 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 2020, 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

Signature
Ciaran McLaughlin, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
24 June 2020

THE FINANCIAL STATEMENTS

For the 2019/20 financial year, the Trust reports an improving financial position by recording a revenue deficit within the target set by NHS England and NHS Improvement (NHSE/I).

Over the last three years (since April 2017) the Trust has continued to improve services by implementing innovative patient pathways while upgrading its estates infrastructure within the limitations of available funding. The progress the Trust is making has been reflected in both an improvement in the conclusions emerging from of our Care Quality Commission inspections as well as better clinical experiences and outcomes for patients. Our efforts to improve our estate received a boost when the trust's large scale plans to redevelop our estate were given the green light by being included in the first wave of the Department of Health and Social Care (DHSC) Health Infrastructure Plan (HIP1). The trust's plans are among six targeted for construction starting within the next five years.

In setting a financial plan for the 2019/20 financial year, the Trust agreed to manage services within the NHS Improvement financial target of a revenue deficit, no greater than £22.7m. This target included expectations for £23.1m of income, based on financial performance, from the 'Provider Sustainability Fund' (PSF) and 'Financial Recovery Fund' (FRF). The Trust ended the 2019/20 year with a revenue deficit of £22.5m, compared with a revenue deficit of £49.6m[1] for the 2018/19 year.

The planned deficit partially relied on achieving savings worth £15.0m equivalent to 4.0% of turnover or 3.7% of costs. This achievement matched the Trust's long term planning ambition to achieve efficiencies each year worth 4% of turnover.

Income for the Trust saw an increase in 2019/20 of 18.1%. (£393.7m in comparison to £333.4m in 2018/19). The main increases were due to:

- A £3.2m increase in income received for attendances to our Accident and Emergency, minor injuries and Urgent Treatment centres. Attendances increased by 5.8% over the previous year.
- £119.4m of our income was linked to patients admitted for emergency (non-elective) care. This was £12.0m higher than 2018/19 levels, with a 13% increase in activity spells.
- Elective income decreased by £1.5m while the volumes were at similar levels to 18/19 overall. We saw a 12% reduction in Day Cases while Elective inpatient admissions increased by 1.9%
- Outpatient income increased by £2.8m to £71.1m driven by volume changes of 6.4% the need to keep pace with the increased referrals.
- Increase in other income of £2.6m for patient pathway redesign and additional winter pressure funding.
- Funding of £27.8m in relation to the Provider Sustainability Fund, the Financial Recovery and a removal of the application of marginal payment rates for emergency admissions in 2019/20.
- An increase in funding of £9.6m from NHS England to match the increase in employer's pension contribution by 6% in 2019/20.

Similar to other years our ability to treat as many patients as possible was limited by a number of incidents requiring the trust to temporarily change the way that services are delivered.

Of course the most significant challenge, that the trust has ever faced, to the normal continuity of care, was the impact of the COVID-19 pandemic. This materially affected service delivery in the last month of the 2019/20 financial year. The late impact of the pandemic in the year limited the additional cost impact to £1.3m. All of these costs were fully funded by DHSC.

[1] This is the deficit reported against the breakeven duty of the Trust. Provider sustainability funds were not earned in that year, as the Trust did not agree to the control total of planned deficit of £7.9m.

The Trust derives most of its income from a contract with Herts Valleys Clinical Commissioning Group (HVCCG). In 2019/20 the Trust agreed to move away from an activity based contract to a block funding based contract for most of the service provided to the CCG. The underlying value of the block sum was paid based largely on activity numbers valued at rates determined by the national tariff payment system.

The Trust's operating costs (excluding impairments) rose from £380.2m in 2018/19 to £411.9m in 2019/20, an 8.3% increase. Within this, staff costs increased by £25.2m. The most notable difference in staff costs was a mandated 6% increase in employer's pension contribution, costing £9.6m. These costs were fully met through increased funding. Leaving this aside, staff cost increases are mainly driven by the growth in patient numbers and the increased dependency of patients (for example reflected in an increase in '1:1' nursing costs). Agency costs reduced compared to the previous year, but these costs are at a premium to employed staff. Non pay expenditure rose by £6.4m from £133.6m in 2018/19 to £140.1m in 2019/20, driven mainly by a change to the trust's IT infrastructure provider. The transition required additional spending to manage the transition, including the migration of data, and the new contract period necessarily started before the existing contract ended to support a seamless transition.

The Trust continued to reduce its reliance on agency staff to reduce costs and improve quality. 2019/20 saw agency costs of £13.7m (the Trust spent £14.9m in 2018/19). Since 2015/16, the Trust has reduced its agency spend from £36.7m to £13.7m. In order to support meeting the 2019/20 income and expenditure target, the Trust expects 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 Trust has made very good progress in recruitment drives from overseas nurses.

The Trust efficiency programme in 2019/20 was £15.0m which is in line with the Annual Plan. 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 recurrent 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.

DHSC recognise the challenge that all NHS Trusts face for 2020/21 in continuing to develop new efficiencies while dealing with the COVID-19 pandemic.

As the Trust recorded a revenue deficit in 2019/20, and did so in previous years, the Trust was unable to break even over a six year period, taking one year with another. Technically the Trust is in breach of the Statutory Breakeven Duty over the permitted five year period.

As highlighted above, the cash impact of the I&E deficit was supported by revenue loans from the Department of Health and Social Care of £33.3m[2]. Investment in new assets (capital expenditure) was supported by a capital loan of £12.7m[3] and additional public dividend capital of £1.3m for national programmes including winter initiatives.

All DHSC loans recorded in the Trust books total £237.8m. The Trust has received confirmation that the cash value of outstanding loans will be replaced with public dividend capital (a form of government equity investment). The Trust will be required to pay a dividend against this new injection of public dividend capital but this will be offset by no longer paying interest on loans and an increase to central revenue funding. In addition the principle value of outstanding loans will not have to be paid back. This will strengthen our liquidity and improve cash flow in future years.

[2] The revenue loans were in form of Uncommitted Single Currency Interim Revenue Support on monthly basis. This includes planned deficit loans of £22.7m and £2.5m for advance in PSF and FRF which will be paid in April 2020 to DHSC. A further £8.1m has been received in advance of PSF and FRF income.

[3] Remaining loan of £8.1m approved in 2017/18 and a new loan approved for £4.8m for emergency capital of which £4.6m is drawn down in 2019/20 and remaining £0.2m will be drawn down in 2020/21.

The Trust spent £21.3m[4] on new, refurbished and replacement capital assets including medical equipment.

The main areas of spending were:

- Over £3.5m on fire safety improvements throughout the Trust to ensure compliance with current Health & Safety standards
- £1.4m on general refurbishment of clinical areas throughout the Trust.
- £1.1m to develop plans to significantly improve theatres at Watford General Hospital.
- £0.4m to develop options, business plans and consultations for the complete redevelopment of the Trust's sites.
- Over £5.0m investment in IT including roll out of Windows 10 and upgrade of the network infrastructure. Several end user devices and other hardware and software were implemented to support clinical teams.
- Over £3.0m spend on various improvements to support capacity for emergency services over winter.
- Over £3.0m spent to replace ageing medical equipment including a new replacement of the CT scanner at Watford.
- £1.5m on the estates backlog maintenance programme.

The Annual Plan for 2020/21 is suspended until 31 July 2020 due to the NHS response to COVID-19. The Trust will receive appropriate funding to support our response without incurring a financial deficit. It is planned after a suitable period (to be confirmed) the Trust will update its plan to manage services while balancing income with expenditure.

Providing services in 2020/21 will require capital investments targeted at managing COVID-19 care as well as other capital investments. All COVID-19 related investments will be funded separately. Other investments will be planned for as part of a Hertfordshire and West Essex system wide agreement for capital investment. Our draft plans target further investment in the estate ahead of our approved HIP1 scheme.

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, it is good news that the DHSC loans will be written off in 2020.

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 53 of the accounts. Internal audit and counter fraud services contract was re-tendered in 2019/20. BDO LLP won the contract for

[4] Includes £0.2m of donated expenditure

Internal Audit Services. Counter Fraud Service contract was retained by RSM. The new contracts commences for two years on 1 April 2020 to 31 March 2022. Successful transition has been completed on internal audit services from RSM to BDO LLP.

External audit

The Trust has a statutory duty to appoint external auditors under the Local Audit and Accountability Act 2014. Grant Thornton UK LLP was appointed after a competitive tender exercise for two years, as from 01 April 2019, for the provision of external audit services. The contract has been renewed for 2 years to 31 March 2021.

In the event that the Trust appoints Grant Thornton for work other than that of external audit, the expense is shown separately in the annual accounts as “other auditor remuneration” (see note 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 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 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.

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 2019/20 was improved in comparison to 2018/19. The improvement was possible due to the deficit loans received in year of £22.7m which supported the Trust in paying suppliers promptly and improving 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 was seen in month March 2020 performance has increased to 91.4%.

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. RSM won the competitive tender in 2019/20 for further 2 years from 1 April 2020 to 31 March 2022.

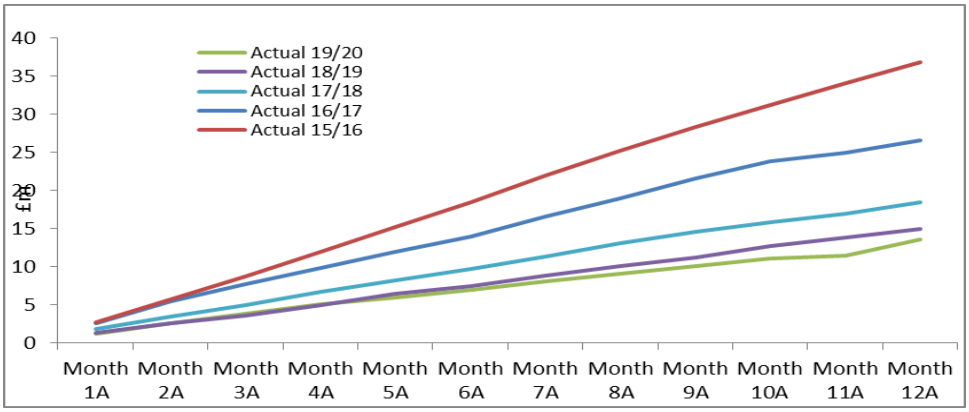
Income generation activities

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

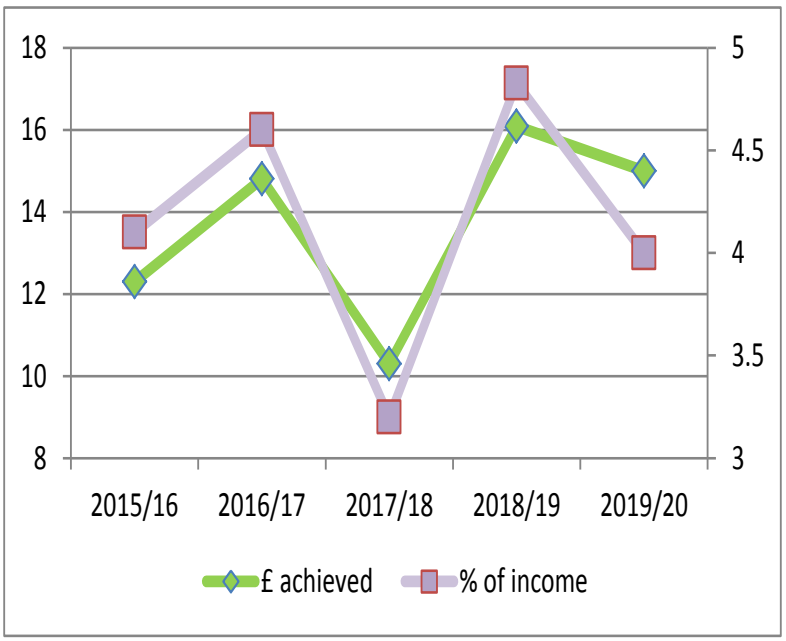
Pensions

Past and present employees are covered by the NHS pension schemes. Details of the benefits payable under these provisions can be found on the NHS pensions website at https://www.nhsbsa.nhs.uk/nhs-pensions. Further details can be found in note 10 of the accounts.

Agency expenditure for financial years 2015/16 – 2019/20



Efficiency savings for financial years 2015/16 – 2019/20 (£k & % of income)



West Hertfordshire Hospitals NHS Trust

Annual accounts for the year ended 31 March 2020

Statement of Comprehensive Income

	Note	2019/20 £000	2018/19 £000
Operating income from patient care activities	3	337,289	307,748
Other operating income	4	56,386	25,619
Operating expenses	7.1, 9	(413,560)	(381,024)
Operating deficit from continuing operations		**(19,885)**	**(47,657)**
Finance income	12	85	69
Finance expenses	13	(4,205)	(2,850)
PDC dividends payable		-	-
Net finance costs		**(4,120)**	**(2,781)**
Deficit for the year from continuing operations		**(24,005)**	**(50,438)**
Deficit for the year		**(24,005)**	**(50,438)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	17.5	3,081	27,436
May be reclassified to income and expenditure when certain conditions are met:			
Total comprehensive income / (expense) for the period		**(20,924)**	**(23,002)**
Adjusted financial performance (control total basis):			
Deficit for the period		(24,005)	(50,438)
Remove net impairments not scoring to the Departmental expenditure limit		1,664	799
Remove I&E impact of capital grants and donations		(130)	(2)
Adjusted financial performance deficit		**(22,471)**	**(49,641)**

The adjusted retained deficit of £22,471,000 is after excluding impairments and the net of donated income and depreciation. The Trust financial performance is measured on the adjusted Breakeven duty deficit of £22,471,000 as described in note 39.

The notes on pages 5 to 37 form part of this account.

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	16	8,726	3,314
Property, plant and equipment	17	190,792	182,562
Receivables	19	1,834	1,793
Total non-current assets		**201,352**	**187,669**
Current assets			
Inventories	18	5,441	4,451
Receivables	19	35,330	19,132
Cash and cash equivalents	20	5,360	2,858
Total current assets		**46,131**	**26,441**
Current liabilities			
Trade and other payables	21	(45,032)	(36,057)
Borrowings	23	(237,761)	(76,741)
Provisions	26	(670)	(617)
Other liabilities	22	(1,929)	(1,626)
Total current liabilities		**(285,392)**	**(115,041)**
Total assets less current liabilities		**(37,909)**	**99,069**
Non-current liabilities			
Borrowings	23	(2,000)	(119,552)
Provisions	26	(4,171)	(3,966)
Total non-current liabilities		**(6,171)**	**(123,518)**
Total assets employed		**(44,080)**	**(24,449)**
Financed by			
Public dividend capital		227,316	226,023
Revaluation reserve		55,613	52,532
Income and expenditure reserve		(327,009)	(303,004)
Total taxpayers' equity		**(44,080)**	**(24,449)**

The notes on pages 5 to 37 form part of these accounts.

Signature _____

Name Christine Allen
Position **Chief Executive Officer**
Date 15 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**226,023**	**52,532**	**(303,004)**	**(24,449)**
Deficit for the year	-	-	(24,005)	**(24,005)**
Revaluations	-	3,081	-	**3,081**
Public dividend capital received	1,293	-	-	**1,293**
Taxpayers' and others' equity at 31 March 2020	**227,316**	**55,613**	**(327,009)**	**(44,080)**

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' and others' equity at 1 April 2018 - brought forward	**224,671**	**25,096**	**(252,566)**	**(2,799)**
Prior period adjustment	-	-	-	**-**
Taxpayers' and others' equity at 1 April 2018 - restated	**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' and others' equity at 31 March 2019	**226,023**	**52,532**	**(303,004)**	**(24,449)**

Information on reserves

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

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

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

Statement of Cash Flows

	Note	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating Deficit		(19,885)	(47,657)
Non-cash income and expense:			
Depreciation and amortisation	7.1	9,072	8,406
Net impairments	8	1,664	799
Income recognised in respect of capital donations	4	(204)	(77)
(Increase) / decrease in receivables and other assets		(16,233)	987
(Increase) / decrease in inventories		(990)	976
Increase / (decrease) in payables and other liabilities		6,551	(8,230)
Increase / (decrease) in provisions		276	(447)
Net cash flows from / (used in) operating activities		**(19,749)**	**(45,243)**
Cash flows from investing activities			
Interest received		79	63
Purchase of intangible assets		(5,837)	(416)
Purchase of PPE and investment property		(12,733)	(11,312)
Receipt of cash donations to purchase assets		204	77
Net cash flows from / (used in) investing activities		**(18,287)**	**(11,588)**
Cash flows from financing activities			
Public dividend capital received		1,293	1,352
Movement on loans from DHSC		43,301	57,040
Interest on loans		(4,016)	(2,438)
Other interest		(40)	-
PDC dividend (paid) / refunded		-	157
Net cash flows from / (used in) financing activities		**40,538**	**56,111**
Increase / (decrease) in cash and cash equivalents		**2,502**	**(720)**
Cash and cash equivalents at 1 April - brought forward		**2,858**	**3,578**
Prior period adjustments			-
Cash and cash equivalents at 1 April - restated		**2,858**	**3,578**
Cash and cash equivalents at 31 March	20.1	**5,360**	**2,858**

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 2019-20 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. 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.

1.2.1 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 £22.5m in 2019/20, and expectation of future financial support. The Trust's Annual Plan process for 2020/21 is on hold due to the Corona virus (covid-19) outbreak in the UK and worldwide as Trust responds to the emergency needs to its patients. Currently the Trust has agreements with its commissioners, a block contract (fixed funding for providing healthcare to its patients). These block contracts have been agreed to 31 July 2020. All Covid-19 related expenditure for capital and revenue to be funded separately by NHS England. Additional funding will be available for the Trust to achieve break-even to 31 July if there is a monthly income and expenditure deficit during this period.
  The Annual Plan preparation and agreement with NHS Improvement will resume in due course. The Trust control total signalled by NHSI is to break-even in 2020/21. Both Provider Sustainability and Finance Recovery Funding (PSF and FRF) will be included in the contracts agreed with commissioners to provide healthcare.

  NHSI have written to all NHS entities on the 27 May 2020 confirming that though contracting arrangements are not in place for rest of 2020/21 and beyond, the Government has issued mandate to NHS England for the continued provisions of services in England in 2020/21. Clinical Commissioning Groups allocations and sufficient funding has been set for the remainder of 2020/21. Providers can therefore continue to expect NHS funding to flow for similar to that previously, provided services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitely in place, it is clear that NHS services will continue to be funded, and government funding is in place for this.

  Directors are not seeking any cash support for revenue but the Trust is likely to submit a request for £4.8m in 2020/21 to support the capital expenditure plan. NHSI has not, at the date of our report, confirmed that they will provide this support. On 2 April 2020, DHSC and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £237,761,000 are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the trust.

  All these factors have improved the finances of the Trust and it'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 2019/20 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.

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

1.2.1 Critical judgements in applying accounting policies (continued)

- The risks and rewards of ownership of assets leased by the Trust rest with the leasing company, and rental payments are charged to the period to which they relate; see note 10.
- 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 crystallised 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 26.1
- Coronavirus (Covid-19) expenditure as agreed by NHS England and Improvement will be fully reimbursed in 2020/21. On this basis all Covid-19 expenditure will have matching accrued income from NHS England. Income will be disclosed in income from patient care activities see note 3.1.

1.2.2 Key sources of estimation uncertainty

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

- from 1 April 2013 income from commissioners for maternity care is received at commencement of the Care Pathway. An estimate of incompleted elements of the pathway has been deferred.
- the valuation of land and buildings using the modern equivalent asset discounted replacement cost method detailed in note 17.5. The basis of estimate for Watford site includes changes to internal area informed by new drawings and revised build dates.
- management have determined that it is appropriate for surplus assets to be held at nil value and not at fair value because they were held for their service potential and there are restrictions that would prevent the marketing of the assets for sale (ie. that they are specialist hospital buildings that are integral parts of the Trust's sites).
- The land at St Albans, Watford and Hemel Hempstead sites has been valued under the Modern Equivalent Asset (MEA) methodology in 2019/20. 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 2019/20, details of the impact of which can be found in note 17.5
- The Trust had its land and buildings valued in August 2019 with a valuation date of 01 April 2019 with a forecast to 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 (Red Book), the Trust's valuer has declared a "material valuation uncertainty" in the valuation report. This is on the basis of unknown future impact that Covid-19 pandemic might have on the real estate market. The valuers have provided additional clarification that the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. This clause is a disclosure, not a disclaimer. It is used in order to be clear and transparent with all parties, in a professional manner that in the current extraordinary circumstances less certainty can be attached to the valuation than would otherwise be the case. The values in the report have been used to inform the measurement of property assets as at 31 March 2020 within these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Given that there is no alternative information to suggest the valuations are materially incorrect, the Trust has assured itself that the values provided are an appropriate reflection of the assets worth within the financial statements.
- Sums from the Provider Sustainability Fund (PSF) and the Financial Recovery Fund (FRF) were allocated to the Trust by DHSC as it agree to a prescribed control total deficit in 2019/20 of £22.7m in the Annual Plan. PSF was not available in 2018/19 as the Trust did not sign up to the control total deficit of £7.9 in the Annual Plan.

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

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

1.3. 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 35.

1.4. 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 was 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.

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.

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.

Revenue grants and other contributions to expenditure

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

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

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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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

1.5. 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.

1.6. 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.

1.7. 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 (UK) Ltd (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 17.5.

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.

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

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.

1.8. 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 is 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.

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

1.9. 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 17.5.

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

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

In compliance with the DH Group Accounting Manual, from 2011-12, impairments relating to property, plant and equipment are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME). The analysis is used by the Department of Health in consolidating the accounts of NHS bodies. In summary, DELs set as part of NHS spending are not expected to be exceeded. AME is less predictable and, subject to Treasury approval, may be revised. The related Trust impairment is classified as AME and is detailed in note 17.5.

1.10. 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.

1.11. 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.

1.12. Useful economic lives of Assets:

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 tables below:

Property,Plant and Equipment

	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.

Intangible assets

	Min life Years	Max life Years
Information technology	1	8
Development expenditure	1	8
Software licences	1	8

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

1.13. 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.

1.14. 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.

1.15. 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.

1.16. 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 in the Statement of Financial Position 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 0.5%, 5 to 10 years at 0.55% and beyond 10 years at 1.99%. Those relating to employee early retirement obligations are discounted at minus 0.50%.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the amount 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)

1.17. 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 26.2.

1.18. 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.

1.19. 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.

1.20. 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.

1.21. 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.

1.21.1 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.

1.21.2 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 1.4.

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.

1.21.3 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.

1.22. 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)

1.23. 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.

1.24. 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.

1.25. 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 value 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.

1.26. 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).

1.27. 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.

1.28. 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 2019/20. 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* – Standard is effective at 1 April 2021 per the FReM
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023 but not yet adopted by the FReM: early adoption is not therefore permitted.

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 1.4

Note 3.1 Income from patient care activities (by nature)	**2019/20 £000**	**2018/19 £000**
Elective income	51,227	52,719
Non elective income	119,388	107,422
First outpatient income	38,815	36,634
Follow up outpatient income	32,327	31,692
A & E income	20,820	17,645
High cost drugs income from commissioners (excluding pass-through costs)	11,198	11,542
Other NHS clinical income	49,011	43,161
All services		
Private patient income	903	763
Agenda for Change pay award central funding*	-	3,408
Additional pension contribution central funding**	9,579	-
Other clinical income***	4,021	2,762
Total income from activities	**337,289**	**307,748**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

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

***Other clinical income includes £1,310k of covid-19 income from NHS England to match expenditure in 2019/20.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2019/20 £000**	**2018/19 £000**
NHS England	32,545	22,258
Clinical commissioning groups	301,882	278,196
Department of Health and Social Care	-	3,408
Other NHS providers	427	361
NHS other	1	197
Non-NHS: private patients	903	763
Non-NHS: overseas patients (chargeable to patient)	545	544
Injury cost recovery scheme	949	1,098
Non NHS: other	37	923
Total income from activities	**337,289**	**307,748**
Of which:		
Related to continuing operations	337,289	307,748
Related to discontinued operations	-	-

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

	2019/20	2018/19
	£000	£000
Income recognised this year	545	544
Cash payments received in-year	207	153
Amounts added to provision for impairment of receivables*	513	383
Amounts written off in-year**	471	80

* The provision for overseas visitors' impairment relates to invoices over 90 days old.
** Only £36,000 written-off relate to 2019/20 invoices.

Note 4 Other operating income

	2019/20			2018/19		
	Contract income	contract income	Total	Contract income	contract income	Total
	£000	£000	£000	£000	£000	£000
Education and training	10,170	265	**10,435**	10,014	128	**10,142**
Non-patient care services to other bodies	15,498	-	**15,498**	12,887	-	**12,887**
Provider sustainability fund (PSF) - see note 6.1	8,337	-	**8,337**	-	-	**-**
Financial recovery fund (FRF) - see note 6.1	14,807	-	**14,807**	-	-	**-**
Marginal rate emergency tariff funding (MRET)	4,648	-	**4,648**	-	-	**-**
Receipt of capital grants and donations	-	204	**204**	-	77	**77**
Charitable and other contributions to expenditure	-	-	**-**	-	26	**26**
Other income	2,457	-	**2,457**	2,487	-	**2,487**
Total other operating income	**55,917**	**469**	**56,386**	**25,388**	**231**	**25,619**
Of which:						
Related to continuing operations			**56,386**			**25,619**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,626	1,529

Note 5.1 Transaction price allocated to remaining performance obligations
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
HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2019/20	2018/19
	£000	£000
Income	2,102	2,128
Full cost	(1,911)	(1,811)
Surplus	**191**	**317**

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 funding from Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) in 2019/20 of £23.1m. In 2018/19 the Trust received no funding for PSF as it had not agreed to the control total deficit of £7.9m.

*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. Car parking income is received net of operator charges.

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

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies - see i) below	5,193	5,377
Purchase of healthcare from non-NHS and non-DHSC bodies - see ii) below	6,051	4,314
Purchase of social care	-	94
Staff and executive directors costs	271,838	246,608
Remuneration of non-executive directors	85	77
Supplies and services - clinical (excluding drugs costs)	29,614	31,168
Supplies and services - general	15,368	13,939
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	22,172	22,896
Consultancy costs - see iii) below	1,938	1,110
Establishment	3,816	3,854
Premises	21,655	17,505
Transport (including patient travel)	551	522
Depreciation on property, plant and equipment	8,647	8,012
Amortisation on intangible assets	425	394
Net impairments - see iv) below	1,664	799
Movement in credit loss allowance: contract receivables / contract assets - see below v)	230	265
Increase/(decrease) in other provisions	545	-
Change in provisions discount rate(s)	253	(35)
Audit fees payable to the external auditor		
audit services- statutory audit	62	49
other auditor remuneration (external auditor only) - see vi) below	9	7
Internal audit costs	118	142
Clinical negligence - see vii) below	16,353	16,687
Legal fees	185	123
Insurance	185	190
Education and training	1,309	1,172
Rentals under operating leases	481	532
Redundancy - see viii) below	16	296
Hospitality	66	26
Losses, ex gratia & special payments	31	46
Other - see ix) below	4,700	4,855
Total	**413,560**	**381,024**
Of which:		
Related to continuing operations	413,560	381,024

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 2019/20 and 2018/19.

iv) The Trust's revaluation of its land and buildings in 2019/20 and 2018/19 has generated impairments. See notes 17.5 and 1.2.2 for further details.

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 included cost of redundancies made in year due to outsourcing of payroll services to Northumbria Healthcare NHS Foundation Trust.

ix) Other expenditure includes the following services:

- £447,000 for security
- £332,000 for external accommodation
- £405,000 for storage rentals
- £364,000 subscriptions
- £599,000 for waste disposal

Note 7.2 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
Other non-audit services - Quality Accounts Review	9	7
Total	**9**	**7**

Note 7.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 8 Impairment of assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	1,664	799
Total net impairments charged to operating surplus / deficit	**1,664**	**799**
Total net impairments	**1,664**	**799**

2019/20 impairments relates to buildings at the Trust. No impairment on intangible assets in 2019/20 is incurred. The analysis by site of the impairment on property, plant and equipment is shown in note 17.5.

Note 9 Employee benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	176,084	165,354
Social security costs	19,647	18,206
Apprenticeship levy*	840	845
Employer's contributions to NHS pensions	31,537	20,447
Pension cost - other	-	19
Temporary staff (including agency)**	44,401	42,033
Total staff costs	**272,509**	**246,904**
Of which		
Costs capitalised as part of assets	655	-

*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 payment 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 2019/20, the apprentice levy together with the top up from government is shown as expenditure in the year.

** Agency costs in 2019/20 is £13.7m (£14.9m in 2018/19) for those engaged directly from agencies. The remaining costs is for directly registered temporary staff with NHS Professionals Ltd. The Trust has outsourced temporary staffing to NHS Professionals Ltd.

Note 9.1 Retirements due to ill-health

During 2019/20 there were 3 early retirements from the trust agreed on the grounds of ill-health (2 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £181k (£224k in 2018/19).

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

Note 9.2 Staff Numbers

The average number of staff employed at the Trust during 2019/20 was 5,067 of which 4,401 were permanently employed. This compares to 4,951 total average number of staff employed in 2018/19. Further details on staff numbers are reported in remuneration and staff section of the annual report.

Note 9.3 Staff Sickness Absence

For further details on average staff sickess per day in 2019/20 please refer to https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates. An average of 7.16 working days were lost per staff member in 2018/19.

Note 9.4 Exit Packages agreed in 2019/20

The total number of exit packages agreed in 2019/20 was 32 compared to 22 for 2018/19. 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 2019/20

The total number of other departures in exit packages agreed in 2019/20 was 30 compared to 19 for 2018/19. Further details on other departures in exit packages are reported in remuneration and staff section of the annual report.

Note 10 Pension costs

NHS Pension Scheme

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 employer contribution rate for 2019/20 is 20.6%, and the Scheme Regulations were amended accordingly.

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

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.

NEST Pension Scheme
Where staff are not eligible for, or choose to opt out of, the NHS Pensions Scheme, they are entitled to join the National Employment Savings Trust (NEST) scheme.
NEST is a government-backed, defined contribution pension scheme set up to make sure that every employer can easily access a workplace pension scheme.
The employer's contribution rate in 2019/20 was 3% (2018/19: 2%).

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,
- The equipment when returned is complete and in reasonable condition.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	481	532
Total	**481**	**532**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	416	456
- later than one year and not later than five years;	474	731
- later than five years.	-	1
Total	**890**	**1,188**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

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

	2019/20	2018/19
	£000	£000
Interest on bank accounts	85	69
Total finance income	**85**	**69**

Note 13.1 Finance expenditure

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

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	4,183	2,905
Interest on late payment of commercial debt	40	(67)
Total interest expense	**4,223**	**2,838**
Unwinding of discount on provisions	(18)	12
Other finance costs	-	-
Total finance costs	**4,205**	**2,850**

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

	2019/20	2018/19
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	40	(67)

Note 14 Other gains / (losses)

There are no gains or losses on disposals in 2019/20 or 2018/19

Note 15 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2020 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 16.1 Intangible assets - 2019/20

	Software licences £000	Internally generated information technology £000	Development expenditure £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	**1,148**	**7,051**	**1,421**	**980**	**10,600**
Additions	-	-	-	5,837	**5,837**
Reclassifications	79	1,738	(1,269)	(548)	**-**
Valuation / gross cost at 31 March 2020	**1,227**	**8,789**	**152**	**6,269**	**16,437**
Amortisation at 1 April 2019 - brought forward	**383**	**6,903**	**-**	**-**	**7,286**
Provided during the year	392	33	-	-	**425**
Amortisation at 31 March 2020	**775**	**6,936**	**-**	**-**	**7,711**
Net book value at 31 March 2020	**452**	**1,853**	**152**	**6,269**	**8,726**
Net book value at 1 April 2019	**765**	**148**	**1,421**	**980**	**3,314**

Note 16.2 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 - as previously stated	**1,148**	**7,051**	**1,421**	**564**	**10,184**
Valuation / gross cost at 1 April 2018 - restated	**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 - as previously stated	**-**	**6,892**	**-**	**-**	**6,892**
Amortisation at 1 April 2018 - restated	**-**	**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 17.1 Property, plant and equipment - 2019/20

	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 2019 - brought forward	**62,807**	**94,081**	**136**	**18,141**	**45,013**	**176**	**14,949**	**2,874**	**238,177**
Additions	-	-	-	15,460	-	-	-	-	**15,460**
Impairments	-	(8,975)	-	-	-	-	-	-	**(8,975)**
Reversals of impairments	-	2,067	-	-	-	-	-	-	**2,067**
Revaluations	-	5,345	(22)	-	-	-	-	(2,242)	**3,081**
Reclassifications	-	5,323	4	(11,244)	3,555	15	-	2,347	**-**
Disposals / derecognition	-	-	-	-	(2,554)	(31)	-	-	**(2,585)**
Valuation/gross cost at 31 March 2020	**62,807**	**97,841**	**118**	**22,357**	**46,014**	**160**	**14,949**	**2,979**	**247,225**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**7,636**	**27**	**-**	**34,243**	**176**	**13,163**	**370**	**55,615**
Provided during the year	-	5,501	30	-	2,474	1	480	161	**8,647**
Impairments	-	(5,070)	(27)	-	-	-	-	(147)	**(5,244)**
Disposals / derecognition	-	-	-	-	(2,554)	(31)	-	-	**(2,585)**
Accumulated depreciation at 31 March 2020	**-**	**8,067**	**30**	**-**	**34,163**	**146**	**13,643**	**384**	**56,433**
Net book value at 31 March 2020	**62,807**	**89,774**	**88**	**22,357**	**11,851**	**14**	**1,306**	**2,595**	**190,792**
Net book value at 1 April 2019	**62,807**	**86,445**	**109**	**18,141**	**10,770**	**-**	**1,786**	**2,504**	**182,562**

Note 17.2 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 - as previously stated	**42,168**	**83,457**	**182**	**17,898**	**44,217**	**176**	**15,023**	**2,586**	**205,707**
Valuation / gross cost at 1 April 2018 - restated	**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	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
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 - as previously stated	**-**	**6,900**	**30**	**-**	**33,767**	**176**	**12,757**	**353**	**53,983**
restated	**-**	**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**
Net book value at 1 April 2018	**42,168**	**76,557**	**152**	**17,898**	**10,450**	**-**	**2,266**	**2,233**	**151,724**

Note 17.3 Property, plant and equipment financing - 2019/20

	Land £000	excluding £000	Dwellings £000	construction £000	machinery £000	equipment £000	technology £000	& fittings £000	Total £000
Net book value at 31 March 2020									
Owned - purchased	62,807	89,597	88	22,153	11,610	14	1,306	2,595	**190,170**
Owned - donated	-	177	-	204	241	-	-	-	**622**
NBV total at 31 March 2020	**62,807**	**89,774**	**88**	**22,357**	**11,851**	**14**	**1,306**	**2,595**	**190,792**

Note 17.4 Property, plant and equipment financing - 2018/19

	Land £000	excluding £000	Dwellings £000	construction £000	machinery £000	equipment £000	technology £000	& fittings £000	Total £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 17.5 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 (UK) Ltd (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 July 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 2019/20 a desk top valuation has been carried out by Avison Young (UK) Ltd (formerly knowm as GVA Grimley Ltd). The last full valuation was carried out in the year 2018/19.

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 2019/20 which has given no change in the valuation.

The Trust had its land and buildings valued in August 2019 with a valuation date of 01 April 2019 with a forecast to 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 (Red Book), the Trust's valuer has declared a "material valuation uncertainty" in the valuation report. This is on the basis of unknown future impact that Covid-19 pandemic might have on the real estate market. The valuers have provided additional clarification that the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. This clause is a disclosure, not a disclaimer. It is used in order to be clear and transparent with all parties, in a professional manner that in the current extraordinary circumstances less certainty can be attached to the valuation than would otherwise be the case. The values in the report have been used to inform the measurement of property assets as at 31 March 2020 within these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. Given that there is no alternative information to suggest the valuations are materially incorrect, the Trust has assured itself that the values provided are an appropriate reflection of the assets worth within the financial statements.

	Watford Hospital	Hemel Hempstead Hospital	St Albans Hospital	Total
	2019/20			
	£000s	£000s	£000s	£000s
Operating expenses - note 7.1				
Buildings, dwellings and fittings - MEA	1,956	(24)	(268)	1,664
Total	1,956	(24)	(268)	1,664
Statement of change in taxpayers equity				
Buildings, dwellings and fittings - MEA	(582)	(2,122)	(377)	(3,081)
	(582)	(2,122)	(377)	(3,081)
Total impairment/(reversal) 2019-20	1,374	(2,146)	(645)	(1,417)
	2018/19			
	£000s	£000s	£000s	£000s
Operating expenses - note 7.1				
Land - MEA	0	0	0	0
Buildings, dwellings and fittings - MEA	2,411	(804)	(808)	799
Total	2,411	(804)	(808)	799
Statement of change in taxpayers equity				
Land - MEA	(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)

The impairment charged to operating expenses is classified as annually managed expenditure for the purposes of NHS consolidated accounts - see note 1.9.

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 1.9 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 1.7). Property Plant and Equipment includes £38.2m of fully depreciated assets.

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

	As at 31 March 2020		As at 31 March 2019	
Asset Class	Maximum remaining asset life Years	Minimum remaining asset life Years	Maximum remaining asset life Years	Minimum remaining asset life Years
Buildings	**43**	**1**	44	1
Dwellings	**3**	**3**	4	4
Plant and machinery	**14**	**1**	10	1
Transport	**6**	**6**	1	1
Information Technology	**6**	**1**	7	2
Furniture and Fittings	**43**	**1**	44	1

The valuation exercise included revision to the remaining asset lives of some buildings and their fittings, consequently the maximum remaining lives between 31 March 20 and 31 March 19 do not necessarily reduce by one year. Cherry Tree House is the only dwelling in both 2019/20 and 2018/19.
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 crèche 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 2020 £000	31 March 2019 £000
Drugs	1,690	1,134
Consumables	3,554	3,210
Energy	197	107
Total inventories	**5,441**	**4,451**
of which:		

Inventories recognised in expenses for the year were £37,729k (2018/19: £39,024k). Write-down of inventories recognised as expenses for the year were £0k (2018/19: £0k).

Note 19.1 Receivables

	2020 £000	2019 £000
Current		
Contract receivables	32,936	17,779
Allowance for impaired contract receivables / assets	(2,522)	(2,475)
Prepayments (non-PFI)	3,578	2,659
Interest receivable	12	6
VAT receivable	1,326	1,163
Total current receivables	**35,330**	**19,132**
Non-current		
Contract assets	1,834	1,793
Total non-current receivables	**1,834**	**1,793**
Of which receivable from NHS and DHSC group bodies:		
Current	27,652	13,719

Note 19.2 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,475**	**-**	**-**	**2,340**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			2,340	(2,340)
New allowances arising	230	-	265	-
Utilisation of allowances (write offs)	(183)	-	(130)	-
Allowances as at 31 Mar 2020	**2,522**	**-**	**2,475**	**-**

Allowances for credit losses is for Non NHS, over 90 days and all classified under contract receivables and contract assets.
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 2019/20. Provisions will form part of the Agreement of Balance exercise.

Note 19.3 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.

	2019/20	2018/19
	£000	£000
At 1 April	**2,858**	**3,578**
Net change in year	2,502	(720)
At 31 March	**5,360**	**2,858**
Broken down into:		
Cash at commercial banks and in hand	52	48
Cash with the Government Banking Service	5,308	2,810
Total cash and cash equivalents as in SoFP	**5,360**	**2,858**
Total cash and cash equivalents as in SoCF	**5,360**	**2,858**

Note 20.2 Third party assets held by the trust
There are no third party assets by the trust in 2019/20 and 2018/19

Note 21.1 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	13,285	11,747
Capital payables	7,269	4,542
Accruals	21,196	11,918
Social security costs	38	2,624
Other taxes payable	45	2,297
Other payables	3,199	2,929
Total current trade and other payables	**45,032**	**36,057**
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	5,255	4,136
Non-current	-	-

Note 21.2 Early retirements in NHS payables above

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

Note 22 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,929	1,626
Total other current liabilities	**1,929**	**1,626**
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC*	237,761	76,741
Total current borrowings	**237,761**	**76,741**
Non-current		
Loans from DHSC	-	117,552
Other loans	2,000	2,000
Total non-current borrowings	**2,000**	**119,552**

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

*All borrowings related to DHSC will be converted to PDC in 2020/21 a total of £237,761,000 and hence classified under current borrowings. There is accrued interest of £1,025,000 payable included in 2019/20. In 2018/19 there was £857,000 interest accrued under IFRS 9.

Other borrowings:

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

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

** The Watford Health Campus is the regeneration of the land surrounding the Watford General Hospital.

Note 23.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2019	**194,293**	**2,000**	**196,293**
Cash movements:			
Financing cash flows - payments and receipts of principal	43,301	-	**43,301**
Financing cash flows - payments of interest	(4,016)	-	**(4,016)**
Non-cash movements:			
Application of effective interest rate	4,183	-	**4,183**
Carrying value at 31 March 2020	**237,761**	**2,000**	**239,761**

Note 23.3 Reconciliation of liabilities arising from financing activities - 2018/19

	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**

Note 24 Other financial liabilities

The Trust has no other payables or financial liabilities.

Note 25 Finance leases

Note 25.1 West Hertfordshire Hospitals NHS Trust as a lessor or lessee

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

Note 26.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2019	**4,287**	**204**	**92**	**4,583**
Change in the discount rate	**253**	**-**	**-**	**253**
Arising during the year	**501**	**-**	**55**	**556**
Utilised during the year	(491)	(24)	(7)	**(522)**
Reversed unused	**(11)**	**-**	**-**	**(11)**
Unwinding of discount	**(17)**	**(1)**	**-**	**(18)**
At 31 March 2020	**4,522**	**179**	**140**	**4,841**
Expected timing of cash flows:				
- not later than one year;	505	25	**140**	**670**
- later than one year and not later than five year	4,017	154	**-**	**4,171**
- later than five years.	-	-	**-**	**-**
Total	**4,522**	**179**	**140**	**4,841**

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 26.2 Clinical negligence liabilities

At 31 March 2020, £426,834k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Hertfordshire Hospitals NHS Trust (31 March 2019: £437,959k).

Note 27 Contingent assets and liabilities

The Trust has no contingent assets and liabilities.

Note 28 Contractual capital commitments

	2020	2019
	£000	£000
Property, plant and equipment	1,233	642
Intangible assets	1	95
Total	**1,234**	**737**

Note 29 Other financial commitments

The Trust has no other financial commitments.

Note 30 Financial instruments

Note 30.1 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 2020 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 £12.7m in 2019/20 (£4.1m in 2018/19) approved by the Department of Health and Social Care to fund capital projects. In the year 2019/20 the Trust had access to Uncommitted Single Currency Interim Revenue and Support Facility. In 2020/21 the government is writing off all the DHSC loans. This will improve the Statement of Financial Position and liquidity of the Trust.

Note 30.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial ass	32,260	-	-	**32,260**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents	5,360	-	-	**5,360**
Total at 31 March 2020	**37,620**	**-**	**-**	**37,620**

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

Note 30.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	237,761	-	**237,761**
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	44,949	-	**44,949**
Total at 31 March 2020	**284,710**	**-**	**284,710**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	194,293	-	**194,293**
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	31,109	-	**31,109**
Total at 31 March 2019	**227,402**	**-**	**227,402**

Note 30.4 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	282,710	107,850
In more than one year but not more than two years	-	48,026
In more than two years but not more than five years	-	57,071
In more than five years	2,000	14,455
Total	**284,710**	**227,402**

*All DHSC loans will be written off in 2020/21 with a value of £237,761,000 and therefore have been classified as in one year or less.

Note 30.5 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 31 Losses and special payments

	2019/20		2018/19	
	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	407	570	50	130
Total losses	**407**	**570**	**52**	**143**
Special payments				
Ex-gratia payments	42	31	52	33
Total special payments	**42**	**31**	**52**	**33**
Total losses and special payments	**449**	**601**	**104**	**176**
Compensation payments received				-

No single item over £300,000

Note 32 Gifts

No gifts were made in the year.

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:

Department of Health and Social Care

Foundation Trusts
Chelsea and Westminster NHS Foundation Trust
Hertfordshire Partnership NHSFT

Trusts
Central London Community Healthcare NHST
Barts Health NHS Trust
East & North Hertfordshire NHS Trust
Hertfordshire Community NHS Trust

Clinical Commissioning Groups (CCG)
Barnet CCG
Bedfordshire CCG
Brent CCG
Buckingham CCG
East and North Hertfordshire CCG
Harrow CCG
Herts Valley CCG
Hillingdon CCG
Luton CCG
West Essex CCG

NHS England
NHS England Core
Central Midlands Local Office
East Local Office
NHS England - Central Specialised Commissioning Hub

Special Health Authorities
Health Education England
NHS Litigation Authority
NHS Blood & Transplant

Other Government Bodies
HM Revenue and Customs
NHS Pension Scheme
NHS Professionals
Department of Work and Pensions
Watford Borough Council

West Hertfordshire Hospitals Charity (Raise) - see note 34 for details

Note 34 West Hertfordshire Hospitals NHS Trust Charity Activities

(Unaudited)	2019/20 £000s	2018/19 £000s
Income	611	320
Expenditure	(587)	(430)
Net Incoming/Outgoing Resources Before Transfers	24	(110)
Investment Assets	(41)	18
Funds b/fwd	949	1,041
Funds c/fwd - Net Assets	932	949

The Trust does not consolidate charitable funds into the financial statements. Please refer to Note 1.3.

Note 35 Events after the reporting date

On 2 April 2020, the DHSC and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 exisiting DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interims loans totalling £237,761,000 as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

The current Coronavirus (Covid-19) global pandemic as declared by the World Health Organisation has affected the Trust's normal operations.The Trust has dedicated majority of its resources to emergency care and made alternative arrangements for the treatment of urgent, cancer and long waiting patients. Digital technology has supported the remote care of routine elective patients.

The Trust from 1 April 2020 to 31 July 2020 is being funded by block contracts (fixed income for patient care activity) from its commissioners plus a top up payment for any residual deficit. All Covid-19 related expenditure, both capital and revenue will be funded separately in 2020/21. It is expected for the duration of the crisis the Trust will breakeven on its finances.

Note 36 Better Payment Practice code

	2019/20	2019/20	2018/19	2018/19
Non-NHS Payables	**Number**	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	64,586	164,370	64,913	145,312
Total non-NHS trade invoices paid within target	46,617	98,183	43,080	86,112
Percentage of non-NHS trade invoices paid within target	72.2%	59.7%	66.4%	59.3%
NHS Payables				
Total NHS trade invoices paid in the year	2,984	28,588	2,466	11,887
Total NHS trade invoices paid within target	1,507	12,833	1,060	3,906
Percentage of NHS trade invoices paid within target	50.5%	44.9%	43.0%	32.9%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 37 External financing limit

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

	2019/20	2018/19
	£000	**£000**
Cash flow financing	42,092	59,112
Finance leases taken out in year		
Other capital receipts		
External financing requirement	**42,092**	**59,112**
External financing limit (EFL)	44,592	59,370
Under / (over) spend against EFL*	**2,500**	**258**

* Undershoot on EFL is due to PSF monies of £2.5m agreed with DHSC to be repaid in 2020/21.

Note 38 Capital Resource Limit

	2019/20	2018/19
	£000	**£000**
Gross capital expenditure	21,297	12,629
Less: Donated and granted capital additions	(204)	(77)
Charge against Capital Resource Limit	**21,093**	**12,552**
Capital Resource Limit	21,093	12,552
Under / (over) spend against CRL	**-**	**-**

Note 39 Breakeven duty financial performance

	2019/20
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(22,471)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2018/19 post-accounts PSF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	**(22,471)**

Note 40 Breakeven duty rolling assessment

	1997/98 to 2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000
Breakeven duty in-year financial performance		5,699	7,530	3,657	1,904	(13,370)
Breakeven duty cumulative position	(4,513)	1,186	8,716	12,373	14,277	907
Operating income		254,308	260,398	266,716	278,230	291,119
Cumulative breakeven position as a percentage of operating income		0.5%	3.3%	4.6%	5.1%	0.3%

	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000
Breakeven duty in-year financial performance	(13,837)	(41,155)	(29,431)	(41,352)	(49,641)	(22,471)
Breakeven duty cumulative position	(12,930)	(54,085)	(83,516)	(124,868)	(174,509)	(196,980)
Operating income	313,291	299,769	322,643	324,772	333,367	393,675
Cumulative breakeven position as a percentage of operating income	(4.1%)	(18.0%)	(25.9%)	(38.4%)	(52.3%)	(50.0%)

i) The adjusted deficit for break-even duty in the year is after adjustments shown in note 39.

ii) In line with note 1.10 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 sixth year of consecutive break-even duty breach achieving a cumulative deficit of £196,980,000 (-50.0% 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. It is planned to breakeven in year in 2020/21 subject to agreement of the Annual Plan with NHS Improvement.

West Hertfordshire Hospitals NHS Trust

The charity dedicated to supporting patient care across Watford General, Hemel Hempstead and St Albans City hospitals https://www.westhertshospitals.nhs.uk/raise/